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Medical Council of New Zealand
Te Kaunihera Rata o Aotearoa

NEWSLETTER OF THE MEDICAL COUNCIL OF NEW ZEALAND

CHAIRMAN'S FOREWORD

Long seen as a professional right, there could be significant risks in providing care to yourself and those close to you, perhaps the greatest being the lack of objectivity and ongoing care.

Latest news headlines

Consultation on proposed changes to registration policies

- The introduction of primary source verification of qualifications, and certificates of registration / licenses to practice; and
- The development of a new pathway to registration in a (provisional) general scope of practice. Read more

Prescription writing for effective and safe collaborative patient management

The pharmacy profession has identified aspects of prescription writing where improvements could be made to enhance patient safety and management.

Mr Andrew Connolly re-elected Chairperson of the Medical Council of New Zealand

Mr Andrew Connolly was has been re-elected Chairperson of the Medical Council of New Zealand.

Good prescribing practice

Good prescribing practice requires that a doctor's customary prescribing conforms within reason to patterns established by the doctor's peer.

Providing care to yourself and those close to you

Every doctor should have his or her own general practitioner because an individual doctor cannot provide objective assessment of his or her own condition.

Statement on telehealth review

Council Chairperson Mr Andrew Connolly says telehealth is a dynamic and ever-changing part of medical care, and this is reflected in the review of the statement.

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GOOD AFTERNOON

In this issue of *Medical Council News,* we look at providing care to yourself and those close to you. Long seen as a professional right, there could be significant risks in providing care to yourself and those close to you, perhaps the greatest being the lack of objectivity and ongoing care. With this in mind, I would urge you to find yourself your own GP if you don't already have one.

There are some situations where treatment of those close to you may be unavoidable. However, such situations should be the exception, and care in that instance should only occur when the overall management of the patient's care is being monitored by an independent practitioner.

Informed consent and a patient's understanding of the risks of treatment is another issue we look at.

Informed consent is an interactive process between a doctor and patient where the patient gains an understanding of his or her condition and receives an explanation of the options available including an assessment of the expected risks, side effects, benefits and costs of each option. This is necessary in order for the patient to make an informed choice and give their informed consent. Any consent given by the patient must precede the treatment or procedure the doctor is proposing.

Finally, the Pharmacy Council of New Zealand have provided an article on prescription writing for effective and safe collaborative patient management. A couple of the key messages from the Pharmacy Council are that:

- handwritten prescriptions should be legible, and the number of items per page should be a maximum of five to reduce errors in interpretation
- pharmacists must legally receive the hard copies of prescriptions that have been faxed or phoned within 7 days or within 2 days for controlled drug prescriptions.

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

The Medical Council would like to thank the Pharmacy Council of New Zealand and other pharmacy stakeholder organisations for their contribution to this article and acknowledges Pharmacy Today for the 'mystery script'.

GOOD PRESCRIBING PRACTICE

The Council recently released its revised statement on good prescribing practice.

The statement sets out best practice for doctors noting, "Good prescribing practice requires that a doctor's customary prescribing conforms within reason to patterns established by the doctor's peers in similar practice. Inappropriate prescribing (which may include indiscriminate, excessive or reckless prescribing) is unacceptable, both clinically and ethically. It is also harmful to patients, the medical profession and society. Doctors are sometimes subject to pressure from patients in respect of prescribing."

The statement offers guidance on prescribing unapproved medicines, prescribing medicines that have the potential for addiction or misuse, shared care, repeat prescriptions and prescribing by other health professionals who have legal and independent prescribing rights.

The statement can be read online, or you can download it from the Council's website.

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

Good prescribing practice

PRESCRIPTION WRITING FOR EFFECTIVE AND SAFE COLLABORATIVE PATIENT MANAGEMENT

New Zealand is a unique healthcare environment, and many prescription writing issues may be addressed by working with your local pharmacist. Pharmacists can also assist with optimising medicine management systems and providing patient information. Improvements in collaboration and information sharing offer increased opportunities to improve patient care, safety and health outcomes.

The pharmacy profession has identified aspects of prescription writing where improvements could be made to enhance patient safety and management.

- Handwritten prescriptions should be legible, and the number of items per page should be a maximum of five to reduce errors in interpretation. Pharmacists also require sufficient space to annotate what has been dispensed. Please do not provide patients with 'double-sided' prescriptions.
- Please ensure that the prescriber details are legibly annotated on the prescription and that prescriptions are signed and dated. If prescribing from a hospital, record your pager number or cell phone contact to enable any prescription queries to occur in a timely manner.
- To improve patient safety, please be available to discuss patient-specific prescription queries in a manner best suited to both parties. In many instances, problems in addressing prescription queries with the prescriber result in unnecessary delays to patient access to medication or delays in treatment.
- It is important to ensure special authority (SA) numbers and specialist endorsements are up to date and renewed as necessary. Remember, you can apply for or renew SA numbers online. For further information, phone the Ministry of Health online help desk on 0800 505 125 or go to the Ministry website.
- Pharmacists welcome discussion with practitioners about medicines you wish to prescribe.

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INTERNATIONAL CONFERENCE ON MEDICAL REGULATION

The International Association of Medical Regulatory Authorities (IAMRA) 12th International Conference on Medical Regulation will take place from 20–23 September 2016 in Melbourne.

The IAMRA 2016 Conference will be hosted by the Medical Board of Australia and the Australian Health Practitioner Regulation Agency (AHPRA) – partners in regulating medical practitioners in Australia.

This conference has become a thought-provoking forum where international medical regulators, policy makers and academics share ideas and experiences and learn from each other. Held biennially, the IAMRA Conference attracts 250–350 delegates from over 30 different countries.

A diverse programme of international and local speakers will underpin IAMRA's purpose – to protect, promote and maintain the health and safety of the public by ensuring proper standards for the profession of medicine. The conference will also provide networking opportunities through a unique social programme to experience Melbourne – Australia's most vibrant, creative and playful city.

Quick links

IAMRA 2016 website

Prescription writing for effective and safe collaborative patient management continued...

- Please contact your local pharmacist if you have any funding queries rather than using MIMS as a source when quoting prices.
- Due to frequent changes to the medication brand funded by PHARMAC, the use of 'favourites' lists can often cause confusion when brands are no longer listed in the schedule or available in New Zealand. Alternatively, prescribe generically unless there is a specific reason not to do so. For medicines such as warfarin, patient safety requires prescribing by brand name, as the Coumadin and Marevan brands are not interchangeable.
- Computer-generated prescriptions make interpretation easier, but please check that repeated items contain the correct instructions, for example, when the original prescription contained titrating or loading dose instructions. Pharmacists often receive prescriptions with titrating dose instructions for subsequent prescriptions.
- When prescriptions are returned for countersigning/amending, please ensure that the information in the patient file is also corrected to prevent the error from recurring on subsequent computer-generated repeat prescriptions.
- Pharmacists are members of the collaborative health team but often have no further information regarding the clinical indication of the medicine prescribed. Patient medicines information and counselling could be optimised in many cases if the medicine indication was written on the prescription. Most often, this is self-evident, but for medicines with multiple indications such as tricyclic antidepressants, further information is beneficial to ensure the practitioner's intention is able to be reinforced by the pharmacist, for example, 'amitriptyline 10mg nocte for nerve pain'.
- The term 'dispensing frequency' has replaced 'close control' for those patients that you have identified as requiring more frequent dispensing than the default period specified in the Pharmaceutical Schedule (which is often 3 months stat). Pharmacists are able to endorse monthly dispensing for patients to optimise adherence. For patients enrolled in the Pharmacy Long Term Conditions Service, pharmacists are permitted to dispense at a frequency appropriate to patient need.
- Safety medicines specified in the schedule, such as tricyclic antidepressants, must be dispensed monthly (or more frequently if

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STATEMENT ON TELEHEALTH REVIEW

The Medical Council is reviewing its statement on telehealth.

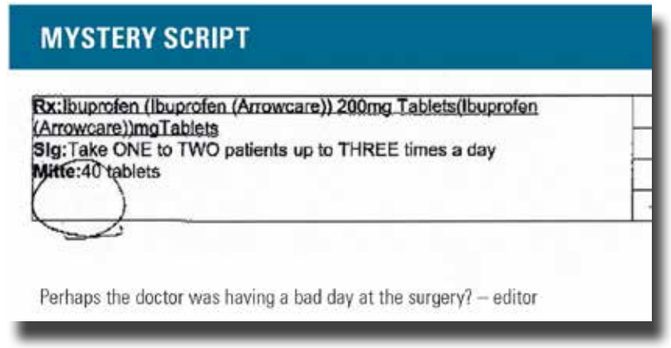
The revised statement is intended to apply to:

- doctors registered in New Zealand and practising telehealth in New Zealand and/or overseas
- doctors who reside overseas and provide health services through telehealth to patients in New Zealand.

Council Chairperson Mr Andrew Connolly says telehealth is a dynamic and ever-changing part of medical care, and this is reflected in the review of the statement.

Read more

MYSTERY SCRIPT



Perhaps the doctor was having a bad day at the surgery? – editor

Prescription writing for effective and safe collaborative patient management continued...

endorsed by the practitioner or pharmacist according to the 'dispensing frequency' rules).

- The Pharmaceutical Schedule dictates that many medications are funded as a single (stat) 3-month supply – where a medicine is being trialled for a patient, please endorse a trial period or prescribe 1 month's supply with repeats (endorsed 'frequent dispensing') to avoid the accumulation of unused medications.
- The Medicines Act restricts the quantity that may be prescribed at one time to a maximum of 3 months' supply. Patients will be unable to have 6 months' supply of their medication dispensed at once if you issue two 3-month prescriptions to a patient. (Note that this does not apply to oral contraceptives.) It is also likely that the second 3-month prescription will expire by the time the patient requires the medication.
- Annotating any changes to patient regimens on the prescription ensures pharmacists understand the prescriber's intention and could reduce the number of phone queries received. Clinical checks by pharmacists often detect changes in dose or additions to regimens. Signalling on the prescription that a medication is being stopped or the dose amended enables the pharmacist to provide more effective patient counselling, improving patient safety and ultimately patient outcome.
- Pharmacists must legally receive the hard copies of prescriptions that have been faxed or phoned within 7 days or within 2 days for controlled drug prescriptions. In instances where the prescriber has not completed this step and cannot be contacted by the pharmacy, the practice may be required to provide a replacement prescription, endorsing it as such in order to satisfy legal requirements.

Additional best practice points:

- Include the age and weight of a child under 5 years.
- Make sure NHI numbers and prescription codes are correct.
- Always include your Medical Council registration number.

Working closely with your local pharmacists helps to improve patient safety through accurate and effective prescription writing.

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INFORMED CONSENT

by Dr Kevin Morris, Medical Council of New Zealand Medical Adviser

Trust is a vital element in the patient-doctor relationship, and for trust to exist, patients and doctors must believe that the other party is honest and willing to provide all necessary information that may influence the treatment or advice.

Informed consent is an interactive process between a doctor and patient where the patient gains an understanding of his or her condition and receives an explanation of the options available including an assessment of the expected risks, side effects, benefits and costs of each option. This is necessary in order for the patient to make an informed choice and give their informed consent. Any consent given by the patient must precede the treatment or procedure the doctor is proposing.

Doctors have a statutory obligation to abide by the Code of Health and Disability Services Consumers' Rights (the Code). Under the Code, every patient has the right to make an informed choice and to give informed consent, except in certain circumstances such as an emergency.

Right 4(5) of the Code upholds the patient's right to co-operation amongst providers to ensure quality and continuity of services. This requires good communication on the part of all health professionals involved in the patient's care.

Under Right 5 of the Code, doctors must convey information to patients in a form, language and manner that enables the patient to understand the advice that is given and the treatment the doctor is proposing. At times, this may involve the services of an interpreter. In addition, doctors should ensure that their practice setting facilitates open, honest and effective communication. Where possible, doctors should minimise being interrupted when they are with a patient, and the consultation room should be set up in such a way that allows the doctor to maintain good eye contact with the patient.

Within a hospital setting, an effective way of learning how to obtain informed consent would be for interns to observe how consultants and experienced registrars obtain informed consent from their patients. It is important for less-experienced doctors to acquire skills in this area and to be aware that the signing of a consent form formalises what has been discussed to date. It is important to document the details of any discussions that have taken place including the procedure that will be performed, the possible risks and side effects and any printed material that is given to the patient. Interns should never be placed in the position of having to manage the entire process on their own and should refuse to obtain informed consent where they do not feel competent (or confident) to do so.

It is critical that a patient is fully aware of and consents to a surgeon or any other member of the surgical team to perform the procedure. Patients should also be told that, at times, the surgical team may need to involve another specialty if clinical findings during the procedure warrant the involvement of another specialty. It is important to document what has been conveyed to the patient and whether the patient agreed to the involvement of other team members and/or other specialties.

In a teaching environment, doctors must also obtain the patient's consent before involving a medical student in the patient's care. It is important that doctors explain beforehand the extent of the student's involvement and the level of experience the student has.

Except for emergencies, doctors should not proceed with any 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
- the doctor is satisfied that the patient has an adequate understanding of the information provided
- the doctor has provided the patient with an opportunity to consider and discuss the information given
- the patient has made an informed choice
- the patient consents to treatment.

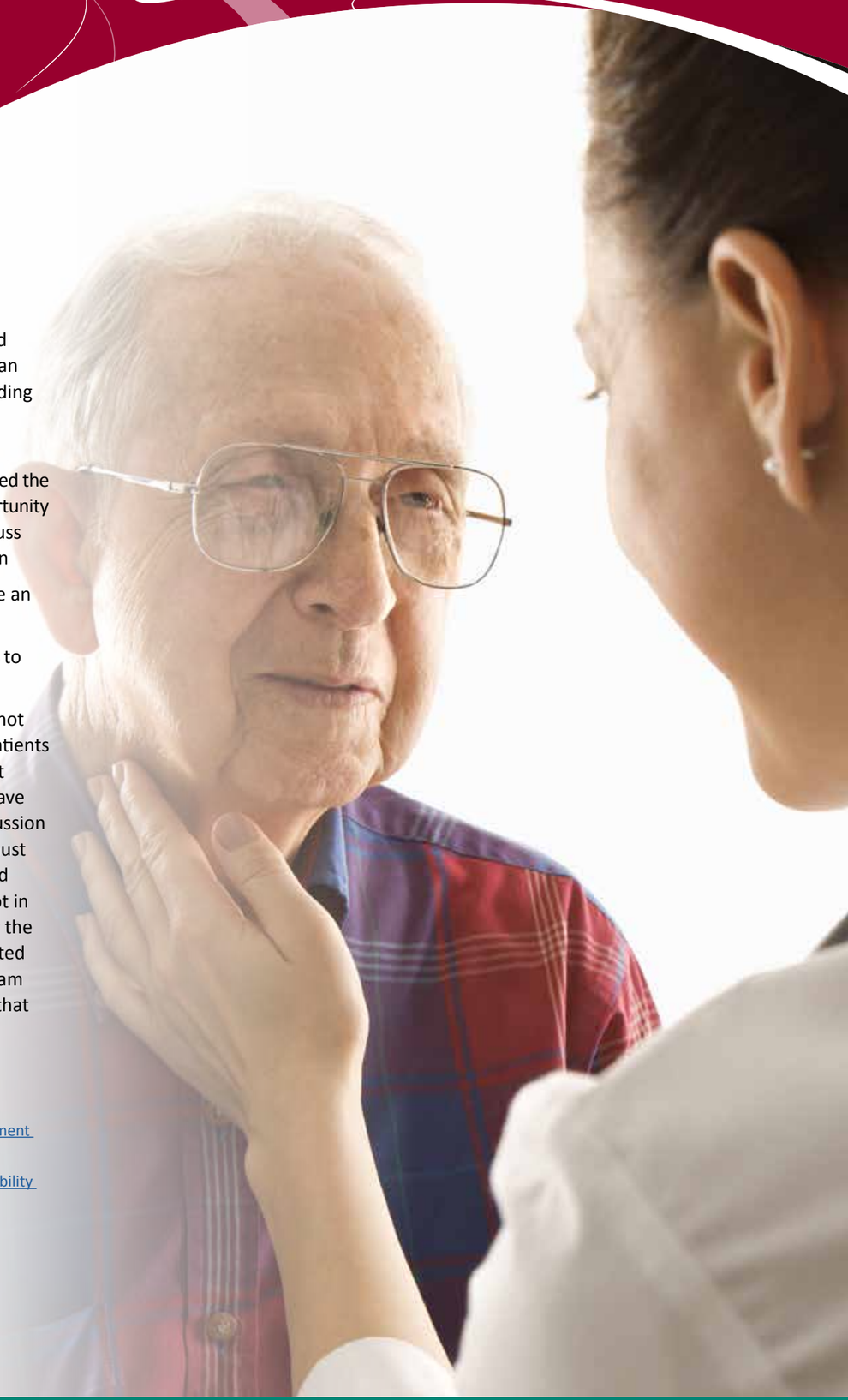
Finally, doctors should not take for granted that patients understand the consent process or what they have consented to. The discussion on informed consent must be clear and explicit and leave no room for doubt in the patient's mind over the procedure they consented to and which clinical team or doctor will perform that particular procedure.

Quick links

Good medical practice

Information, choice of treatment and informed consent

The Code of Health and Disability Services Consumers' Rights



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The following article has been provided by Connect Communications

LEARNING EPORT AND SHARPENING MEDICAL SUPERVISION SKILLS

Supervising younger doctors is an expected part of our vocation from the time that we begin on the wards. Most of us can remember our best and worst teachers vividly, with much of what 'works' being left to chance and personality. However, over the last 18 months, the Council has facilitated a major new upgrade to this model – not only regarding what is required of new doctors and how it is recorded but also providing practical help with supervision skills for senior doctors.

The New Zealand Curriculum Framework for Prevocational Training is the result of several years of wide consultation and outlines the new requirements for prevocational training of PGY1 and PGY2 (postgraduate year 1 and year 2) doctors. The Council's Strategic Programme Manager Joan Crawford has been the driving force behind a nationwide roll-out of this new training model and also the new electronic interface called ePort used to deliver it. So far, 21 nationwide supervision workshops have been hosted by the Council, involving a total of more than 500 senior doctors as participants. The function of the workshops was twofold. One was to orientate the clinical and prevocational educational supervisors to ePort, and the second was to provide an opportunity to sharpen the supervision skills required to support young doctors to move through their time on the prevocational registration pathway.

Connect Communications has been helping the Council to facilitate the Supervision Skills part of these workshops. Connect is a partnership of three doctors all with a GP and teaching background – Drs Richard Fox, Fiona Moir and Renske van den Brink. Using an interactive style, Connect has focused on presenting practical topics such as identifying the doctor in difficulty, how to engage with defensiveness, low insight and how to respond when a sensitive health issue seems to be impacting on clinical competence. There were light-hearted opportunities to 'channel your most difficult intern' and provide each other with practice scenarios to try out new supervision techniques.

Opportunities for group discussions have been invaluable. It's not often that we get an opportunity to see a live supervision session demonstrated with a 'marginal' intern who is defensive and who disagrees with the supervisors assessment. This moderation exercise was used to provoke a stimulating discussion on how to maintain a supportive relationship at the same time as holding your ground with the perceived 'bad news' of a marginal pass.

The hundreds of evaluations that were faithfully scanned and discussed have been very formative in shaping adjustments to the structure and content of the sessions, both of which have been honed to result in a concise and richly valuable learning opportunity to positively benefit our young doctors.

Quick links

Connect Communications

Prevocational training requirements

Supervision for interns

MR ANDREW CONNOLLY RE-ELECTED CHAIRPERSON OF THE MEDICAL COUNCIL OF NEW ZEALAND

Mr Andrew Connolly was has been re-elected Chairperson of the Medical Council of New Zealand.

At the Council's first meeting of the year, Mr Connolly was again unanimously elected Chairperson of Council for another 12 months.

Council members also again unanimously re-elected lay member Ms Laura Mueller as the Council's Deputy Chairperson.

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ETHICS 101

Responses to our previous column

Our last column asked what you would do in the following situation:

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 would you do?

We received one response to this question.

Dr Stephen Hoskin, a Te Anau GP and rural hospital specialist, said:

When injured patients say, "But the boss doesn't want me back until I'm fully fit," I point out that:

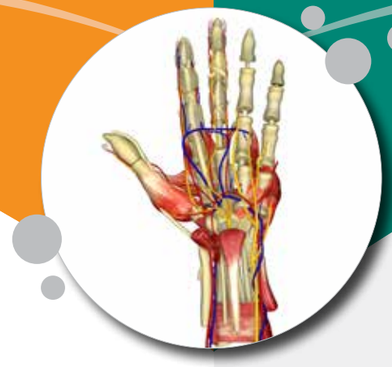
a) I am obliged to say what they can do, for example, "If you can pick up a telephone with your other hand and speak, I cannot, in all honesty, say you are fully unfit for work."

b) ACC does not require me to do a workplace assessment to determine whether or not there are other suitable duties. If there are no duties suitable for the fitness I have listed, then it is equivalent to being put off work.

c) They may be able to earn more if I put them fit for some duties (100 percent of wages rather than 80 percent since ACC continues to pay their 80 percent while patients are working up to 20 percent of usual hours).

I also find it handy to give them the ACC frequently asked questions handout that addresses these issue, for example, what if there are no light duties at work. I sometimes also point out about better recovery rates for people who continue to do what work they can.

In this particular case, I'd still try to apply the same process though accept it is much harder when a colleague has signed them off as fully unfit, there are financial implications for the patient and you don't have an ongoing relationship (though perhaps that makes it easier). I think I try to take a 'virtue' ethics approach, asking myself, "Am I being honest here?" (alternatively: "Could I explain this to a tribunal or court?")



PROVIDING CARE TO YOURSELF AND THOSE CLOSE TO YOU

It's often seen as a professional right. But is the right to prescribe prescription medications by doctors to themselves, family or friends any longer a right?

The Council's view is that, although there are some situations where treatment of those close to you is unavoidable, this should only occur when the overall management of the patient's care is being monitored by an independent practitioner.

Wherever possible, doctors should avoid treating people with whom they have a personal relationship rather than a professional relationship. Providing care to yourself or those close to you is neither prudent nor practical due to the lack of objectivity and discontinuity of care.

> Every doctor should have his or her own general practitioner because an individual doctor cannot provide objective assessment of his or her own condition.

Self-assessment may impair judgement about the diagnosis or treatment. Concern about personal and professional commitments may mean that you do not seek and receive proper care.

A lack of objectivity can also be a problem when providing care to family members, those you work with and close friends. Those with whom you have close emotional ties should have their own general practitioner who can provide appropriate care after an objective medical assessment.

When providing care to yourself or those close to you is inappropriate

Specific situations when you must not treat yourself, family members, people you work with or friends are:

- prescribing or administering medication with a risk of addiction or misuse
- prescribing psychotropic medication
- undertaking psychotherapy
- issuing certificates
- performing invasive procedures (unless an appropriate referral process has been followed).

Exceptions in certain situations

The Council acknowledges that there are some exceptions where providing care to yourself or those close to you may be unavoidable. In particular, this may be:

- in an urgent situation, where you may be required to provide treatment to yourself or those close to you until another doctor is available
- if you are working in a particular community where there are people close to you who are patients because it is difficult for them to access other practitioners. However, in this situation, there may be additional pressures, and you should be aware that objectivity may be compromised. You should have a low threshold for referring these patients to an independent doctor for consultation.

Quick links

Good prescribing practice

Council's Statement on providing care to yourself and those close to you

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