MEDICAL COUNCIL NEWS

NEWSLETTER OF THE MEDICAL COUNCIL OF NEW ZEALAND

GOOD AFTERNOON

In this issue of *Medical Council News*, we look at outcomes and initiatives from the Council's planning day, our discussion paper *Better Data – the benefits to the profession and the public*, Council's revised *Statement on advertising*, doctors' responsibilities around aviation safety and the need to provide more detail on medical certificates.

The election has been held, and I would like to take this opportunity to thank all those who stood for office and those in the profession who voted. The strength of the profession is enhanced by such participation. I look forward to working with our new colleagues on Council once the appointment process is completed.

Looking forward

In mid-March, Council staff and senior managers held a planning day to talk about initiatives that the Council will undertake in the next financial year and beyond.

Some of the key initiatives are highlighted below.

Better Data – the benefits to the profession and the public

The Council will take a lead role in defining the principles and framework for the collection and use of health outcome data. This will include engaging with the profession and other stakeholders by describing the Council's view. The Council has a leadership role because:

- the purpose and functions of the Council (sections 3 and 118 of the Health Practitioners Competence Assurance Act 2003) require the Council to protect public health and safety, promote competence, set standards and promote public awareness;
- well informed patients may come from well informed doctors; and
- outcome data is valuable for doctors in identifying areas for CPD.

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TAKING TIME OUT BEFORE SPEAKING TO THE MEDIA

On occasion, doctors are approached by journalists seeking comment for their 'expert opinion' on a particular issue or subject.

Very often, this is an important way of communicating more about research, an issue of public concern or simply raising awareness. However, it is an area that can be fraught with difficulty and misinterpretation by both colleagues and the public when a news item goes to air or print.

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THE FOLLOWING ARTICLE HAS BEEN PROVIDED BY THE CIVIL AVIATION AUTHORITY OF NEW ZEALAND

NEW ZEALAND AVIATION SAFETY: DOCTORS' RESPONSIBILITIES

To operate safely a complex system, such as aviation and the practice of medicine, depends on the contribution of many people operating at all levels in that system. One element of aviation safety is the medical safety of the personnel involved, including pilots and air traffic controllers.

The day-to-day medical certification of licensed pilots and air traffic controllers is undertaken by a group of specialised doctors, but those same aviation personnel also attend other clinics and hospitals for a wide variety of reasons.

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MEDICAL COUNCIL UPDATES ITS STATEMENT ON ADVERTISING

The Council in March released its updated *Statement on advertising*.

Council Chairman Mr Andrew Connolly says the purpose of the statement is to protect the public from advertising that is false, misleading or deceptive and to provide guidance to doctors about the advertising of health-related products and services.

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TUMESCENT LIPOSUCTION FOR DOCTORS HOLDING A GENERAL SCOPE BUT NOT PARTICIPATING IN A VOCATIONAL TRAINING PROGRAMME

At its August 2014 meeting, the Council considered whether doctors in the general scope of practice and who are not participating in a vocational training programme should be granted an extension to their general scopes of practice to enable them to perform tumescent liposuction procedures whilst meeting the requirements of Council's Policy for doctors registered in a general scope or a vocational scope of general practice who wish to perform tumescent liposuction.

Council resolved to approve this

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COUNCIL STILL RECEIVING COMPLAINTS ABOUT MEDICAL CERTIFICATES

The Council continues to receive complaints from employers and agencies about the standard of certificates that have been issued by doctors.

The Council's *Statement on medical certification* provides important information that all doctors should be aware of when completing a medical certificate.

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OUTCOME OF MEDICAL COUNCIL ELECTION

The names of the four highest-polling nominees in order of voting were:

- Dr Curtis Walker
- Dr Pamela Hale
- Dr Jonathan Fox
- Dr Kathryn Baddock

'I have written to the Minister of Health, the Hon Dr Jonathan Coleman, letting him know the outcome of the election, and I look forward to the appointment of these candidates as members of Council by him.

'The nominees are all well-known doctors within the profession and, with their experience, will add value to Council,' said Mr Pigou, the Council's Returning Officer and Chief Executive.

Mr Pigou expects that the nominees will be appointed by the Minister for a 3-year term from 1 July 2015.

A total of 15 candidates stood in the Council election, and the total number of valid votes was 3,914.

There were 14 invalid votes.

The return percentage was 22.33 percent, being 3,924 votes from 17,591 doctors who were eligible to vote.

THE MEDICAL COUNCIL WOULD LIKE TO THANK RADIO NEW ZEALAND FOR PERMISSION TO SHARE THIS ITEM.

MEDICAL REGULATOR AIMS TO BETTER INFORM

Karen Brown, Health Correspondent – karen.brown@radionz.co.nz

Updated at 6.08pm on 29 December 2014

The body charged with regulating doctors is promising to provide more information to the public about doctors' performance and competence.

The Medical Council, which celebrated its centenary in March 2015, tends to be seen as protective of doctors, at the expense of patients.

LISTEN TO OUTSPOKEN - (27 min 54 sec)

ETHICS 101

Is it inappropriate to accept a gift from a patient? Can I limit patients to one medical complaint per visit? Is it okay to refuse to accept a new patient if their medical history is complex?

There will be no right or 'wrong answers – rather, we aim to hold a thoughtful discussion about the pros and cons of various approaches. We hope that this approach will allow doctors to benefit from the wisdom of their colleagues and also create interest amongst the profession about practical ethical issues.

What would you do?

A doctor in your practice (Dr A) has several young patients whom Dr A sees regularly for a variety of conditions. One of Dr A's patients is a 2-year-old child with asthma and allergies to a range of foods (Child B). Dr A is aware that Child B's parents have given Child B up for adoption and that Child B is living temporarily with extended family.

READ MORE

GOOD AFTERNOON *continued*

Recertification for doctors on a vocational scope of practice

The Council will establish clear principles that guide the development of recertification programmes and tools, including that they are:

- professionally led – with consumer engagement;
- focused on improving the practice of doctors;
- based on identified professional learning needs;
- relevant to the specific practice of the doctor;
- formative; and
- evidence based.

Recertification for at-risk groups

Consistent with the broader recertification principles that are approved, the Council will consider establishing specific recertification programmes for at-risk groups of doctors (including working with Colleges and employers to identify their respective roles), including:

- ageing doctors, focusing on identifying barriers to safe practice such as cognitive impairment (if any) and how to maintain a fulfilling career;
- doctors working in isolation from colleagues; and
- doctors with a record of poor compliance with their continuing professional development.

Promotion of generalism

The Council will promote generalism in medical education and training – from prevocational through all vocational programmes. Generalism focuses upon clinical skills and competencies (being capable across the broad scope of vocational practice) and the skills and attitudes required for effective person/relationship-centred care. These include the ability to oversee a person's healthcare, collaboration with peers and colleagues, teamwork and communication.

Accreditation standards

The Council will work with the Australian Medical Council (AMC) and the Medical Board of Australia to develop standards of accreditation for Australasian Colleges that reflect:

- the principles guiding recertification programmes and tools; and
- the Council's requirements for College programmes to promote generalist education and training.

The Council will require New Zealand-only Colleges to meet the revised accreditation standards.

Collegial relationships

The Council will review the nature of collegial relationships and the expectations on colleagues. This will include giving consideration to whether the collegial relationship might fit into the recertification – credentialing – appraisal framework being developed by the Council, Council of Medical Colleges and District Health Boards.

Council's policies and standards for the profession

The Council will ensure its standards for the profession are clear and enforceable, i.e. that the language stands up to legal scrutiny. Priorities for standards are to:

- review the policy and standard for doctors providing tele-medicine;
- review the policy and standards on complementary and alternative medicine; and
- review the policy and standards on unprofessional behaviour and the healthcare team.

Protecting patient safety

The Council will:

- review the standards on Good prescribing practice and Prescribing drugs of abuse with a view to combining both;
- review the standards on Providing care to yourself and those close to you; and
- review and update all standards over 5 years old.

Registration and examination processes

The Council will review the AMC policy on workplace-based assessments and determine whether it is appropriate for New Zealand.

The Council will review the Educational Commission for Foreign Medical Graduates (ECFMG) Electronic Portfolio of International Credentials (EPIC) and determine whether it would be an additional valuable tool for assessing International Medical Graduates.

The Council will review the AMC's examination processes and determine whether they are appropriate for New Zealand.

As always, I would value any comments or feedback on the issues we've raised in this issue of Medical Council News ,which can be emailed to me at chair@mcnz.org.nz

Kind regards

Andrew Connolly
Chairman
Medical Council of New Zealand

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TAKING TIME OUT BEFORE SPEAKING TO THE MEDIA *continued*

The Council would offer the following general advice to doctors before undertaking a media interview, including:

- never agree to do an interview on the spot;
- remember that you do not have to answer any question immediately;
- consider whether an interview will compromise you in any way – there is absolutely no obligation for you to do an interview;
- tell the journalist you will call them back and ask what their deadline is – remember to ask for their direct line and mobile phone numbers as well as their email address;
- ask the journalist what their question line will be;
- offer to send the journalist any background material that is in the public domain that will increase their understanding of the issue or subject;
- seek the advice of your colleagues or your organisation's communications team before agreeing to undertake an interview – if it is a big story, seek professional media training;
- if you do agree to undertake an interview, identify your three or four key messages
- keep your messages short, simple and in plain English – the average sound bite for radio and television is 10–20 seconds;
- the length of time you speak to the journalist is no indication of the coverage your quotes will get;
- beware that some interviews may be adversarial;
- if you want to speak 'off the record' or offer the 'back story', make sure the journalist agrees, but be aware they do not have to honour this request and your quote may identify you as a 'reliable' or 'informed' source;
- if you want to avoid being misquoted, ask the journalist to put their questions in writing to you, and when replying, ensure that your reply is to the point and factual – often it is useful to have a colleague review your reply before sending your response; and
- if you have been misquoted or you feel that something has been taken out of context, phone the journalist, chief reporter or news editor and ask that it be corrected.

The bottom line is that if you don't want to read, see or hear something you've said, then don't say it.

Speaking and commenting to the media can be very rewarding when it goes right, but should it go wrong, the fallout will be quick, unforgiving and brutal.

The Medical Protection Society in the United Kingdom's publication A Guide for Doctors on Handling the Media is a must-read for all doctors and offers sound and practical advice on dealing with the media.

Quick link

Medical Protection Society A Guide for Doctors on Handling the Media

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THE FOLLOWING ARTICLE HAS BEEN PROVIDED BY THE CIVIL AVIATION AUTHORITY OF NEW ZEALAND

NEW ZEALAND AVIATION SAFETY: DOCTORS' RESPONSIBILITIES

continued

Because of the importance of medical aviation safety and because aviation personnel are often seen by non-aviation doctors, our government enacted a requirement for doctors to report certain cases to the Civil Aviation Authority (CAA). This legislation also contains unprecedented powerful protection for the reporting doctors.

Recently, the Chief Coroner wrote to all New Zealand District Health Boards as well as the Medical Council of New Zealand and the New Zealand Medical Association to remind them, in the wake of a tragic loss of life, of these obligations.

This article is intended as a reminder of some of the obligations and protections that apply to all doctors who see pilots and air traffic controllers as patients. This article also explains how those public safety obligations override your obligations under the Privacy Act 1993.

The risks

As a doctor, you will be aware of the potential for medical conditions to degrade aviation safety. Clearly, it would be inappropriate for an epileptic patient to be flying an airliner carrying dozens or hundreds of passengers. What is not always clear is just where the medical safety line lies.

Epilepsy is relatively straightforward, along with some serious mental health problems, but what about migraines? What about after a myocardial infarct, head injury or malignant disease? What about any of the many medical conditions that you routinely see in your day-to-day practice? What about prescribed medications?

It would not be reasonable to expect every doctor to also be expert in the field of aviation medicine or to also understand the safety thresholds that are applied by the CAA. To allow for this and to help maintain aviation safety, the civil aviation legislation (Civil Aviation Act 1990) includes requirements for doctors to report certain cases to the CAA. Those statutory requirements have a very low threshold for action, offer robust protection to the reporting doctor and ensure that it is the CAA's aviation medicine experts that make any final decisions concerning aviation medical safety.

Section 27C (3) of the Civil Aviation Act sets out the circumstances when a doctor has an obligation to report. There are three elements to the circumstances described: subject to General Directions issued by the Director of Civil Aviation; reasonable grounds to believe the patient is a pilot or air traffic controller; and reasonable grounds to suspect the patient has a medical condition that may interfere with aviation safety.

The first circumstance is very straightforward. The Director of Civil Aviation has not issued any General Directions that specifically relate to a doctor's responsibilities under this legislation.

The second circumstance simply requires the doctor to have reasonable grounds to believe that the patient is a pilot or air traffic controller.

In most cases, that information will have come to your attention from the occupational or recreational aspects of the history you've taken. In other instances, you may have been told by family members or others who know the patient. If you suspect your patient may be a pilot or air traffic controller but are not satisfied you have 'reasonable grounds to believe', you can always contact the CAA to check.

The third circumstance is based on a 'reasonable grounds to suspect' requirement, which is a relatively low burden of proof. This is entirely appropriate in a public safety situation where many people can be placed at risk from the actions of one person.

As a doctor, you do not need to be certain that your patient's medical condition may interfere with aviation safety; you merely need to have reasonable grounds to suspect.

Similarly, you are not required to believe that aviation safety will be adversely affected but just that it may.

What you must then do is also covered in the legislation. Once the circumstances outlined above have been met, your responsibilities are relatively straightforward. You have an obligation to advise the CAA (the Director) and an obligation to inform the pilot/air traffic controller that the CAA will be advised.

Informing your patient

How you do this will depend on the circumstances at the time. During a consultation, this will usually take the form of verbal advice and an entry in the patient's notes. At other times, it may take the form of a brief letter to the patient.

The CAA website www.caa.govt.nz/medical/Med_Info_Sheets/Med_info_sheets.htm) includes two medical information sheets (MISs) designed to assist doctors in this area. CAA MIS 002 describes your obligations, and CAA MIS 003 is intended to be a handout you can give to your patients that describes your obligations along with theirs. If you are experiencing any difficulty or if your patient disagrees with your decision to inform the CAA and you are unsure of your obligations, you may wish to seek advice from Medical Protection Society or from the CAA Medical Unit.

Advising the CAA

The legislation requires a timeline of 'as soon as practicable', and the fastest way to advise the CAA is to telephone and talk with a CAA staff medical officer or medical adviser. If that is not convenient, you can email, fax or write. Prompt advice is desirable, and it would be inappropriate to delay advising the CAA of a safety-relevant medical condition.

In advising the CAA, you should provide the name of the patient, their date of birth (which is often helpful for identifying an individual who may have a common name) and a basic description of the medical condition that has triggered your concern. You do not need to provide extensive detail at this point. Once it is aware of the basic issue, the CAA has responsibilities and powers to obtain additional details as necessary. You should also make a note in the patient's records of your contact with the CAA.

If you are not sure whether your patient's medical condition warrants reporting, especially if you do not have any expertise in aviation medical matters, you should contact the CAA Medical Unit and discuss the condition with one of their medical staff.

Protection

The Civil Aviation Act also provides robust protection for doctors who report to the CAA under s 27C (3). A doctor is 'not subject to any civil or criminal liability' if that doctor reports in good faith to the CAA that a pilot or air traffic controller may be unsafe.

The CAA is not aware of any doctor having faced court proceedings, civil or criminal, as a result of complying with their obligations to report such medical matters to the CAA.

Privacy

Some doctors are uncomfortable reporting a patient to another agency and sometimes (incorrectly) believe they are unable to do so because of privacy legislation. On some occasions the patient may try to dissuade the doctor from advising the CAA.

Your public safety responsibility to advise the CAA overrides your obligations under the Privacy Act. You must advise the CAA, even if your patient does not want you to.

The reason that this obligation trumps your privacy obligations is contained in section 7 of the Privacy Act. The first provision of that section provides for another 'enactment' (in this case the Civil Aviation Act) to not be derogated (overridden) by privacy principles 6 or 11. This means that your aviation safety obligations outweigh privacy principles 6 and 11.

No doctor has faced prosecution or Privacy Commissioner sanction as a result of complying with their obligations to report such medical matters to the CAA.

The pilot or air traffic controller must also report

The fact that the pilot or air traffic controller also has an obligation to report their medical situation to the CAA does not remove the obligation of a doctor to do so. You must still advise the CAA accordingly.

Failure to report

In the past, some doctors have felt, despite advice to the contrary, that the Privacy Act prevented them from advising the CAA about their patient. In those cases, the CAA chose not to pursue prosecution of the doctors but instead advised the Medical Council of New Zealand of the doctor's failure. Without exception, it resulted in the doctor reporting accordingly to the CAA.

Pilots and air traffic controllers

These obligations apply to all air traffic controllers and many, but not all, pilots. The pilots who are covered by these requirements include:

- all airline pilots;
- all other professional pilots;
- all private pilots; and
- some parachutists, hang-glider pilots, microlight pilots, home-built aircraft pilots, glider pilots, parapente pilots and so on.

If you are unsure if your pilot patient is included in these groups, you can telephone the CAA Aviation Medical Unit to seek guidance.

Section 27C (3) of the Civil Aviation Act

Subject to any directions that the Director may issue under s 27G (1)(b), if a doctor has reasonable grounds to believe that a person is a licence holder and is aware, or has reasonable grounds to suspect, that the licence holder has a medical condition that may interfere with the safe exercise of the privileges to which the licence holder's medical certificate relates, the doctor must, as soon as practicable,–

(a) inform the licence holder that the Director will be advised of the condition; and

(b) advise the Director of the condition.

Quick links

Civil Aviation Act 1990

Civil Aviation Authority of New Zealand

Civil Aviation Authority Medical Information Sheets

Privacy Act 1993

CONTACTING THE CIVIL AVIATION AUTHORITY MEDICAL UNIT

Address: Level 15, 55 Featherston Street, Wellington 6011.

Postal address: PO Box 3555, Wellington 6140.

Phone: 04 560 9466

Fax: 04 560 9470

Email: med@caa.govt.nz

Website: www.caa.govt.nz/medical/medical_home.htm

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TUMESCENT LIPOSUCTION FOR DOCTORS HOLDING A GENERAL SCOPE BUT NOT PARTICIPATING IN A VOCATIONAL TRAINING PROGRAMME *continued*

Council's policy has been amended to also allow doctors to practise tumescent liposuction, provided that they:

- hold a general scope of practice;
- are not in vocational training;
- have been practising tumescent liposuction since 2006 (when the Statement on cosmetic procedures was first introduced);
- have suitable training qualifications in appearance medicine (and especially tumescent liposuction); and
- can provide evidence of competence and safe practice in tumescent liposuction.

This is in addition to those practising tumescent liposuction who:

- are registered in a general scope (and participating in an approved vocational training programme); or
- are registered in a vocational scope of general practice.

If you meet the criteria above and are currently practising tumescent liposuction but do not hold the extension on your practising certificate, please make an application in writing to Laura Lumley, Vocational Registration Team Leader at llumley@mcnz.org.nz

Quick link

Medical Council Policy on tumescent liposuction in general practice

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COUNCIL STILL RECEIVING COMPLAINTS ABOUT MEDICAL CERTIFICATES *continued*

Most complaints relate to the brevity and/or lack of information that is provided in the certificate. Council's statement on certification details in paragraphs 10–15 the contents of a certificate. All the points made are important, but particular note is made of the need to date the certificate not only with the date of completion but also the date of examination.

Retrospective certificates must be clearly identified, being certain to distinguish between your clinical observations and findings and patient comment.

Certificates are usually intended to help to inform an employer or agency, and you should have a conversation with your patient about the information that is included to ensure that you balance appropriately your patient's privacy and what the employer/agency needs to know.

Remember always that statements and advice provided on a medical certificate must be able to be supported on the basis of your medical expertise and experience.

Quick link

Medical Protection Society Statement on medical certification

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ETHICS 101 *continued*

Dr A has been caring for Child B for over a year and has developed a bond with Child B. Dr A is considering adopting Child B as Dr A is confident that they would be able to raise Child B effectively and provide Child B with a conducive home environment. Dr A is seeking your views on the intention to adopt Child B. What would you advise Dr A?

Responses to our previous column

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

A new patient comes to see you, and although she is now well, she has a history of an anxiety disorder and had a pregnancy termination as a young woman. She is very sensitive about this information and wants assurance that it is being kept in a confidential fashion.

At her second visit, the patient expresses concern regarding her information being stored in an electronic medical record (EMR). Despite not having raised this issue at the first appointment and assurances that your office has fulfilled all of the necessary privacy and security requirements, including staff privacy training, the patient does not feel that computer systems are secure enough to safeguard her medical information. As a result, she asks that her medical information be removed from the EMR, that no future information be added to her EMR chart and has requested that you keep a paper-based medical record instead.

Your office has not used paper processes for several years, nor do you wish to revert to paper charting, but you also want to respect your patient's rights to control their own information.

What would you do?

We received four responses to this question.

Dr Catherine Gray, a Hastings GP, said:

I would do as the patient has requested. This would inspire confidence in you as a practitioner that you are hearing her concerns and acting appropriately. Perhaps I would ask her permission to keep more mundane health matters in the electronic record, e.g. URTI.

Dr John Welch, a Picton GP, suggested:

How about raising a paper record and letting the patient keep it in her possession on the understanding that it must accompany her to each consultation for updating?

Dr Simon Rowley, Auckland neonatal paediatrician:

I would point out that, regardless of privacy issues, this information is important for her reproductive/gynaecological and psychiatric health and needs to be available to her obstetrics and gynaecology and psychiatric practitioners. I would then probably open a paper folder labelled 'miscellaneous and confidential' and keep it in my practice in a locked drawer. This could be used for other similar issues of confidentiality. This sounds old fashioned, but we need to do our best to safely honour the patient's request in order to ensure future openness of medical disclosure.

Dr John Hudson:

In this case, I would discuss with her which bits of her medical info she was concerned about and remove these to a paper record held in my office (I have done this before with HIV patients).

I would encourage her to allow us to use the electronic records for routine stuff and keep the confidential bits on paper. I would ask her permission to have a key staff member in this loop, but if she refused, I would accept this. I would explain all the pitfalls inherent in a 'two-record system' without attempting to dissuade her. Most important to give her the confidence that you understand and empathise with her concerns.

So there you are. Four well-considered responses and subtly different responses. There are some common threads in that all responses aim to balance the patient's request to keep her medical history private and secure whilst ensuring that the practice also fulfils its professional obligation in relation to maintaining contemporaneous clinical records. We are very grateful to these doctors for providing their views.

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