NEWSLETTER OF THE MEDICAL COUNCIL OF NEW ZEALAND

GOOD AFTERNOON

In this issue of *Medical Council News*, I reflect on how Council is taking a leadership role and stimulating debate amongst health organisations about the urgent need to address Māori health inequity.

We also profile the three new Council members – Drs Kate Baddock, Pamela Hale and Curtis Walker – as well as Dr Jonathan Fox who was reappointed to Council following the Council election earlier this year.

Other stories I hope will catch your attention include Dr Steven Lillis, one of the Council's medical advisers, who looks at concerns regarding the processing of laboratory results, while our other medical adviser, Dr Kevin Morris, offers some sage advice about making retrospective changes to patient records.

Professor Robin Gauld and Dr Simon Horsburgh have written an interesting article on the reasons why British doctors move to New Zealand, which is well worth a read. We've also included some insights from Dr Rick Acland and Professor Dick Sainsbury who reflect on their years as Council members.

Eliminating inequity – why not?

Earlier this year, I met with representatives of the Ministry of Health and the board of Te Ohu Rata o Aotearoa – the Māori Medical Practitioners Association (Te ORA) to discuss how the Council could take a leadership role and stimulate debate amongst health organisations and the urgent need to address Māori health inequity.

The meeting highlighted the need for further progress to be made in health organisations if the support of Māori and Māori doctors is to be advanced, with the ultimate objective being the elimination of health inequity for Māori.

I strongly believe that the Medical Council has a responsibility and a leadership role in improving quality and promoting excellence in the medical profession. Cultural competence is a fundamental part of this as it will enhance our understanding and knowledge of our patients.

In 2006, Council published standards for cultural competence. We recognised that the population of New Zealand is culturally diverse and that inequities exist in health outcomes for different cultures and ethnicities within our population.

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IN THIS ISSUE

'Good afternoon' continued...

A particular focus of our standards is on best practices when providing care to Māori patients and their whānau. In the Council's resource booklet Best health outcomes for Māori: Practice implications, we discuss in greater detail the importance of cultural competence and how health inequities can be addressed.

Today, almost 10 years since the publication of the Council's standards on cultural competence and 175 years after the signing of the Tiriti o Waitangi (Treaty of Waitangi), inequities continue to exist. Many health statistics continue to highlight the poor outcomes achieved by Māori when compared to other groups in our population.

For example, the latest perioperative mortality publication from the Health Quality and Safety Commission (HQSC)[1] again highlights the disparities that exist with the delivery of health care to Māori. Māori perioperative mortality exceeds other groups in all areas assessed by the HQSC.

The reality is, however, that the issues surrounding inequity belong not just to Māori and Māori doctors but to all of us.

We know there is clear clinical evidence that many Māori suffer inequity of access, quality and outcomes. To turn around these inequalities, we need better integration between organisations, and as a profession, we need to lead this change.

I see the Council's role in making change happen as:

- stimulating and leading the debate
- overseeing the accreditation of college policies and practices
- examining curriculum development and how colleges train doctors
- exposing interns to the issues of inequality
- reviewing our existing statements that focus on Māori
- creating awareness of cultural diversity.

Some thoughts on myMCNZ

As many of you will know by now, you are able to apply for your practising certificate online and update things like your change of address details through myMCNZ, the Council's portal for doctors.

The feedback we've received to date has been overwhelmingly positive from doctors, many of whom have felt our online initiative was long overdue.

Today, it's become second nature for the vast majority of us to interact online to some extent – book travel, do banking, shop overseas, read newspapers or watch films – without a second thought.

Because of what we believe is widespread acceptance of doing business online, we have decided that from January 2016 completing your practising certificate online through myMCNZ will be the only option for all doctors applying for a practising certificate.

The consequences of not completing a practising certificate application are serious for both you and your patients.

If you are having difficulties accessing myMCNZ or entering the necessary information to complete your practising certificate application, I would encourage you to call the Council's helpline on 0800 636 555, and staff will be more than happy to help you.

Council would urge all doctors to check via myMCNZ that we have your preferred email address.

I would value any thoughts or comments you may have on this or any other issue, which you can email to me at chair@mcnz.org.nz.

Andrew Connolly
Chairman
Medical Council of New Zealand

[1] Perioperative Mortality in New Zealand: Fourth report of the Perioperative Mortality Review Committee. Report to the Health Quality & Safety Commission New Zealand, June 2015.

EVALUATING REGULAR PRACTICE REVIEW

For the past year, through Malatest International, the Council has been undertaking an evaluation of the regular practice review (RPR) programme, which forms part of the recertification programme for doctors registered in a general scope of practice.

RPR involves a doctor being visited in their usual practice setting and a collegial review taking place over the course of a day. The long-term outcome of the RPR is to focus on quality improvement by helping individual doctors identify areas for improvement and build them into their professional development plan.

The evaluation of RPR began in July 2014 and will continue through to 2020 and is being undertaken through an online survey and interviews.

Initial results from the evaluation show that, 2 weeks after taking part in RPR, nearly half of doctors (48 percent) said they had already made changes to their practice, and a further 15 percent said they intended to make changes.

Examples of changes made were:

- Improved records and note taking – most commonly mentioned

  Ensuring appropriate documentation of clinical notes. Going deeper into patient history beyond presenting complaint.

- The consultation – style and interaction with patients

  Tried to change consultation style, trying to prioritise patient questions.

  Communicating more effectively with patients who present with lists to ensure priority of needs addressed in 15-minute consultations.

- Review of prescribing and ordering lab tests

  I am a bit more critical about which lab tests I order.

- Improving cultural competence

  Taking specific interest in Māori and Pacific cultural aspects of patients and trying to integrate them in consultations.

Importantly for patients, around half the doctors in the evaluation agreed or strongly agreed that participating in RPR had improved the care they deliver to their patients (47 percent) and improved their practice in other ways (54 percent), and more than half (58 percent) said they had already made changes to their professional development as a result of RPR.

Examples of changes made were:

- Fine-tuning their Professional Development Plan (PDP)

  Broadening and fine-tuning my CME via the bpacnz system will keep improving my standard of care, keeping me current, interested and stimulated. Benefits to my patients my colleagues and myself.

- Cultural competence

  Taking notice of cultural and social aspects of medical practice.

- Entering vocational training

  I intend to start specialist training within the next few months.

- Improving their management of their professional development.

  I have added several PDP goals in my e-portfolio.

Changes to PDP and practice were more likely if doctors had learned about new development opportunities in their RPR report or spoke English as a second language.

A year on, just over half (52 percent) of doctors agreed or strongly agreed they had made changes to their PDP.

So what were the factors influencing the effectiveness of RPR? Influencers included:

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'Evaluating regular practice review' cont...

- expectations – fewer expected it to be useful (35%) than said they would recommend it afterwards (60%), and there was still some lack of clarity about the purpose – quality not audit
- the practice visit – there were some challenges for those in atypical practice in using tools and scheduling patients but it was generally positive – highlighting the importance of the reviewer
- the reviewer – must be respected as someone with the knowledge and experience to provide input into their practice.

Most doctors valued the report, but some commented that they wanted more practical feedback they could act on to improve their practice. Almost all doctors who had new opportunities for development identified in their reports knew what steps they should take to improve their practice.

Going forward, 2-week and 12-month surveys and interviews continue as will a survey and interviews of reviews. Importantly, additional analysis of results will become possible as numbers included in the surveys increase.

Quick link

Malatest International

RETROSPECTIVE CHANGES TO PATIENT RECORDS, BY DR KEVIN MORRIS, MEDICAL ADVISER, MEDICAL COUNCIL OF NEW ZEALAND

This is an issue that may become contentious particularly in the context of the investigation of a complaint. However, such changes are most often completely appropriate and done to ensure notes are accurate and in the patient's best interest. Read more

The ideal time to record notes in the patient record is during or at the end of the consultation while the patient is still with you. This provides the opportunity to cross-check what is recorded with the patient to ensure accuracy from their perspective. It also means that if, when writing up the record, you realise that some point is not clear in your mind or that you have forgotten to ask or to examine something, you still have the opportunity to do so.

While ideal, this is not always possible. However, it should always be the case that the notes are completed within a short time after the consultation and certainly the same day as the consultation.

If notes are recorded other than on the day of consultation or if there are changes or additions made to notes at a later time, there must be clear documentation that identifies that the note refers to a consultation on the earlier date or that there has been an addition or amendment made. This must include the date of the addition/amendment and your name. Do not delete any previous notes. You may put a line through the original note but so that it can still be read.

Patients also have the right to ask for correction of their records if they believe they are inaccurate. This right is set out in the Rule 7 of the Health Information Privacy Code 1994. Rule 8 also places an obligation on doctors to ensure that information they propose to use is accurate.

Quick links

Cole's Medical practice in New Zealand

Health Information Privacy Code 1994

MPS New Zealand – Casebook and resources

A QUICK WORD FROM THE CORONER

In a recent Coroner's report, the Coroner made the following comments:

> 'Evidence given at the inquest highlighted the need for health professionals to take care when providing reports to a court … Health professionals should ensure that they are aware of the purpose for which the report is sought. They should advise the court of the information relied upon and its sources and set out any limitations of the report.'

Providing reports or certificates for patients is a part of medical practice. The Coroner's comments are a reminder of how important it is to understand the purpose of the report, who will be reading the report and how it will be used.

The Council has two statements available on its website that are relevant in this matter – Statement on medical certification and Non-treating doctors performing medical assessments of patients for third parties.

Quick links

Statement on medical certification

Statement on non-treating doctors performing medical assessments of patients for third parties

TESTING TIMES, BY DR STEVEN LILLIS, MEDICAL ADVISER, MEDICAL COUNCIL OF NEW ZEALAND

Recently, the Medical Council has been notified of concerns where processes for receiving and acting on the results of investigations have led directly to adverse patient outcomes. The cases include incidents in general practice, public hospitals and private secondary care.

Error in laboratory testing is usually divided into pre-analytic (wrong label on specimen, for example), analytic (wrong setting on analyser) and post-analytic.

It is the post-analytic phase that has resulted in the complaints, in particular:

- failure to see the abnormal result
- failure to recognise that the result is abnormal
- failure to organise appropriate follow-up.

In a similar vein, failure to act upon information sent to the practitioner has also caused direct harm and is caused by the same circumstances. Some of these cases are useful to explore in more depth.

There were two cases where an abnormal cervical smear was received by the practice and the result not acted upon. The cause in both cases was poor systems. In one, the practice was changing software systems, and the laboratory result was considered to be a duplicate and therefore not read. In the other, there was lack of clarity about who had responsibility to act upon the abnormal result, with the outcome that no one took action.

A previously well young man presented to his general practitioner with what appeared to be a viral illness for a week but was sufficiently unwell for the doctor to order blood tests. The results (marked neutrophilia, acute renal impairment, anaemia and markedly elevated C-reactive protein (CRP) were seen by the doctor and understood to be of direct and immediate clinical relevance but not acted upon. The outcome was a 3-day delay in treatment. The doctor's response was that pressure of work may have contributed to failure to act appropriately.

A surgeon removed lesions suspicious of being basal cell carcinomas from a patient but overlooked reading the histology reports. Some 6 months later,

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'Testing times' continued...

it became clinically obvious that the excisions were incomplete and a major procedure was required.

Two cases have been received where the doctor concerned had ordered a full blood count and serum ferritin on elderly patients and was in receipt of the results indicating iron deficiency anaemia but failed to act upon this. In both cases, gastrointestinal malignancy was eventually diagnosed but only after an unnecessary delay.

An anaesthetist ordered a chest x-ray at a pre-anaesthetic clinic for a patient who was a smoker. A different anaesthetist undertook the anaesthetic a few days later but failed to note the chest x-ray results, which were suspicious of tumor. Each doctor believed the other would review the x-ray report. The patient developed symptoms some months later that were investigated and the diagnosis made.

A general practice was sent clinical notes of a patient where it was documented the patient had a severe and life-threatening reaction to a particular medication. The information was not entered into the practice system, and the medication was later prescribed with serious consequences.

Defective management of important results from investigations is unfortunately common. The Health and Disability Commissioner wrote in a report:

> 'As this Office has stated on numerous occasions, doctors owe patients a duty of care in handling patient test results, including advising patients of, and following up on, abnormal results. Primary responsibility for that duty of care lies with the clinician who ordered the test…'

There is, of course, no single solution that can resolve all such defective processes. However, it is also clear that confusion over responsibility, poor design of processes, failure to follow processes and lack of protected clinical time to attend to investigation results are all contributors. Further, all these factors are open to critique and improvement.

There is always tension between allocation of time to direct patient contact and clinical administrative work. Commonly, the administrative side seems to be relegated to 'When I have time' or 'I'm not sure what the system is but it seems to be working' and the all too common 'I review the results when I get a break between patients'. Important clinical information needs to be conscientiously attended to despite competing imperatives. A common and perceptive refrain heard in safety in medicine advocacy groups is 'If you think safety costs, you should try a mistake.'

ETHICS 101

What would you do?

You are providing cover for a colleague. Mr A, who has de Quervain's tenosynovitis, informs you of further injury to his right wrist while lifting an item at work yesterday. Mr A works at a warehouse, and his responsibilities include stacking and storing goods using a forklift. The clinical records over the past 3 weeks show that your colleague has administered steroid injections and issued medical certificates to Mr A.

Your colleague documented that the availability of lighter duties such as desk-bound tasks were 'on and off' in that there may be some light duties here and there but it was insufficient to fill a working week.

Mr A is requesting another medical certificate for his right wrist. He tells you that he is experiencing sharp pains and needs to rest at home. When you revisit the option of alternative work duties, Mr A tells you that he has resigned from the warehouse and is leaving in a fortnight to start another job.

What should you do?

Email your answers to Kanny Ooi, Senior Policy Analyst, at kooi@mcnz.org.nz (use the subject line 'Ethics 101'). If you have ideas for topics for future columns, please feel free to send them to us as well.

WHAT YOU NEED TO KNOW ABOUT REMAINING ON OR BEING RESTORED TO THE MEDICAL REGISTER

Remaining on the medical register

Your name will stay on the medical register unless:

- you ask us to cancel your registration
- you do not give us a reliable contact address
- we do not receive a response to any mail we send you.

There is no charge for your name to stay on the register when you are not practising in New Zealand.

To cancel your registration and have your name removed from the register, please send us a written request or email us at pc@mcnz.org.nz. There is no charge to be removed from the register.

Being restored to the medical register

In some circumstances, you can be restored to the medical register.

If you previously held permanent registration that was cancelled in error or at your request or because you did not respond to our letters sent to your registered address, we may restore you to the register.

Under the Health Practitioners Competence Assurance Act 2003, we may restore you to the register if you:

- satisfy the criteria for fitness for registration
- are not subject to any pending disciplinary proceedings
- are not subject to an order under section 101(1)(a) of the Act
- satisfy us you are competent to practise
- previously held a permanent form of registration.

To assess your competence to practise, we require details of your clinical practice, professional development since you last worked in New Zealand and your record of good standing in other jurisdictions.

Quick link

Get restored to the register

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NEW COUNCIL MEMBERS

In late June, the Hon Dr Jonathan Coleman, Minister of Health, appointed the top four polling candidates to Council for a 3-year term commencing on 1 July 2015.

In this edition of Medical Council News, we profile three new Council members – Drs Kate Baddock, Pamela Hale and Curtis Walker – as well as Dr Jonathan Fox who was reappointed to Council.

Dr Kate Baddock

MB ChB 1981 Otago, Dip Obst 1983 Auckland, MRCGP 1986, M 1994 F 1998 RNZCGP

Kate Baddock qualified MB ChB from Otago in 1981, and after completing a Diploma in Obstetrics and Gynaecology, travelled overseas for a number of years. While in the United Kingdom, she completed her postgraduate training in general practice and obtained Membership of the Royal College of General Practitioners. After her return to New Zealand in 1988, she joined a rural practice in Warkworth and has been working there full-time for the past 27 years. In 1994, she obtained her Fellowship of the Royal New Zealand College of General Practitioners.

Kate is part of a teaching practice that has grown steadily over the last decade and now has 13 doctors including registrars and postgraduate doctors as well as medical and nursing students. She has also been involved at a regional level in health organisations and on the board of Waitemata Primary Health Organisation for the past decade. Prior to that, she was the Chair of one of the first Independent Practitioner Associations in New Zealand for 12 years.

In national roles, she has been the Chair of the General Practitioner Council of the New Zealand Medical Association for the past 5 years and is currently the Deputy Chair of the New Zealand Medical Association. She also sits on the Executive Board of General Practice New Zealand, is a member of the General Practice Leaders Forum and also a member of the Ministerial Medicines Classification Committee.

In her spare time, she is a Swimming New Zealand referee, and in what time that remains, she enjoys landscaping, reading and travelling.

Dr Jonathan E M Fox

MB BS 1974 Lond, MRCS Eng LRCP Lond 1974, MRCGP 1981, FRNZCGP 1998

Dr Fox is a general practitioner based in Auckland. He is a past President of the Royal New Zealand College of General Practitioners and immediate past Chair of the Council of Medical Colleges in New Zealand. He is a Board member of ProCare Health Limited, the Auckland Independent Practitioners Association. He is also a member of various charitable and research trusts in the Auckland region.

His previous positions included membership of the Board and GP Council of the NZMA, Competence Advisory Team of the Medical Council, Medical Officer to Kings College Auckland and many RNZCGP Auckland Faculty positions.

Dr Fox qualified from Guys Hospital Medical School, London, in 1974. He then spent 7 years working as a medical officer in the Royal Navy, before completing his vocational training in the United Kingdom. After leaving the Navy, he spent 8 years as a general practitioner in Rugby, UK, where he was also Medical Officer to Rugby School.

He came to New Zealand in 1990 with his GP wife and children. Over the last 19 years, their practice has grown and is now a five-doctor practice in Meadowbank, Auckland.

Dr Fox has been awarded an Honorary Fellowship by the Royal Australian College of General Practitioners.

Pamela Hale

MB ChB Otago 1982, FRACP 1991

She graduated from Otago University in 1982 and completed medical training in various hospitals around New Zealand, including Christchurch, Tauranga, Hamilton and Dunedin, and a brief stint in the United Kingdom while travelling, becoming a Fellow of the Royal Australasian College of Physicians in 1991.

For many years, Dr Hale worked part-time while busy with her family.

Dr Hale has been a specialist physician in Nelson for 23 years developing the diabetes and endocrinology service and has had various other roles including being an intern supervisor. She is currently Head of the Department of Medicine and Clinical Senior Lecturer for The University of Otago with respect to the Nelson trainee interns in medicine.

Dr Hale has always been interested in professionalism and ethical behaviour and has led annual tutorials on this with resident doctors.

Her interests include acute general medicine and the holistic management of type 1 diabetes and, outside of work, her family.

Dr Curtis Walker

MB ChB 2007 Auckland, FRACP 2015

Dr Walker was elected to Council in 2015.

Ko Whakatōhea rāua ko Ngāti Porou ngā iwi.

Formerly a veterinarian, Dr Walker retrained in human medicine and qualified from Auckland in 2007. He started work as a House Officer at Waikato Hospital and commenced internal medicine training there before moving to Palmerston North and Wellington to complete his Fellowship in nephrology (Fellow of the Royal Australasian College of Physicians) in 2015.

During his time as a resident doctor, he was President of the New Zealand Resident Doctors Association (NZRDA) for 5 years and also served on the board of the Māori Medical Practitioners Association (Te ORA). These roles reflect the strong commitment that Dr Walker has to improving health outcomes for Māori and to supporting doctors during the long and challenging years spent in specialist training.

He commenced work as a renal and general physician in 2015 at MidCentral DHB and loves living in Palmerston North with his wife and two young children.

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The following article has been provided by Professor Robin Gauld and Dr Simon Horsburgh, Centre for Health Systems, Department of Preventive and Social Medicine, University of Otago, Dunedin.

OVERSEAS DOCTORS COMING, GOING … AND NOW STAYING

International medical graduates (IMGs) comprise 43.6 percent of New Zealand's medical workforce – the highest proportion in the OECD. Half of New Zealand's present 3,500 international medical graduates hail from the United Kingdom. A year after registration, only 53 percent remain, dropping to 30 percent after 2 years and 20 percent after 8 years. By contrast, 70 percent of New Zealand-trained doctors are still here 8 years on.

In June 2014, we invited all United Kingdom-trained doctors registered with the Medical Council of New Zealand who had arrived within the previous 10 years to complete a survey (n=1,354) – 47 percent (n=632) responded, and we are grateful to those of you who did. We also interviewed 16 doctors.

The survey asked about motivations for the move to New Zealand. 'Quality of life (or that of my family)' was indicated as important or highly important by 96 percent of respondents, 87 percent indicated more attractive working conditions and 72 percent said it was availability of career opportunities. Notably, 65 percent indicated a 'desire to leave the National Health Service (NHS)', with one-third of all respondents indicating that this was highly important. Only 38 percent agreed that 'more attractive salary and incentives' motivated their move, with less than 10 percent saying this was highly important.

Regression analyses highlighted that older respondents (those 41 years of age and above) were less inclined to agree than those aged 20–30 years (the reference group) that quality of life was an important motivator (all regression findings henceforth discussed are statistically significant at $p<0.05$). Registrars were also less likely than hospital specialists or general practitioners (GPs) to be seeking a better quality life but over twice as likely as GPs to be motivated by 'training and development goals'. When it came to the desire to leave the NHS, we found that younger doctors (20–30 years of age) were around four times as likely as older doctors (aged 51 and over) to agree that this was a motivating factor.

In the interviews, these findings were explored in more detail. New Zealand was an appealing destination for the small number of interviewee registrars, who were also attracted by an outdoors lifestyle.

We asked survey respondents about their work and living environment in New Zealand – factors deemed important to workforce sustainability. Overall, they were a relatively happy group, with over 90 percent satisfied with their workload, work colleagues and community life and with the New Zealand health system being 'easy to work in', and 80 percent agreed that 'the New Zealand health system is better to work in compared to the UK system', with over 40 percent strongly agreeing with this statement. Regression results showed males and older respondents (41 years and over) were less likely to agree, while hospital specialists and registrars were considerably more likely to agree than GPs.

When asked about motivations to leave the NHS, GP respondents, in particular, cited a stressful working environment with a high volume of patients and very limited time for each. Said one of general practice in New Zealand, 'Few home visits [due to a dedicated after-hours centre staffed by rostered GPs], longer GP consult times, less squeeze on appointments, more opportunity to perform practical procedures and work patients up before referring to secondary care' [GP, arrived 2012]. Specialists also emphasised a desire to leave behind stress and frustration: '… the constant reorganisation and a lot of constant directives coming from above. It didn't seem to really relate to patient needs, just kind of political objectives' [Specialist, arrived 2010].

We asked survey respondents whether they were considering a move away from New Zealand, with 29 percent indicating this. We asked this subset (n=181) to rate their level of agreement or disagreement with a series of considerations. At 76 percent, the highest-scoring factor was 'desire to return to a country (e.g. UK) where I had previously lived/worked'.

Next in order of importance, at 55 percent agreement, was availability of career opportunities elsewhere. Some 24 percent were motivated by 'more attractive salary and incentives elsewhere' and 20 percent by a 'better lifestyle elsewhere'. Only 15 percent cited a 'poor working environment' in New Zealand as being a consideration.

We asked interviewees what would motivate them to want to leave New Zealand. Many suggested home and family: 'Will return to UK for family reasons. All other aspects of work/life balance in NZ are better' [Specialist, arrived 2010].

Finally, we asked the 16 interviewees to compare and contrast the NHS and New Zealand health systems, including which they found preferable to work in. There were a mix of views:

> 'I think work conditions [in NZ] are vastly superior to the UK – at the moment. I enjoy working here, and I suspect I would be quite burnt out if I had remained in the UK' [GP, arrived 2012].
>
> 'Although overall it is a better place to work than the UK, the NZ health system is not a bed of roses. PHARMAC [New Zealand's drug-buying agency] is more restrictive on drug availability than NHS, social support in the community is poorer, there are more co-payments that act as a disincentive for poorer people to seek health care' [GP, arrived 2008].

As New Zealand works to grow its medical workforce to keep pace with health care demands, it is likely, in the short term, to continue relying on international medical graduates, but the situation could change quickly for two reasons. First, opportunities in Australia, a traditional destination for New Zealand doctors, are diminishing as it graduates doctors from new medical schools. Second, new schemes to keep New Zealand doctors at home after graduation are starting to have an impact, along with the increased medical school output.

Meanwhile, if the United Kingdom is concerned about the flow of doctors Down Under, it could consider strategies aimed at retaining younger doctors and those concerned about quality of life and training opportunities and, perhaps very importantly, pay attention to workforce stress and put a halt to the ongoing NHS reforms as these appear to be a major propellant.

For more information on this survey, please email Professor Robin Gauld robin.gauld@otago.ac.nz.

Quick link

What motivates doctors to leave the UK NHS for a "life in the sun" in New Zealand; and, once there, why don't they stay?

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The following article has been provided by the Health Funds Association of New Zealand.

HFANZ MEMBERS SET UP INTEGRITY REGISTER TO CRACK DOWN ON SUSPICIOUS CONDUCT

Health Funds Association New Zealand (HFANZ) members have established an integrity register to tackle suspicious conduct and undesirable practices in health insurance.

The register, which went live at the end of July and is maintained by PricewaterhouseCoopers, aims to identify the conservatively estimated 2 percent of health insurance claims believed to be fraudulent, thought to cost $20 million in claims a year or $15 in premium for every private health insurance member.

HFANZ members will submit details of any suspicious conduct encountered by sending an encrypted email to the PwC forensic personnel. That will then be cross-referenced to determine any pattern or the extent of suspicious conduct. PwC will report back to HFANZ and members about the suspicious behaviour, and where there is clear evidence of fraud, the police may be notified.

HFANZ acting Chief Executive, Chris Pentecost, said the register's automated detection abilities will enable members to tackle suspicious conduct and fraud on a more consistent basis, and the coordinated approach to sharing information will lessen the investment required by individual insurers and hopefully keep a lid on rising premiums.

This joint industry approach to suspicious conduct and fraud will also give the industry a truer idea of its scale and ensure a very clear zero-tolerance message is delivered to those who knowingly commit it.

Suspicious conduct can take a variety of forms. Suppliers might bill for services, procedures and/or supplies that were not provided, submit duplicate bills, charge for items that would normally be free or perform medically unnecessary services in order to obtain insurance reimbursement. Customer conduct might take the form of using someone else's coverage or insurance card, filing claims for services or medications not received, or forging or altering bills or receipts.

Quick links

Health Funds Association of New Zealand Integrity Registry – FAQs

Integrity Registry for HFANZ Members – Privacy Impact Assessment

CHANGES TO FEES

The changes to fees follow consultation with the profession that began on 25 May 2015. The consultation process advised doctors and other stakeholders of the desire to ensure that there was greater transparency and equity across all fees charged by Council. The new methodology uses activity-based costing to ensure that cross-subsidisation amongst fees is minimised.

Following consideration of submissions, the Council resolved on 15 July 2015 to adopt the changes with effect from 1 September 2015.

Increase on practising certificate fee

This increase follows consultation by the Council with all doctors with current practising certificates, in accordance with Council's established practice of consulting on changes to prescribed fees. Doctors and other stakeholder groups received notification in mid June 2015 indicating a proposed increase of $40.00 plus GST, providing an explanation of the proposed increase and inviting submissions. In the information provided to medical practitioners, the Council noted:

> 'Until the impact of the new fees structure is in place and Council has a true indication of income from any changes made, Council needs to be able to pay for the day-to-day activities of Council … Increases in the costs, particularly in relation to education, competence and conduct processes are significant.'

Following consideration of submissions, the Council resolved on 24 July 2015 to adopt an increase of $40.00 plus GST in the practising certificate fee with effect from 1 September 2015.

Quick links

Amending a Notice – Fees Payable to the Medical Council of New Zealand From 1 September 2015 (published 20 August 2015) – Amendment to the New Zealand Gazette, Issue No. 90, Notice No. 2015-gs4765.

Fees Payable to the Medical Council of New Zealand From 1 September 2015 (published 31 July 2015) – New Zealand Gazette, Issue No. 84, Notice No. 2015-gs4476.

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REFLECTIONS ON THE MEDICAL COUNCIL

Dick Sainsbury, elected member 2009–2015

I had not thought of standing for election to the Medical Council but for a chance corridor conversation with my colleague Dr Julie Kidd who told me in 2009 that there was an election pending and that people in the department wanted me to stand.

I agreed and somewhat to my surprise was elected. I had looked at the Registered Medical Practitioners section of the Auckland telephone book and thought only about 5 percent of the huge number of doctors listed would have heard of me – clearly I had been Stein Father at enough medical students' parties to ensure myself an electorate! But what of an election for Council? Only 20 to 25 per cent of registered doctors cast their vote and yet the profession howls with rage if it is suggested that elected members should be done away with or on the one occasion when the Minister of Health did not appoint the four top polling candidates. If the election is so precious, the majority of those eligible should vote. This would also give more credence to those ready to sound off at Council decisions (often without the full facts).

I found the first year of membership quite tough. Indeed, I contemplated resigning. I am extremely glad that I didn't. I found it challenging because of the amount of reading and my unfamiliarity with Council policies, particularly in the area of registration. I am also not a confident natural talker in a Committee arena. I am very grateful to John Adams and Kate O'Connor, Chair and Deputy Chair at the time, Philip Pigou, CEO, and Liz Hurd for encouraging me through this period. I've always seen registration as my Achilles heel. We have had so many bogus doctors and frauds in New Zealand over the years that we can't be too careful, and yet sometimes I'd hear of a case and think, 'This person is an able surgical registrar, why are we requiring her/him to do some first year medical runs?' There is such a variety of training and experience that Council is wise to have robust guidelines for registration.

Is the current membership of the MCNZ – four appointed lay members, four appointed medical members and four elected medical members – appropriate? Five years ago, MCNZ commissioned a review of its activities by the UK-based Council for Healthcare Regulatory Excellence (CHRE). The MCNZ was appropriately reassured by the overall very positive comments, particularly about efforts in continuing professional development and regular practice review, but what about the recommendations for the composition of Council? The CHRE suggested the consideration of a nine-person Medical Council – five lay members and four medical. Moreover, the Chair would be a layperson. This would give more transparency and help to dispel the still widely held impression that 'doctors regulate their own'.

These recommendations were quickly buried, but what could be the harm? Having seen how effectively Council works, I would have no qualms. Council does need access to expert opinion, but this can be obtained externally on a case-by-case basis – a nine-person council could release funding for more independent specialist medical opinions in competence cases, for example. As far as any paranoia on the part of doctors that lay members are the 'opposition' or the 'enemy', I can vouch that all nine lay members with whom I have worked have been very respectful of the difficult road that doctors have to travel and are by no means 'anti-doctor'. The norm I have found is that doctors on Council are generally more critical of their peers than the lay members. On only one occasion in my time was there a vote in which all medical members voted one way and all lay members the other. The Chairman immediately expressed his concern, and the matter was reconsidered for further debate.

The Medical Council has been particularly well led in my time, and I have the utmost respect for the Council staff who prepare well considered, carefully researched papers. I was particularly fortunate to serve on the Health Committee, which performs an expert role in balancing the rehabilitation need of the unwell doctor with the need to ensure the safety of the public. I will always be grateful that circumstances led me to a period on the Medical Council and particularly to working with the highly professional team in the offices and my fellow councillors. I miss it greatly – why I am I not still there?

Rick Acland, elected member 2006–2015

I was elected onto the Medical Council in 2006 and survived two further elections, compulsorily quitting this year. Being on the Medical Council has been a rewarding experience. I maintain that the election process is somewhat of a farce, in that candidates have no real means of informing the electorate of their worthiness. At the first election, I assume I romped in by being at the top of the alphabetical list of candidates! It is of concern that barely a quarter of doctors ever cast a vote. I also consider that a Board of 12 is too large, and this can be overwhelming for 'visitors' when one doubles that number with staff in attendance.

My medical career has spanned both anaesthesia and rehabilitation medicine, and I think I may have been the first from these specialties to be elected onto Council. It has been a privilege to represent the medical profession on such an important body. The Medical Council does have an important leadership role as it strives to carry out its duties under the Health Practitioners Competency Assurance Act. We have an astute leader in our current Chairman, Andrew Connolly. This can be an onerous task. During my tenure, amongst other things, I was pleased to have been instrumental in rewording our mission statement from having a duty to 'protect public health and safety' to 'protecting the public and promoting good medical practice'. I have always maintained that we do have a responsibility to ensure that New Zealand has good (happy) doctors.

During my time on Council, I have witnessed some major changes to our processes, particularly as we began to embrace the paperless world. The mountain of agenda papers that were often cursed by the failed ringbinder have been superseded by Dropbox and its like. We have been challenged to achieve greater electronic processing in the office. I was thrilled to complete my registration renewal this year online and have it confirmed immediately. The lack of transparency has often been a criticism levelled at the Council. I feel we achieve a good balance – that of doctors' rights along with our accountability to outside agencies.

Thank you once again for electing me to 9 years of service on the Medical Council New Zealand.

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