



NEWSLETTER OF THE MEDICAL COUNCIL OF NEW ZEALAND

Chairman's foreword



Workplace bullying – everyone's responsibility

Workplace bullying. We know intuitively what it is, we may well have experienced it personally and we have probably witnessed it at some stage.

Bullying and harassment – where are we now?

Dr Kenneth Clark, Chair, New Zealand District Health Boards Chief Medical Officers Group, writes about bullying and efforts to stop it in the workplace.

Bullying, harassment and inappropriate behaviour within health

Dr Deborah Powell, National Secretary, New Zealand Resident Doctors' Association, writes, 'Since our profession was confronted by the depth and significance of this issue within our own ranks ...'

Choosing Wisely

Choosing Wisely is a new campaign that encourages health professionals to talk to patients about unnecessary tests ...

Social media: To use or not use, that is the question

Let us know what you think about the Council using Twitter or Facebook or keep in touch with you.

Concerns about a doctor's health, conduct or competence

Find out what to do if you have concerns about a colleague.

Strategic directions update

Find out more about Council's initiatives on issues such as cultural competence, prevocational training requirements, recertification and community placements for interns.

Keeping up to date

Read about changes to Council's statements on issues such as providing care to yourself and those close to you.

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CHAIRMAN'S FOREWORD

In this issue of *Medical Council News*, we look at workplace bullying. It's an issue that is everyone's responsibility and something we should all have zero tolerance for.

Doctors Ken Clark, Chair, New Zealand District Health Boards Chief Medical Officers Group, and Deborah Powell, National Secretary, New Zealand Resident Doctors' Association, share their perspectives on bullying with us.

We've recently published a number of new or revised statements on providing care to yourself and those close to you, advertising, telehealth and the use of the internet, which I'd encourage you to read.

Council is also currently looking at the use of social media to keep in touch with the profession, and I would be interested in any feedback you may have for us on this potential initiative.

As always, I would value any comments on the issues raised in this newsletter, which may be sent to me at chair@mcnz.org.nz

A handwritten signature in black ink, appearing to read 'Andrew Connolly'. The signature is stylized and cursive.

Andrew Connolly
Chairman
Medical Council of New Zealand



WORKPLACE BULLYING – EVERYONE'S RESPONSIBILITY

Workplace bullying. We know intuitively what it is, we may well have experienced it personally and we have probably witnessed it at some stage.

Sadly, perhaps because of a power imbalance, we've probably ignored workplace bullying for fear of the repercussions or not wanting to get involved.

Workplace bullying and the need to change a culture that turns a blind eye to it is everyone's responsibility, no matter where they work in the health care sector.

So what is workplace bullying?


WorkSafe New Zealand defines workplace bullying as:

"... repeated and unreasonable behaviour directed towards a worker or a group of workers that creates a risk to health and safety.

- Repeated behaviour is persistent and can involve a range of actions over time.
- Unreasonable behaviour means actions that a reasonable person in the same circumstances would see as unreasonable. It includes victimising, humiliating, intimidating or threatening a person.

A single incident of unreasonable behaviour is not considered workplace bullying, but it could escalate and should not be ignored."

Workplace
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responsibility



It is no longer
OK to be silent
about bad behaviour

Council has zero tolerance of any discrimination, bullying or sexual harassment

Council's view is that there should be zero tolerance of any discrimination, bullying or sexual harassment by all health practitioners. These things are not a rite of passage but actions that are totally unacceptable in any workplace. There is clear evidence that clinical care suffers if the culture of the workplace is poor.

Council is actively working with other stakeholders to shift attitudes that have been ignored or have simply been accepted as the norm.

Every health practitioner - students, interns, trainees, consultants and nurses and so on - needs to know that bad behaviour, whether in the theatre, recovery room, clinic, office or ward, is totally unacceptable.

We need to create a safe work environment that values and nurtures people and gives them the confidence to speak out about unsafe work practices without further intimidation or harassment.

It is no longer OK to be silent about bad behaviour.

Everyone has a responsibility to speak out on things that we know are wrong. We also all have a responsibility to support those being victimised. We have a lot of work to do to improve the culture of our workplaces and to create an environment where anyone can raise a concern. In a well-functioning culture, concerns would be openly discussed and resolved before issues escalate to a point where any formal action is required.

Finding solutions

There are a number of organisations, including Council, working collectively to address the issue of bad behaviour and change the culture of hospital workplaces.

These organisations include the New Zealand Resident Doctors' Association, the Association of Salaried Medical Specialists, the Council of Medical Colleges, the Ministry of Health, district health board chief medical officers and district health board human resource groups.

We all have to be part of the solution of making every workplace safe for the benefit of all health practitioners and patients alike.

Where to find help

There are organisations that can help you decide how to respond to workplace bullying. These include:

- [Association of Salaried Medical Specialists](#)
- [CultureSafe NZ](#)
- [Medical Protection Society](#)
- [New Zealand Resident Doctors' Association](#)
- [WorkSafe New Zealand](#)





BULLYING AND HARASSMENT – WHERE ARE WE NOW?

It is now well over a year since the landmark report from the expert advisory group to the Royal Australasian College of Surgeons (RACS) was published with respect to discrimination, bullying and sexual harassment within surgical disciplines.

Much discussion and activity followed, including the New Zealand Resident Doctors' Association (NZRDA) survey of its members that clearly indicated a significant level of inappropriate behaviours within the New Zealand health work environment.

So, where are we now?

The surgeons, both RACS itself and of course many specialists in their everyday practice, are still doing great work and, in fact, are leading the profession in this respect. RACS is working with District Health Boards in New Zealand and also working with some of the other Medical Colleges, particularly other procedural Colleges, with sharing of its resources and approaches.

This work is making a real difference and will continue to do so in the future.

Other Colleges are also developing their own approaches, building on the work of the College of Surgeons within their own contexts. The Ministry of Health has been leading a National Working Group, particularly focused on the medical profession working within District Health Boards. This group's activities appeared to be waning but have regained momentum recently.

A number of members of the group, along with some other individuals from the sector, have visited Victoria, Australia to look at a Cognitive Institute programme that might have relevance to the New Zealand environment and could be introduced into some of our District Health Boards. The 'medical' unions, the NZRDA and the Association of Salaried Medical Specialists are active in

this space while on the ground there does appear to be a genuine increase in awareness of bullying in particular, with some real changes occurring in professional behaviours.

While all of the above are clearly constructive, positive steps, we are far from 'there' yet and there are some reports of perhaps rather perverse behaviours arising.

For instance, it seems the days of the instrument-throwing doctor, whether that be in a theatre or anywhere else, are over, but it may be that we are seeing less overt, somewhat more sophisticated forms of inappropriate professional behaviours, whether this is by doctors or senior managers exhibiting manipulative behaviours, misrepresentation within references for resident doctors, subtle use of favouritism, and so on.

Anecdotally, there have also been cases where medical leaders have confronted doctors whom they believe are harassing or bullying other staff; when confronted in this manner, the individuals have then accused the medical leader of bullying behaviour. While our responses to criticism are seldom simple, this appears to be an interesting twist we perhaps hadn't thought may occur?!

On a more systemic basis across the profession, many are still observing that doctors, whether they be senior or resident medical officers, and for that matter medical students, are often still fixated with factual knowledge and technical skills, with a seemingly low awareness of broader domains of professional behaviours and their importance, especially in relation to team culture, respect, communication et cetera, et cetera.

How, then, does the doctor of today navigate and negotiate through all of this? The health care environment is challenging, with innumerable everyday stressors as well as ever increasing expectations from



patients, families, other staff, employers and society. Clearly the ongoing efforts of our professional Colleges, regulatory body and other organisations are important here, but doctors need time to practise medicine in the full breadth and span of that term, where all the various domains of professional behaviour can be developed and valued.

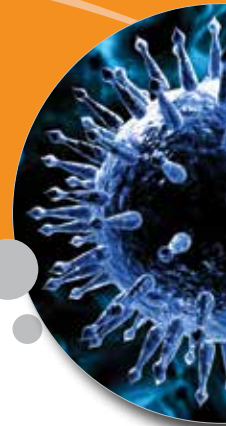
Doctors need time to do this, they need training to do this, and they need to work within organisations that are supportive, that have strong values, and with leaders who model these values and enable all the underpinnings of professionalism to thrive within the clinical workplace.

It seems then that there are good signs, but there is still much to be done and certainly we can't relax or take our focus away from the furthering of strong professional behaviours across the profession.

Dr Kenneth Clark

**Chair, New Zealand District Health Boards Chief
Medical Officers Group**



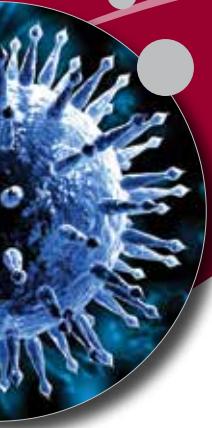


BULLYING, HARASSMENT AND INAPPROPRIATE BEHAVIOUR WITHIN HEALTH

Since our profession was confronted by the depth and significance of this issue within our own ranks just less than 2 years ago, we have seen not simply ownership of the problem, but material change for the better. We should all be proud to be part of a profession that can demonstrate such significant change for good. The New Zealand Resident Doctors' Association (NZRDA) wishes to thank the Royal Australasian College of Surgeons (RACS) specifically for their role, acknowledging the past and moving on to now include tangible and determinative systems to secure improvement. Their work has been graciously made available to us all, reducing the need for rework and giving us considered processes to work with.

The coming together of leading organisations within the profession to support and drive change is also testament to the commitment we have to do better, and is also acknowledged. In this forum concerns about 'overshooting the mark' with people becoming too afraid to raise criticism at all, were heard and the need to train in and support the giving and equally receiving of constructive criticism highlighted. So too the challenge for many of standing up; from those fearful of career repercussions, to those disempowered within our hierarchical structures. The impact on quality care when team members feel unable to speak up on a matter of safety, psychological or clinical, needs resolution.

For NZRDA, the ongoing use of confidential references is a current focus as these are a potent source of the fear of career retribution which in turn results in resident medical officers (RMOs) feeling unable to stand up and raise complaints. No longer a feature of medical school, confidential references first arise in the ACE (1st year house officer) appointment process. The perception that to 'rock the boat' will result in career suicide not only starts early in RMO-hood, it is very real to Resident Doctors; whilst confidential references continue to exist, we have no way of reassuring them that this perception is wrong.



The impact on quality care when team members feel unable to speak up on a matter of safety, psychological or clinical, needs resolution

Confidential references also fail to facilitate constructive criticism and feedback which is essential for a doctor's learning and remediation. So hand in hand with the abolition of confidential references is the need to ensure the adequacy of systems and skill sets to deliver appropriate feedback and support for the giving and receiving of constructive criticism, plus remedial action that may be required.

While the culture within our profession is something we can, and have owned, we are impacted by the culture around us also. As leaders in health, our ability to demonstrate a better way is immensely powerful, but we would gain support and more traction if the whole of the system was doing likewise. While sharing and extending of our learnings with the wider health community is under way, one thing is absolutely clear: to be effective, cultural change must be led from the top. If Boards or CEOs are going to accept inappropriate behaviour 'when it suits', health will continue to suffer, and with it, those giving and receiving care therein.

We believe the biggest challenge for our profession as we continue on this journey is maintaining our own momentum. But after that, challenging management to take a 'no blink' approach; to adequately address inappropriate behaviours including those within their own ranks that are too often excused as commercial or political reality. Managerialism must recognise and then confront its own demons, just as we have had to, if health as a whole is to be empowered to move forward.

Dr Deborah Powell

National Secretary, New Zealand Resident Doctors' Association





A COUNCIL OF MEDICAL COLLEGES
IN NEW ZEALAND CAMPAIGN

and part of Choosing Wisely work internationally.



CHOOSING WISELY

Choosing Wisely is a new campaign for New Zealand that encourages health professionals to talk to patients about unnecessary tests, treatments and procedures.

It is health professional led and is about providing the best quality of care for the patient.

The campaign is being run by the Council of Medical Colleges, in partnership with the Ministry of Health, Health Quality & Safety Commission and Consumer New Zealand. It is supported by many health sector groups.

Choosing Wisely is centred on helping patients make good choices and focuses on areas where evidence shows that a test, treatment or procedure provides little or no benefit to a patient and could even cause harm. These are not grey areas where evidence is debatable. Health professionals will be encouraged to discuss the risks and benefits of these tests with patients, so patients can make an informed choice.

Choosing Wisely encourages patients to ask their health professionals these four questions:

- Do I really need to have this test treatment or procedure?
- What are the risks?
- Are there simpler, safer options?
- What happens if I do nothing?

Council of Medical Colleges Chair Dr Derek Sherwood says there are a large number of medical tests, treatments and procedures available, but that doesn't always mean we should use them.

"For example, not only do X-rays and CT scans expose patients to potentially cancer-causing radiation, but many studies have shown scans frequently identify things that require further investigation but often turn out to be nothing. This means patients can undergo stressful and potentially risky follow-up tests and treatments for no reason.

"Other examples of tests and interventions to consider carefully before use are imaging for patients with non-specific acute lower back pain and avoiding prescribing antibiotics for upper respiratory tract infection."

Choosing Wisely
is centred on
helping patients
make good choices

He says there is evidence some inappropriate clinical interventions and treatments are being used in Australia and New Zealand.

"The common factors across countries that contribute to health professionals ordering unnecessary services include patient expectation, lack of consultation time, overall uncertainty and fear of missing a diagnosis or malpractice concerns, reimbursement incentives, the way health professionals are taught and avoiding the challenge of telling a patient they do not need specific tests. The result can be care for patients that adds little or no value and may cause harm."

Seventeen medical colleges and speciality societies in New Zealand have already developed recommendations about which tests, treatments and procedures should be avoided. These have





To try and make it easier for doctors to stay current with Council updates, we are looking at the possibility of using social media

been developed with health professional input and consultation after review of the evidence. Each recommendation is supported by evidence and resources to assist health professionals.

Dr Sherwood encourages health professionals to review the lists of tests, treatments or procedures to be questioned and act accordingly.

“It is important to talk with patients about the care that is being recommended and use shared decision making. This includes listening to the patient about their experience of illness, their social circumstances, attitude to risk and their goals, values, preferences and support needs.”

It is important to talk with patients about the care that is being recommended and use shared decision making

Patient education and engagement is an important part of *Choosing Wisely*, and the Council of Medical Colleges is working with Consumer New Zealand and other organisations to promote campaign messages and develop resources for consumers/patients.

The campaign will communicate these messages in a number of ways, including via a website, posters and other printed material, online advertising and on social media.

Quick link

- www.choosingwisely.org.nz

SOCIAL MEDIA: TO USE OR NOT USE, THAT IS THE QUESTION

We know from feedback doctors have given us that many doctors simply do not have the time to read all of the emails Council sends with news and other information such as updates to policies, statements and standards.

To try and make it easier for doctors to stay current with Council updates, we are looking at the possibility of using social media, for example, Facebook or Twitter, to communicate with doctors about consultations, new statements (or updates to existing ones) and other matters doctors need to know about.

We are undertaking a survey of a number of doctors to gauge their interest in Council using social media to communicate with the profession.

If you haven't been part of our survey but would like to let us know what you think, we would appreciate your feedback. This can be emailed to George Symmes, our Communications Manager, at gsymmes@mcnz.org.nz



Council encourages individual practitioners and health providers to notify Council of concerns about a doctor's competence or conduct

CONCERNS ABOUT A DOCTOR'S HEALTH, CONDUCT OR COMPETENCE

Council has a published statement on what to do if you have concerns about a colleague. At the end of this statement, there is a decision tree that is reprinted on the next page.

This decision tree indicates that there is an end to the process if you are satisfied that the responsible person or body has taken adequate action. However, it should be highlighted that, for situations where there is a responsible authority involved, it may be that there are obligations for that body to notify the Council.

These obligations are provided for in the memoranda of understanding (MOUs) that Council holds with DHBs, PHOs and private hospitals

Under section 34(3) of the Health Practitioners Competence Assurance Act 2003 (HPCAA), whenever a doctor resigns or is dismissed from his or her employment for reasons relating to competence, the employer of that doctor must notify the Council's Registrar.

Under section 34(1) of the HPCAA, any health practitioner who reasonably believes that a doctor may pose a risk of harm to the public by practising below the required standard of competence, may notify Council's Registrar of the concerns and the facts on which they are based.

In practice, in the context of the overarching statutory purpose of the Council to protect the health and safety of the public, Council encourages individual practitioners and health providers to notify Council of concerns about a doctor's competence or conduct:

- that have not been able to be addressed within a PHO or a contracted practice
- when a doctor has left a PHO or a contracted practice because of competence/conduct concerns
- when a doctor resigns or is expelled from a medical partnership.

Dr Kevin Morris

Medical Adviser, Medical Council of New Zealand

Quick link

- [Statement on *What to do when you have concerns about a colleague*](#)

DECISION TREE

1

If your colleague:

- behaves in a way that is not conducive to good team work or
- does not treat others fairly and with respect or
- makes malicious or unfounded criticisms of colleagues or
- is not readily available when on duty or
- does not handle a conflict of interest appropriately or
- does not keep colleagues well informed when sharing the care of patients or
- behaves in any other manner that you do not feel is appropriate or professional

Speak to them and raise your concerns in a constructive manner

Does your colleague respond appropriately and professionally?

Yes

End of process

2

If you have reason to believe that patients are, or may be, at risk of harm for any reason

Find out the facts

Follow your employer's procedures or policies, or tell an appropriate person or organisation straight away

Keep a record of your concerns and the steps you have taken

Are you satisfied that the responsible person or body has taken adequate action?

Yes

End of process

3

If there is an immediate risk to patients from a colleague and an external body needs to be alerted straight away (though in such cases you should also, at the same time or as soon as possible afterwards, make the appropriate local person or body aware of your concerns and the action you have taken)

- if there is no responsible person or body locally that you can report to or
- if you cannot raise the issue with the responsible person or body locally because you believe that they are part of the problem or
- if you have concerns about a colleague's competence or
- if you believe that a colleague is unable to perform the functions required to practise because of a physical or mental condition or
- if you are an intern supervisor and have a concern about an intern's suitability for registration or
- if you are a supervisor or a newly registered doctor and have a concern about deficiencies in a doctor's practice

Notify the Medical Council



Council will further encourage doctors and health organisations to establish and strengthen their partnership with Māori organisations

STRATEGIC DIRECTIONS UPDATE

Cultural competence

Cultural competence and genuine partnership with Māori are important aspects of achieving excellence in medical practice. Council is working collaboratively with Te Ohu Rata o Aotearoa (Te ORA) on a joint work programme focused on developing the cultural competence of doctors as a method of improving the experience of Māori within the health system and reducing the unacceptable inequities in health that exist between indigenous Māori and Pākehā populations. To further this, a symposium focusing on cultural competence, partnership and health equity will be held on 1 June 2017.

Prevocational training requirements

Council has implemented a number of changes to prevocational medical training over the past 2 years. The goal is to improve the quality of training of doctors in their first 2 years after graduating from medical school. A review of the implementation, led by Dr Ken Clark, Chair of the New Zealand District Health Boards Chief Medical Officers Group, has recently been completed.

[The prevocational medical training implementation review report](#) which has recently been published on the Council website, demonstrates that, overall, the

changes have been effectively implemented. Although it is too early to tell if it is achieving the long-term outcomes, the early indications are positive. The report notes that the changes are contributing to a change in culture and attitudes towards prevocational medical training.

Recertification

Council is enhancing its principle-based approach to recertification, emphasising the importance of evidence-based recertification that is led by the profession. A robust system is in place for recertification of doctors registered in a general scope of practice, which was implemented in 2012.

Council is now focusing on strengthening the recertification of vocationally registered doctors to ensure it aligns with Council's [Vision and principles for recertification for doctors in NZ](#). A consultation document was released in January 2017 proposing strengthened recertification requirements for vocationally registered doctors. Over 140 responses were received, and these will be considered prior to any decisions being made.

Community placements for interns

A key initiative is the introduction of one 3-month community-based clinical attachment for all interns in their first 2 years of practice. This is

being implemented in a step-wise fashion over the next few years. Completing a clinical attachment in a community setting will familiarise interns with the delivery of health care outside of the hospital setting. This will assist interns to understand the interface between community and secondary care, prepare them for future practice and stimulate graduates to think of ways in which the system could change to provide greater benefits for patients. Community attachments are not restricted to general practice, and we have attachments established in urgent care, mental health, hospice and integrated care.

Community attachments are now established in every DHB, and in 2017, we expect 30 percent of interns will complete a community attachment by the time they complete postgraduate year 2. By 2020, it is expected that all interns will complete a community attachment. Council views the community attachment initiative as a tangible step towards the implementation of the New Zealand Health Strategy.

A symposium focused on community attachments in prevocational training is scheduled to be held on 10 April 2017.





KEEPING UP TO DATE

Medical Council of New Zealand Advisory – changed or revised Council’s statements

Council’s statements are often used by the Health Practitioner Disciplinary Tribunal, professional conduct committees and the Health and Disability Commissioner as a standard by which to measure professional conduct. Because of this, it is imperative that you keep up to date with Council’s statements to ensure that you are practising within Council’s standards. These statements have been revised after extensive consultation with stakeholders and after consideration of international evidence and regulatory trends. The position taken by Council in each area is broadly in line with the views expressed by the overwhelming majority of submitters.

The Council has changed or revised the following statements:

- [Statement on providing care to yourself and those close to you](#)
- [Statement on advertising](#)
- [Statement on doctors and performance enhancing medicines in sport](#)
- [Statement on use of the internet and electronic communication](#)
- [Good medical practice](#)

You have an ongoing obligation to ensure that you keep up to date with Council’s statements. Please take some time to familiarise yourself with these.

Revised *Statement on providing care to yourself and those close to you*

The significant changes to this statement include the following:

- Defining key terms used in the statement such as ‘family member’, ‘those close to you’, ‘care’, ‘minor condition’ and ‘urgent situation’.
- Placing more emphasis on the doctor exercising their professional and objective judgement in circumstances where doctors must decide whether it is appropriate to treat family members or those close to the doctor.
- Clarifying Council’s position that doctors should not provide care to themselves or those close to the doctor in the vast majority of clinical situations.
- Explaining in more detail why Council believes it is essential for all doctors to have their own general practitioner.

- Clarifying that it is also inappropriate to provide recurring episodic treatment or ongoing management of an illness or condition to family members or those close to the doctor, even where that illness or condition is minor, and that another registered health practitioner must be responsible for treatment and management of those conditions.

Quick link

- [Statement on providing care to yourself and those close to you](#)



You have an ongoing obligation to ensure that you keep up to date with Council’s statements



Revised Statement on advertising

The significant changes to this statement include the following:

- Noting that testimonials can create an unrealistic expectation of outcomes in patients. As such, testimonials must not be used or quoted in your advertising or on any websites, social media forums or any other platforms you control that advertise your services.
- Defining ‘testimonials’ and pointing out that they are not limited to comments from patients but may also include feedback and endorsements from colleagues, other health care professionals, friends, family and other persons in the doctor’s network.
- Highlighting ways in which testimonials are provided and including guidance to doctors that you must not encourage patients to leave testimonials on websites or other platforms you control that advertise your or your practice’s services, nor should you encourage patients to submit testimonials about your or your practice’s services to third-party websites.

- Pointing out your responsibility to monitor regularly the contents of websites or platforms you control that advertise your or your practice’s services and to remove any testimonials that are posted there. However, you are not responsible for any unsolicited testimonials or comments that are published on another website or on social media.
- Replacing all references to the Advertising and Standards Authority’s (ASA) Therapeutic Services Advertising Code and the Therapeutic Products Advertising Code with the Therapeutic and Health Advertising Code, which came into effect on 1 September 2016. Key points from ASA’s new Code are outlined in the revised *Statement on advertising*.

Quick link

- [Statement on advertising](#)

Doctors and performance enhancing medicines in sport

The revised statement on *Doctors and performance enhancing medicines in sport* extends beyond prescribing in that it also covers situations where doctors administer, traffic or supply performance enhancing medicines or assist in doing so. It is intended to apply to doctors who provide care to individuals involved in recreational sporting activities in addition to professional athletes. The revised statement places a greater emphasis on ethical conduct and professionalism on the part of doctors and includes guidance on the use of dietary supplements and record keeping in a sporting context.

Quick link

- [Doctors and performance enhancing medicines in sport](#)





Revised Statement on the use of the internet and electronic communication

The significant changes to this statement include the following:

- You should not discourage patients from using the internet to research their condition or treatment but may need to remind them that internet research cannot take the place of an in-person consultation and that some information on the internet may well not have a clinically accepted foundation.
- You should exercise caution when publishing information where it can be accessed by members of the public. In particular, 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 and their families.

Quick link

- [Statement on the use of the internet and electronic communication](#)

Changes to Good medical practice

Our *Good medical practice* publication has been amended (page 37):

- by the deletion of the reference to our statement on *Confidentiality and public safety* (which has been withdrawn to reflect legislative changes)
- by the addition of our *Statement on telehealth*.

Quick link

- [Good medical practice](#)

