



Cole's Medical Practice in New Zealand

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Cole's Medical Practice in New Zealand

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Preface to the 14th (2021) edition

The 14th edition aims to follow David Cole's broad intentions set out in the preface of the first edition. That is to provide a reference for all doctors new to practice in New Zealand, be they international or New Zealand medical graduates.

It also aims to be a useful reference for practising doctors wanting to refresh and update their understanding of the practice of medicine in New Zealand.

Cole's Medical practice in New Zealand was first published in 1995, and in the preface, David Cole noted that overseas trained doctors "will be expected to make themselves familiar with the legal, regulatory and professional ethical conduct requirements that are the norm for this country".

The publishing of this edition comes at a time when the New Zealand health system is facing and managing significant issues. Firstly the challenges that have arisen from the current COVID-19 global pandemic. This has meant changes and adaptations have been required in standards and statements and these have been reflected in the updates in this edition. Secondly the health system will be significantly restructured in 2022. The changes to be implemented will follow on from the government's announcements following their consideration of Health and Disability System Review that was released in June 2020. The section of this edition that details the health system reflects the system as it is at the time of publication as it is not possible to accurately reflect the changes that are to come. Readers are advised to use the provided links to obtain up to date information.

Today, to ensure that doctors practise safely, ethically and within the law, all doctors need to be familiar with the Health Practitioners Competence Assurance Act 2003, the Health and Disability Commissioner Act 1994, the Code of Health and Disability Services Consumers' Rights, the New Zealand Medical Association *Code of Ethics* and the guidance provided by their regulatory authority, the Medical Council of New Zealand – the publications *Good medical practice* and the *Statements* – standards for doctors.

Cole's *Medical practice in New Zealand* was originally published to give some practical guidelines around professional medical conduct and practice. The advice and guidance provided by the authors of this new edition of Cole's updates and adds further context to the laws, regulations and formal statements building on the foundations set by previous editions. I am grateful to all the contributors who have helped in the publication of this edition.

Kevin Morris, November 2021

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CHAPTER 1

The doctor-patient relationship

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Introduction

Professional relationships are central to the practice of medicine and to achieving good clinical outcomes. In contrast to the usual biomedical focus on symptoms, investigations, diagnosis and treatments, the doctor-patient relationship is the felt experience of the patient and doctor; their ongoing thoughts, feelings and behaviours in response to each other. As with all relationships, associated feelings can range from mild to strong. Health practitioners can derive a deep sense of satisfaction through respectful and effective relationships with their patients.¹ Clinical relationships need to be understood and developed effectively, as they can also be a source of great discomfort and even harm to both patients and doctors. Relationship skills can be learned through close observation and emulating others through their role modelling, but specific educational interventions are required for higher levels of competence.²

Most practitioners derive a deep sense of satisfaction through respectful and effective relationships with their patients.

This chapter outlines some of the underlying qualities and competencies within the doctor-patient relationship and how listening is essential to good medical care. We will discuss one of modern approaches to clinical practice called patient-centred clinical method. Reflection on practice is essential if relationship skills are to be monitored and improved. Finally, we will discuss more challenging interactions and the use of chaperones. We conclude with comments on ending the doctor-patient relationship.

1 Mendoza MD, Smith SG, Eder MM, Hickner J. The seventh element of quality: the doctor-patient relationship. *Family Medicine*. 2011;43(2):83–89.

2 Egnew TR, Wilson HJ. Role modeling the doctor-patient relationship in the clinical curriculum. *Family Medicine*. 2011;43(2):99–105.

Qualities of an effective doctor-patient relationship

Professionalism is the basis of medicine's relationship to society and can be viewed as a social contract.³ As part of this contract, doctors have an obligation to maintain their competence. In addition, doctors are expected to be trustworthy, moral, honest, compassionate and accountable. They need to work in the best interest of the patient and to maintain their own professional standards.

Although the clinical context is rapidly changing, what patients want from their doctor is not only a diagnosis and treatment but also care, kindness, courtesy and compassion.⁴ General practitioners often focus on a 'holding relationship', which aims to maintain a trusting, reliable and supportive relationship, often over long periods of time.⁵

Doctors will interact with patients from a wide range of ethnic, cultural, social and economic backgrounds. Patients' lifestyles may embody quite different underlying values to those of the doctor; it is essential that respect for all patients and their whānau is upheld. This is also mandated within the Code of Health and Disability Services Consumers' Rights.

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

Professionalism is the basis of medicine's relationship to society and can be viewed as a social contract.

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- 3 Cruess RL, Cruess SR. Expectations and obligations: professionalism and medicine's social contract with society. *Perspectives in Biology & Medicine*. 2008;51(4):579–598.
 - 4 Youngson R. *Time to care: How to love your patients and your job*. Raglan: Rebelheart Publishers; 2012.
 - 5 Cocksedge S, Greenfield R, Nugent GK, Chew-Graham C. Holding relationships in primary care: a qualitative exploration of doctors' and patients' perceptions. *British Journal of General Practice*. 2011;61(589):e484–491.

Trust is an important quality in the therapeutic relationship. Usually, however, trust is not explicitly negotiated with the patient. Given their clinical situation, many patients are quite vulnerable. Their decision to trust their doctor is sometimes based on only a brief interaction. However, trust can be developed and deepened if doctors show an early interest in the patient, display sensitivity to the patient's emotions, give time and build rapport.⁶ Doctors who encourage patients to talk, check understanding, provide information and use humour are less likely to receive complaints.⁷

Modern undergraduate training

Older doctors usually have their own particular style of consulting, largely learned through trial and error. While many have an effective bedside manner, the research on consulting skills indicates that good communication can be taught and learned and that it is not necessarily an innate or intuitive skill.⁸ For these reasons, most medical schools now include consultation training as part of their clinical skills programmes. Students are taught about the structure of each consultation and how to use 'micro-communication' skills such as introductions, open and closed questions, exploring the patient's ideas, mini-summaries and negotiating the plan of care.⁹

Further, many medical schools are now also focusing more specifically on particular skills and competencies within the doctor-patient relationship. It is explicitly stated that students need to be able to attend effectively to the emotional content of each doctor-patient relationship, are aware of their own feelings and the links between their feelings and clinical decisions, can review and reflect effectively on their interactions with various patients

6 Skirbekk H, Middelthon A-L, Hjortdahl P, Finset A. Mandates of trust in the doctor-patient relationship. *Qualitative Health Research*. 2011;21(9):1182–1190.

7 Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *JAMA*. 1997;277(7):553–559.

8 Kurtz S, Silverman J, Benson J, Draper J. Marrying content and process in clinical method teaching: enhancing the Calgary-Cambridge guides. *Academic Medicine*. 2003;78(8):802–809.

9 Kurtz SM, Silverman J, Draper J. *Teaching and learning communication skills in medicine*. Oxford: Radcliffe Medical; 1998.

including biomedical and relationship aspects and can learn and grow from the common interpersonal issues and challenges within modern clinical practice.

Most medical schools also provide specific training workshops on key professional tasks such as breaking bad news to a patient, the shift to palliative care, motivational interviewing, advance care planning, cross-cultural consultations and the use of interpreters, the Meihana and Pacific models,¹⁰ LGBTIQ awareness and so on. Communication skills in all these areas require knowledge of one's own biases and self-awareness of feelings evoked in those situations.

Skills in the doctor-patient relationship

While the qualities of the doctor-patient relationship above underpin doctors' behaviours, there are several particular competencies related to the effective doctor-patient relationships that are identifiable and learnable. These competencies include the capacity to:

- listen and communicate effectively with a wide range of patients and within a wide range of contexts
- know each individual patient as a unique person within their social situation
- respond compassionately to patients who are suffering
- vary their style for the needs of different patients
- identify and respond to the patient's thoughts, feelings and emotions
- identify sources of their own thoughts and feelings in relation to the patient and to respond appropriately
- identify and effectively manage clinical uncertainty

10 Pitama S, Robertson P, Cram F, Gillies M, Huria T, Dallas-Katoa W. Meihana model: a clinical assessment framework. *New Zealand Journal of Psychology*. 2007;36(3):118–135.

- manage their own use of time, resources and energy
- use a range of methods to review and learn about their relationships with patients.

A benchmark competency for doctors is their capacity for effective listening. This is an essential skill that reflects the doctor’s underlying values and attitudes as listed above.

The importance of listening

The three major functions of listening are to make an accurate diagnosis, to develop and maintain a high quality doctor-patient relationship and to act as a healing and therapeutic agent.¹¹ Adler for example, has researched the “socio-physiology of caring”, where empathic listening can physiologically improve patients’ muscle tension and blood pressure.¹² It can be profoundly helpful if the doctor is fully present and engages with the patient’s story and situation. ‘Being heard’ in this way can help the patient make better sense of their illness.

The three major functions of listening are to make an accurate diagnosis, to develop and maintain a high-quality doctor-patient relationship and to act as a healing and therapeutic agent.

Biomedicine and the biopsychosocial model

Briefly, the underlying knowledge basis of modern medicine has been based on what is known as the biomedical model – a particular approach to managing illness that emerged in the 16th and 17th centuries. This

11 Jagosh J, Boudreau J, Steinert Y, MacDonald M, Ingram L. The importance of physician listening from the patients’ perspective: enhancing diagnosis, healing and the doctor-patient relationship. *Patient Education and Counseling*. 2011;85 (3):369–374.

12 Adler HM. The sociophysiology of caring in the doctor patient relationship. *Journal of General Internal Medicine*. 2002;17(11):883–890.

particular medical model has of course been very powerful, affording an advanced understanding of the problems of the human body.¹³

However, modern undergraduate training programmes, especially in Australia and New Zealand, are now largely based on what is known as the biopsychosocial model, which alongside biomedical details helpfully considers each patient's personal and social context.¹⁴ One of the rationales for using this approach is the increasing evidence that communication skills within each consultation will improve the health outcomes of patients.¹⁵ Such evidence underpins emerging models of clinical practice such as the patient-centred clinical method¹⁶ – a specific version of the biopsychosocial model.¹⁷

Patient-centred methods usefully differentiate between the 'disease' (symptoms, pathophysiology, diagnosis, investigations and treatment) and the 'illness' (the patient's ideas, feelings, effect on daily life, the meaning of being unwell and any anguish or suffering), or in other words, the personal experience of illness.¹⁸ While the patient's disease is never really 'separate' to that person, this conceptual differentiation is useful as it affords some objectivity for both doctor and patient. The doctor has a body of knowledge about each disease that usually helps to predict the clinical course, while the patient's concerns are validated and justified as their problem is now legitimised.

13 Angell M, Kassirer J, Relman A. Looking back on the millennium in medicine [editorial]. *New England Journal of Medicine*. 2000;342(1):42–49.

14 Engel GL. The need for a new medical model: a challenge for biomedicine. *Science*. 1977;196(4286):129–136.

15 Griffin SJ, Kinmonth AL, Veltman MWM, Gillard S, Grant J, Stewart M. Effect on health-related outcomes of interventions to alter the interaction between patients and practitioners: a systematic review of trials. *Annals of Family Medicine*. 2004;2(6):595–608.

16 Stewart M. *Patient-centered medicine: transforming the clinical method*. Oxford: Radcliffe Publishers; 2003.

17 Wilson H, Cunningham W. *Being a doctor: understanding medical practice*. Dunedin: Otago University Press; 2013.

18 Helman CG. Disease versus illness in general practice. *The Journal of the Royal College of General Practitioners*. 1981;31(230):548–552.

In the patient-centred clinical method, doctors weave between the disease and the illness within each consultation, attending to relevant disease details while also eliciting the patient’s concerns and illness experience. This approach leads to a better negotiation of the outcome of the consultation where the patient’s ideas and expectations can often impact on decision making and the shared plan of management.

Being patient centred does not imply giving patients what they want; instead, the name emerged as a reaction against older more paternalistic styles of biomedical practice where doctors simply expected that all patients would follow their unilateral decisions. The biopsychosocial and patient-centred approaches to clinical practice have been very influential, even if most senior doctors were not explicitly trained in their use.

Monitoring your own interactions with patients

Another feature of modern undergraduate medical training is the emphasis on careful review of clinical work. Reflection involves “thoughtfully considering one’s own experiences in applying knowledge to clinical practice, while being coached by professionals within the discipline”.¹⁹ Most medical students are now required to analyse and review their consulting skills as well as to write about or discuss their seminal learning experiences. These reflective activities are known as ‘reflection on action’, as they usually occur after the event. The overall goal is ‘reflection in action’ – the capacity for increased

Reflection involves “thoughtfully considering one’s own experiences in applying knowledge to clinical practice...”

19 Schon D. The reflective practitioner: how professionals think in action. New York: Basic Books; 1983.

awareness of the ebb and flow during each consultation, whether in hospital practice or in primary care.

Modern methods of reflection include peer groups, video analysis, Balint groups, mentoring and professional supervision, as outlined below.

Peer groups have been well developed in New Zealand and are included in general practitioners' requirements for recertification. These groups started in the 1980s and are self-run by small groups of doctors who meet regularly to discuss their clinical work. Video analysis of a series of consultations is now required by general practice trainees. Many report that such analysis has enabled a better understanding of their own style of consulting.

Balint groups emerged in the UK in the 1950s when Dr Michael Balint developed methods for general practitioners to discuss their more 'difficult' or troubling patients.²⁰ The method itself has since evolved considerably, and Balint groups are now becoming more popular, especially with multi-disciplinary members.²¹ Some medical schools in the UK and Europe now provide Balint groups for their students.

Mentoring and supervision are one-to-one methods of clinical review and support. Mentoring is usually with a more senior colleague who can help a junior enter their chosen field, provide support when doctors are under stress or help a doctor start work in a new country.²² Professional supervision is usually provided by a therapist, psychologist or doctor. The focus includes the doctor-patient relationship as well as the working context. Doctors can improve their psychological understanding of patients through this ongoing mode of professional support.²³

All these methods are aimed at better understanding of the quite diverse doctor-patient relationships within modern clinical practice.

20 Balint M. *The doctor, his patient, and the illness*. London: Pitman; 1957.

21 Davis M, Wilson H. Why are Balint groups still relevant and important for GPs? *GP Pulse*. 2011;12:6–7.

22 Freeman R. *Mentoring in general practice*. Oxford: Butterworth-Heinemann; 1998.

23 Wilson H. Self-care for GPs: the role of supervision. *New Zealand Family Physician*. 2000;27(5):51–57.

Challenging clinical interactions

These methods of reflective practice are useful when clinical interactions are challenging in some way to the doctor. Historically, the problems with such interactions have usually been attributed to the patient. For example, there is a thread of literature from the UK about the ‘heartsink’ patient, where the doctor’s heart ‘sinks’ to the floor when consulting with, or even thinking about, a particular patient.²⁴ While a few patients will prove problematic for almost all doctors, most patients who are labelled in this way illustrate specific problems within the doctor-patient relationship. There are also links between doctors’ perception of their numbers of ‘difficult’ patients and an increased incidence of burnout.²⁵

‘Challenging’ patients tend to confront the doctor’s assumed authority, while ‘clinging’ patients are felt to make unrealistic demands on the doctor’s time or potential effectiveness. Those labelled as ‘self-destructive’ include patients with alcohol, drug and gambling problems; many doctors find it difficult to acknowledge that they are relatively powerless to intervene.²⁶ Cultural barriers or other factors preventing adequate communication can also induce feelings of frustration and impotence, especially if the clinician has not been trained in models of cross-cultural care.

Cultural barriers or other factors preventing adequate communication can also induce feelings of frustration and impotence.

24 Mathers NJ, Gask L. Surviving the ‘heartsink’ experience. *Family Practice*. 1995;12(2):176–183.

25 An P, Rabatin J, Manwell L. Burden of difficult encounters in primary care: data from the minimizing error, maximizing outcomes study. *Archives of Internal Medicine*. 2009;169:410–414.

26 Clark R, Croft P. Heartsink patients. In: Clark R, Croft P, editors. *Critical reading for the reflective practitioner*. Oxford: Butterworth-Heinemann; 1998. p. 267–291.

Doctors can perceive any of these patients to be ‘troublesome’, perhaps because the patient is not behaving in the ‘proper way’ as a patient or because the doctor’s internalised expectations of being competent and effective are not being met or realised. Identifying and analysing why each interaction is perceived to be ‘challenging’ or ‘heartsink’ can be extraordinarily helpful, both for the doctor and for the patient.²⁷

In brief, challenging interactions are due to a complex interaction of factors involving:

- the doctor – their internalised expectations, inexperience, feeling overworked or burnt out
- the patient – their personal attitudes, illness behaviour and culture
- the illness – complexity, chronic illness and/or whether the disease is treatable
- social factors – economic and health system inequities.

Acknowledging that some patients are challenging and disruptive to the doctor’s self-esteem and equilibrium is helpful, as without the benefit of such insight, some doctors may avoid further engagement with the patient. While this can lead to poor outcomes for patients, the doctor can also miss out on their usual sense of purpose and meaning that emerges from productive therapeutic relationships.²⁸ In this way, reflective practice about these challenging or ‘heartsink’ relationships patients can also help to avoid burnout and compassion fatigue.

A randomised prospective study reported on doctors’ use of the BREATHE OUT model (Table 1). This is an efficient and effective method of improving clinical satisfaction when the patient is perceived to be ‘difficult.’²⁹

27 Wilson H. Reflecting on the ‘difficult’ patient. *Journal of the New Zealand Medical Association*. 2005;118(1212).

28 Suchman AL, Matthews DA. What makes the patient-doctor relationship therapeutic? Exploring the connexional dimension of medical care. *Annals of Internal Medicine*. 1988;108(1):125–130.

29 Edgoose J, Regner C, Zakletskaia L. BREATHE OUT: a randomized controlled trial of a structured intervention to improve clinician satisfaction with “difficult” visits. *Journal of the American Board of Family Medicine*. 2015;28:13–20.

Table 1. The BREATHE OUT model

Pre-consultation check list: BREATHE

- List one **B**ias/assumption you have about the patient.
- **R**eflect on why you identify this patient as ‘difficult’
- List one thing you wish to **A**ccomplish today during this consultation.
- **T**Hink about one question you’d like to address today that would enable you to further explore your assumptions.
- Stop before you **E**nter the room and take three deep breaths.

Post-consultation check list: OUT

- Reflect on the **O**utcome of the encounter:
- Patient perspective – what was their agenda?
- Your perspective – did you accomplish your agenda? If not, how do you feel about it today?
- Did you learn anything **U**nexpected ?
- List one thing you look forward to addressing if you were to run into this patient **T**omorrow.

The BREATHE OUT model is a good example of structured reflection on the interaction between doctor and patient. It is a very useful way of developing more insight into the doctor-patient relationship and how that varies with each patient. Using this model regularly (applying the process to one patient per week and keeping private notes) will steadily increase doctors’ intuition about patients as well as their capacity for empathy.

‘Unexplained’ symptoms and syndromes

There is a strong thread in the medical and academic literature about patients with medically unexplained symptoms (MUS). This is a subset of patients who many doctors find ‘difficult’, largely because they were never

taught about them or weren't provided with effective explanations to give to each patient.³⁰

Such patients often present with one or more somatic complaints including chronic pain, and despite investigations, no 'organic' pathology is found. While many patients can be educated about links between stress and their symptoms, most doctors have a small group of patients whose management is more difficult.³¹

Unnecessary investigations often emerge from these unsatisfactory consultations, illustrating what is known as 'somatic fixation' where both doctor and patient collude in avoiding possible links between symptoms and the patient's personal and social context. Learning how to approach and manage the 'somatising' patient is an important clinical skill in all areas of medical practice. Despite initiatives now in medical schools to better equip students with certain skills, most doctors require specific postgraduate training on strategies to manage the consultation if they are to function effectively when interacting with these patients.³²

Interestingly, modern neuroscience is providing new understandings about the pathophysiology of these syndromes related to sensitised neurophysiological pathways. These insights are now being translated to pain neuroscience education (PNE) – an emerging explanatory model that is proving effective, especially in musculoskeletal and orthopaedic pain.^{33,34} It seems likely that further clinical advances will reduce the burden of uncertainty and mystery around such illnesses for both patient and doctor.

30 Stenhoff AL, Sadreddini S, Peters S, Wearden A. Understanding medical students' views of chronic fatigue syndrome: a qualitative study. *Journal of Health Psychology*. 2015;20(2):198–209.

31 Mann B. Generalism – the challenge of functional and somatising illnesses. *New Zealand Family Physician*. 2007;34(6):398–403.

32 Stone L, Clarke DM. Somatising disorders. untangling the pathology. *Australian Family Physician*. 2007;36(3):234–239.

33 Louw A, Zimney K, Puentedura EJ, Diener I. The efficacy of pain neuroscience education on musculoskeletal pain: a systematic review of the literature. *Physiotherapy: Theory and Practice*. 2016;32(5):332–355.

34 Dunbar J, Wilson H. Emerging models for successful treatment of complex regional pain syndrome in children and young adults. *Journal of Primary Health Care*. 2019;11(3):283–287.

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

Professional and sexual boundaries

Given the power imbalance between doctor and patient, setting and maintaining appropriate professional boundaries is the responsibility of the doctor. A sexual relationship with a patient is never acceptable, as it violates the trust in the relationship and is harmful to both parties. The Council provides clear guidelines about sexual boundaries.³⁵ If you are feeling

sexually attracted to a patient, the first step is recognise this as a potential problem that will inevitably interfere with your professional responsibilities for that patient. You are strongly advised to discuss the clinical situation with a trusted colleague and to take their advice. As professional role boundaries are complex, medical students need specific education as they learn about their future responsibilities.

A related issue is sexual harassment of medical trainees or junior doctors by senior staff – something that is never acceptable in the workplace or in training institutions. Unfortunately, there is evidence that this does occur and that there are difficulties in reporting it.³⁶ It is important that senior doctors and clinical teachers provide safe and effective role modelling of professional and sexual boundaries for their junior staff at all levels of training.^{37,38}

A sexual relationship with a patient is never acceptable, as it violates the trust in the relationship.

35 <https://www.mcnz.org.nz/assets/standards/3f49ba8048/Sexual-boundaries-in-the-doctor-patient-relationship.pdf>

36 Braid H, et al. Sexual harassment of junior doctors: helping whistle blowers who reveal a significant mental health issue. *Journal of Ethics in Mental Health*. 2019;10:1–13.

37 White GE. Setting and maintaining professional role boundaries: an educational strategy. *Medical Education*. 2004;38(8):903–910.

38 Spickard WA, Jr., Swiggart WH, Manley GT, Samenow CP, Dodd DT. A continuing medical education approach to improve sexual boundaries of physicians. *Bulletin of the Menninger Clinic*. 2008;72(1):38–53.

Use of chaperones or practice monitors

It is recommended best practice to offer a chaperone for all intimate examinations. A chaperone acts as an independent person within the consultation, for both the safety of the doctor and of the patient. Patients may also request their support person to be present, who can provide practical and emotional support for the patient. Many colleges now recommend that a notice is placed in clinic rooms informing patients of their right to have a chaperone if they wish.

All medical students (and some doctors under Medical Council review) are required to have a chaperone or practice monitor present when intimate examinations are conducted.³⁹

Ending a clinical relationship

The usual reason why doctors end their therapeutic relationships with their patients is their impending retirement or when they plan to sell or transfer their practice to another doctor, whether in specialist or general practice. The general guideline for all these situations is to carefully advise your patients in advance about why you are leaving and when and who your replacement will be. Many doctors also provide opportunities for patients to meet with the new doctor who is taking over.

The patient and the doctor must be clear about the reasons for ending the relationship, and the transfer of care needs to be managed carefully.

The process of ending a practice needs to be respectful of the mutual investment in the clinical relationship by both doctor and patient. Not taking time and care about such handovers may be felt as a betrayal by

39 <https://www.mcnz.org.nz/assets/standards/befe33a3ce/When-another-person-is-present-during-a-consultation.pdf>

some patients. Doctors who are buying into a practice are advised to enquire about the proposed plan for transfer of patients into their care.

Occasionally, however, the therapeutic relationship may become so troublesome and damaged that it feels better to stop seeing that patient, although in general, it is preferable to see if the problems can be resolved. The patient and the doctor must be clear about the reasons for ending the relationship, and the transfer of care to another doctor or clinic needs to be managed carefully.⁴⁰ In some situations, expert medical and legal advice is helpful, but cessation of care cannot occur if the patient needs acute or emergency medical help. Stokes has outlined further models for ending this sort of relationship in the general practice setting.⁴¹

On the other hand, doctors can also be ‘fired’ by their patients, often by requesting their medical notes to be transferred to another doctor. Such rejection from patients can trigger feelings of awkwardness and self-doubt, illustrating the depth of the doctor’s unconscious investment in that therapeutic relationship.⁴² Such experiences are useful triggers for reflection, which can lead to greater insight into one’s motivations for and expected rewards from being a doctor.

In summary, the doctor-patient relationship is central to the practice of medicine. Clinical relationships require as much focus and attention to detail as do technical competence or biomedical issues. The end result of this focus on relationship skills includes enhanced practitioner satisfaction, better clinical outcomes and a greater sense of professional wellbeing.

40 <https://www.mcnz.org.nz/assets/standards/e223e8f01b/Ending-a-doctor-patient-relationship.pdf>

41 Stokes T, Dixon-Woods M, McKinley RK. Ending the doctor-patient relationship in general practice: a proposed model. *Family Practice*. 2004;21(5):507–514.

42 Smith AK, Buss MK, Giansiracusa DF, Block SD. On being fired: experiences of patient-initiated termination of the patient–physician relationship in palliative medicine. *Journal of Palliative Medicine*. 2007;10(4):938–947.

CHAPTER 2

Interdisciplinary collaboration: working in teams for patient care

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Introduction

New Zealand health care relies on the skills of many health and other professionals. This has been highlighted during the COVID-19 pandemic where professionals have worked together collectively in pursuit of a common goal.^{43,44} This collaborative approach across health and social care is necessary now more than ever. Health care provided by a range of health disciplines is especially needed for those with long-term or complex needs, particularly those who experience inequity in health outcomes. People in these situations are often less able to advocate for themselves or coordinate their own health care, thus increasing the need for health professionals involved in their care to proactively work together. This focus leads to patient-centred, whole-person-focused and equity-intended care.^{45,46,47} Doctors have a key role in enabling a coordinated and collaborative approach⁴⁸ because interdisciplinary models of team care result in safer, higher-quality care for patients, providers and systems.^{49,50}

A culturally safe focus on the patient (and family and whānau) is needed along with collaborative care provided by a range of health disciplines

43 Huston P, et al. COVID-19 and primary care in six countries. *BJGP Open*. 2020;4(4).

44 Bandyopadhyay G, Meltzer A. Let us unite against COVID-19 – a New Zealand perspective. *Irish Journal of Psychological Medicine*. 2020;37:218–221.

45 Phelan M, Stradins L, Morrison S. Towards a global definition of patient centred care. *BMJ*. 2001;322:444–445.

46 Starfield B. Is patient-centered care the same as person-focused care? *The Permanente Journal*. 2011;15(2):63–69.

47 Department of the Prime Minister and Cabinet. Our health and disability system. Wellington: Department of the Prime Minister and Cabinet; 2021.

48 Cohen DJ, et al. Integrating behavioral health and primary care: consulting, coordinating and collaborating among professionals. *Journal of the American Board of Family Practice*. 2015;28:S21–S31.

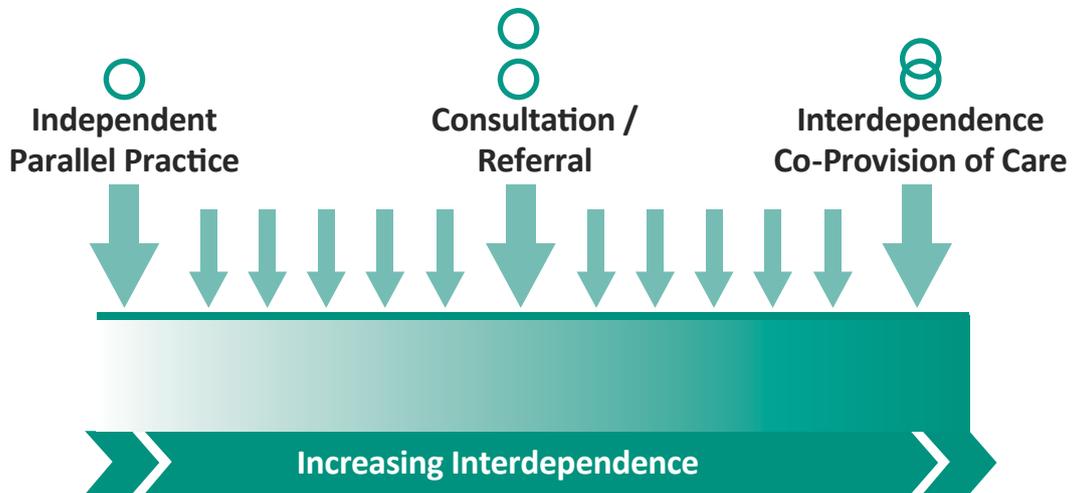
49 Gawande A. How do we heal medicine? [Internet]. Ted Talks;2012; Available from: https://www.ted.com/talks/atul_gawande_how_do_we_heal_medicine

50 Paterson R. Lessons from complaints: implications for medical education. *New Zealand Medical Journal*. 2010;123:6–11.

Collaboration – always needed?

While particularly necessary for patients who have long-term or complex conditions, interdisciplinary fully collaborative care is not always appropriate, needed or effective. For example, the diagnosis and treatment of a sore throat in an otherwise well adult is generally and appropriately undertaken by one health professional. The spectrum of collaboration best explains this continuum (see Figure 1).

Figure 1. The spectrum of collaboration.⁵¹



51 Oandasan I, et al. Teamwork in healthcare: promoting effective teamwork in healthcare in Canada. Ottawa, Ontario: Canadian Health Services Research Foundation; 2006.

What is collaboration?

While the terms ‘teamwork’ and ‘collaboration’ are often used in the same breath, the words convey different meanings. Individuals of different disciplines may provide care to the same patient and consider themselves as part of a team. However, for teamwork to be effective, there must be collaboration. The following definition of interdisciplinary collaboration describes partnership and mutual decision making within a working relationship: “An active and ongoing partnership often between people from diverse backgrounds with distinctive professional cultures and possibly representing different organisations or sectors, who work together to solve problems or provide services.”⁵²

Collaborative interdisciplinary care aligns with New Zealand policy and law (see Figure 2). It also aligns with models of health care delivery, notably Te Whare Tapa Whā, with the four cornerstones of health encompassing all facets of wellbeing: taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health) and taha hinengaro (mental health).⁵³ This is particularly important when clinicians work in partnership with individuals and communities to enable improved Māori health outcomes and reduce inequity.^{54,55,56}

Collaborative interdisciplinary care aligns with New Zealand models of health care delivery, notably Te Whare Tapa Whā...

52 Morgan S, Pullon S, McKinlay E. Observation of interprofessional collaborative practice in primary care teams: an integrative literature review. *International Journal of Nursing Studies*. 2015;52:1217–1230.

53 Durie M. A Maori perspective of health. *Social Science & Medicine*. 1985;20:483–486.

54 See footnote 47.

55 Waitangi Tribunal. HAUORA Report on stage one of the Health Services and Outcomes Kaupapa Inquiry (Wai 2575). Wellington: Waitangi Tribunal; 2019.

56 Ministry of Health. Whakamaua: Māori Health Action Plan 2020–2025. Wellington: Ministry of Health; 2020.

Figure 2. Collaborative interdisciplinary care.



New Zealand health care practitioners are legally required by the Health Practitioners Competence Assurance Act 2003 to promote and facilitate interdisciplinary collaboration and cooperation when delivering health services. The Code of Health and Disability Services Consumers’ Rights also recognises each consumer’s right to cooperation among health care providers to ensure quality and continuous health care services through Right 4: Right to Services of an Appropriate Standard.

The Health Quality & Safety Commission New Zealand names teamwork and communication as one of seven domains of the New Zealand Health and Safety Capability Framework. This domain is defined as “working with others across professional, organisational and cultural boundaries to achieve shared quality and safety goals”.⁵⁷ Interdisciplinary collaboration reduces clinical error as well-functioning teams make fewer mistakes than individuals.⁵⁸ It also leads to more-timely referrals, more-effective

57 <https://www.hqsc.govt.nz/assets/Quality-Improvement/PR/From-knowledge-to-action-Oct-2016.pdf>

58 <https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/HQSI-indicators-summary-report-Dec-2012.pdf>

resource allocation, better use of disciplinary skill sets and more-holistic care provision, and patients are less likely to fall between services. When enacted, patients have higher levels of satisfaction and are more likely to have better access to health care and improved self-management skills.^{59,60} Staff also enjoy higher levels of work satisfaction, with workforce retention and efficiency savings likely to occur.⁶¹

Policy also directs health professionals to work collaboratively to achieve the best outcomes for consumers. Practising as one team is a core theme of the New Zealand Health Strategy.⁶² One team involves professionals from multiple disciplines and organisations working together with the person and their family and whānau at the centre of care. To realise this goal requires health professionals to develop new or stronger skill sets that enable effective communication, mutual respect and shared values.^{63,64} This model also acknowledges the person, their family and whānau as members of the team, fully involved in shared decision making and achieving consensus about goals of treatment and care. This goal has been reiterated by the 2020 Health and Disability System Review,⁶⁵ which identified an urgent need to facilitate interdisciplinary learning to gain a broader understanding and trust of other disciplines and reduce professional silos.

We have recognised the need to change the culture of how we practice towards a greater degree of collaboration. Most disciplines now define

59 Thornhill J, Dault M, Clements D. CHSRF knowledge transfer: Ready, set... collaborate? The evidence says “go,” so what’s slowing adoption of inter-professional collaboration in primary healthcare? *Healthcare Quarterly*. 2008;11:14–16.

60 Orchard C, Curran V, Kabene S. Creating a culture for interdisciplinary collaborative professional practice. *Medical Education Online*. 2009;10:1–13.

61 Richards DA, et al. Clinical effectiveness and cost-effectiveness of collaborative care for depression in UK primary care (CADET): a cluster randomised controlled trial. *Health Technology Assessment*. 2016;20(14):1–192.

62 <http://www.health.govt.nz/publication/new-zealand-health-strategy-2016>

63 Lingard L, et al. Communication failures in the operating room: an observational classification of recurrent types and effects. *Quality & Safety in Health Care*. 2004;13:330–334.

64 See footnote 57.

65 <https://systemreview.health.govt.nz/assets/Uploads/hdsr/health-disability-system-review-final-report.pdf>

interdisciplinary competencies.^{66,67,68,69} Experienced doctors and other health professionals can achieve these competencies through intentionally learning about roles and skills of others and by engaging in interdisciplinary programmes of postgraduate study (see Figure 3). New Zealand pre-registration students now attain collaborative practice competencies^{70,71} through interprofessional education programmes in the classroom,^{72,73,74,75} in clinical workplaces⁷⁶ and in remote environments.^{77,78,79} It is vital, however, that students see effective teamwork in practice to consolidate academic learning and reduce the risk that entrenched hierarchical attitudes or suboptimal processes are perpetuated through a ‘hidden curriculum’.^{80,81} Experienced or senior practitioners need to be made aware of how they come across to colleagues and be open to input from their younger colleagues in relation to what they have learned about interprofessional practice.

66 https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx

67 <https://www.physioboard.org.nz/standards/physiotherapy-thresholds>

68 <https://www.amc.org.au/wp-content/uploads/2019/10/Standards-for-Assessment-and-Accreditation-of-Primary-Medical-Programs-by-the-Australian-Medical-Council-2012.pdf>

69 <https://www.dietitiansboard.org.nz/Portals/12/RCR's.pdf?ver=2016-08-25-144832-837>

70 <https://www.mcgill.ca/ipeoffice/ipe-curriculum/cihc-framework>

71 <https://www.otago.ac.nz/healthsciences/staff/ipe/otago741928.pdf>

72 Darlow B, et al. The positive impact of interprofessional education: a controlled trial to evaluate a programme for health professional students. *BMC Medical Education*. 2015;15:98.

73 Pullon S, et al. Interprofessional education for physiotherapy, medical and dietetics students: a pilot programme. *Journal of Primary Health Care*. 2013;5:52–58.

74 Pullon S, et al. Transition to practice: can rural interprofessional education make a difference? A cohort study. *BMC Medical Education*. 2016;16:154

75 McKinlay E, Pullon S. Having interprofessional education during the undergraduate years is essential for building teamwork skills in general practice. *Journal of Primary Health Care*. 2014;6:331–333.

76 McKinlay E, et al. Interprofessional education for cancer care. *The Clinical Teacher*. 2018 15:1–6.

77 Pullon S, et al. Five years on: influences on early career health professionals from a rural interprofessional pre-registration immersion program. *Australian Journal of Rural Health*. 2021;29(2):146–157.

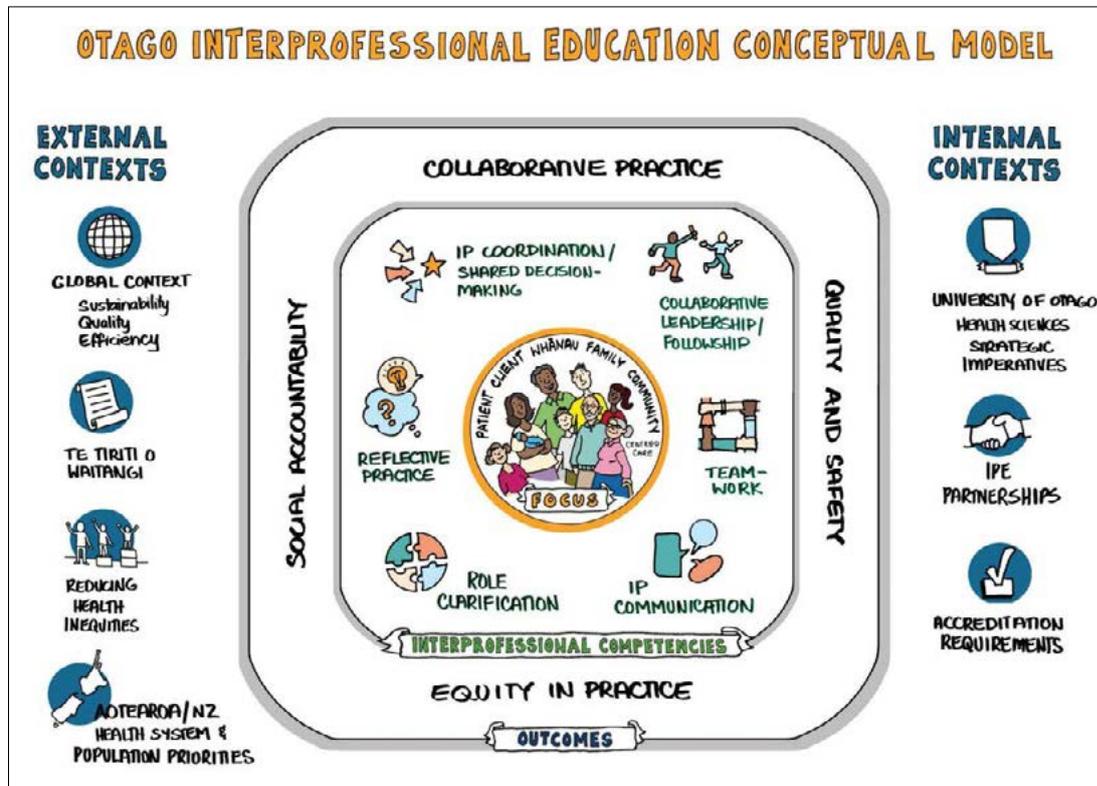
78 Darlow B, et al. Longitudinal impact of interprofessional education on attitudes, skills and career trajectories: a protocol for a quasiexperimental study in New Zealand. *BMJ Open*. 2018;8:e018510

79 Doolan-Noble F, Pullon S, Symes A. Trusting me, trusting you: creating conditions for successful pre-registration interprofessional education in rural New Zealand workplace settings. *Australian Journal of Rural Health*. 2021;29:291–293.

80 Andarvazh MR, Afshar L, Yazdani S. Hidden curriculum: an analytical definition. *Journal of Medical Education*. 2017;16:198–207.

81 Frenk J, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*. 2010;376:1923–1958.

Figure 3. Policy, legislation, quality and interprofessional education supports collaborative teamwork.



Collaborative teamwork

Collaborative interdisciplinary teams explicitly commit to cooperate in order to meet shared goals, starting with those of the patient and family and whānau. Members focus on achieving an agreed management plan.⁸² These types of teams are “characterised by a greater interdependence, jointly defined goals and client-centred plans”⁸³ giving recognition and value to the expertise and perspectives of other disciplines.⁸⁴ All are reliant on the skills of others to achieve the necessary goals of treatment or care. This means the unique skills of each discipline are best utilised and

82 See footnote 51.

83 Solheim K, McElmurry BJ, Kim MJ. Multidisciplinary teamwork in US primary health care. *Social Science and Medicine*. 2007;65:622–634.

84 Drinka T, Clark P. *Health care teamwork: Interdisciplinary practice and teaching*. Westport, Connecticut: Auburn House; 2000.

common values and skills affirmed by all. Communication equity means all disciplines are able to contribute to care and speak up about quality and safety concerns.

We all recognise collaborative teamwork when it's working well with a range of disciplines working seamlessly together. Here are two examples:

- The Emergency Department (ED) team is undertaking resuscitation. The team of health professionals (most often doctors and nurses) train together and know and trust each other. Each person has a particular role and yet there is flexibility, with some skills able to be undertaken by a range of health professionals (chest compressions, cannulation) and others that are discipline specific (intubation). The team measures success by the delivery of timely, competent and appropriate resuscitation procedures undertaken by a team who each undertook their roles in a seamless, coordinated manner. Even though ED teams should and do continually strive to better their resuscitation outcomes, success is also about good team processes that achieve best possible outcomes in often difficult circumstances.
- The community-based team is working with an older person with arthritis, type 2 diabetes and obesity who has pain and immobility and is struggling to remain independent at home. The team might include a mix of the following: diabetes nurse educator, dietitian, general practitioner or nurse practitioner,⁸⁵ pharmacist, physiotherapist, primary health care nurse, social worker and possibly an endocrinologist, exercise or sports instructor, occupational therapist, physiotherapy specialist⁸⁶ and rheumatologist. It should also include the patient and the family, whānau or close supporters in the patient's social network.^{87,88} Roles

85 https://www.nursingcouncil.org.nz/NCNZ/Education-section/Nurse_practitioner.aspx

86 <https://www.physioboard.org.nz/i-want-to-be-registered/specialist>

87 McKinlay E, McDonald J, Darlow B, Perry M. Social networks of patients with multimorbidity: a qualitative study of patients' and supporters' views. *Journal of Primary Health Care*. 2017;9:153–161.

88 McKinlay E, McDonald J, Darlow B, Perry M. The social networks of New Zealand patients with multimorbidity and the work of those nominated as their 'significant supporters': an exploratory study. *Health and Social Care in the Community*. 2019;27:392–399.

may be organised by skills, possibly performed by one of several disciplines (assessment and support of ability to stay at home, prescribing, home assessment) or by the support or care able to be provided by a particular discipline (physiotherapy for maximising mobility and function, occupational therapy for home modification, nursing for mobilising family support, pharmacist for medicines use review). The team measures their success by effectively forming a partnership with the patient (and family and whānau) in order to meet their goals and, when possible, to appropriately self-manage. If this is not possible, the team will continue to support them by putting other measures in place.^{89,90,91} Other important professional roles could be Whānau Ora patient navigators, community support workers, kaiawhina, health coaches and health improvement practitioners. These new roles play an explicit role in supporting a patient/client's mental wellbeing and positive behaviour change. They also improve communication between everyone and support better understanding of health conditions and treatments and decisions.

However, in contrast other team structures can have restrictive or hierarchal structures that can lead to inadequate or poor collaboration:

- In some teams, different disciplines are each involved in the patient's care but report back on referrals solely to the senior doctor leader, who then unilaterally directs patient care. The limitation of this model is not that the senior doctor is the team leader – they may indeed be the best person to lead the team at a particular time – but that there is little or no opportunity for sharing wisdom or shared decision making. This might be appropriate

89 See footnote 44.

90 Seale B. Patients as partners: building collaborative relationships among professionals, patients, carers and communities. London: The Kings Fund; 2016.

91 Habel C, et al. COVID-19 outbreak management in a hospital ward: lessons learned to prevent, prepare for and respond to infectious disease outbreaks in healthcare settings. *New Zealand Medical Journal*. 2021;134:97–102.

in some settings (perhaps in the consultation/referral stage in the spectrum of collaboration), but the approach has significant limitations wherever ongoing complex care is needed. Not only does it inadvertently reduce possible alternative quality options for patients, it can also sideline or ignore members of other disciplines or disempower junior staff, making it hard for them to contribute to care or speak up, even about issues of basic safety.⁹² It is teams like this that are the source of the extensive literature in nursing ethics on moral distress: “Often, nurses’ difficulty is not in determining what the right course of action is, it lies in determining when the choice is apparent, but nurses are not able to implement the morally acceptable action.”⁹³

- Some teams require the input of many services in and outside of health care – for example, when helping people with addiction or post-traumatic stress disorder or young people with behavioural problems. Typically, these teams may include members from health, social care, corrections, education, justice and Oranga Tamariki. Unless methods to collaborate are decided up front and the rules around sharing of information agreed, collaborative teamwork may fail and patient care will suffer just when it is needed the most.

We know collaborative teams do not happen by chance. Within New Zealand, a number of factors have been shown to contribute to successful interdisciplinary teams including skilful leadership in each discipline, readiness for an interdisciplinary culture, commitment to change, interdisciplinary respect and opportunity for trust to develop between individuals and across the team.⁹⁴ Physical geography (including co-location or not of disciplines or services) also impacts on ability to work collaboratively. Effective building design positively influences team

92 See footnote 63.

93 Deschenes S, Kunyk D. Situating moral distress within relational ethics. *Nursing Ethics*. 2020;27:767–777.

94 Pullon S. Competence, respect and trust: key features of successful interprofessional nurse-doctor relationships. *Journal of Interprofessional Care*. 2008;22:133–147.

members' ability to talk frequently and informally and thus gain trust and confidence in each other.^{95,96} Organisational structures can support institutional change⁹⁷ or lead to the formation of cross-disciplinary arrangements such as the Integrated Health Care Framework for Pharmacists and Doctors, which endorses doctors and pharmacists working together.⁹⁸ All these things result in positive “alterations to existing health professionals' values, socialisation patterns and workplace structures”.⁹⁹

Even though the evidence points to the benefits of collaborative approaches in health care delivery for patients with long-term and/or complex conditions, the application of these models is variable and far from being universally adopted. Champions are needed to support collaborative processes wherever these are appropriate for optimal patient care, regardless of tradition or discipline, and to actively work to overcome barriers to collaboration. Meeting in teams can be time and resource intensive with organisational and funding support being necessary. Practicalities need consideration: having a place or method to meet, time to build trust and a form of payment for members who are private businesses.¹⁰⁰ Entrenched attitudes about scopes of practice, professional ‘turf’ and historical power structures can sabotage the essence of what good teamwork is.¹⁰¹

95 Pullon S, Morgan S, Macdonald L, McKinlay E, Gray B. Observation of interprofessional collaboration in primary care practice: a multiple case study. *Journal of Interprofessional Care* 2016;30:787–794.

96 Morgan S, Pullon S, McKinlay E, Garrett S, Kennedy J, Watson B. Collaborative care in primary care: The Influence of practice interior architecture on informal face-to-face communication – an observational study. *HERD*, 2021;14:190–209.

97 See footnote 59.

98 <https://www.nzma.org.nz/publications/integrated-healthcare-framework>

99 See footnote 60.

100 See footnote 52.

101 Khalili H, Hall J, DeLuca S. Historical analysis of professionalism in western societies: implications for interprofessional education and collaborative practice. *Journal of Interprofessional Care*. 2014;28:92–97.

Doctors have had a key role in supporting collaborative interdisciplinary teams by fostering professional respect for and trust in other disciplines by initiating patient-centred, person-focused forms of clinical decision making in which various disciplines take the lead.^{102,103}

The patient and whānau as members of the care team

It is now accepted that the patient must be a member of the care team and that including the family/whānau leads to better outcomes for everyone.¹⁰⁴ Partnering with the patient and family/whānau includes developing an agreed management plan. We know that having an agreed management plan leads to an increased likelihood of behaviour change, concordant health care decisions, patient activation (skills knowledge and confidence to manage one's own health) and greater adoption of self-

management skills.^{105,106,107,108} The Health Quality & Safety Commission New Zealand support this. They state: “enabling consumers/patients to become equal partners in care requires support that builds consumers’/patients’ self-efficacy, self-awareness, confidence and coping skills”.¹⁰⁹

There are many benefits of involving patients within the care team.

102 Stiggelbout A, et al. Shared decision making: really putting patients at the centre of healthcare. *BMJ*. 2012;344:e256.

103 Coulter A. Making shared decision-making a reality: no decision about me, without me. London: The Kings Fund; 2011.

104 Cassim S, et al. Indigenous perspectives on breaking bad news: ethical considerations for healthcare providers. *Journal of Medical Ethics*. 2021;0:1–5.

105 See footnotes 90 and 103.

106 Coulter A, Ellins J. Effectiveness of strategies for informing, educating, and involving patients. *BMJ*. 2007;335:24–27.

107 https://www.health.govt.nz/system/files/documents/publications/self-management-support-people-with-long-term-conditions-feb16_0.pdf

108 Hibbard JH, Greene J. What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. *Health Affairs*. 2013;32(2):207–214.

109 See footnote 57.

Wherever possible, patients need to be able to both establish and revisit their role within the team; some may choose at some times to be passive receivers of proffered treatment but at other times to reject or substantially alter management recommendations.

That is not to say that patients either need or should be expected to take sole responsibility for all care decisions, especially when wellbeing and ability to self-manage fluctuates (for example, with multimorbidity,¹¹⁰ mental health conditions and palliative care).¹¹¹ Patients and family/whānau are entitled to hear clearly expressed, thoughtfully considered recommendations for care from health professionals, particularly in complex situations where there is no single right answer.¹¹²

Leading and following: roles in collaborative teams

Different disciplines can take the lead or share leadership within a distributed model,¹¹³ which acknowledges “no one leader can provide all the leadership in any complex situation”.¹¹⁴ Teams need good leaders and good followers. Knowing when it is appropriate to take the leader role and when it is time to be a supporting member of a team is a key skill in being a good team player and ensures effective communication and good team processes are followed by everyone.^{115,116} Being an effective follower offers the possibility of mentoring or supporting new or rotating leaders by shaping and supporting their decisions and assisting the implementation;

110 Mangin D, Stephen G, Bismah V, Risdon C. Making patient values visible in healthcare: a systematic review of tools to assess patient treatment priorities and preferences in the context of multimorbidity. *BMJ Open*. 2016;6:e010903.

111 Austin CA, Mohottige D, Sudore RL, Smith AK, Hanson LC. Tools to promote shared decision making in serious illness: a systematic review. *JAMA Internal Medicine*. 2015;175:1213–1221.

112 <https://www.mcnz.org.nz/assets/standards/79e1482703/Statement-on-informed-consent.pdf>

113 Chatterjee R, Suy R, Yen Y, Chhay L. Literature review on leadership in healthcare management. *Journal of Social Science Studies*. 2018;5:38–47.

114 See footnote 84.

115 Varpio L, Teunissen P. Leadership in interprofessional healthcare teams: empowering knotworking with followership. *Medical Teacher*. 2021;43:32–37.

116 Uhl-Bien M. Complexity leadership and followership: changed leadership in a changed world. *Journal of Change Management*. 2021;21(2):1–19.

this is shown in our examples above. In the ED resuscitation situation, a resuscitation nurse specialist or nurse practitioner may take the lead to ensure good communication and that all essential tasks are undertaken, while another nurse undertakes chest compressions and the ED physician concentrates on intubating the patient. In the community-based example, a physiotherapist may lead the team and, as well as undertaking a functional assessment of the patient's mobility, scan the home environment and family and whānau network for factors that can then be discussed with the occupational therapist, general practitioner and practice nurse. A bonus of this model is that the burden of leading and providing care is shared between all disciplines and the risk of staff burnout is reduced.

Being an effective follower offers the possibility of mentoring or supporting new or rotating leaders by shaping and supporting their decisions.

Knowing what your own role is in a team (leader, responsible for a particular task) is just as important as knowing what others' roles are, and this is particularly so when the composition of teams change or teams form for time-limited periods. Roles may be defined by the specific skill sets disciplines possess, but where skills are held in common (communication or common procedural skills), roles need to be negotiated.¹¹⁷ It is only by discussing and practising how the different team members each contribute to patient care that role clarification is achieved. Role clarification is one of the most important requirements of a well-functioning team. Once it is achieved, the team is well placed to swing into action in any given situation, often with just a few well-chosen words, as each member anticipates and trusts in each other's respective roles.¹¹⁸

A common concern when a team of disciplines is involved is the issue of who is ultimately responsible for the patient's care. In the past, doctors

117 Hall P, Weaver L. Interdisciplinary education and teamwork: a long and winding road. *Medical Education*. 2001;35:867–875.

118 Vyt A. Interprofessional and transdisciplinary teamwork in health care. *Diabetes/Metabolism Research and Reviews*. 2008;24:S106–S109.

have assumed varying degrees of responsibility for the practice of other clinicians involved in patient care. The regulatory framework is now clear that each professional is responsible for their work within their scope of practice.¹¹⁹

Student health professionals (including medical students) hold a limited responsibility for patient care, as they are working under the direct supervision of a more experienced colleague. However, they can be included within the team for the purposes of learning.^{120,121,122} Once junior staff are registered, they must work within a scope of practice commensurate with their qualification and level of experience, reporting to more senior colleagues but still responsible for their own practice within their expected scope. Adequate communication and collaboration with all health professional colleagues is also expected and essential practice. The Health and Disability Commission reports more frequently on a breakdown of collaboration between professionals than on the responsibility of the individual clinicians being deficient.¹²³

Interdisciplinary collaboration in primary and community care

Great gains can be made in reducing inequity in health care if professionals work collaboratively in primary and community care services.

Collaborative service delivery models enable best use of other disciplines' skill sets in a time when general practitioners and nurse practitioners are dealing with increasingly complex patients in the community. This means patients may not access general practitioners or nurse practitioners for all health presentations but can still receive excellent and appropriate care

119 Health Practitioners Competence Assurance Act 2003.

120 Young J, et al. An exercise to map patient-centred care networks. *The Clinical Teacher*. 2016;13:1–3.

121 Egan T, Jaye C. Communities of clinical practice: the social organization of clinical learning. *Health*. 2009;13:107–125.

122 Jaye C, Egan T. Communities of clinical practice: implications for health professional education. *Focus on Health Professional Education*. 2006;8:1–10.

123 Paterson R. *The good doctor: what patients want*. Auckland: Auckland University Press; 2013.

from nurses, community pharmacists or other health professionals working within primary care services.¹²⁴

Some factors may need to be changed when developing new collaborative teams or enhancing existing teams. As noted, limited geographical co-location of services, mixed capitation/fee for service funding and the owner-operated business model of many New Zealand general practices can make collaboration more difficult.¹²⁵ Furthermore, barriers need to be overcome so professionals with

patient permission can access a common electronic platform with each other's summary care records including prescribed medicines.¹²⁶ A shared plan also provides each member of the team a more holistic view of the patient's goals, priorities, problem list and management plan for each issue rather than siloed plans by each profession. Thought also needs to be given to increase opportunities to meet physically or virtually together,¹²⁷ develop processes for equal access to funding and ensure equality in decision making.¹²⁸

A number of factors have been shown to contribute to successful interdisciplinary teams including skillful leadership in each discipline, readiness for an interdisciplinary culture, commitment to change.

Measures to increase interdisciplinary collaboration

The management of people with long term conditions is often shared between primary and community health and social care professionals

124 McKinlay EM, Morgan SJ, Gray BV, Macdonald LM, Pullon SR. Exploring interprofessional, interagency multimorbidity care: case study based observational research. *Journal of Comorbidity*. 2017;7(1):64–78.

125 Pullon S, McKinlay E, Dew K. Primary health care in New Zealand: the impact of organisational factors on teamwork. *British Journal of General Practice*. 2009;59:191–197.

126 <https://www.health.govt.nz/our-work/digital-health>

127 See footnote 96.

128 See footnote 125.

but also across primary and hospital or specialist care services. It is an increasingly important area where more attention to effective team work can reap dividends.^{129,130}

An example of an effective interdisciplinary and interorganisational partnership approach is the Ngā Kaitiaki Manawanui Whai Ora (NKMWO) programme¹³¹ led by Hauraki PHO and Healthcare New Zealand. In this programme, patients with the most complex health issues and risk of hospitalisation are first seen by a nurse and kaiawhina (non-clinical health worker) for a needs assessment. The client is then assisted to develop a shared care plan that is shared electronically with the wider health care team. This is followed by a series of home visits to provide self-management support with referrals to other social, community and health services as required. In many cases, the kaiawhina takes the lead role when social or cultural issues dominate, helping patients with housing and financial issues or to engage with addiction services once relationship and trust are established.

The MKMWO programme was found to improve health literacy, decision making, self-management support, social issues and patient activation. It also resulted in more-appropriate general practitioner utilisation (an overall increase in general practitioner visits in initial low and medium users and decreased visits in initial high users). A formal evaluation noted “the combination of the registered nurse and the kaiawhina role are central to this model...The kaiawhina were particularly important for reaching highly disengaged or underserved patients, who were also Māori. Kaiawhina were seen as having a better understanding of the lived experience of the clients and were able to communicate more effectively

129 Smith S, Cousins G, Clyne B, Allwright S, O’Dowd T. Shared care across the interface between primary and specialty care in management of long-term conditions. *Cochrane Database of Systematic Reviews*. 2017;2(2):CD004910.

130 Karam M, Brault I, Van Durme T, Macq J. Comparing interprofessional and interorganizational collaboration in healthcare: a systematic review of the qualitative research. *International Journal of Nursing Studies*. 2018;79:70–83.

131 <https://www.haurakipho.org.nz/ng257-kaitiaki-manawanui-whai-ora.html>

than Pākehā health care professionals.”¹³² This approach is required for those with the most complex needs.¹³³

Tools and enablers for collaborative interdisciplinary care

Increasingly, electronic tools are being used to enhance collaborative interdisciplinary care. This has been particularly evident since the start of the COVID-19 pandemic with increased use and comfort with digital consultation technologies (such as video conference and telephone consulting).^{134,135} This can often be a more efficient way of delivering health care, especially for the patient, although is a complement to rather than a substitute for face-to-face encounters when relationship building is needed. Similarly, electronic patient portals enable patients to easily access their health information, make appointments or message members of the health care teams. Team members can in turn collaborate electronically with other professionals if needed before getting back to the patient.

Electronic shared care plans are gaining currency. These are developed either in primary care by the practice nurse and general practitioner or nurse practitioner or in secondary services by nurse practitioner or clinical nurse specialists, oriented around the needs and goals of the patient and available electronically across sectors and agencies.¹³⁶ This has proved especially beneficial during the discharge planning process.¹³⁷ In

132 Appleton-Dyer S, Boswell A, Goodwin D. Manawanui Whai Ora Kaitiaki: implementation and initial outcomes. Auckland: Synergia; 2015.

133 Singer M, Bulled N, Ostrach B, Mendenhall E. Syndemics and the biosocial conception of health. *Lancet*. 2017;389:941–950.

134 Imlach F, et al. Telehealth consultations in general practice during a pandemic lockdown: survey and interviews on patient experiences and preferences. *BMC Family Practice*. 2020;21:1–14.

135 Imlach F, et al. Seeking healthcare during lockdown: challenges, opportunities and lessons for the future. *International Journal of Health Policy and Management*. 2021. doi:10.34172/IJHPM.2021.26.

136 van Dongen JJJ, van Bokhoven MA, Daniëls R, van der Weijden T, Emonts WWGP, Beurskens A. Developing interprofessional care plans in chronic care: a scoping review. *BMC Family Practice*. 2016;17:137.

137 Gonçalves-Bradley DC, Lannin NA, Clemson LM, Cameron ID, Shepperd S. Discharge planning from hospital. *Cochrane Database of Systematic Reviews*. 2016;1: CD000313.

collaboration with the patient, the care plan can be accessed and edited by the hospital specialists, specialist nurses and physiotherapist and then in primary care by the general practitioner or nurse practitioner, nurse and community pharmacist. There is facility for electronic messaging and tasking between all the professionals involved to facilitate necessary changes in care. Patients also access summary information (including medications and goals of care) through an electronic portal. It is likely that smart phones¹³⁸ and collaborative tools like e-prescriptions¹³⁹ between doctors or nurse practitioners or prescribing pharmacists¹⁴⁰ and pharmacists will increase the capability for similar collaboration in the future.

Doctors and other health professionals can actively support patients to become more knowledgeable about their conditions by supporting them to access and use New Zealand evidence-based patient information and self-care resources (including effective mobile apps) from the Health Navigator New Zealand website.¹⁴¹ It has been shown that using localised evidence-based patient information helps patients participate in shared decisions about treatment.¹⁴² Similarly, most health professionals can access localised interdisciplinary HealthPathways,¹⁴³ which provide district health board tailored treatment pathways.

Conclusion

In New Zealand, doctors work in collaborative interdisciplinary teams, particularly in the management of patients with long-term and complex conditions, and have an important role in supporting the further development of collaborative models of care. There are models of shared

138 Brown-Manhertz D. Using smartphones to improve interdisciplinary collaboration. *The Nurse Practitioner*. 2017;42(4):1–5.

139 <http://www.health.govt.nz/our-work/ehealth/other-ehealth-initiatives/emedicines/new-zealand-eprescription-service>

140 <https://www.health.govt.nz/our-work/health-workforce/new-roles-and-initiatives/established-initiatives/pharmacist-prescriber>

141 <https://www.healthnavigator.org.nz/>

142 See footnotes 106 and 107.

143 <https://www.healthpathwayscommunity.org/Home/Access-to-HealthPathways>

care between disciplines, across health sectors, including a range of health and professional groups as well as partnering with patients, family and whānau. Within teams, role clarification is necessary together with the building of professional trust in other disciplines' specialist skills. Current regulatory processes already enable shared decision making and shared leadership. However, institutional policies and funding mechanisms may not, and these need to be worked upon. In modern health care practice, collaborative care is not a 'nice to have'. It is essential for the delivery of high-quality, safe and effective care that benefits patients, family, whānau, communities and health professionals.

CHAPTER 3

End-of-life issues

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Introduction

One of the major success stories of the last century is the dramatic improvement in the health and longevity of our society. As we move further into the 21st century, this change is showing no signs of slowing.

Coupled with the ‘baby boom’ of the 1950s and 1960s, we are now experiencing a rapid growth in the size of the older population. As the population ages and medical interventions become more sophisticated, end-of-life issues are becoming more frequent and complex. Sudden unexpected death is much less common with most people now dying after a period of decline from chronic disease, often with multiple co-morbidities and frailty. As a doctor, you play an important role in assisting patients, whānau and the community in dealing with the reality of death. In caring for patients at the end of life, you share with others the responsibility to take care that the patient dies with dignity, in comfort and with as little suffering as possible. You should take care to communicate effectively and sensitively with patients and their whānau so that they have a clear understanding of what can and cannot be achieved. You should offer advice on other treatment or palliative care options that may be available to them. You should ensure that support is provided to patients and their whānau, particularly when the outcome is likely to be distressing to them.

Although most people at the end of life have known life-limiting conditions, most have not had the opportunity to consider and communicate their preferences about end-of-life care to clinicians or family. In a survey conducted by the Royal Australasian College of Physicians (RACP), only 17% of responding physicians considered that doctors know the patient’s preferences for end-of-life care. Far too often,

As a doctor, you play an important role in assisting patients, families and the community in dealing with the reality of death.

when an end-of-life discussion does occur, it is during a health crisis and at a time when the patient can no longer participate.

An RACP position statement on end-of-life care¹⁴⁴ identified five essential elements for the provision of good patient and whānau-centred end-of-life care as:

- diagnosing dying or the risk of dying
- respecting patient autonomy and supporting decision making and providing personalised care
- ensuring that medical treatment decisions respect the patient's best interests
- managing symptoms
- supporting carers and family/whānau.

One of the most vital ingredients of end-of-life care is communication. When difficulties arise, they are often due to inadequate communication. It is important to spend time with the patient and family and document contacts fully and accurately in the patient's record. For a person with speech impairment – dysphasia after stroke, for example – the assistance of a speech-language therapist may be invaluable in determining a patient's wishes or capacity. For a person who speaks another language, an interpreter will be required.

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

Where people die

Most deaths occur in the older age group. Only 5% of deaths in our society occur before the age of 40. For those aged 65 years and over, 38% die in

144 <https://www.racp.edu.au/docs/default-source/advocacy-library/pa-pos-end-of-life-position-statement.pdf>

age-related residential care (ARRC), 34% in acute hospitals and only 28% in the community (home, workplaces, roads and so on). Some hospital deaths are of people who have been admitted from ARRC, which means that nearly half of older people who die have an ARRC facility as their final residence.¹⁴⁵ Doctors who support ARRC facilities need to be skilled at managing end-of-life issues.

Cognitive impairment and mental capacity

One of the main principles of treatment decision making is informed choice (previously generally called informed consent). The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights Regulation (1996) – more frequently, and understandably, referred to as the Code of Rights – states:

Right 7(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent ...¹⁴⁶

This assumes that the patient has the mental capacity to make an informed choice. Mental competence (or capacity) is always presumed present until proven otherwise. Courts quite rightly take the stance that an individual's liberty is their most important possession and they should only be deprived of it for compelling reasons. However, there are times when the patient cannot participate in the discussions about treatment choices. Doctors should feel confident about assessing the capacity of their patients. Guidance about how to do this is covered elsewhere (see [Chapter 14 – Mental capacity](#)).

145 Broad J, et al. Likelihood of residential aged care use in later life: a simple approach to estimation with international comparison. *Australia and New Zealand Journal of Public Health*. 2015;39(4):374–379.

146 <https://www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/>

In situations where the patient is not able to participate, it is important to identify if the patient has an appointed alternative decision maker (enduring power of attorney for welfare or court-appointed welfare guardian) or has a valid advance care plan or advance directive (see below).

Where a consumer is not competent to make an informed choice, no proxy decision maker exists and no advance care instructions have been made, Right 7(4) of the Code of Rights applies. This allows the provision of health care services where it is in the best interests of the consumer and reasonable steps have been taken to ascertain and follow the consumer views and/or views of other suitable interested persons have been taken into account.

Doctors should be familiar with the Code of Rights and should clearly document the process that they have followed.

Advance care planning

One of the basic principles of health care decision making is informed choice. However, patients are often unable to participate in discussions at the end of life. Advance care plans (ACPs) are a way for the patient to guide this process. Advance care planning is for everyone. ACP discussions are an opportunity for you as a health care provider to understand what is important to your patients, what matters to them and what makes life meaningful to them. This makes it easier for you to make treatment decisions on their behalf, if and when the situation arises. ACPs have been shown to increase the chances of patient preferences being adhered to and to reduce hospital admissions and resource use at the end of life.

It is never too early to have an ACP conversation. However, there are situations that should trigger the process. The diagnosis of a life-limiting condition or an admission to hospital with a chronic condition or a planned medical review would be appropriate times. There are also tools to assist in identifying which patients to consider. It is particularly important to

initiate a conversation in those with early cognitive impairment or those likely to lose the ability to communicate. Once cognitive impairment has progressed, such conversations become more difficult.

ACPs are usually in a documented form and ideally readily available to treating health professionals. They may or may not include a more specific advance directive (see below).

The Health Quality & Safety Commission New Zealand’s advance care planning resource¹⁴⁷ provides extensive information for consumers and clinicians and training for clinicians. It is recommended that all doctors should undertake at least the initial levels of ACP training.

Doctors should be familiar with the Code of Rights and should clearly document the process that they have followed.

Advance directives

While an advance care plan focuses on what matters to patients, advance directives are more-specific statements about what treatments will or will not be acceptable to the patient in a given scenario. In the legal sense, these are anticipatory refusals of consent for treatment in the situation where the patient is no longer competent to decide. A statement from a Jehovah’s Witness about declining blood products or a patient-initiated do not resuscitate order are advance directives. However, any health care procedure could be included.

Right 7(5) of the Code of Rights allows that “Every consumer may use an advance directive ...”. In New Zealand, an advance directive may be written or oral. However, it will always be preferable to have a directive clearly documented including the reasons behind any instructions.

147 <https://www.hqsc.govt.nz/our-programmes/advance-care-planning/>

Doctors are obliged to follow the requirements of an advance directive unless there is reason to question its validity. To be valid, an advance directive must clearly relate to the current scenario, must have been understood by the patient at the time, should be current and must be made without any undue influence. A person may have made an advance directive many years earlier so may have changed their mind about some issues. It is also impossible for an advanced directive to cover all medical contingencies. It is therefore important to check with the patient or their proxy as to whether the advanced directive still applies to the present situation. It may be necessary to complete a competency assessment or to determine whether the patient has an activated enduring power of attorney (EPOA) in considering the provisions of the advanced directive.

If a treating clinician has concerns about validity of an advance directive, they should err on the side of preservation of life. Right 7(4) of the Code of Rights may then apply.

Ceiling of care and do not resuscitate orders

Do not resuscitate (DNR, NFR, DNAPR) orders have been in common use in the acute hospital sector and in age-related residential care for many years. Provision of full emergency treatment is the default option within all health care facilities in New Zealand, unless an advance decision is made that it should not be provided.

Increasingly, DNR orders are being broadened to cover other urgent interventions such as ventilation, inotrope support, dialysis and so on. These are called ceilings of care. The goal of a ceiling of care order is to identify appropriate limitations to interventions that are likely to be futile, burdensome or contrary to the patient's wishes. It should encompass more than simply cardiopulmonary resuscitation and DC cardioversion. Unless the patient is unable to participate, the conversation about such an order should always follow a discussion with them. It should also include what treatments are appropriate.

The patient or their proxy should be consulted about vigour of treatment for other health problems. Where a patient is not able to participate in the discussion, ceilings of care can still be defined. These are determined by the patient's best interests as outlined in Right 7(4) of the Code of Rights. Legal patient proxies (for example, a welfare guardian or power of attorney) are not legally able to consent to or decline life-saving interventions. Their role is to provide consultation and advice about what they believe the patient's preferences would be. It is also important to note that the doctor is not obliged to offer a treatment that they believe is against the patient's best interests. In cases of disagreement, careful explanation will usually help. A second opinion should also be considered.

Age-related residential care

Age-related residential care (ARRC) facilities are the most common place for older people to die and hence need to have a good understanding of end-of-life issues. Most commonly, the ARRC doctor is a local general practitioner who allocates a small amount of time to the facility. Most rest homes will ask the resident's wishes on admission about their resuscitation status and, increasingly, other ceiling of care issues. This, together with other treatment wishes, is usually documented and filed in the residential care patient record. If the resident is then admitted to an acute hospital, information about DNR status should transfer with the patient. Patients and relatives can find repetitive questioning about DNR and treatment status upsetting if their wishes have already been clearly conveyed. Most hospitals require the DNR status to be clearly displayed in the patient's notes.

A large proportion of residents of aged care facilities have significant cognitive impairment, and it may not be possible to establish their preferences for end-of-life care. Most residents have not completed an enduring power of attorney process, so there is no formal proxy decision maker in the situation where mental capacity has been lost. This makes it

even more important to be able to assess mental competency and have discussions about advance care plans much earlier in the course of their illnesses. Unfortunately, the DNR advance directive in the resident file is often completed without substantial input from the affected individual. It frequently represents an agreement between the facility doctor and staff on one side and family representatives on the other. While this is considered to represent patient best interests, it is not an ideal way to determine patient preference.

Enduring power of attorney

In New Zealand, the ability to appoint a proxy decision maker in the event of loss of mental competence is covered by the Protection of Personal and Property Rights Act 1988. An individual appointing an attorney must be mentally competent to do so, and the appointee can only assume the powers of decision making for welfare once the patient has lost mental competence. This loss of competence requires confirmation by a medical practitioner on a specified form. The person taking on the legal role as decision maker has all the rights of the patient apart from certain restrictions. These restrictions include not being able to consent or decline life-sustaining treatments. Hence, when it comes to decisions about end-of-life treatments, the proxy's role is often as an adviser rather than decision maker.

An individual appointing an attorney must be mentally competent to do so, and the appointee can only assume the powers of decision making for welfare once the patient has lost mental competence.

It is desirable that everyone should have made these choices of proxy decision makers when well. Lawyers will often include this in discussions about making wills. It should also be included in discussion about advance care plans.

Further information is available on the Office for Seniors website.¹⁴⁸

Withdrawing life-sustaining treatments

A common end-of-life care decision that has to be made is the withdrawal of life-extending or life-sustaining treatment, recognising that the patient is dying. This is often associated with a conscious decision to move to a palliative care approach and focusing on symptom control. Life-sustaining treatments include supplemental oxygen, intravenous fluids, artificial nutrition, inotrope support and artificial ventilation. Ideally, withdrawal of such treatments in the end-of-life setting will be guided by an ACP or advance directive, but this is not commonly available. If the patient retains competence, this should be addressed directly and sensitively with them.

Most frequently, treatment decisions are made in consultation with family/whānau. The role of whānau is to use their knowledge of the patient to aid decision making. Patients and families may have widely differing view on this subject, and great care must be taken to explain the change in management goals. Focusing on symptom management and withdrawing more-aggressive treatments does not represent euthanasia. It does require sensitive handling, close consultation with whānau, ensuring the patient's best interests are met and that all decisions are consistent with accepted medical practice and any available guidelines.

Good communication and documentation is vital at these times. Clear communication extends beyond doctor, patient and family as other

148 <http://superseniors.msd.govt.nz/finance-planning/enduring-power-of-attorney/>

members of a health team may have differing opinions and people's own beliefs must be respected. All concerned must know the reasons for the change in plan, and a debrief after the patient's death is wise practice.

The Health Quality & Safety Commission New Zealand has excellent resources and training materials for managing serious illness conversations,¹⁴⁹ and Robert Logan and Louise McKenzie's journal article on reducing the uncertainties of withdrawing and withholding treatment¹⁵⁰ is a useful resource that covers the legal framework.

Palliative care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems – physical, psychosocial and spiritual.

New Zealand is fortunate to have well-developed palliative care services covering most of the country. These services generally (but not always) provide support to primary care, hospitals and the age-related residential care sector to assist with managing patients at the end of their lives. Most provide care for all patients at the end of life and not just cancer patients.

Information about palliative care resources and how to access local palliative care services is available on the HealthPathways sites of each district health board.¹⁵¹ Any medical practitioner new to an area should ensure they are aware of what services are locally available.

149 <https://www.hqsc.govt.nz/our-programmes/advance-care-planning/information-for-clinicians/tools/serious-illness-conversations/>

150 Logan R, McKenzie L. Reducing the uncertainties of withdrawing or withholding treatment. *New Zealand Medical Journal*. 2002; 115(1148):81–82.

151 See footnote 143.

Physician-assisted suicide and assisted dying

The last few years has seen a lot of debate and change in this area. The End of Life Choice Act was passed in 2019 with implementation dependent on a referendum held at the time of the 2020 general election. A majority of New Zealand voters supported this Act.

As a result, from 7 November 2021, people have the option to request assisted dying. If certain criteria are met, medical practitioners and nurse practitioners may administer medications with the express intention of ending life. (Until that date, participating in assisted dying contravened the Crimes Act 1961 and could lead to criminal charges.)

To be eligible, a person must meet all criteria laid out in the End of Life Choice Act. This includes that they are competent to make an informed decision about assisted dying. There is a formal assessment process set out in this Act.

As a health professional, you cannot suggest assisted dying as an option or initiate discussion about assisted dying. The conversation must be initiated by the patient. Only medical practitioners can assess for eligibility to receive assisted dying. These practitioners must be skilled at assessing mental capacity (see Chapter 14 – Mental capacity).

If you have a conscientious objection to assisted dying, your obligation is to inform your patient of your objection and to inform them of their right to seek contact details of medical practitioners who are willing to participate. A detailed list of providers is held by the Support and Consultation for End of Life in New Zealand group (SCENZ) group. Full information about the End of Life Choice Act and implementation resources for health professionals and the public are available on the Ministry of Health website,¹⁵² and the Ministry has also developed an online learning module.¹⁵³ It is strongly

152 <https://www.health.govt.nz/our-work/regulation-health-and-disability-system/end-life-choice-act-implementation>

153 <https://learnonline.health.nz/enrol/index.php?id=444>

recommended that all medical practitioners are aware of the provisions related to assisted dying and undergo the online training whether or not they are intending to be participants.

Conclusions

Dealing with end-of-life situations can be challenging for the doctor but can also be very rewarding. We all need to identify those patients entering the late stages of their lives and assist them to make their preferences known. Doctors need to build skills including good communication, advance care planning and competency assessment. Knowledge of the New Zealand context around patient rights, proxy decision making, lawfulness of treatments and available services is required for good patient care decisions. Good documentation of discussions and decisions is essential. Supporting whānau and staff during and after death can provide a positive and fulfilling experience.

CHAPTER 4

The purpose of medical records and notes

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Dr D's documentation in relation to the consultation on 21 June was inadequate and, accordingly, he breached Right 4(2) of the Code.¹⁵⁴

154 <https://www.hdc.org.nz/decisions/search-decisions/2012/10hdc00753/>

Introduction

Thirty years ago, the medical record was very different to what is expected now. Many hospital records were brief and posed problems in understanding what was clinically relevant. General practitioners were slowly migrating from 5 x 8 inch cards to handwritten entries on more-structured clinical records. The modern electronic medical record in particular has provided a framework for recording and sharing information that simply wasn't possible with handwritten notes. Not only have expectations on content and quality of notes changed, the purpose has too. Clinical notes have become an increasingly important part of evidence to support a doctor if concerns over care have been raised. The clinical note is a tool for management and for communicating with other doctors and health professionals and has become the primary tool for continuity of care in many practices as well as in hospitals. The notes can also be used for audit of quality of care and to look at the clinical reasoning of a doctor.

Structures for recording information usually follow a pattern of (S) subjective, (O) objective, (A) assessment and (P) plan. It is also important that the notes can be ascribed to the appropriate patient (so the name, date of birth or other identifying details must be recorded accurately), at an identifiable time and by a recognisable author. A common error found in clinical notes is failure to record important negative findings. This particularly applies to vital signs. A record showing that there was no fever, a normal pulse, blood pressure and respiratory rate and a normal oxygen saturation is very useful information if the patient subsequently deteriorates and the doctor is criticised for not taking a more proactive stance at the time of the consultation.

A useful rule of thumb about how much information to include is to think about another doctor reading the notes. Is there sufficient information to allow another doctor to arrive at the same or similar conclusion and could justify the management plan? Could this doctor reasonably exclude other important diagnoses on the basis of the clinical information?

Clinical notes have become an increasingly important part of evidence to support a doctor if concerns over care have been raised.

Sometimes, on reviewing an earlier record entry, a doctor may feel that it is inaccurate, incomplete or potentially misleading. It is appropriate to augment a record in such cases, making it clear when and by whom the augmentation or annotation was added. The earlier entry should never be deleted, obliterated or changed. Such amendments might later raise suspicion of covering up an error in treatment or diagnosis. This is particularly important if there has been an adverse event. In such circumstances, it is wise to record a more detailed note of the consultation or procedure. The extra information should be clearly marked as being non-contemporaneous, signed and accurately dated.

Health Information Privacy Code (HIPC)

The HIPC¹⁵⁵ provides rules for health agencies, including doctors working on their own account or for others, on their handling of health information that is about identifiable individuals. Health information covers everything from consultation notes through to medical test results and also includes the incidental information used in conducting the business side of health care such as address and billing details.

The HIPC provides important pointers for doctors around health information. These are set out under 12 rules.

A brief outline of the 12 rules at the heart of the HIPC is given in this chapter, but in case of any doubt, doctors should refer to the words of the HIPC itself or obtain advice from someone else who is more familiar with the HIPC. The HIPC is published with accompanying commentary by the

155 See footnote 146.

Privacy Commissioner. The commentary is not legally binding but contains a wealth of practical pointers and observations that will answer many a query.

Rule 1: Purpose of collection

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

Rule 2: Source of the information

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

Rule 3: Collection of health information

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

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

Rule 4: Means of collecting health information

You must collect health information by means that are lawful and fair and do not intrude unduly on the individual's personal affairs. Medical professionals become used to dealing with very sensitive personal

information but must remain mindful of its importance to the individual concerned.

Rule 5: Storage and security

Anyone holding health information must take the steps that are reasonable in the circumstances to ensure that it is guarded against loss or unauthorised access and use. Amongst other precautions, this means that the more personal information should not be voiced where others can hear it if those others have no business to know it.

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

Rule 6: Right of access

Individuals have the right to have access, on request, to health information about them. Access should usually be given without charge and in the form that the individual prefers. A request for access must be responded to promptly and certainly within 20 working days. The health agency should verify the individual's identity before giving the information to them.

There are circumstances in which the request for access may be refused, but these are exceptional cases, and the only valid reasons for refusal are those set out in the Privacy Act 2020. Any doctor making records should do so on the assumption that they may be seen by the individual concerned.

It sometimes happens that a doctor is given information about a patient by someone else, and the source of the information may ask that the patient is not to be told that the doctor has the information or who gave it. However, no matter what the doctor promises, the right of access

under the Privacy Act still exists, so doctors should never give unqualified promises of confidentiality if they receive information about a patient from third parties.

Rule 7: Correction of health information

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

Every individual has the right to request correction of health information about them if they believe it to be wrong.

Rule 8: Check before use

You must not use health information without first taking reasonable steps to ensure that it is accurate and not misleading. The steps taken will depend on the use to which the information is to be put. The more important that item of information is in the proposed action, the more rigorous should be the steps to ensure that it is accurate, up to date, complete, relevant and not misleading.

Rule 9: Retention of medical records

This HIPC rule states that health information is not to be kept for longer than it is required for those purposes for which it may lawfully be used. Given that health information is normally kept for purposes that include future diagnoses and care, the rule itself will not often impose

a limit on retention. Furthermore, there are specific regulations – the Health (Retention of Records) Regulations 1996 – requiring that health information relating to an identifiable individual must be retained for a minimum of 10 years from the day after the last treatment or care of that individual by the agency holding the information. Unless the accuracy of certain health information is being questioned, the most likely form of complaint in relation to retention is that it has not been retained for long enough. The Medical Council’s guideline, and the advice of several colleges, is that records are retained for more than 10 years.

Rule 10: Limits on use

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

Rule 11: Limits on disclosure

Disclosures that were anticipated and intended when the information was obtained can proceed as planned. Other disclosures can be made with the authorisation of the individual. A further group of exceptions applies to allow other disclosures where it is not desirable or practicable to obtain the individual’s authorisation and the situation fits into one of the limited exceptions set out in the full rule. Examples of this group are where the disclosure is directly related to the purpose for which the information was obtained, where the disclosure is for a professionally recognised accreditation or quality assurance programme or where the disclosure is for statistical or approved research programmes. The rule against disclosure applies to health information about individuals until 20 years after their death.

Rule 12: Unique identifiers

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

Audit of your records

It is a useful exercise to periodically undertake an audit of your own records, or get a colleague to do it for you. It can be surprising sometimes just how revealing audit can be of problems when we were not aware of them.

Transfer of patient records to another doctor

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

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

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

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

Acknowledgement

The contribution of Robert Stevens as author of this chapter in previous editions is gratefully acknowledged.

CHAPTER 5

The management of clinical investigations

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The management of clinical investigations has been the subject of many complaints to the Health and Disability Commissioner (HDC). Below are some examples:

- **15HDC01387:** Dr C, as the clinician who ordered the blood tests, had a responsibility to communicate to Mr A the diagnosis of CLL and its implications. Provision of this information would have enabled Mr A to be a partner in his own treatment.
- **14HDC01030:** Dr A told HDC that he does not recall seeing Ms B's smear result in his inbox but thinks he must have viewed the result on its arrival and then probably he filed the result without actioning it.
- **15HDC00677:** Dr A filed the elevated PSA result as "normal" and did not discuss the result with Mr B at his next consultation on 10 March 2012 or take any further follow-up action.

- **12HDC01133:** At 3.24am on Day 5, the postoperative CXR was performed by radiology. It was not reviewed by any member of clinical staff until over 24 hours later.
- **13HDC00599:** On 23 January 2010, Dr C referred Mrs A to an orthopaedic surgeon for a review of her left shoulder problems. The referral letter made no mention of the possibility of a bony metastasis being present, as stated in the imaging report, and referred to Mrs A's previous breast cancer only briefly.

As the above HDC cases indicate, patients do suffer harm as a result of mismanagement of clinical investigations. The number of doctors being reported to the Medical Council because of these errors is high and would appear to be rising. It is likely that an underlying cause responsible for this is the emergence of more-fragmented care in primary and secondary care where the medical record has become central as a communication system amongst a loose team, yet the systems and processes of the medical record and how health care workers interact with it have not kept pace with these changes in medical culture.

The RNZCGP has produced guidance for general practitioners about what standards are expected:

- There is a policy describing how laboratory results, imaging reports, investigations and clinical correspondence are managed.
- All incoming test results or other investigations are sighted and actioned by the practice team member who requested them or by a designated deputy.
- Patients are provided with information about the practice procedure for notification of test results.
- The practice can demonstrate how it identifies and tracks potentially significant investigations and urgent referrals.
- A record is kept of communications with patients informing them about test results.

bpac^{NZ} produced an article ‘Taking responsibility for test results: A discussion’¹⁵⁶ in 2014 that also addressed the issue and noted that there is often a lack of agreement and consistency between clinicians, practices and health organisations as to what is reasonable and practical. In a paper in *New Zealand Doctor*,¹⁵⁷ the previous Health and Disability Commissioner expressed his view about the key principles that should apply when managing clinical investigations:

- At the time any test is proposed, patients have a right to be told by their doctor why the test is recommended and when and how they will be informed of the results.
- If a doctor or medical centre has a standard practice of not notifying normal test results, patients must be informed and their consent obtained to not notifying in such circumstances.
- It must be made clear to patients that they are entitled to be notified of all test results, and even if they agree to be notified only of abnormal test results, they are welcome to call the medical centre and check whether their results have been received and what they are.
- In the absence of any other such arrangement being made, when results are received by a medical centre, the patient must be informed. This is especially important if the results raise a clinical concern and need follow-up.
- A doctor is responsible for having an efficient system for identifying and following up overdue test results.

The Medical Protection Society article ‘Handling test results’¹⁵⁸ looks at the issue of doctors’ responsibility for tests they did not order and notes the primary responsibility for following up abnormal results rests with

156 <https://bpac.org.nz/BT/2014/August/testresults.aspx>

157 <https://www.hdc.org.nz/media/3089/managing-patient-test-results-5nov08.pdf>

158 <https://www.medicalprotection.org/newzealand/casebook-may-2015/handling-test-results>

the clinician who ordered the tests. However, the HDC has an expectation that an abnormal result will be followed up by a treating doctor regardless of who ordered the test to avoid patients falling through the cracks. This makes sense. If a general practitioner is in receipt of information that is of particular concern about a patient's health (a markedly raised PSA, for example), there is the expectation that they would act on this test even if they were not the doctor who ordered it.

There is a final issue that is worth noting. In some of the cases notified to the Council where test results were the central issue, it was also clear that the doctor did not have protected time to manage the inbox of results and letters to the doctor. This is commonly due to the umbrella organisation not acknowledging the time required to look at and action what are sometimes complex issues that require professional judgement. While there is a financial drawback to providing protected time for managing test results, the implications of poorly managed and poorly considered policy on this issue can be devastating to the patient, doctor and the employing organisation.

If a general practitioner is in receipt of information that is of particular concern about a patient's health (a markedly raised PSA, for example), there is the expectation that they would act on this test even if they were not the doctor who ordered it.

CHAPTER 6

Doctors in other roles

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Introduction

In the course of a medical career, a doctor may become involved in roles other than that of being a clinician. Most of the roles will fall under the jurisdiction of the Medical Council of New Zealand.

The Medical Council’s definition of the practice of medicine is broad. It defines the practice of medicine as advertising, holding out to the public or representing in any manner that a person is authorised to practise medicine in New Zealand, the signing of any medical certificate, the prescribing of medicines and the assessing, diagnosing, treating, reporting or giving advice in a medical capacity.¹⁵⁹

Any work undertaken by a doctor that relates to the care of an individual patient is clinical practice. Conversely, any work undertaken by a doctor that does not relate to the care of an individual patient is not clinical practice.¹⁶⁰

The clinical role is well understood and the parameters of the role established through the apprenticeship that doctors have served in their training years. The call to consider the health and wellbeing of the patient to be your first priority is well known as the first point in the New Zealand Medical Association *Code of Ethics* (see Appendix B).¹⁶¹ However, when working in other roles, the last two points in the *Code of Ethics* are relevant:

- Accept a responsibility to advocate for adequate resourcing of medical services to assist in achieving optimal and equitable health outcomes across the community.
- Accept a responsibility for maintaining and improving standards of the profession.

159 <https://www.mcnz.org.nz/assets/Publications/Definitions/0ef2bf29d6/Definition-of-the-practice-of-medicine.pdf>

160 <https://www.mcnz.org.nz/assets/Publications/Definitions/6bf3c0e94a/Definition-of-clinical-and-non-clinical-practice.pdf>

161 https://assets-global.website-files.com/5e332a62c703f6340a2faf44/5fbd645fe15640fa981fa469_Code%20of%20Ethics%20Redesign%202020%20version%204.pdf

Doctors accept their ethical responsibilities to act in the best interests of their patients, and the population as a whole, and undertake this in a caring, compassionate, competent and trustworthy manner.

The need to accept responsibility across the community and to look to resourcing means that the health and wellbeing of the patient must be looked at in the wider context of the health and wellbeing of the population as a whole.

This wider context was recognised when the NZMA, in 2011, developed with input from a wide range of practitioners a consensus statement on the role of the doctor in New Zealand.¹⁶²

This statement recognised doctors as scientists, health professionals, leaders, health advocates and teachers and learners. It also notes the following:

- Doctors have diverse roles, within and outside of the health sector, in the promotion and maintenance of both individual and population health.
- Doctors accept their ethical responsibilities to act in the best interests of their patients, and the population as a whole, and undertake this in a caring, compassionate, competent and trustworthy manner.
- Doctors work in partnership with patients in the delivery of their health care and serve as advisors and interpreters in the pursuit of optimal health outcomes using evidence-based medicine and in accordance with available resources.
- Doctors work effectively as leaders. As members of health care teams, doctors recognise and respect skills and attributes of other practitioners.

162 https://assets-global.website-files.com/5e332a62c703f653182faf47/5e332a62c703f6739c2fdeb5_content.pdf

The CanMEDS initiative began in the 1990s. The Royal College of Physicians and Surgeons of Canada developed the CanMEDS framework, which recognises seven roles for doctors of:¹⁶³

- medical expert
- communicator
- advocate
- scholar
- professional
- collaborator
- manager.

Doctors as leaders and managers

Doctors are increasingly involved in both leadership and management roles. The purpose of clinical leadership is to bring about movement and constructive change, while the role of medical management is to provide stability, consistency, order and efficiency.¹⁶⁴

Starting from isolated pockets of excellence and innovation, clinical leadership still has a long road to travel. But it is an essential road for both clinicians and their patients.¹⁶⁵

It is the clinical skills and knowledge inherent in medical training that separate clinical leaders from health service executives. In making day-to-day management decisions, the clinical leader is applying their medical knowledge to assess the impact, risk and clinical outcome of decisions. It is the role of the medical leader to apply clinical medicine to the development of policy, strategy, service design, behavioural change and

163 <https://www.royalcollege.ca/rcsite/canmeds/canmeds-framework-e>

164 Kotter JP. A force for change: how leadership differs from management. London: Collier Macmillan; 1990.

165 Mountford J, Webb C. When clinicians lead. McKinsey Quarterly. 2009 Feb;2.

effective clinical processes. The clinical leader is uniquely responsible for ensuring patient safety and monitoring both service and individual outcomes.

To be an effective clinical leader requires a different set of skills from those required to be a good clinician. Clinician leaders need to be able to develop a cohesive team, work across disciplines and work within an organisational culture and communicate the impact of change to executives and senior managers.

The clinician leader bridges the cultural divide between clinicians and managers.

The Royal Australasian College of Medical Administrators (RACMA) medical leadership and management curriculum competency framework uses and adapts the seven CanMEDS role competencies of medical expert, communicator, advocate, scholar, professional, collaborator and manager.

The Medical Council recognises medical administration as a vocational scope of practice. Medical administration is defined as:

... administration or management utilising the medical and clinical knowledge, skill and judgement of a registered medical practitioner, and capable of affecting the health and safety of the public or any person.

This may include administering or managing a hospital or other health service, developing health operational policy, or planning or purchasing health services. Medical administration does not involve diagnosing or treating patients.¹⁶⁶

RACMA is the recognised body that trains and certifies doctors as competent in the vocational scope of practice of medical administration.

¹⁶⁶ <https://www.mcnz.org.nz/registration/scopes-of-practice/vocational-and-provisional-vocational/types-of-vocational-scope/medical-administration/>

The Medical Council provides guidance for doctors in management and governance roles in its statement on responsibilities of doctors in management and governance.¹⁶⁷

Notifying poor performance

In effectively fulfilling their clinical governance role, the clinical leader often becomes aware of performance issues amongst their colleagues.

Clinical leaders may become aware of poor practice when undertaking their audit or advisory role. This poor practice may relate to doctors working within the organisation or who are providing a service to patients of the organisation.

The enquiry into clinical issues at the Bristol Royal Infirmary highlighted that the clinical leader has a responsibility to identify and report failing performance, even when that clinical leader is not in active clinical practice.¹⁶⁸

Under section 45 of the Health Practitioners Competence Assurance (HPCA) Act 2003, a doctor has a legislated requirement to report to the Registrar of the Medical Council another doctor who they believe is not fit to practise medicine because of some mental or physical condition.¹⁶⁹ There is also legislated provision under section 34 of the HPCA Act for a doctor to report another doctor to the Registrar of the Medical Council if they have reason to believe that the doctor is practising below the required standard of competence and may pose a risk of harm to the public. The HPCA Act provides for protection from civil or disciplinary proceedings in both circumstances unless the doctor acted in bad faith.

167 <https://www.mcnz.org.nz/assets/standards/667244bffa/Responsibilities-of-doctors-in-management-and-governance.pdf>

168 <https://www.mcnz.org.nz/assets/standards/667244bffa/Responsibilities-of-doctors-in-management-and-governance.pdf>

169 See footnote 167.

As an employee, the clinical leader has a duty to work within their organisational governance structures. Every clinical leader should clarify their organisation's expectations and processes around their reporting of fellow employees' and other colleagues' performance to the Medical Council.

Disagreement about clinical decisions

When a clinical leader becomes concerned about a decision that an organisation has made and believes that it will compromise patient outcomes, lead to serious harm or constitute serious wrongdoing, they must follow the procedures outlined in the Protected Disclosures Act 2000. Where the doctor follows these procedures, they have the right of confidentiality.

Serious wrongdoings may include inappropriate use of public funds, gross negligence or mismanagement by a public official and acts or omissions that constitute serious risk to public safety or constitute an offence.

The clinical leader must put their concerns in writing and ensure they are addressed to the appropriate person. Where their concerns are not adequately addressed, they may raise the issue with the Director-General of Health, the Health and Disability Commissioner or the Medical Council. It is strongly advised that they seek legal advice before raising the issue with an external party or the media.

Providing opinions about patients or other doctors

A clinical leader may be asked to provide an opinion on the adequacy or appropriateness of another doctor's report. This opinion is usually based solely on information recorded in the patient's file. The non-treating doctor must ensure they have access to all the necessary information and that they can provide an opinion based on the information on hand.¹⁷⁰

170 <https://www.mcnz.org.nz/assets/standards/6aa7da6e21/Conducting-medical-assessments-third-parties.pdf>

Where additional information or a clinical examination is required, the non-treating doctor should either refrain from providing an opinion or note the need for further information in their report.

Working in a resource-constrained environment

The New Zealand Government allocates a defined amount of money for the provision of health services each year. The distribution of this money has to balance the needs of the population with the needs of the individual patient.¹⁷¹

This can be a particularly vexing dilemma for the clinical leader who is asked to provide advice on the marginal benefit of two competing priorities.

Clinical leaders will also be asked to provide advice on whether certain expensive procedures are medically necessary or appropriate. Such decisions are both funding decisions and medical decisions.

In all roles, doctors should use evidence from research and audit to inform their decisions and advice on the best use of the resources that are available within their organisation.

Doctors have a responsibility to ensure that the process of assigning priority is appropriate and that patients referred to a service with limited resources are adequately assessed and consistently receive treatment in accordance with the clinical priority criteria. Prioritisation systems should be fair, equitable, systematic, consistent, evidence-based and transparent.

If a patient is discharged or transferred early to allow a sicker patient to take the bed, the clinical leader has a responsibility to ensure that appropriate arrangements are in place to optimise the discharged patient's recovery.

171 <https://www.mcnz.org.nz/assets/standards/ca25302789/Safe-practice-in-an-environment-of-resource-limitation.pdf>

Where a patient is unable to access the preferred treatment due to funding constraints, they should be informed what the preferred treatment involves and what the available options are. This discussion should be documented.

Doctors in advisory roles

Doctors are often engaged to serve on advisory committees to government agencies, district health boards or non-governmental organisations.

When invited to serve on a committee, the medical practitioner should determine whether they are invited as an individual with a desired set of clinical skills or as the representative of an organisation or industry body. Where they are engaged as a representative, they should ensure they have a mandate from the nominating body before proffering an opinion or providing endorsement to a planned strategy or process.

It is good practice to distribute an agenda and briefing papers well in advance of a meeting to allow representatives to seek advice from the nominating body on issues that are to be discussed. Failure to do so compromises the value of the meeting. Where inadequate time has been allowed for consultation or consideration of an issue, the doctor may need to withhold their advice. In such cases, it is helpful to indicate when advice will be forthcoming.

Cabinet Guidelines set out a framework for government agencies engaging expert advisors.¹⁷² Amongst other things, they currently preclude the payment of locum fees to a practitioner who is required to be absent from their practice.

Doctors accept their ethical responsibilities to act in the best interests of their patients, and the population as a whole, and undertake this in a caring, compassionate, competent and trustworthy manner.

172 <https://www.publicservice.govt.nz/resources/board-appointment-guidelines/?e714=6515-cabinet-fees-framework>

Expert witness

The High Court publishes a set of rules to guide expert witnesses.¹⁷³ These provide a sound basis for any doctor who is providing an expert opinion, be it to a court, insurance company or medical review panel.

These rules note that the expert witness has an overriding duty to impartially assist the Court on relevant matters within the expert's area of expertise. The expert witness must not act as an advocate for the party who engaged them.

When giving evidence as an expert witness, the doctor should:

- clearly state their qualifications as an expert and indicate how the evidence they provide lies within their area of expertise
- provide the facts and assumptions on which their opinions are based, which should include any literature or other material they have used in forming their opinions, a description of any examinations, tests or other investigations that helped them reach their conclusions and, when these were undertaken by a third party, the qualifications of the person who carried out the tests or examinations
- give the reasoning behind their opinions.

The expert witness must also clearly indicate any provisos that would make their evidence incomplete or inaccurate. They also need to make it clear if they have been unable to reach an opinion because of insufficient research or data or for any other reason.

Acknowledgement

I acknowledge the work of Dr David Rankin who wrote this chapter in earlier editions. This chapter is based upon his work with updates drawn from recently published documents and materials.

173 <https://legislation.govt.nz/regulation/public/2002/0132/latest/DLM126775.html>

CHAPTER 7

Doctors' health

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Introduction

As doctors, we are constantly exposed to stresses and hazards that can impair our function: working long hours, increasing workloads, fatigue, patients' and colleagues' demands, dealing with emotionally traumatic situations, fear of complaints and litigation, demands of external bodies (including the Council and colleges), infectious diseases, debt from student loans and many others.

As doctors, we are constantly exposed to stresses and hazards that have the potential to impair our relationships and impact on our health.

Research indicates the prevalence of mental health issues such as depression, anxiety and substance abuse (including excess alcohol use) is more common in the medical profession than the general population. In addition, we are vulnerable to the same physical and psychological disorders as the rest of the community.

Being a patient

As doctors, we are often unwilling to seek help when we become unwell. Some reasons for this are:

- fear that our confidentiality won't be protected and who may have access to our medical information
- fear of being recognised in waiting rooms
- fear of having a serious condition
- shame or embarrassment, particularly if the problem relates to a mental health disorder or substance abuse
- a misperception that we lack time to see to our own health needs
- feeling a duty to patients and worrying about increasing the load for colleagues

- reluctance to impose on a busy colleague
- difficulty reversing roles from doctor to patient
- a belief we should be able to heal ourselves
- financial pressures to maintain high levels of income
- risking our careers or future access to insurance
- shame at having 'let ourselves down' and also our family and the profession at large
- difficulty relinquishing control
- a fear of disciplinary action and deregistration.

We often fail our colleagues by not raising their health issue with them when it is clear they are sick and their practice is or could be affected. Some of the reasons for this failure include:

- the 'there but for the grace of God go I' syndrome
- lack of knowledge of the notification process and the consequences of notification to the doctor
- lack of knowledge around your obligations to notify
- fear of the reaction, especially if the doctor is in a position of power
- misplaced loyalty – 'he/she has always been a good doctor'
- judgemental attitudes
- denial that there is a problem.

Why you should have your own GP

We deserve the same care that we offer our patients, so it is worth spending the time to find a GP you're comfortable with. Your own GP will:

- provide objective assessment and appropriate management of your health problems
- offer psychological support in times of stress

- provide preventive care such as monitoring blood pressure, diabetes screening and so on
- help detect the onset of illness and provide the opportunity for early intervention
- help you avoid potential conflicts between your health needs and professional person demands
- keep a documented clinical record for you.

Pitfalls of providing care to yourself and those close to you

All doctors should be aware of the Medical Council's information related to doctors' health.¹⁷⁴

You may only provide treatment to yourself or those close to you in exceptional circumstances, such as when someone has an illness or injury that needs immediate attention.

In certain situations, you must never provide treatment or care to yourself or those close to you. These include the issuing of certificates or the prescribing of medication with a risk of addiction or misuse (including sleeping pills), psychotropic medication (including antidepressants) or controlled drugs.¹⁷⁵

Breaches of the Council's statement on providing care to yourself and those close to you¹⁷⁶ are considered very seriously and may come before the Health Practitioners Disciplinary Tribunal.

174 <https://www.mcnz.org.nz/support/support-for-doctors/doctors-health/>

175 <https://www.health.govt.nz/our-work/regulation-health-and-disability-system/medicines-control/controlled-drugs>

176 <https://www.mcnz.org.nz/assets/standards/1ea7db06d0/Statement-on-providing-care-to-yourself-and-those-close-to-you.pdf>

Being a doctor's doctor – the challenges that arise and one doctor's suggestions for managing these

Being a doctor to a colleague can be challenging for a number of reasons. These include:

- fear of being seen as inadequate in front of them
- difficulty if you disagree with your doctor patient's self-diagnosis
- difficulty establishing an appropriate professional doctor-patient relationship
- difficulty separating a therapeutic relationship from other relationships with the colleague
- difficulty saying no to a colleague, particularly one who is stressed
- issues of privacy and confidentiality, such as pressure not to record all or part of the consultation
- difficulty challenging a colleague, particularly with respect to lifestyle issues.

Dr Hilton Koppe is an expert in the arena of doctors' wellbeing. He is a GP at Lennox Head NSW and also runs workshops on burnout and compassion fatigue for health practitioners. He suggests a six-step consultation model when seeing a colleague as a patient.¹⁷⁷ The principles are those used in any consultation – the key issue being to retain these principles and your usual professionalism in this unusual encounter.

- **Connection:** As part of the process of agreeing to see a colleague, you should make a formal appointment in your rooms. You may need to discuss whether the doctor is comfortable to wait in the waiting room or elsewhere and whether an appointment at a

177 Koppe H. Self care strategies for doctors: making changes. *Australian Family Physician*. 2002 Jun;31(6):569–572.

quieter time of day would be easier. At the first appointment, issues of confidentiality, notes, payment and your expectations of each other (including how to address each other) should be clarified.

- **Information gathering:** You will need to walk the tightrope of acknowledging your colleague's knowledge while taking a thorough and, if necessary, challenging history as you would with any patient. It is important not to make assumptions, for example, that the doctor would tell you of symptoms without your needing to ask specifically. You will need to clarify what they think is the diagnosis and then take the history and examine the patient to establish the diagnosis for yourself rather than accepting that diagnosis.
- **Exploring thoughts and feelings:** At this stage, you may need to reaffirm confidentiality and the difficulty of being a patient. You will need to explore the doctor's fears and look for any other issues. It is particularly important to be aware of the dangers of self-disclosure and identification or collusion. Keep the focus on the doctor who is here as a patient and avoid discussing mutual patients or experiences.
- **Education:** Again, you will need to walk a tightrope between assuming your colleague has specific knowledge and causing offence by imparting that knowledge. It can help to explain that hearing information about yourself is different from giving it to others so you will explain it as you would to any patient. Acknowledge their fear if relevant, and admit the limits of your own knowledge. As with any patient, it will be important to negotiate the choice of treatment.
- **Safety net:** You should give clear instructions about follow-up and after-hours contact. Ask whether the doctor patient wishes to receive copies of test results and negotiate about minor procedures – for example, removal of sutures.

- **Closure:** This is just as important as starting the consultation. Check that everything has been dealt with, reinforce your commitment to them and agree on how to book the next appointment.

You can read more about this topic in the December 2009 edition of *Medical Council News*,¹⁷⁸ where Drs Janet Frater and Sara Weeks share their experiences and the challenges of having a patient who is a doctor.

Doctors should be aware of their own stress management and how to stay healthy.

Maintaining good health

The practice of medicine can place huge physical and emotional demands on doctors. Increasing pressures coupled with the subtly induced ethos of 'doctors must always cope' can be very demanding.

Doctors should be aware of their own stress management and how to stay healthy despite these demands. Each doctor must find their own solutions, but these are some simple guidelines:

- Establish good health habits early.
- Set aside time each day to maintain your own fitness and health and to pursue other interests outside of medicine.
- Deal with your own reluctance to seek help and identify the barriers, both real and imaginary, that prevent help-seeking behaviour.
- Have your own GP – someone who is comfortable treating doctors.
- Avoid corridor consultations about your own health or anyone else's.
- If you are feeling stressed, consider contacting support groups from your professional body, college or insurer.
- When you visit your GP, leave your 'medical mantle' at the surgery door – allow yourself to be a patient

178 <https://www.mcnz.org.nz/assets/publications/Newsletters/784cb9b087/Medical-Council-News-December-2008.pdf>

- Do not become isolated. Join professional bodies and a peer-support group, and attend meetings regularly. Isolation is not always geographic and can occur even in the biggest cities.
- Plan holidays and recreation, and make sure work does not intrude on them.
- Remind yourself often that you are 'responsible to' your patients, not 'responsible for' them. Being responsible to your patients means providing the best care you can for them, which may mean organising somebody else to care for them from time to time.
- When ill health strikes, seek help early (as you would like your patients to).
- Consider income protection so financial pressures are not a consideration in preventing you from taking sick leave if it is necessary.
- Consider planning for your retirement so you do not feel you have to keep working for financial reasons.

Doctors' health and what the HPCA Act expects

The way that health issues are addressed in the HPCA Act reflects the potential impact on our practice and patients if we are struggling, stressed or unwell. The approach taken reinforces the importance of us being aware of our fitness to practise in terms of our health.

We must consider the impact any mental or physical condition could have on the care we give to our patients. It is also important for us to act when we see signs of ill health in colleagues with the potential to impact their practice. We should raise it with them, offer support and seek help if considered necessary.

The HPCA Act notes that “a mental or physical condition means any mental or physical condition or impairment, and includes, without limitation, a condition or impairment caused by alcohol or drug abuse”. The Council expands on this:¹⁷⁹

Whether a doctor is in good health or has a health problem, a practising doctor must always be able to:

- make safe judgments
- demonstrate the level of skill and knowledge required for safe practice
- behave appropriately
- not risk infecting patients
- not act in ways that impact adversely on patient safety.

There are several common disorders that impair doctors' ability to practise.

Psychiatric disorders include:

- mood disorders such as bipolar disorder and severe depression
- anxiety disorders
- adjustment disorders, personal and professional stress and situational crises
- substance use disorders (both alcohol and drugs)
- dementias.

Medical disorders include:

- head injury
- neurological diseases such as Parkinson's disease and stroke
- malignancy
- major transmissible viral infections.

179 <https://www.mcnz.org.nz/our-standards/fitness-to-practise/health-concerns-about-a-doctor/>

If you believe a doctor is unwell and not fit to practise, the HPCA Act mandates that you notify the Council Registrar promptly in writing. This requirement applies to all doctors, their employers, medical officers of health and persons in charge of a hospital or other organisation that provides health services. It includes treatment providers. Persons in charge of health professional education programmes (for example, deans of medical schools) are similarly required to give written notice to the Registrar if students who are completing a course would be unable to perform such functions.

This notification provision extends across and between all registered health practitioners. It means doctors have the same obligations to notify the relevant board or council if they believe a dentist, nurse, pharmacist, midwife, psychologist or one of the other 11 registered health professions may be unable to practise. These other health professionals have the same obligations.

People considering making a notification are entitled to seek medical advice to assist them in forming an opinion and must state whether such advice has been obtained when giving notice to the Registrar. There is information on the Council's website to help decide whether concerns reach the threshold for notification about doctors.

Disruptive behaviours may indicate a health and/or competence problem, so it is important to make a notification rather than attributing the behaviour to 'personality'.¹⁸⁰

Any person making a notification is protected from civil or disciplinary proceedings unless the person acts in bad faith. If you have reasonable belief that a doctor is unfit to practise and don't notify the Council, you may be in breach of your professional obligation and you could face disciplinary proceedings.

180 <https://www.mcnz.org.nz/assets/standards/e4ddbfd758/Statement-on-unprofessional-behaviour.pdf>

The Council's Health Committee

The Council's Health Committee is authorised by the Council to exercise the functions, duties and powers contained in sections 45–51 of Part 3 of the HPCA Act.

The Health Committee currently has five members of the Council, including two public members. The Council's Health Manager is responsible for the functioning of the Health Committee's work between meetings and keeps close liaison with the Committee Chair.

Summary of key steps the HPCA Act provides for once a notification is received

The Committee may order a doctor to attend a medical assessment or testing by an assessor at the Council's expense. The assessment is by a practitioner with expertise relevant to the suspected (health) condition, and the Committee would consult with the doctor about that practitioner. If the circumstances warrant, the Committee can impose restrictions on a doctor's scope of practice or a temporary suspension of their practising certificate while expert advice is pending.

The doctor will receive a copy of the report and is entitled to make written submissions and can appear before the Committee when it meets to consider the matter and decide what, if any, action to take. If it considers the doctor is not fit to practise, the Committee can suspend the doctor's registration or order conditions on their scope of practice. The Committee will also encourage the doctor to seek the health care and support they need.

If the Committee orders an assessment of the doctor and they fail to attend this, the Committee may consider suspending the doctor's

registration if they feel this is required to protect the public, or if the circumstances warrant, the Committee can impose restrictions on the type of work the doctor is allowed to do.

A doctor who may be adversely affected by these decisions has the legal right to ask the Council to review any decision made. Doctors can also appeal to the District Court against decisions or directions to suspend their practising certificate or registration or to include or vary any condition in their scope of practice.

How the Health Committee deals with notifications

When a notification is received about the possible impairment of a doctor or graduand, the notice is passed to the Committee. Only rarely would a doctor's practising certificate be immediately suspended or conditions be placed on their practice.

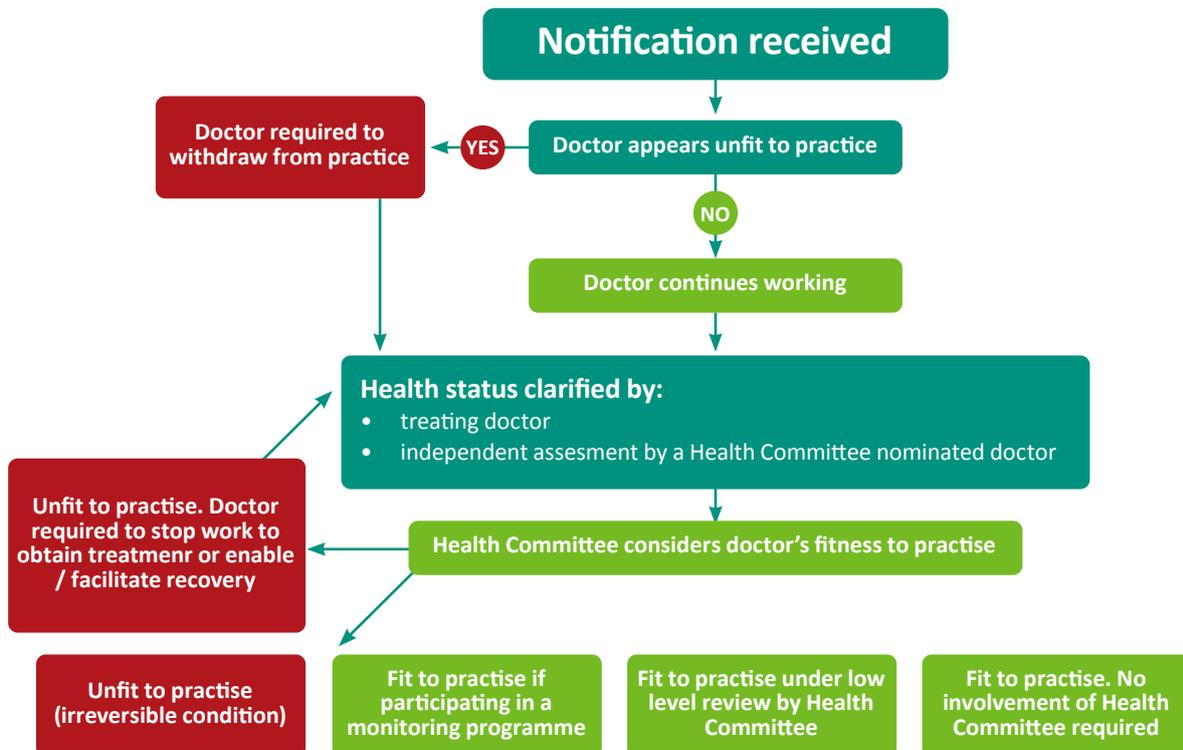
The doctor will be contacted by one of the Council's health case managers to discuss the concerns and how these might be impacting on the doctor's practice. If appropriate, a report might be requested from the doctor's general practitioner and/or specialists. Sometimes the doctor may be asked to make a voluntary agreement to limit their practice to ensure public safety while an expert assessment is arranged.

If the reports from their own doctors or the ordered assessment indicate that a mental or physical condition is affecting the doctor's ability to practise, the Committee will consider any actions necessary. If appropriate, the doctor will be invited to attend a meeting of the Committee to discuss the report and implications. They may bring whānau or other support person(s) and/or a lawyer with them if they choose to attend.

Sometimes, the doctor may be asked to make an agreement that limits their practice of medicine in relevant ways to ensure public safety while an expert examination is arranged.

See Figure 4 below.

Figure 4. Steps taken when a health notification is received.



If the doctor's ability to practise is affected by a mental or physical condition, the Committee usually decides on one or more of the following:

- Asks to receive follow-up reports on progress after a specified period of time – for example, before the next practising certificate renewal.
- Asks the doctor to sign an agreement about treatment and monitoring. This can include appropriate restrictions on practice to ensure public safety in light of their condition and also what information needs to be shared with employers/associates and relevant others such as hospitals where a doctor may work.
- Recommends that conditions be placed on the doctor's scope of practice or that registration is suspended – for example, while the doctor attends a rehabilitation or treatment programme.

The agreement is underpinned by the acknowledgment that conditions may be placed on the doctor's practice if the agreement is breached in any material way. In doing this, the Committee's intention is to help the doctor to regain and maintain health so that they can continue to practise, subject to appropriate limitations, and also ensure the health and safety of the public are protected.

A typical agreement may include the following:

- Limiting the doctor's practice to the place(s) of work, type(s) of work to be undertaken, workload and hours of work.
- Supervision of the doctor's practice if that is indicated.
- Treatment to be undertaken and the names of the treating doctors, therapists and agencies who may be involved in the doctor's treatment programme, with some indication as to the frequency of consultation. There may be provision for each to communicate with the Committee if problems arise – for example, non-compliance or relapse.
- Where relevant, provision for a key person in the doctor's workplace to be aware of the condition.
- Some monitoring by the Committee – for example, where the doctor has a substance use disorder, random urinalysis or blood or hair testing will also form part of the agreement.
- Restricted access to prescription drugs and medicines (if relevant).
- No self-prescribing – this is consistent with being a 'patient'.
- Regular assessment of progress by a Committee-nominated doctor.

Doctors monitored by the Health Committee may meet with members of the Committee at intervals to discuss their progress and current state and to make changes to the agreement. When the situation has stabilised and the doctor's recovery is firmly established, the doctor may be monitored by an annual exchange of letters. Then, if all is going well, the doctor is discharged from Committee monitoring.

It should be stressed that the Committee does not become involved in treatment decisions directly but ensures the appropriate treatment is taking place and the doctor's health is maintained at the most satisfactory level possible. The doctor chooses their own treating team.

This process has been designed to separate matters of impairment from matters of professional misconduct and discipline. The assumption is that, with treatment of the impairment, a doctor should be able to return to the medical workforce. The process is intended to be rehabilitative, not punitive.

Management of health information held about doctors

The Council and Health Committee follow the information privacy principles set down under the Health Information Privacy Code 1994 and Privacy Act 2020.

Confidentiality is paramount. Council has has robust IT and cybersecurity systems that are continuously reviewed.

Where relevant, information the Committee has can sometimes be used to inform other Council decisions about a doctor's competence, conduct or compliance with set recertification programmes.

Conclusion

'Physician heal thyself' is not a policy the Medical Council endorses. Doctors are a valuable asset. We must take responsibility for maintaining our own health as much as is possible and seek professional help when we are ill. While the HPCA Act gives the Committee (through Council) powers to restrict doctors' practice when necessary to protect public safety, it is preferable if the Committee can reserve the use of these powers and assist doctors to continue to work as appropriate and recover from their illnesses. This is best achieved by early notification and early intervention.

The Health Committee can be contacted via the Health Manager – phone (04) 384 7635 or 0800 286 801 extension 774.

Acknowledgement

The contribution of Kate O'Connor and Joanna MacDonald as authors of this chapter in previous editions is gratefully acknowledged.

CHAPTER 8

Maintaining competence

Steven Lillis is a general practitioner in Hamilton and Medical Adviser for the Medical Council of New Zealand.

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Introduction

Like all professions, medicine is granted professional autonomy by society under the assumption that its practitioners will be deemed competent on entry into practice and will maintain competence for as long as they practise.

Evidence-based education

Although no one would negate the importance of lifelong learning, there has been considerable debate as to how to ensure that useful learning occurs. The principal purpose of the Health Practitioners Competence Assurance Act 2003 is “to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their

professions”. The Council currently requires all doctors to participate in approved continuing professional development (CPD) activities in order to recertify,¹⁸¹ but there is disquiet that the currently practised CPD, with its emphasis on continuing medical education, does not necessarily identify or improve underperformance and therefore cannot ensure doctors are competent.

Traditional continuing medical education (CME) employed planning models that were devised 50 years ago. The effectiveness of such methods has been substantially questioned, and it is generally accepted that such techniques have little to offer modern complex professional practice. CPD comes somewhat closer to the needs of doctors but is generally deficient

The Council currently requires all doctors to participate in approved continuing professional development (CPD) activities in order to recertify

181 <https://www.mcnz.org.nz/registration/maintain-or-renew-registration/recertification-and-professional-development/>

in its ability to understand learning deficits at an individual level. Alongside these limitations is increasing awareness of the dangers inherent in self-assessment of learning need where inadvertent self-deception can colour objectivity.

Does continuing professional development work?

Using the criteria of making positive changes to what a doctor does and better patient outcomes as the criteria for success, it is clear that ongoing education does work. The most convincing evidence comes from a paper published in 2015 that combined eight systematic reviews, all published since 2003.¹⁸² There are now 39 systematic reviews over all years in the medical education literature that present an overwhelming conclusion of ongoing education having a beneficial effect.

What forms of ongoing professional development work?

Audit

Audit is currently a required component of recertification. A Cochrane review was undertaken on 104 studies into effectiveness of audit on both physician performance as well as patient outcomes.¹⁸³ Modest gains were found overall, but better outcomes occurred when the baseline performance of the physician was poor. It appears that the supportive structures available to assist with reflection on audit results and instituting change in practice have significant impact on how successful audit is in assisting with improving practice.

182 Cervero RM, Gaines JK. The impact of CME on physician performance and patient health outcomes: an updated synthesis of systematic reviews. *Journal of Continuing Education in the Health Professions*. 2015 Spring;35(2):131–138.

183 Ivers N, et al. Audit and feedback: effects on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews*. 2012 Jun 13;(6):CD000259.

Multisource feedback

Two systematic reviews on multisource feedback provide evidence of effectiveness. A review of 16 studies into workplace-based assessment concluded that “multisource feedback can lead to performance improvement, although individual factors, the context of the feedback, and the presence of facilitation have a profound effect on the response”.¹⁸⁴ A further review of 15 papers on the impact of feedback on workplace-based assessment also found that well-implemented feedback was influential in increasing effectiveness of this modality.¹⁸⁵

Education based on the practitioner’s needs

As would be expected, education that focuses on providing solutions to problems that exist at a practitioner level is associated with positive change. The most-effective teaching reflects practice needs. A study of 23 research papers into teaching evidence-based medicine found that learning on real-world problems resulted in a greater depth of education.¹⁸⁶ Teaching that is relevant to real-world practice has the capability to improve skills, knowledge, attitudes and behaviours, whereas stand-alone teaching that is not based on practice improves knowledge only.

Outreach visits

Academic outreach visits (trained facilitators visiting the workplace of the doctor) have historically been utilised mainly as a method of improving prescribing practice. A Cochrane review of 69 studies revealed that such visits are effective in changing physician performance with modest

184 Miller A, Archer J. Impact of workplace based assessment on doctors’ education and performance: a systematic review. *BMJ*. 2010 Sep 24;341:c5064.

185 Saedon H, Salleh S, Balakrishnan A, Imray CH, Saedon M. The role of feedback in improving the effectiveness of workplace based assessments: a systematic review. *BMC Medical Education*. 2012 May 2;12:25.

186 Coomarasamy A, Khan KS. What is the evidence that postgraduate teaching in evidence based medicine changes anything? A systematic review. *BMJ*. 2004 Oct 30;329(7473):1017. Review.

results.¹⁸⁷ Prescribing changes would appear to reliably improve, but other facets of practice have more variable results. Physician peers rather than non-physician peers are advantageous.

Observation of practice

This modality of improving practice has been used in undergraduate and vocational training for many years and is the cornerstone of workplace-based assessment. It has a track record for being able to distinguish between differing levels of performance of trainees.¹⁸⁸ Again, the nature and form of feedback given after the use of rating scales is critical to the educational value of rating tools such as mini-CEX.¹⁸⁹

Multiple methods and multiple exposures

A review of 105 papers for evidence of both short-term (<30 days) and long-term (>30 days) gains in physician practice performance indicated that strong evidence exists for using multiple exposures, multiple instructional techniques and multimedia delivery.¹⁹⁰ The review also found convincing evidence that single print media is ineffective

Further information on feedback

Feedback, defined as any clinical summary of clinical performance over a specified period of time, features as a variable that predicts the effectiveness of many learning modalities. A review of factors that increase effectiveness was reported in a systematic review of 41 studies.¹⁹¹

187 O'Brien MA, et al. Educational outreach visits: effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews*. 2007 Oct 17;(4):CD000409.

188 Fromme HB, Karani R, Downing SM. Direct observation in medical education: a review of the literature and evidence for validity. *Mount Sinai Journal of Medicine*. 2009 Aug;76(4):365–371.

189 Lee V, Brain K, Martin J. Factors influencing mini-CEX rater judgments and their practical implications: a systematic literature review. *Academic Medicine*. 2017 Jun;92(6):880–887.

190 Davis D, Galbraith R, American College of Chest Physicians Health and Science Policy Committee. Continuing medical education effect on practice performance: effectiveness of continuing medical education: American College of Chest Physicians Evidence-Based Educational Guidelines. *Chest*. 2009 Mar;135(3 Suppl):42S–48S.

191 Veloski J, Boex JR, Grasberger MJ, Evans A, Wolfson DB. Systematic review of the literature on assessment, feedback and physicians' clinical performance: BEME Guide No. 7. *Medical Teacher*. 2006 Mar;28(2):117–28. Review.

Over 70% of the studies showed beneficial effect of feedback on performance. The source and the duration of feedback are both important. Feedback from professional groups or administrative groups had greater effect than from academic groups. The duration was also positively associated with effectiveness. Contrary to commonly held belief, involvement in the design of the feedback process was not associated with better effectiveness. Comparison with local statistical norms or guidelines did not have a significant effect. A scoping review of 650 research papers on feedback added different insights.¹⁹² The review found that praise improved knowledge and skills but criticism did not, yet feedback needs to clearly describe deficiencies too for it to be effective. Similar to other studies, feedback that is both immediate and longitudinal is more effective, and individual rather than group feedback increases effectiveness.

How should educational evidence be used when planning your own CPD?

Educational evidence should not straight-jacket what you undertake for your professional development. However, it is wise to consider evidence of effectiveness when planning activities. It is clear that conferences and didactic lectures hold little value in changing the behaviour of a doctor or in improving patient outcomes. It becomes important to focus time, energy and resources on activities with greater effectiveness.

Educational evidence should not straight-jacket what you undertake for your professional development.

192 Bing-You R, Hayes V, Varaklis K, Trowbridge R, Kemp H, McKelvy D. Feedback for learners in medical education: what is known? A scoping review. *Academic Medicine*. 2017 Sep;92(9):1346–1354.

Regular practice review

The Council has requested Colleges to offer practice visits (RPR) in CPD programmes as an option. Such visits are formative (designed to assist learning) rather than being summative (designed to test minimum standards). The professional bodies rather than the Medical Council administer the scheme to ensure that it is in line with professional need in various disciplines and there is a focus on developing the concepts to ensure they are acceptable and feasible to the profession. The advantage of RPR is that many of the effective modalities discussed above are to be found in the structure of a regular practice visit.

CHAPTER 9

Credentiailling

Robyn Carey is the Chief Medical Officer at the Timaru Hospital, South Canterbury District Health Board.

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Definition of credentialling

Credentialling is a process used by health and disability service providers to assign specific clinical responsibilities to health practitioners on the basis of their education and training, qualifications, experience and fitness to practise within a defined context. This context includes the particular service provided and the facilities and support available within the organisation.

Credentialling is a continuous process that commences on a doctor's appointment, with determination of clinical responsibilities, and then extends for the length of employment. Credentialling reviews take place in a number of ways:

- An annual confirmation of credentialled status, which is sometimes undertaken in conjunction with a performance review.
- A periodic formal review by a credentialling committee.
- Non-routine reviews for events such as the introduction of a new treatment or service or when there is reason to confirm a doctor's competence across a range of specific clinical responsibilities.

The interface with medical regulation

The Medical Council of New Zealand is the medical regulator and is responsible for ensuring that doctors maintain high standards of practice. Doctors working in New Zealand are respected for the high standard of care they provide, albeit in a constantly evolving medical environment. The profession and the Council are leaders in providing assurance to the public and patients that their trust and confidence in doctors is warranted.

The profession and the Council need to take the lead in providing assurance to the public and patients that their trust and confidence in doctors is warranted.

The Health Practitioners Competence Assurance Act 2003 prescribes the responsibilities of regulatory authorities for each professional group. The Council is responsible for broadly defining scopes of practice, detailing the necessary qualifications for registration, ensuring doctors are competent and fit to practise and, in accordance with these parameters, registering doctors.

In comparison, credentialling processes are undertaken by service providers to define the clinical responsibilities for individual doctors within the scope in which they are registered and within the context in which they work. This is a key feature of credentialling – the level of services available in the organisation, the capability of other health professionals in the organisation and the facilities and equipment available to the doctor are entirely relevant to which clinical responsibilities the doctor can take up.

Credentialling is part of clinical governance, and responsibility for credentialling lies with organisational governing bodies. However, credentialling processes must be owned by the profession, and quality assurance and improvement will only occur if there is clinical leadership of the process.

Te Tiriti o Waitangi

Credentialling processes must work in partnership with Māori to honour the obligations and responsibilities that arise from te Tiriti o Waitangi and its principles. A guide to the application of the principles of partnership, protection, equity and options to health governance can be found in the Council's statement *He Ara Hauora Māori: A Pathway to Māori Health Equity*.¹⁹³

193 <https://www.mcnz.org.nz/assets/standards/6c2ece58e8/He-Ara-Hauora-Maori-A-Pathway-to-Maori-Health-Equity.pdf>

Consumer input

Credentialling aims to improve outcomes for patients. Effective credentialling processes can provide assurance to the public of the quality of care they can expect from their doctor. Consumers play an important role in credentialling processes – for example, as members of the credentialling committee of a health provider or through patient experience data of care provided by a practitioner or service. A consumer representative is also often involved in credentialling during the process of appointment of doctors.

Benefits of credentialling

Credentialling should be seen primarily as a quality assurance and improvement tool, both in respect to individual doctors and in respect to identifying system errors within health provider organisations.

Effective credentialling systems for the medical profession:

- help to ensure patient safety
- help address Māori health needs and health equity
- promote professional practice development among doctors
- improve risk management in provider organisations
- support clinical quality improvement activity
- improve public confidence in the health system.

Fairness and transparency

Credentialling processes must follow due process and be procedurally fair, unbiased and transparent. It is important that policies accurately document the process and that the policies are adhered to. Credentialling processes must follow the tenets of natural justice, and there must be a documented and robust appeal process.

There is a public interest in the outcome of credentialling processes.

Policies need to identify what information is made available to patients. The credentialled status of a doctor should be made available to the public. However, the information generated during the credentialling process may be confidential.

Credentialling information should also be shared amongst service providers. This includes between public and private hospitals and service providers. It is essential that the doctor is informed if and when such information is shared between providers.

Policies need to identify what information is made available to patients. The credentialled status of a doctor should be made available to the public.

Standards of credentialling

There is a need for consistent processes to be followed to ensure effective credentialling across all health service providers. *The Credentialling Framework for New Zealand Health Professionals*¹⁹⁴ lays out general principles with a purpose of promoting a nationally consistent credentialling system.

Within medicine, credentialling is reasonably well established in hospital settings, both public and private. Future directions in the development of credentialling include revision of the foundation document consistent with te Tiriti o Waitangi, more-extensive coverage of procedures outside usual training programmes and the introduction of new medical devices and formal extension of the credentialling process to other groups of health care practitioners such as general practitioners and nurse practitioners.

Acknowledgement

The contribution of Ken Clark as author of this chapter in previous editions is gratefully acknowledged.

194 <https://www.health.govt.nz/system/files/documents/publications/credentialling-framework-nz-health-professionals.pdf>

CHAPTER 10

Doctors who use complementary and alternative medicine

Shaun Holt holds pharmacy and medical degrees and is a researcher, teacher, speaker and commentator on the topic of evidence-based natural therapies.

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What is complementary and alternative medicine (CAM)?

Treatments that are not commonly accepted in mainstream medical practice have been given a number of names over the years, from quackery to unproven to unorthodox to unconventional. The most widely used current description is complementary and alternative therapies and medicines, shortened to CAM. Complementary therapies are health care and medical practices that are used alongside conventional medical treatments but are not currently an integral part of conventional medicine, whereas alternative therapies are used instead of standard medical treatments.

Complementary therapies are health care and medical practices that work alongside traditional medical treatments but are not currently an integral part of conventional medicine, whereas alternative therapies are used instead of standard medical treatments.

There are hundreds of CAM therapies. and the National Centre for Complementary and Alternative Medicine (NCCAM), a United States government agency that carries out scientific research on complementary therapies, classifies them into five categories:

- **Alternative medical systems** have a completely different theory and practice to the conventional Western way of understanding and treating medical problems. Some of these systems were developed in the Western world, such as homoeopathy, but most originate in other parts of the world, particularly in the East, such as acupuncture. In addition to homoeopathy and acupuncture, they include ayurvedic medicine from India and traditional Chinese medicine.

- **Manipulative and body-based systems** are methods of treating a person by way of moving part(s) of the body or by using substances on/in the body for their physical properties (for example, water, heat or oxygen) rather than for their pharmacological properties. Such systems include acupuncture, Alexander technique, chiropractic, colonic irrigation, craniosacral massage, cupping, ear candling, Feldenkrais technique, hyperbaric oxygen, iridology, massage therapy, osteopathy and reflexology.
- **Mind-body interventions** harness the undoubtedly powerful but currently poorly understood power of the mind to influence a person's physical health. A good example of such an interaction would be the placebo effect, which can lead to improvements in 90% of people with some medical conditions. Other examples, some of which have proven benefits while others do not, include aromatherapy, art therapy, biofeedback, hypnosis, hypnotherapy, meditation, music therapy, psychic surgery, qigong, reiki, shiatsu, spiritual healing, t'ai chi and yoga.
- **Biologically based therapies** fit most closely with modern medical practice in Western countries whereby medicines are often taken to relieve symptoms or even cure medical conditions. They include herbs, supplements, vitamins and diets, which are considered to be complementary therapies if they have not been fully accepted by the majority of traditional health care professionals.
- **Energy therapies** aim to harness invisible energy fields in order to improve health. There is a wide range of credibility within this category, ranging from measurable, proven energy therapies such as transcutaneous nerve stimulation (TENS) through to implausible and unproven ones such as crystal healing and magnetic therapy.

CAM use is increasing, and there are now more visits to CAM practitioners than there are to primary care or family doctors in many developed countries. An interesting aspect of CAM use is that it is almost totally patient-driven. Proponents and consumers of CAM will often say that they

are worried about the safety of conventional medicines and medical procedures, that the patient-doctor relationship is unsatisfactory for them in terms of the perceived power disparity and that traditional Western medicine treats them as a disease to be cured rather than a person to be healed. The vast majority of New Zealanders take dietary supplements or use CAM.^{195,196} Despite this, health professionals receive little if any training on this subject, and often the patient may know more than the health professional they are consulting with. Studies investigating the knowledge of health care professionals show that they mostly rate their knowledge in this area as inadequate and are not confident in answering patient enquiries, but they do want to learn more.¹⁹⁷

An interesting aspect of CAM use is that it is almost totally patient-driven.

How CAM can harm

There is a widespread misconception that CAM is safe because it is natural. Not only is this not true, but CAM can harm in a number of ways that may not be immediately apparent.

Direct harm

Adverse events from CAM can range from a trivial stomach upset from a herbal preparation to serious injury, disfigurement or even death. Many of the drugs that are used in everyday medical practice are of course

195 Holt S, et al. A survey of use and knowledge of vitamins and supplements in the Bay of Plenty, New Zealand. *New Zealand Medical Journal*. 2010;123(1308):114–116.

196 Nicholson T. Complementary and alternative medicines (including traditional Maori treatments) used by presenters to an emergency department in New Zealand: a survey of prevalence and toxicity. *New Zealand Medical Journal*. 2006;119(1233):U1954.

197 Holt S, Gilbey A. A survey of New Zealand general practitioners' understanding of CAM therapies and recommendations they make. *Focus on Alternative and Complementary Therapies*. 2011;16(2): 189–190.

extracts from plants themselves, and many more are closely related to plant extracts – in other words, natural products can be every bit as powerful (and harmful) as prescription medications. CAM proponents argue that severe side effects are rare, and to a large degree, they are correct. However, it is also likely that side effects are more common than is claimed, because unlike for conventional medicines, there are no good systems in place to monitor side effects from CAM therapies.

Indirect harm

- **Delay:** In general terms, the earlier a disease is detected and treated, the better the outcomes will be. Delays in using conventional, proven, effective treatments due to decisions to try CAM therapies first can lead to much worse outcomes including death.
- **Substitution:** A real danger arises when CAM is used as an alternative to proven medical treatments. This can lead to delays in seeking medical treatment, as described above, or even not seeking medical treatment at all. Although homeopathy, for example, cannot cause any direct harm, harm can result in other ways, including if it used as a substitute for proven medical treatments or if it delays medical therapy.

Bad advice

Most CAM practitioners are not trained health care professionals, and they have little or no training in anatomy, physiology, pharmacology, microbiology and many other areas of knowledge that health care professionals must have in order to give sound advice and diagnose and treat patients effectively. Without this training, many CAM practitioners give out bad advice that can be dangerous in itself or cause harm in other ways. There is a whole spectrum of advice quality, from excellent to appalling, and the problem for laypeople is knowing which advice can be relied upon.

Psychological harm

People with cancer and other serious diseases are often emotionally and psychologically very vulnerable. Extravagant claims for unproven therapies can give a patient false hope. Denial is one of the stages in the

There cannot be two kinds of medicine – conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work

grief process that occurs with a diagnosis of a serious disease, and bad advice leading to false hope from misguided or deliberately dishonest CAM practitioners reinforces this denial stage, interfering with the natural process of grief (which eventually leads to the acceptance phase) and therefore causes psychological harm.

Financial harm

It has been estimated that around US\$1 billion per year is wasted on CAM therapies for cancer that do not work, around the same amount that is spent each year on cancer research. Any money spent on a CAM therapy that does not work is wasted, and

there are many sad reports of people who, not wanting to leave any stone unturned, have spent all their savings or even lost their family home trying a variety of expensive and ineffective treatments.

Evidence-based CAM

Most CAM therapies are not supported by robust clinical trial data but instead by some or all of word of mouth, anecdote, inaccurate media reports and exaggerated and inaccurate marketing claims. There are three main reasons why people may think that a treatment – CAM or orthodox – works when in fact it does not.

Placebo effect

This is a beneficial effect – an improvement in health or a reduction in symptoms – that occurs when a treatment is administered but is not due to the treatment itself. Instead, it is a result of complex mind-body interactions whereby the expectation of a benefit from a treatment actually results in real benefits. Depending on the condition, up to 90% of patients can have an improvement in their health when taking a placebo, which is usually an inert substance such as a sugar pill that looks like a real treatment. Up to 30–40% improvements are common in clinical trials in participants who are in the placebo group.

Natural history

The role of the natural history of the illness when looking at whether a treatment works is often overlooked. Natural history refers to the likely course of events of an illness if it is not treated. For example, symptoms of the common cold will generally last 3–4 days, and a cold sore will generally last 5–6 days without specific treatments. In other words, many illnesses will simply get better by themselves over time as the body heals itself.

Additional measures

Often when a person is ill, they will do several things to get better at the same time, but they may attribute the recovery to a single therapy. For example, a person with a chronic condition may think that they got better because of the homeopathic remedy that they used, whereas the real reason (if not placebo effect or natural history) could be that they also changed their diet, started doing more exercise or made some other lifestyle change.

Controlled clinical trials factor in these and other sources of error. Although they will still be present to some degree, they will be present to around the same level in both the active and control groups and therefore the difference between the two groups will be due to the treatment

under investigation. This of course applies equally to the investigation of orthodox medical treatments as well as CAM.

The New England Journal of Medicine summarised the requirement for CAM therapies to be supported by robust research as follows:¹⁹⁸

There cannot be two kinds of medicine – conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work ... But assertions, speculation and testimonials do not substitute for evidence. Alternative treatments should be subjected to scientific testing no less rigorous than that required for conventional treatments.

Some recommended sources of reliable information on CAM are listed in the [resources section](#) at the end of this chapter.

Medicolegal guidance

The Council issued an updated statement on CAM in November 2017,¹⁹⁹ and it is strongly recommended that doctors who recommend or practise CAM therapies are familiar with the contents. The statement was written to inform doctors of the standards of practice that are expected of them by the Council should they choose to practise CAM or if they have patients who use CAM. It may be used by the Health Practitioners Disciplinary Tribunal, the Council and the Health and Disability Commissioner as a standard by which a doctor's conduct is measured.

198 Angell M, Kassirer JP. Alternative medicine – the risks of untested and unregulated remedies. *New England Journal of Medicine*. 1998;339(12):839–841.

199 <https://www.mcnz.org.nz/assets/standards/7eb60db2d2/Doctors-and-CAM-Complementary-and-alternative-medicine.pdf>

The key points are that, when CAM therapies have demonstrated benefits for the patient and have minimal risks and patients have made an informed choice and given their informed consent, the Council does not oppose their use, and that no doctor

... will be found guilty of a disciplinary offence under the Health Practitioners Competence Assurance Act 2003 merely because that person has adopted and practised any theory of medicine or healing if, in doing so, the person has acted honestly and in good faith.²⁰⁰

Therefore the key issue is the strength, if any, of research evidence that supports the practice, as this underpins whether it has demonstrated benefits.

Previous decisions by the Medical Practitioners Disciplinary Tribunal also provide important guidance as to what is expected of doctors in this regard. For example, decision 02/89D²⁰¹ stated:

Whilst section 109(4) recognises that a practitioner is not to be found guilty ‘merely’ because he has adopted or practised a theory of medicine or healing, it does not follow that his adoption and practice of any theory of medicine or healing is by itself a sufficient answer.

In another case, the Tribunal stated, among other things:²⁰²

Where a registered medical practitioner practises ‘alternative or complementary’ medicine, there is an onus on that practitioner to inform the patient not only of the nature of the alternative treatment offered but also the extent to which that is consistent with conventional theories of medicine and has, or does not have, the support of the majority of practitioners. The Tribunal

200 See footnote 199.

201 <http://www.mpd.org.nz/decisionsorders/decisions/0289dfindings.pdf>

202 See footnote 201.

recognises that persons who suffer from chronic complaints or conditions for which no simple cure is available are often willing to undergo any treatment which is proffered as a cure. As such, they are more readily exploited. The faith which such persons place in practitioners offering alternative remedies largely depends on the credibility with which such practitioners present themselves. Where such remedies are offered by a registered medical practitioner, it is difficult to escape the conclusion that the patient derives considerable assurance from the fact that the practitioner is so registered. It follows, therefore, that a registered medical practitioner cannot discharge his or her obligation to treat the patient to the acceptable and recognised standard simply by claiming the particular treatment was 'alternative or complementary' medicine.

In assessing complaints or concerns related to the practice of a doctor who has adopted or advocated CAM investigations or treatments, the Council will apply the standards that have been developed for reviewing the competence of any practitioner. In the case of CAM practices, it will particularly consider questions relating to the above comments by the Medical Practitioners Disciplinary Tribunal.

It will also consider whether the methodology promoted for a diagnosis is reliable, the risk/benefit ratio for any treatment is acceptable, the treatment is extrapolated from reliable scientific evidence or is supported by a credible scientific rationale, there is a reasonable expectation that the treatment will result in a favourable outcome compared with placebo, the practitioner is excessively compensated for the service (i.e. whether there is any suggestion of exploitation) and whether informed consent has been adequately documented in the medical record.

In assessing the performance of a doctor practising CAM, the Council will not attempt to evaluate the alternative therapy itself, although the critical appraisal skills of doctors may be of concern. The usual domains of competence are assessed rather than the principles of CAM practice.

Resources

Web

- Scientific evidence for popular supplements
<http://www.informationisbeautiful.net/play/snake-oil-supplements/>
- Mayo Clinic
<http://www.mayoclinic.com/health/alternative-medicine/PN00001>
- National Centre for Complementary and Alternative Medicine (NCCAM)
<http://www.nccam.nih.gov/>

Books

- Ernst E, Pittler M, Wider B, Boddy K. Oxford handbook of complementary medicine. Oxford, UK: Oxford University Press; 2008.
- Hoffman R, Fox B. Alternative cures that really work. Emmaus, PA: Rodale Books; 2008.
- Holt S. Complementary therapies for cancer. Nelson: Craig Potton Publishing; 2010.

Journals

- Focus on Alternative and Complementary Therapies (FACT)
[http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)2042-7166](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)2042-7166)
- Complementary Therapies in Medicine
http://www.elsevier.com/wps/find/journaldescription.cws_home/623020/description

CHAPTER 11

Digital health

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Introduction

The combination of increased processing speed, cloud-based technologies and miniaturisation has resulted in an explosion in the digital world over the past two decades, bringing with it opportunity and threat in similar measure. We can now carry in our pockets a similar amount of computing power to that which was once only available from

warehouse-sized computer systems. The very human practice of medicine has been drawn into the digital age, and clinicians have a responsibility to ensure this enhances, rather than erodes, patient care.

The very human practice of medicine is being drawn into the digital age, and clinicians have a responsibility to ensure this enhances, rather than erodes, patient care.

In almost every example of digital health, there is an overlap with the analogue world – a world in which traditionally some patients have had inequitable or inefficient access to health care. Digital health affords us an opportunity to address these inequalities and inefficiencies while at the same time opening up a selection of traps, pitfalls and temptations.

The terminology of digital health can be confusing, thus it is important to confirm mutual understanding of terms when discussing the topic. For the purposes of this chapter:

- eHealth is the electronic management of health information.
- Clinical informatics is the application of informatics and information technology to deliver health services
- Digital health encompasses all of the digital and information communication technologies and processes that support the practice of health care, including prevention, diagnosis, treatment and monitoring.

New Zealand Health Strategy and Digital Health Strategic Framework

The New Zealand Health Strategy²⁰³ published in 2016 sets out a 10-year strategy for the health sector that contains goals for creating a more sustainable and equitable health system. It outlines the need to embrace digital tools in order to achieve these goals. From a patient perspective, this means encouraging use of patient portals and digital consultation tools, and for vendor partners, it entails improving interoperability between systems and accessibility (with appropriate controls) of the data held within them.

The Digital Health Strategic Framework²⁰⁴ is the primary tool used by the sector to ensure its initiatives further the New Zealand Health Strategy by promoting personal control of health information and the use of health information to improve equity and outcomes, including the development of digital services to provide new and augmented services.

Health reforms

At the beginning of 2021, the government announced proposed changes to the health sector as a result of the New Zealand Health and Disability System Review.²⁰⁵ This includes disestablishing the current district health board (DHB) model and replacing DHBs with two primary commissioning agencies: Health New Zealand, with four regional offices, and the Māori Health Authority. As part of the review, it was acknowledged that New Zealand lacked the required investment in digital health systems to adequately support health and disability services. \$400 million of additional funding for data and digital infrastructure has been approved in the 2021 budget for the next 4 years.

203 See footnote 62.

204 <https://www.health.govt.nz/our-work/digital-health/digital-health-strategic-framework>

205 See footnote 65.

National Health Information Platform

New Zealand is introducing a National Health Information Platform²⁰⁶ known as Hira, which will enable access to a virtual electronic health record as needed by drawing together a person's latest health data from trusted sources. Tranche 1 of Hira runs to January 2024 (subject to final Cabinet approval). It will provide access for providers and consumers to important health information including demographics (such as gender, ethnicity, name and date of birth), enrolled general practice, Community Service Card entitlements, prescribed and dispensed medicines, vaccination status and laboratory test results. As part of Tranche 1, consumers will have the ability to update information held in the national health index (NHI), such as their contact details.

Access to health information in Tranche 1 will be enabled through multiple consumer and provider channels (websites and apps) focusing on those that improve equity of access to health information and empower consumers and whānau to better manage their health and wellbeing. Tranche 1 will also deliver technology enablers such as digital identity and interoperability services.

Data sovereignty

Data sovereignty is the concept that data is subject to the laws and governance structures within the nation it is collected. In 2010, New Zealand signed the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).²⁰⁷ The UNDRIP sets out the minimum standards for the survival, dignity, wellbeing and rights of the world's indigenous peoples, and this includes rights of access and control to information. The topic of who owns what data and data management is complex and worthy of a

206 <https://www.health.govt.nz/our-work/digital-health/other-digital-health-initiatives/hira-national-health-information-platform>

207 <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html>

whole book in its own right, for the purposes of this chapter, I will bring to your attention that Māori data sovereignty is an important topic and anyone looking to acquire or use data should be mindful of the concepts of sovereignty and seek appropriate counsel on the topic.

Coding and transfer of information

Software applications that implement terminologies, classifications and code systems provide a common language that can be understood between different systems and are key to supporting interoperability and for providing information in a searchable form (critical for audit and research). The Health Information Standards Organisation (HISO) has endorsed the use of SNOMED CT (the Systematised NOMenclature of mEDicine – Clinical Terms) as the standard clinical terminology to be used across the health and disability system in New Zealand. SNOMED CT is the most comprehensive multi-lingual clinical terminology in use around the world. A SNOMED CT-enabled system supports the capture and reuse of clinical information in a consistent and reliable way, enabling this information to be stored and shared without ambiguity. The scope of SNOMED CT provides the ability to capture relevant and critical clinical information in an electronic health record – for example, clinical findings, disorders, procedures, observable entities, substances, body structures, social context and events. The Ministry of Health releases the SNOMED CT NZ edition twice a year, which includes the SNOMED CT international edition along with concepts that are unique to New Zealand, patient-friendly terms and te reo Māori translations of terms.

Another digital health standard endorsed by HISO is the Fast Healthcare Interoperability Resource (FHIR). It is the latest generation of the HL7 standard that drives the exchange of health information between different organisations. It will bring a new level of interoperability between health systems in New Zealand and will be a significant enabler of Hira. It is a technical standard so there is no need for the majority of clinicians to

know how it works, but it is important to know that it exists and ensure that future health software can utilise it. In New Zealand, it is managed by HL7 NZ, and further information about it can be found on their website.²⁰⁸

The self-educated patient

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

The challenge for patients is to find the true and relevant information that is bobbing about in a sea of conjecture, opinion and marketing and then apply it to their own health. With the growth of digital tools, there is also a concomitant growth of disinformation – information that is deliberately incorrect in order to advance an often hidden agenda. Doctors are in a privileged position to guide patients, particularly if they understand the internet themselves. The United States National Library of Medicine has produced a resource to help patients evaluate health information.²⁰⁹ In New Zealand, an excellent resource for patients and clinicians is the Health Navigator website.²¹⁰

While most of the information on the internet is general and passive, some is interactive and thereby specific to an individual patient – for example, in the form of a symptom checker. Amongst these tools, usually some type of mobile application, there is a wide range of complexity and accuracy. To date, the level of accuracy has been low, but some of these systems are now ‘learning’ from patients and therefore improving to a level where they are useful. ADA is one example.²¹¹

208 <https://hl7.org.nz>

209 <https://medlineplus.gov/evaluatinghealthinformation.html>

210 <https://www.healthnavigator.org.nz/>

211 <https://ada.com/>

The digital patient

Alongside improved access to health information sits the ability for patients to be increasingly involved in the inner workings of their own bodies. Whether this is via home blood pressure machines, implanted glucose monitors, smart watches or other monitoring devices, patients and their clinicians have increased access to large amounts of personal health data that was previously unobtainable. These devices create opportunities for targeting interventions that may reduce morbidity (and even mortality), but we are yet to establish all of the pitfalls and benefits of using such devices. It is important to remember that, unless a device has been clinically validated, recordings (in particular ‘one-off’ recordings) should not guide medical therapy. In the future, it is highly likely that devices will be able to be ‘prescribed’ in some form, and clinicians should make themselves aware of relevant devices in their area of expertise as there is no doubt of the patient demand.

Communicating with or about patients

When you communicate with or about a patient in person, you do so in a secure and private manner – no one else can intercept the communication and no one else can observe the communication at its source or destination unless invited. When you use an electronic method of communication, it becomes harder to give a guarantee of privacy and security. Nonetheless, the same rules as set out in the Privacy Act and its associated codes and regulations and the Code of Health and Disability Services Consumers’ Rights apply to digital communication in the same manner as they do to in-person communication.

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

that any results sent by email will be read by the patient only? Is this information so sensitive that it is inappropriate to send it by email? Can you be sure that the patient has received the information? Is there someone monitoring your email in-box if you are away? Ideally, when emailing sensitive health information to patients, the information should be packaged into a secure zip file that can be password protected and the password sent separately. When communicating by email, it is important to consider how this method of communication may affect the flow of communication with patients and how this can at times lead to a misunderstanding or miscommunication.

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All of the above apply in greater measure to communicating with patients by text message. Before deciding to use email or text messaging routinely as a communication tool with patients, it is worth identifying in advance what data you are comfortable sending to patients and what data or subjects you would only discuss with a patient as part of a consultation, as some subjects and test results may be more confidential and sensitive than others. You can then discuss your internet information release policy with your patient before seeking their consent to send data to them by email. You can also use this opportunity to discuss with them your schedule of charges for responding to questions or requests for comment via email.

Patient portals²¹² are secure online sites where patients can access their health information and interact with their general practice. From 1 October to 31 December 2020, there was a 5.5% increase in patients registering to use patient portals, a 20% increase in practices offering patients access to clinical notes and 267 practices reported 183,900

212 <https://www.health.govt.nz/our-work/digital-health/other-digital-health-initiatives/patient-portals>

appointments were booked online. The use of patient portals can solve some of the problems mentioned above. Patients can more easily exercise their right to access their information, and most portals support the secure transfer of messages between doctor and patient with the ability to confirm that the message has been received and read. Over 1 million New Zealanders are now registered to use a patient portal.

Using any form of social media in relation to specific patients is very difficult to justify, and you should do so with great caution. You may feel that you are not identifying a patient to others, but if they or their family are able to identify themselves, they may find this distressing. Even when you are not using social media in relation to your work, your patients may be able to see what you post, and this may determine, rightly or wrongly, how they view you as a professional. The Medical Council has detailed its view on the use of social media in its statement on the use of the internet and electronic communication.²¹³

Creating a website for your practice to inform your patients of your opening and closing times, after hours arrangements, charges and privacy and email policy is a start to establishing a healthy partnership. Constructing your website to encourage your patients to use it to obtain information from good evidence-based health resources should improve the quality of your interaction with patients. Any information that you supply to patients through your website should follow the Health on the Net certification (HONcode).²¹⁴ The Healthpoint website²¹⁵ provides information about health care providers, referral expectations and hours of practice.

Communication between doctors about patients can for the most part now be done electronically. Referrals into secondary care are done in this way, which allows for better security and tracking of the referral. To date,

213 <https://www.mcnz.org.nz/assets/standards/4874967a0f/Statement-on-use-of-the-internet-and-electronic-communication.pdf>

214 <https://www.hon.ch/en/certification.html>

215 <https://www.healthpoint.co.nz/>

this has been a one-way process, but the advent of eTriage means that GPs can receive a rapid response to their referral, which may include advice on patient management before they are seen in the hospital.

Cybersecurity and protecting health information

Outside of an organisation's health intranet, the internet is essentially an unsecured network, and unless you take adequate precautions, the data on your computers and computer terminals themselves can be captured (hacked) and read by persons outside of your medical practice. Health information is very lucrative, and there are effectively a sea of pirates who surf the internet looking for opportunities to make money out of distress. Before you embark on any process that involves you or your practice sending or receiving information about patients over the internet, especially if you intend to operate outside of the health intranet, you should consider whether the system you are using is secure and able to maintain patient confidentiality and privacy.

The website of the Privacy Commissioner²¹⁶ sets out the Commissioner's requirements for data security. HISO has developed a Health Information Security Framework,²¹⁷ and for a deep look into the topic, try the New Zealand Information Security Manual.²¹⁸ A much easier guide to get you started is the checklist put together by Patients First,²¹⁹ and if this raises any doubts in your mind about the security of your system or network, you should seek professional advice. The recent hacking of the Northern Ireland health system and the ransomware attack on the Waikato District Health Board, disrupting health services for weeks, should give a very clear warning as to the dangers of cybercriminals. Cybersecurity should be everyone's concern, and clinicians must take measures to protect health

216 <https://www.privacy.org.nz/>

217 <http://www.health.govt.nz/publication/hiso-100292015-health-information-security-framework>

218 <https://www.gcsb.govt.nz/publications/the-nz-information-security-manual/>

219 <https://patientsfirst.org.nz/resources/cybersecurity-guidance/#SecurityChecklist>

information as much as possible. This ranges from taking care in how patient information is displayed in your practice, ward or clinic through to how information is transmitted and received. It is worthwhile considering your own cybersecurity arrangements and what you would do in the event of an outage or cybersecurity attack and run drills in much the same way that you would a fire or natural disaster drill to ensure your preparedness. Every practice should have a cybersecurity and information protection policy that is robust and well used. At the most basic level, it must ensure that information is only accessible to those who need to have access, is password protected and that up-to-date protective security measures are maintained.

Telehealth

Most doctors would accept that at least 90% of their differential diagnoses are made during history taking. On many occasions, particularly for follow-up visits, no physical examination is necessary. The use of information and communication technologies to deliver health care when patients and care providers are not in the same physical location is defined as telehealth.

Under this umbrella term sit four modalities:

- **Video consultation** – video conferencing used for real-time consultation in which there is typically direct patient involvement. However, episodes exist where the patient is not directly involved yet remains the focus of the consultation– for example, multi-disciplinary meetings and case conferences.
- **Store and forward** – collecting clinical information and sending it electronically to another site for evaluation by a clinician at their convenience. Transmitted information typically includes demographic data, medical history, documents such as laboratory reports and image, video and/or sound files.
- **Telemonitoring** – remotely collecting and sending patient data so that it can be interpreted and then contribute to the patient's

ongoing management. It allows the patient to stay in their home or usual place of residence and maintain contact with the team providing their care. Most commonly, the data collected is a physiological variable such as blood pressure, but it can also be self-reported symptoms or activity levels. In addition, alarm systems, fall detection, treatment adherence and environmental monitoring are also forms of telemonitoring. Collecting and sending the data in real time is referred to as telemetry.

- **mHealth** – the use of mobile communications technologies in medical and public health practice, including the delivery of health information, health services and healthy lifestyle support programmes. Mobile communications devices include mobile phones (these days generally smartphones such as iPhones or Android-based phones), tablet computers, mobile sensors and other devices that use cellular networks, WiFi or Bluetooth. Specific functionality that mobile communications technology enables include text messaging (SMS), smartphone/tablet apps, mobile web browsing, video calling, MMS/pxt and allowing the mobile use of technologies such as QR code scanning and GPS locating.

The New Zealand Telehealth Forum and Resource Centre²²⁰ is a valuable source of further information, particularly if you are contemplating setting up a telehealth service.

Telehealth in practice

Video consulting is now quite widely practised. It has evolved from occurring primarily between secondary care sites to now involving links between primary and secondary care and directly into a patient's home. In addition, complex video consulting systems are used within clinical networks to allow multiple specialists to discuss individual patients while simultaneously viewing radiology, histology and pathology images and results.

220 <https://www.telehealth.org.nz/>

Video consulting helps to enable equitable and efficient access to care, and that may apply particularly to rural, Māori and Pasifika patients. It may actually improve the quality of care.

The advantages seem obvious. For the patient, this means less travel, decreased exposure to infectious disease, better access to health services, improved timeliness of care, less need to take time off work, less need to make family or day care arrangements and less time away from home – all of these advantages are perhaps greater for rural communities. For the specialist, telehealth raises the possibility of providing specialist services in rural communities, more-frequent clinics, less travel to rural clinics, provision of a new method of communication with rural medical staff and the opportunity to upskill them in different specialities. There are advantages for the health system too.

Video consulting helps to enable equitable and efficient access to care, and that may apply particularly to rural, Māori and Pasifika patients. Although telehealth is aimed at a level of equivalence to in-person care, in some cases, it may improve the quality of care because it is efficient, may support the sustainability of the New Zealand health care system, can reduce the cost of care and can make better use of the contemporary specialist workforce.

The Council has provided a statement on telehealth²²¹ showing clear support for doctors who work in this way, as long as the same standard of care as an in-person consultation is able to be provided. This means that, if a physical examination is required to make the right treatment decision, one must occur before you proceed. The Council also provides specific guidance on prescribing, discussed in the next section.

As well as guidance from the Council, remember that all Acts and their associated codes and regulations that govern the practice of in-person medicine apply equally to care provided by telehealth. It is particularly

221 <https://www.mcnz.org.nz/assets/standards/c1a69ec6b5/Statement-on-telehealth.pdf>

important to consider the consent process when providing a telehealth consultation so that your patient has a clear understanding of the risks and benefits of a consultation that is not in person.

Store and forward/image sharing

The use of store and forward technology is very common – for example, in radiology where all images are now captured digitally. Although most are read within the organisation that acquires them, many are read at a distance by radiologists based overseas. Since 2010, the Council has provided a teleradiology special-purpose scope of practice,²²² which limits access to radiologists whose qualifications and registration are recognised by the Council and who are employed by a fully credentialled health care provider in New Zealand. Dermatology is another speciality that lends itself to store and forward.²²³ The efficiency of these systems is key given that access to an in-person dermatologist is very limited in most of our public hospitals.

Sharing of images carries particular nuances of safety, security and consent. It may be that one doctor is seeking advice from another – for example, a rural hospital medicine specialist is working with a plastic surgeon to determine whether a patient needs to be transferred to a burns unit. The lack of appropriate tools in the past has meant that images have been shared via the use of a personal mobile device to capture the image, which is then sent by text or email. The New Zealand Medical Association has provided some guidance on how to do this properly,²²⁴ and secure image capture and transfer applications are starting to become available. At the time of writing, both Waitematā DHB and Waikato DHB have available imaging tools for sharing of patient images with secure consenting processes and ability to attach the image to the patient record.

222 <https://www.mcnz.org.nz/get-registered/scopes-of-practice/special-purpose-scope/special-purpose-teleradiology-registration/>

223 <http://www.nzteledermatology.com/>

224 <https://www.nzma.org.nz/media-releases/getting-smart-with-smart-phones-guidance-for-doctors>

This sort of technology should be considered the gold standard for the sharing of images.

Mobile applications

Mobile health is plagued with the same difficulties as the internet in that a small number of safe, secure, accurate and effective apps are buried under a landslide of games and apps designed to acquire personal data and track spending habits and movements. The Health Navigator website offers a curated app library.²²⁵ Remember that, if you promote an app to a patient as a form of treatment, just as with prescribing a medication, it is important to check understanding, compliance and effectiveness. At an organisational level, approaches to mobile device management are being developed so that staff can use apps at work, often on their own device, without compromising the security of patient data or the organisation's network.

Safety and regulation of telehealth in clinical practice

It is important to consider whether telehealth technologies are being implemented to complement or compete with more-traditional ways of providing care. In the latter case, there is the potential for increased risk to patients – for example, an online-only doctor where the main form of interaction with the patient is a web page or questionnaire where the patient may get specific treatment advice. The consultation, including the writing of a prescription and dispensing of a medicine, is conducted often without the knowledge of the patient's regular medical provider or access to the patient's clinical record. These services are being supplied by a number of medical practitioners in New Zealand and around the world, and the quality of the advice offered and the professional standards applied vary enormously.

225 <https://www.healthnavigator.org.nz/apps/>

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

Internationally, medical licensing authorities such as the Council and the Federation of State Medical Boards of America and regulatory authorities such as Medsafe have indicated that they are prepared to prosecute doctors involved in online medical practice who provide inadequate care, and have done so on multiple occasions. Medsafe has already successfully prosecuted a pharmacy that was supplying prescription medicines to consumers in the United States and has investigated several cases where doctors are signing or countersigning prescriptions for patients overseas to allow medicines to be dispensed from New Zealand pharmacies. This activity is contrary to best medical and pharmacy practice, and the Council’s statement on telehealth and the Pharmacy Council’s statement on the promotion and supply of medicines over the internet²²⁶ are examples of how the regulatory bodies for these professions are no longer prepared to tolerate such activities. Before embarking on any scheme to prescribe over the internet, you should take legal advice on your potential liabilities under both New Zealand law and under the law of the countries where your patients reside. You should also check that the terms of your medical practice (malpractice) insurance would cover you for care of patients in other countries.

226 https://www.pharmacycouncil.org.nz/dnn_upload/Uploads/Documents/standardguidelines/Promotion%20and%20Supply%20of%20Medicines%20over%20the%20Internet%20-%20November%202015.pdf?ver=2017-02-20-104757-057

Examples of telehealth interactions

- Brian Pink comes online and tells the doctor he has a mole that has changed colour and moves so that the lesion on his shoulder is in front of the camera. The doctor is not reassured by its appearance (actually she rarely is and certainly never online) and asks him to come in for a closer look. The treatment room will be ready for possible excision biopsy.
- Susan White makes an online follow-up hypertension appointment and tells the doctor her home recordings. She looks healthy and happy. Routine enquiry elicits no problems. It is time to recheck her bloods, so the doctor sends her a form electronically as well as her prescription and instructions that next time will be her annual in-person check.
- Katy Ingles has a recurrence of her breast cancer. She lives in a small rural community and is awaiting the result of her most recent CT. In the comfort of her own home, at her choice of time and in the presence of her whānau, she is able to discuss her CT results with her oncologist and her options for care.
- Jim Mikaere manoeuvres his red hot swollen 1st MTPJ in front of his laptop camera. It is his third attack of gout in 5 years, triggered by a dietary indiscretion on a background of familial hyperuricemia. The doctor introduces the idea of allopurinol, and they discuss the pros and cons, but he opts for the short sharp course of naproxen that has promptly settled it in the past, understanding it may not be his last.

None of these patients has phoned for an appointment, taken a taxi to the surgery, taken 2 hours off work, negotiated their way past a protective receptionist, inadvertently sat in a small puddle of vomit or picked up influenza in the waiting room. There is nothing second rate or unsafe about the care they receive. It is also cheap green care – the doctor does

not need a high-rent, well-equipped consulting room for these meetings, so her room at the practice is, for the time, free for another doctor to do in-person work.

Prescribing in the digital environment

The issuing of prescriptions is legally restricted:

- Under clause 39 of the Medicines Regulations 1984, no doctor is permitted to prescribe medication to an individual unless it is for the treatment of a patient under their care.
- Prescriptions must be legibly and indelibly printed and personally signed by the prescriber with their usual signature (not a facsimile or other stamp). Therefore, those issued only by email or other electronic means do not meet New Zealand legislative standards under clauses 40–41 of the Medicines Regulations.²²⁷ The Council's statement on telehealth provides some clarity around how these legal requirements apply in the context of telehealth. You should also review the statement on good prescribing practice.²²⁸
- At the time of writing, there is a Director-General of Health waiver to regulation 41 of the Medicines Regulations that allows prescribers to issue prescriptions electronically without needing to personally sign the prescription if the prescription has an NZePS barcode, the barcode (or identifier) is used at the pharmacy at the point of dispensing and the prescription is for a non-controlled drug.

227 However, it is worth noting that regulation 43 of the Medicines Regulations 1984 allows the Director-General of Health to issue a waiver and authorise a form of prescription that does not comply with all of the requirements in regulation 41, including the requirement that the prescription must be personally signed. If your telehealth service may be unduly compromised by this requirement, you might consider contacting the Ministry of Health to request a waiver.

228 <https://www.mcnz.org.nz/assets/standards/ceae513c85/Statement-on-.pdf>

The Council's statement on good prescribing practice advises that you may issue a prescription, including repeat prescriptions, only when you:

- have adequate knowledge of the patient's health
- are satisfied that the medication or treatment are in the patient's best interests.

The Council also expects that, before any prescription is issued, you should have had at least one in-person consultation with the patient or have discussed the patient's treatment with another New Zealand registered health practitioner who can verify the patient's physical data and identity. Some exemptions to the requirement apply where a video consultation may suffice, with examples including the urgency of the situation or the unavailability of a doctor. Nonetheless, you should be very cautious before issuing a prescription by means of telehealth outside of this broad expectation. If you are not the patient's usual doctor, you also need to seek the patient's permission to share information about your prescribing with the patient's principal health provider (who will usually be their general practitioner).²²⁹ Electronic prescribing is available via the New Zealand ePrescription Service (see below).

It is illegal for a patient to be in possession of a prescription medicine other than that obtained by filling a prescription written by a registered medical practitioner. Prescription medicines purchased over the internet are therefore likely to be stopped at the border and the patient asked for proof that they have a prescription. If you are asked to write a prescription to allow your patient to obtain a medicine they have bought over the internet, you should consider a number of ethical and practical questions. Many medicines purchased on the internet are counterfeit products. Are you prepared to facilitate patient access to such medicines? Is the medicine available in New Zealand? Does the patient actually need the medicine? Are you satisfied that the medicine being imported meets the

²²⁹ See <https://www.mcnz.org.nz/assets/standards/85fa1bd706/Good-Medical-Practice.pdf> – Sharing information with colleagues.

necessary standards of safety, quality and efficacy of locally available medicines or in fact even that the product actually contains the stated active ingredient? There may be legal liabilities if harm is caused by the use of medicine purchased on the internet.²³⁰

New Zealand ePrescription Service (NZePS)

A success story of interoperability in recent years is the NZePS, which provides secure messaging of prescriptions from practice management systems to pharmacy dispensing systems. This enables clinicians to issue barcoded signature-exempt prescriptions that can be sent directly to a pharmacy or given to patients to scan at any pharmacy for dispensing. This has been of particular use during the COVID-19 pandemic when most consultations were completed virtually. As of April 2021, over 1 million prescriptions per month are being issued electronically.

Continuing professional development

As with all revolutions, increased availability of medical information challenges the status quo and creates a number of threats and opportunities for doctors. Doctors cannot know everything so an essential skill is the ability to access good information efficiently. The internet contains a vast number of useful medical information resources, which unfortunately are hidden in a perplexing forest of conjecture, opinion and marketing. There may also be outright deception.

Many sites are not peer reviewed and are not subject to the publishing and review rules that we expect of evidence-based medical information.

230 <https://www.medsafe.govt.nz/profs/PUarticles/counterfeit.htm>

To determine the value of information you find on the internet, you must therefore check each article for the basics of quality evidence-based medicine:

- Who authored the article? What are their qualifications?
- Have they disclosed any potential conflict of interests?
- Is the article appropriately referenced, and are these references from acceptable peer-reviewed sources?
- Where is the article published? Is the journal subject to adequate peer review?
- Does the website disclose any potential conflict of interests, such as who has paid for the site to be maintained?

The Health on the Net Foundation has developed a code of conduct and databases of health information resources that have been assessed as meeting the requirements of their HONcode.²³¹ Practitioners intending to publish information on the internet should follow the HONcode when writing and publishing.

As with any form of medical literature review, when searching the internet, it is best to stick to mainstream, peer-reviewed, evidenced-based information resources. The availability of electronic copies of mainstream medical journals makes internet literature review easier, and abstracts of some of the lead articles in these journals can be obtained free of charge from their websites. Another key information resource is Pubmed. This database contains all articles and letters published in over 5,600 peer-reviewed medical journals from around the world. Abstract data can be obtained free from Pubmed, and you can purchase copies of complete articles from the website. Alternatively, you can use Pubmed to identify the key references and then request them through your local medical school library. Taking up an academic or honorary clinical lecturer position will often come with online access to the medical library subscriptions.

231 See footnote 214.

The Ministry of Health, PHARMAC, Medsafe (the New Zealand Medicines and Medical Devices Safety Authority) and the Health and Disability Services Commissioner all maintain websites that contain information relevant to medical decision making. For example, the Medsafe website contains the latest medicines safety and prescribing information for over a thousand of the most commonly used medicines in this country as well as an electronic version of its publication Prescriber Update and information for consumers. The New Zealand Formulary²³² is an excellent independent resource that provides a validated source of prescribing information in the New Zealand context. The Ministry of Health and PHARMAC have also funded the supply of a series of decision support and reporting tools for integration into GP practice management systems.

Bringing it all together

The logical evolution of digital health is to bring all the various components mentioned above together in a specific and planned way to create a complete modern version of health care, transforming it in ways that we have already seen in finance, commerce and travel. The opportunity this provides is not simply to replicate what we do at the moment but to change the focus and rearrange the workflow to solve problems of access, equity and efficacy. Analogue health care is location based, and usually the patient comes to the doctor. Digital health care can bring together the patient and doctor, as well as the wider health care team, regardless of location. This has already happened in New Zealand, with Waikato claiming the title of Virtual DHB and offering a service termed SmartHealth in 2016. Other organisations and individuals, both public and private, will be sure to learn from the Waikato DHB experience and develop more robust processes to implement a full digital health experience for patients.

232 <https://nzformulary.org/>

The only thing that is certain is that, if we as doctors aren't involved in shaping these changes, we won't have the opportunity to influence them and advocate for the best digital outcomes for our patients. When involved, we must seek a balance between profit and professionalism, between altruism and entrepreneurialism, and must, as always, consider what we are doing in terms of beneficence, non-maleficence, autonomy and distributive justice.

Acknowledgement

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CHAPTER 12

Choosing Wisely – more isn't always better

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Introduction

Choosing Wisely is a part of a global movement²³³ that began in the United States in 2012, which now spans 20 countries across five continents including Australia and New Zealand. The campaign promotes a culture where low-value care and inappropriate clinical interventions are avoided and health professionals and patients have well-informed conversations about their treatment options, leading to better decisions and improved outcomes.²³⁴

Choosing Wisely in New Zealand began in 2016 and has been championed by the Council of Medical Colleges with the support of over 44 health sector groups and Consumer NZ.

Choosing Wisely in New Zealand began in 2016 and has been championed by the Council of Medical Colleges with the support of over 44 health sector groups and Consumer NZ. It has involved a wide range of health professionals including doctors, nurses, midwives, pharmacists and allied health professionals. Some discrete Choosing Wisely work is ongoing within the Health Quality & Safety Commission New Zealand.

Low-value care

Health care could be seen as a rare and precious resource, and stewardship of that resource should be viewed in tandem with climate change. Indeed, the carbon footprint of global health care sits in fifth place behind that of the US, China, India and Russia. In addition to fair and more rational resource utilisation, the allocation and sustainability of health care must be a priority.²³⁵

233 <https://choosingwiselycanada.org/campaign/international/>

234 Levinson W, et al. 'Choosing Wisely': a growing international campaign. *BMJ Quality & Safety*. 2015;24:167–174.

235 Shojania K. Keynote presentation. Sixth Choosing Wisely International Roundtable. 2019, November 5–6.

Society increasingly recognises the importance of excess medical care, and estimates of up to 30% of total health care spending being wasteful includes unnecessary services and inefficient care.^{236,237} Such low value has little or no benefit to patients, the risk of harm exceeds possible benefits and the costs do not provide proportional health gain. This includes overtreatment and overdiagnosis in some disease screening with earlier detection, increasingly sensitive tests, widening definitions of illness and ever-lowering threshold levels for treatment resulting in treatment of disease that would not have otherwise affected the lives of the patient.²³⁸

Choosing Wisely seeks to identify these areas of practice, changing practitioner behaviour and promoting shared decision making with patients. Health professional colleges, societies and associations and service delivery groups are encouraged to develop lists of Choosing Wisely recommendations about tests, treatments or procedures that are not supported by evidence, that could harm and avoidable cost for patients and/or our health care system. In single-funder (government, tax-payer) health care systems such as New Zealand, Australia, Canada and the UK where financial cost to the patient is de-emphasised, there is still a cost to the country and Choosing Wisely-like programmes are about rationalising, not rationing of the health care resource.

The lack of time for shared decision making²³⁹ and fear of missing a diagnosis or of a complaint contribute to low-value care. However, medico-legal experts reassure us that these fears are unfounded. So too do financial incentives, the way doctors are taught, patient expectations and avoiding the challenging conversation of telling patients they do not need

236 Blumenthal-Barby JS. “Choosing wisely” to reduce low-value care: a conceptual and ethical analysis. *Journal of Medicine and Philosophy*. 2013;38(5):559–580

237 Canadian Institute for Health Information. *Unnecessary care in Canada*. Ottawa, ON: Canadian Institute for Health Information; 2017.

238 Moynihan R, Doust J, Henry D. Preventing overdiagnosis: how to stop harming the healthy. *BMJ*. 2012;344:e3502.

239 Zikmund-Fisher BJ, et al. Perceived barriers to implementing individual Choosing Wisely recommendations in two national surveys of primary care providers. *Journal of General Internal Medicine*. 2017;32(2):210–217.

specific tests, treatments or procedures.²⁴⁰ An understanding of what lies behind unnecessary care is required to inform ways of reducing the use of these interventions.²⁴¹

Choosing Wisely in New Zealand

The concepts behind the Choosing Wisely campaign are not new. What links proponents of the Choosing Wisely campaign across the world is acceptance of five Choosing Wisely principles, which are that all programmes are health professional-led, patient and consumer focused, multi-professional, evidence-based and transparent. The programme therefore avoids capture by funders or governmental agents who might be inclined to ration care, privileges good doctor-patient communication, includes all health professionals and relies on evidence and clearly stated conflicts of interest.

In New Zealand, Choosing Wisely has worked with health professional groups to develop a list of tests, treatments or procedures that health professionals and patients should question. At the end of 2019, over 35 groups had developed lists of over 200 recommendations.

Recommendations have also been developed by the New Zealand Medical Student Association who have adopted a WISE acronym to help promote Choosing Wisely and to help students remember the key concepts:

- **Why?** What will this test, treatment or procedure change?
- Is there an alternative? Less invasive, less resource intensive?
- **Seek clarification.** Clarify why the doctor ordered this test.
- **Explore/explain.** Be the patient's advocate. Explore concerns, take time to explain why a test, treatment or procedure is/isn't necessary.

240 Levinson W, et al. 'Choosing Wisely': a growing international campaign. *BMJ Quality & Safety*. 2014;0:1–9.

241 Colla CH, et al. Physician perceptions of Choosing Wisely and drivers of overuse. *American Journal of Managed Care*. 2016; 22:337–343.

A core element of Choosing Wisely is to promote shared decision making between health professionals and patients and to develop accessible, plain-language materials for the public about the recommendations. In New Zealand, over 48 Choosing Wisely resources have been developed for patients, which are promoted on the Choosing Wisely and Consumer NZ websites.

Choosing Wisely also encourages patients to ask the following four questions:

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

Surveys of New Zealand health professionals undertaken by the Council of Medical Colleges in 2016 and 2018 showed a large increase knowledge of Choosing Wisely (from 40% to 80%), an increase in health professionals advising against and not providing particular tests, treatments or procedures (from 77% to 84%) and a decrease in health professionals advising against a test but providing it anyway (from 14% to 9%). The percentage of health professionals who considered the provision of unnecessary tests, treatments or procedures a somewhat serious or very serious issue for New Zealand rose from 62% to 68%.²⁴²

Although a number of respondents considered that the survey options do not reflect the complex and nuanced reality faced by practitioners, these surveys confirm that it is quality of care rather than cost reduction that is the predominant factor in New Zealand doctors' decision making as to whether tests, treatments or procedures are appropriate. While doctors

A core element of Choosing Wisely is to promote shared decision making between health professionals and patients and to develop accessible, plain-language materials for the public about the recommendations.

242 In 2016 and 2018, the Council of Medical Colleges surveyed doctors in New Zealand with the assistance of the New Zealand Medical Association and Association of Salaried Medical Specialists.

are conscious of cost, time and resources, this is a secondary factor in their considerations. Doctors also noted that the decision whether or not to provide a potentially unnecessary test, procedure or treatment is not clear cut – rather “the decision on whether to do the test, treatment or procedure is a nuanced one and shared decision making with the consumer is vital”.²⁴³

Choosing Wisely means choosing equity

Choosing Wisely in New Zealand became aware that, as Choosing Wisely is adopted, care must be taken to ensure that the ‘do less’ aim does not increase existing inequities for Māori.²⁴⁴ For example, Māori children and adults are more likely to experience unmet need for primary health care, including not being able to get an appointment at their usual medical centre within 24 hours, not being able to attend because of cost or lack of transport or to miss out on prescription medication because of cost.²⁴⁵ Māori also tend to receive fewer tests and referrals²⁴⁶ and are less likely to get satisfactory answers when they do ask questions, less likely to have things explained to them well and less likely to feel listened to by health professionals. Health campaigns such as Choosing Wisely New Zealand, must be careful to not exacerbate these existing inequities.

In 2019, Choosing Wisely New Zealand partnered with Te Ohu Rata o Aotearoa (Te ORA) – Māori Medical Practitioners Association on a research project to ensure Choosing Wisely would not exacerbate inequitable Māori health outcomes. This collaboration is the first Choosing Wisely project to deploy an indigenous lens to look at its programme. The report recommends a number of changes to make the Choosing Wisely campaign more effective for Māori.²⁴⁷

243 <https://choosingwisely.org.nz/wp-content/uploads/2020/04/Summary-of-evaluation-initiative-as-at-17-3-2020-.pdf>

244 Read D, Sherwood D, Ineson S. Choose Wisely – is more always better? *New Zealand Medical Journal*. 2016;129(1447):10–11.

245 <https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-ratonga-hauora-kua-mahia-health-service-use>

246 <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/>

247 Adcock A, Tipene-Leach D. *Choosing wisely means choosing equity*. Wellington: Choosing Wisely Aotearoa New Zealand; 2020.

Research participants raised concerns about the governance and programme decision-making processes of Choosing Wisely, which had systematically not incorporated effective Māori participation. Not surprisingly then, the Choosing Wisely resources were also critiqued as needing to include both culturally and literacy-appropriate health messaging traversing consumer, practitioner, organisational and health system aspects.

Perhaps the biggest finding from the report was that cultural safety was deemed vital to enabling the right environment for shared decision making between medical practitioners and Māori patients. Following up on this key finding, the Council of Medical Colleges and Te ORA have partnered to explore the development of a cultural safety framework that will include practical guidance and educational outcomes that support doctors across specialities to develop culturally safe practice.

Putting Choosing Wisely into practice

Many services in New Zealand are now implementing Choosing Wisely recommendations and, where possible, measuring changes. Implementation is best carried out at a local level from the bottom up.²⁴⁸ This may involve an individual department or service selecting relevant recommendations that have already been developed, modifying these recommendations to suit local circumstances or deriving their own recommendations.

Just developing recommendations is insufficient. Health professionals need to start to challenge themselves and their colleagues on the way they think about health care, questioning the notion 'more is always better'. They need to start a conversation with their colleagues about what care is truly needed, identifying which practices are helpful and which are not. Rational health care resource stewardship is a critical responsibility for all health professionals.

248 Stinnett-Donnelly JM, Stevens PG, Hood VL. Developing a high value care programme from the bottom up: a programme of faculty-resident improvement projects targeting harmful or unnecessary care. *BMJ Quality & Safety*. 2016;25:901–908.

The question of equity – in particular, equitable health outcomes for Māori – has come to fore over the period of Choosing Wisely's development, and the recent research findings²⁴⁹ will be a vital part of its ongoing life. The Choosing Wisely New Zealand programme has not escaped critique – and rightly so. Consultation with Te Ora was only begun in year 3 of the programme.

Eleven resources on how to operationalise Choosing Wisely have already been developed alongside 30 sets of recommendations for areas of practice change.

There are other challenges ahead. In the words of Choosing Wisely New Zealand project lead Dr Derek Sherwood, "I'm hopeful that even though Choosing Wisely has little ongoing funding eventually the work will be carried on in health provider organisations, in the universities, in vocational training, and this work will become business as usual in 10 years' time."²⁵⁰ The Council of Medical Colleges, Te ORA and the Health Quality & Safety Commission will strive to ensure that this occurs.

Choosing Wisely New Zealand resources

These resources are available for download from <https://choosingwisely.org.nz/resources/>:

- **Starter kit for your Choosing Wisely campaign** – an introduction to the Choosing Wisely concepts.
- **Developing Choosing Wisely recommendations** – to assist colleges, societies and other organisations to develop a list of recommendations for their Choosing Wisely campaign.
- **Implementing Choosing Wisely principles in a service** – guide aimed at service delivery organisations wanting to implement a Choosing Wisely programme including departments in district health boards and services in primary care.

249 See footnote 247.

250 Choosing Wisely Aotearoa New Zealand. Choosing Wisely in Aotearoa New Zealand: The achievements and the challenges. Wellington: Council of Medical Colleges; 2019

- **Measuring the impact of Choosing Wisely** – provides basic information and tools to help you develop and measure your Choosing Wisely interventions.
- **How to write up your Choosing Wisely project** – how to record your successful implementation of a Choosing Wisely recommendation.
- **Starter kit for implementing Choosing Wisely in hospitals** – to assist smaller hospitals with the implementation of Choosing Wisely.
- **Promoting shared decision making** – information and resources on shared decision making.
- **Communicating risk: a guide for health professionals** – information on risk and how to explain risk to consumers.
- **Behaviour change toolkit** – options for the range of tools available to implement Choosing Wisely initiatives to change health professional behaviour.
- **A high-value culture change survey** – captures specific areas for targeted value-improvement interventions and provides a pathway for health system managers to address the underlying culture within hospital divisions, practices and training programmes.
- **A synopsis of Choosing Wisely literature** – a list of Choosing Wisely references arranged by year and alphabetically by author.
- **A combined list of all choosing wisely recommendations** – a list of all New Zealand Choosing Wisely recommendations on tests, treatments and procedures health professionals should question, in one list for easy reference.

Choosing Wisely international websites

- <https://www.choosingwisely.org.au/>
- <https://choosingwiselycanada.org/>
- <https://www.choosingwisely.co.uk/about-choosing-wisely-uk/>

CHAPTER 13

Informed consent

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Introduction

Medical practitioners must ensure that there is a clear legal authority to provide medical treatment or health services of any kind to their patients. Most commonly, this legal authority will be by the medical practitioner obtaining a legally valid informed consent from the patient to the treatment.

It is a fundamental legal and ethical principle that valid informed consent must be obtained before providing any medical treatment or health service of any kind to a person unless there is some other clear legal authority to treat. The right to give informed consent applies irrespective of what a medical practitioner considers to be in the patient's best interests.

The modern ethical and legal duty on practitioners to obtain informed consent marks a shift away from paternalistic medicine. Practitioners cannot dictate to patients how they will be treated. The principle empowers competent patients to be confident to make informed health care choices, and it requires that practitioners respect those choices, however unwise the choices may be. Patients cannot, however, demand treatment that is not clinically indicated. Ultimately, the principle serves to protect patient autonomy and a patient's right to determine what they want to do with their body.

A patient's right to give informed consent is entrenched in the New Zealand Bill of Rights Act 1990, the common law and the Code of Health and Disability Services Consumers' Rights 1996 (Code of Rights). Informed

It is a fundamental legal and ethical principle that valid informed consent must be obtained before providing any medical treatment or health service of any kind to a person unless there is some other clear legal authority to treat.

consent is more than getting a patient to sign a consent form. It is also more than a one-off action. It is a process that continues throughout all stages of the treatment or procedure. The Medical Council has a statement on informed consent.²⁵¹

Code of Health and Disability Services Consumers' Rights 1996

The Code of Rights is a regulation made under the Health and Disability Commissioner Act 1994 and has full legal effect. Alongside the New Zealand Bill of Rights Act and the common law, it provides the basis upon which the principle of informed consent is recognised in law. It is very important that practitioners understand patients' rights and practitioners' duties under the Code of Rights, including the rights related to informed consent. The right to make an informed choice and give informed consent is found in:

- **Right 5:** the right to effective communication
- **Right 6:** the right to be provided with all necessary information, including information about options, risks and benefits
- **Right 7:** the right to make informed choices and give fully informed consent to the extent of the person's competence.

Right 7(1) warrants particular attention as it sets out the basic tenet of informed consent:

Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent except where any enactment of the common law or any other provision of this Code provides otherwise.

251 See footnote 112.

Key elements of legally valid informed consent

There are three key elements for informed consent:

- **Competence:** the person must have the necessary capacity to consent to the intervention or refuse the treatment.²⁵²
- **Information:** the person must be appropriately informed in order to make an informed choice about the proposed treatment.
- **Voluntariness:** the person's consent must be given voluntarily and without pressure from any other person.

Competence

A patient must be competent to give or refuse consent to treatment. Consent will not be legally valid if the patient does not have sufficient competence to make an informed decision.

Every patient is presumed competent unless there are reasonable grounds for believing that the patient is not competent. This presumption is set out in Right 7 of the Code of Rights. A patient may be wholly or partially competent, and competency can vary throughout a course of treatment. Capacity may fluctuate – for example, from anesthesia or as a result of a head injury. It is the responsibility of the practitioner who will be providing the treatment to consider whether at any given point in time the patient has sufficient competence to consent to the specific treatment decision in question. Sometimes, the responsible practitioner may need to obtain the assistance of another medical practitioner who specialises in making this type of assessment.

Assessing competence is a matter of clinical judgement. A person will have capacity to make a particular decision if they can.²⁵³

252 Practitioners should be aware that 'capacity' is sometimes used interchangeably with 'competence'. Insofar as the principle of informed consent is concerned, capacity and competence have the same meaning.

253 *Re C (adult): refusal of medical treatment* [1994] 1 All ER 819, 824.

- understand the nature, purpose and effects of the proposed treatment or of refusing the treatment (**comprehension**)
- weigh up the options, balancing the risks and benefits (**appreciation**)
- foresee the consequences of consenting or refusing to consent (**reasoning**)
- communicate the decision (**communication**).

A person does not lack capacity just because they make an unwise, reckless or bad decision. Practitioners should be mindful that patients may have a set of values, views and beliefs that may lead to a decision that does not fit neatly with medical advice. A competent patient's right to refuse treatment is recognised by Right 7(7) of the Code of Rights, the common law right to self-determination and section 11 of the New Zealand Bill of Rights Act, which provides that everyone has the right to refuse to undergo any medical treatment.

A competent patient's right to refuse treatment is recognised by Right 7(7) of the Code of Rights, the common law right to self-determination and section 11 of the New Zealand Bill of Rights Act, which provides that everyone has the right to refuse to undergo any medical treatment.

Irregular decision making should not be equated with incompetent decision making. It is, however, appropriate to question capacity if a decision puts the person at significant risk of harm or abuse or the decision is markedly different from the person's usual decisions.

A higher level of competence may be required for interventions that are particularly invasive or carry material risk than is required for treatment for a minor health matter. A child, for example, may be able to consent to a knee being bandaged but may not have competence to make complex decisions about cancer treatment. Where it is unclear whether a patient

has the level of competence required for the particular decision, the health practitioner responsible for the patient's care should seek a second opinion by a senior medical practitioner. Where the decision in question has potentially serious consequences, it may be necessary to obtain the opinion of a psychiatrist or another health professional with particular expertise in assessing competence.

Information

A competent patient or a person legally entitled to consent on behalf of an incompetent patient must be given sufficient information to enable them to make an informed choice and give or refuse informed consent. The practitioner providing the treatment is responsible for ensuring the patient has sufficient information. The bottom line is that a patient must receive all information that a reasonable patient in the circumstances would expect or that is needed to make an informed choice or give informed consent.²⁵⁴

The patient has a right to be fully informed. Right 6 of the Code of Rights breaks this down further to require, at a minimum, that a patient receives:

- an explanation of their condition
- an explanation of expected side effects, risks, benefits, options and costs
- notification of whether the patient will be involved in teaching or research
- any other information required by legal, professional, ethical and other relevant standards
- the results of tests or procedures
- an estimated time of when services are likely to be provided
- honest and accurate answers to questions relating to services including:
- the identity and qualifications of the provider

254 Right 6(1) and (2) of the Code of Rights.

- the recommendation of the provider
- how to gain a second opinion
- the results of research.

If at any time prior to the treatment a practitioner is privy to information that is relevant to the treatment, the practitioner must pass that information on to the patient. In one case, abnormal liver function blood tests were not noticed by the surgeon until after the patient was anaesthetised. The patient died during the surgery from complications associated with the abnormal liver function. The Health and Disability Commissioner found that the surgeon should have woken the patient from anesthesia and discussed the significantly increased risks associated with the abnormal results and only proceeded after fresh consent was obtained from the patient.²⁵⁵

Right 5 of the Code of Rights provides that patients are entitled to effective communication in a form, language and manner that enables the patient to understand the information provided to them. This includes ensuring that information is conveyed in clear and simple language and, if required, an interpreter is present. Patients should be given time to digest the information and the opportunity to ask questions.

Sometimes, a competent patient wants treatment but does not want to be told all the details of the treatment. If a patient refuses to hear the 'gory details', it is unlikely that they will fully understand what is involved in the procedure. This raises serious questions as to whether they can give informed consent. In relation to a patient's right not to hear the details necessary to understand the proposed surgery, the High Court has said that:²⁵⁶

... the weight of authority seems to be that the surgeon should insist on the patient listening to sufficient detail, at least where major surgery carrying high risks is proposed.

255 Health and Disability Commissioner Case 07HDC11318.

256 *Harman v Director of Proceedings* HC Auckland, CIV-2007-404-3732 12 March 2009.

In this type of situation, health practitioners should proceed with care, and it would be prudent to have the patient confirm in writing that they were offered a full explanation of the treatment and all relevant information but that they refused to be fully informed.

If the patient still declines information and the treatment proposed involves an invasive procedure or major surgery that carries high risks, the practitioner may insist that the procedure cannot proceed until the patient has received information. The practitioner may want to seek further assistance or advice in this type of situation.

If the patient still declines information and the treatment proposed involves an invasive procedure or major surgery that carries high risks, the doctor may insist that the procedure cannot proceed until the patient has received information.

Voluntary

Consent must be given freely without undue pressure or coercion. It is common for patients to receive information and advice from others and even for the patient to be influenced by the opinions of others and to make their decisions as a result. This is acceptable as long as the other person does not overbear the patient's decision.

Sometimes, after considering all of the information, patients can still be unsure about what to do. They may ask their doctor what they would do if they were the patient. It is reasonable in this circumstance to give an honest answer to the question, but practitioners must avoid dictating to the patient what to do. Patients should be given sufficient time and space to make an informed choice.

Obtaining informed consent

The practitioner responsible for administering the treatment has the obligation to provide information to the patient and obtain informed consent. In some situations, it may be reasonable for the responsible

practitioner to delegate the task of obtaining consent to another member of the treatment team. The practitioner to whom the task is delegated must have sufficient knowledge of the treatment, risks, benefits and options to be able to provide the patient with the information required. Where delegation occurs, the practitioner responsible for undertaking the treatment remains primarily responsible for ensuring that there is a valid informed consent to the treatment. If another practitioner obtains the patient's consent, the patient should be aware that practitioner is not the person ultimately responsible for providing the treatment.

Form of consent

Generally, the law does not stipulate that informed consent be given in any particular way. It may be given verbally or in writing, and it may be express or implied – for example, by the patient extending out their arm to receive an injection.

Only in a few situations does the Code of Rights mandate that written consent must be obtained:²⁵⁷

- The patient is to participate in any research.
- The procedure is experimental.
- The patient will be under general anaesthetic.
- There is significant risk of adverse effects to the patient.

Regardless of the legal requirements, obtaining consent in writing and/or recording the options and risks discussed with the patient in their clinical notes is a “simple and obvious precaution” available to health practitioners.²⁵⁸ There may be situations where obtaining written consent is impracticable, but ensuring there is written record, completed as contemporaneously as possible from when consent was obtained, is the best protection for health practitioners where there is any later complaint or concern as to the validity of the consent. However, the more invasive

257 Right 7(6) Code of Rights.

258 *A v Nelson Marlborough District Health Board*, High Court, Blenheim, 15 March 2005.

the procedure or the more risks it involves, the more prudent it is to have the patient sign a consent form.

Giving informed consent on behalf of another person

The only individuals who are entitled to grant consent on behalf of a patient are:

- a welfare guardian appointed under the Protection of Personal and Property Rights Act 1988
- a parent of an incompetent child or a guardian appointed under the Care of Children Act 2004
- an attorney holding an enduring power of attorney (EPOA) for personal care and welfare).

A spouse or next of kin cannot consent to or refuse medical treatment on behalf of an incompetent adult unless they hold an EPOA or are their welfare guardian.

A spouse or next of kin cannot consent to or refuse medical treatment on behalf of an incompetent adult unless they hold an EPOA or are their welfare guardian. While a welfare guardian or an EPOA can consent to treatment on behalf of the person they represent (unless such power has been specifically excluded), they cannot refuse to grant consent to the administration of “standard medical treatment” or procedures intended to save a patient’s life or to prevent serious damage to that person’s health.²⁵⁹ The extent of a welfare guardian or EPOA’s authority to consent will be

set out in the specific court order or document appointing the person. It will likely be necessary to review the relevant document before relying on the consent of the welfare guardian or EPOA. It is also important

259 Protection of Personal and Property Rights Act 1988, section 18(1)(c).

to confirm the EPOA has been activated – for example, by sighting the medical certification of incapacity that activates the EPOA.²⁶⁰

Children and informed consent

There is no age of consent for treatment, and the right to give informed consent applies equally to all patients regardless of age. The relevant question is whether the level of understanding of the child enables them to consent to a particular treatment. This position confirms the common law view that minors may provide legally effective consent for medical treatment if they are mature enough to understand what is proposed and are capable of expressing their own wishes.²⁶¹

It is helpful to think of consent for children and young persons in three age groups:

- **Persons aged 18 years and over:** Presumption of competence. The law treats persons 18 years and over as an adult for purposes of consent and refusing consent. Legal guardianship of parents and any other court-appointed guardian ends at 18 years of age.
- **Young person aged 16–17 years:** Presumption of competence. In New Zealand, young persons 16 and 17 years of age have the statutory right to consent and refuse consent as if the child were of full age. Guardians continue to have a guardianship role until a child is 18 years old and are able to consent or refuse consent for an incompetent 16 or 17-year-old in most situations. A refusal of consent can only be overridden by the courts.
- **Child aged less than 16 years:** Presumption of competence, but this will readily be rebutted where the child is of a very young age. Children can consent to treatment for which they have been judged competent, and a guardian's consent will not be required. Guardians

260 Health and Disability Commissioner Case 16HDC00720.

261 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

can also consent and refuse consent for a child under 16 years. Where there is doubt about who can make the decision or a conflict between the child and a guardian, advice should be sought.

Unexpected events

Unexpected events may occur during the provision of treatment – for example, surgery – which mean the patient might benefit from an additional procedure that goes beyond what was consented. The practitioner should only proceed with the additional procedure without consent if it is in the patient’s best interests and any delay would endanger the patient’s life or cause serious damage to health. Otherwise, the practitioner will need to obtain consent from the patient before proceeding with further treatment. In some cases, an operation will need to be stopped and the patient woken up in order to get consent to proceed. An additional procedure should not be performed just because it is convenient and cost effective to do so.

In one case, a woman consented to surgery on the understanding her left fallopian tube might need to be removed. During surgery, the surgeon found that the right fallopian tube was also infected. The surgeon was concerned about ongoing infection and sepsis and considered it to be in the woman’s best interests to remove both fallopian tubes. The Health and Disability Commissioner found that, while there was no doubt the surgeon’s decision was made with “the best possible intentions”, this was not an emergency situation and it was unacceptable to remove the right fallopian tube without consent.²⁶²

When informed consent is not necessary

There are rare occasions when it is not necessary to get informed consent.

In an emergency situation, a practitioner can (and in most cases must) treat a patient who is not competent to consent to treatment where the

262 Health and Disability Commissioner Case 15HDC01847.

treatment is necessary to preserve the patient's life, health or wellbeing and where the treatment is in the patient's best interests.

The key features of an emergency are extreme urgency or serious adverse consequences of failure or delay in acting. However, even in an emergency, a competent patient has the

right to consent to or refuse medical interventions. Only those treatments that are necessary to preserve life or health should be done at this time. Any procedure that can be reasonably be delayed should be delayed until an opportunity can be given for the patient to consent. Moreover, if a patient has a valid advance directive refusing treatment in an emergency, unless there is any reason to doubt the validity of the directive, treatment should not be provided.

The principle of necessity is a common law principle that overrides the requirement for informed consent. It allows treatment to proceed where a patient is not competent to give consent and treatment is necessary to save the patient's life or prevent a serious risk to health. The action taken must accord with good medical practice – it must be one that a reasonable practitioner would take in the circumstances acting in the patient's best interests. The most common application of this principle will be in an emergency situation. A practitioner cannot justify treatment on the basis of necessity when it is contrary to a valid advance directive or the known wishes of the patient.

In an emergency situation, a doctor can (and in most cases must) treat a patient who is not competent to consent to treatment where the treatment is necessary to preserve the patient's life, health or wellbeing.

Right 7(4) of the Code of Rights provides:

(4) Where a consumer is not competent to make an informed choice and give informed consent, and no person entitled to consent on behalf of the consumer is available, the provider may provide services where—

(a) it is in the best interests of the consumer; and

(b) reasonable steps have been taken to ascertain the views of the consumer; and

(c) either,—

(i) if the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or

(ii) If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

A number of statutory exceptions also exist that override the requirement to obtain informed consent – for example:

- a person can be detained and treated without consent under the Health Act 1956 to prevent the spread of infectious disease
- compulsory treatment for a person's mental disorder can be provided where a person is subject to a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992

- under Right 7(10), body parts or bodily substances may be removed from a living person as part of a health care procedure and stored, preserved or used without consent if done for a professionally recognised quality assurance programme, an external audit or evaluation of services or for research that has been approved by an ethics committee.

Teaching and research

The Code of Rights provides that patients have a right to be informed of any proposed participation in any research or teaching, including whether the research requires and has received ethical approval, and the right to be informed of any results of the research (Rights 6(1)(d) and 6(3)(d)). If the research or procedure is experimental consent must be in writing.

Where medical trainees are involved in the treatment or care of a patient, the patient should be informed about the extent of the involvement of the trainee and the trainee's experience. Patients should be informed of any increased risks arising where treatment is provided by a trainee.²⁶³ Consent should be obtained from the patient if the care or treatment is part of the trainee's education. This is a requirement even if the trainee is simply observing. The patient has a right to refuse to participate in teaching or have an observer present.

Consequences of treating without consent

The consequences to a practitioner of treating a patient without consent may be serious. As a general rule, it is unlawful to treat a competent person without their consent or to treat an incompetent person without the consent of a person who is legally able to consent for that person (unless there is other legal authority to treat without consent). This is even if the practitioner carries out the treatment in good faith and in the

263 Health and Disability Commissioner Case 13HDC01345.

patient's best interests. There are various forms of liability that may be incurred:

- **Code liability:** A failure to obtain informed consent may amount to a breach of the Code of Rights. The Health and Disability Commissioner may investigate an alleged breach of the Code and, if the allegations are proven, a practitioner and/or health provider may be the subject of an adverse opinion from the Health and Disability Commissioner.
- **Disciplinary liability:** A practitioner may face disciplinary action from the Council for a failure to obtain consent. A finding of professional misconduct against the practitioner may result in the Health Practitioners Disciplinary Tribunal imposing a penalty on the practitioner, such as a fine, conditions on their practice and/or, in severe cases, suspension or cancellation of registration.
- **Criminal or civil liability:** Touching a patient without valid consent or other legal authority could amount to battery or assault. In most cases, any injury sustained as a result of the tort will come within the scope of the ACC regime, and a practitioner will not be liable for compensatory damages. However, criminal liability for assault or battery remain a possibility.
- **Public law damages:** Although there have been no cases to date, public law compensation could be awarded to a patient for a breach of section 11 of the New Zealand Bill of Rights Act.

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CHAPTER 14

Mental capacity

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Introduction

This chapter provides an introduction to mental capacity law and clinical practice. It covers the key concepts, the legal framework and a checklist for assessing capacity. It is based on a clinical and legal guide for health practitioners when assessing an adult's capacity to make decisions.²⁶⁴

The toolkit was developed with input from doctors, lawyers and ethicists. It aims to provide a nationally consistent and systematic approach to assessing capacity specific to the New Zealand health care setting. The law in this area is out of date.²⁶⁵ The New Zealand Law Commission has begun a review of the laws relating to adults with impaired decision-making capacity.²⁶⁶

Mental capacity (or simply capacity) refers to an individual's ability to make particular decisions or take actions. A capacity assessment focuses on whether the person retains that ability and, if not, who should decide on their behalf and on what basis. These decisions can range from a simple everyday decision about what to have for breakfast to far-reaching decisions about medical treatment or financial investments. A person's inability to make decisions may have legal consequences for them or others. For example, how do we decide whether a patient who has suffered a stroke can give informed consent or make informed choices about their treatment and care? How does a young adult with learning disabilities negotiate choices about their living arrangements? How do we support an older adult experiencing onset of dementia to decide their next steps? In some instances, where a person is in a coma on life support, for example, the extent of a person's incapacity means they are unable to participate in the decisions made about them.

264 Douglass A, Young G, McMillan J. A toolkit for assessing capacity. In Douglass A, editor. *Mental capacity: updating New Zealand's law and practice*. Appendix D. Report for the New Zealand Law Foundation; 2016. <http://www.alisondouglass.co.nz/>

265 Douglass A, editor. *Mental capacity: updating New Zealand's law and practice*. Report for the New Zealand Law Foundation; 2016. <https://www.lawfoundation.org.nz/>

266 <https://www.lawcom.govt.nz/news/law-commission%E2%80%99s-202021-work-programme>

Assessing capacity is an essential skill for doctors.²⁶⁷ Any doctor seeking consent for investigation or treatment needs to be able to assess the patient's capacity to give or refuse consent. Doctors may also be asked to assess a patient's capacity to decide about their care and living arrangements, to make a will, to make or activate an enduring power of attorney (EPOA) or to make financial decisions.

Any doctor seeking consent for investigation or treatment needs to be able to assess the patient's capacity to give or refuse consent.

Although assessing any particular capacity does not require detailed legal knowledge, a doctor must understand in broad terms the relevant legal tests or thresholds for capacity. The failure of a doctor to perform a formal assessment of capacity to appoint an EPOA and certifying a woman's capacity to appoint an EPOA contrary to her own opinion resulted in a finding by the Health and Disability Commissioner that the doctor failed to comply with legal and professional standards and was in breach of Right 4(2) of the Code of Rights.²⁶⁸

The increasing prevalence of dementia and Alzheimer's disease means there are now more people with impaired capacity in the community, and there is a greater need to support them within the health system. A review of 58 international studies of capacity reported that 45% of patients in psychiatric settings and 34% of patients in general medical settings lacked decision-making capacity.²⁶⁹ Dementia is the leading cause of incapacity and is expected to affect over 78,000 New Zealanders by 2026.²⁷⁰ In view

267 See footnote 265, para 7.31.

268 Health and Disability Commissioner Case 20HDC00126.

269 Lepping P, Stanly T, Turner J. Systematic review on the prevalence of lack of capacity in medical and psychiatric settings. *Clinical Medicine Journal*. 2015;15(4):337–343.

270 <https://www.health.govt.nz/publication/new-zealand-framework-dementia-care>

of the growing prevalence of dementia along with many other brain conditions that affect capacity, it is likely that doctors will need to assess capacity more frequently in the future.

The focus in this chapter is on providing a basic introduction to key capacity concepts and on how to carry out a capacity assessment. There are other aspects of capacity law and practice with which a doctor should be familiar:

- **Advance directives:** An instruction (written or oral) made by an adult person, while still capable, to refuse specified medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment (see Chapter 3 – End-of-life issues).
- **End-of-life decision making:** Many decisions in end-of-life care depend on whether the patient has capacity for decision making (see Chapter 3 – End-of-life issues).
- **Children and capacity:** The rights and interests of children under the age of 18 to make decisions for themselves or when parents withhold consent to medical treatment (see Chapter 13 – Informed consent).
- **Mental health law:** People may be subject to both laws. However, mental health law is specifically for the compulsory assessment and treatment of a patient's mental illness (see Chapter 23 – The psychiatric patient and the law).
- **Research:** Clinical trials may involve a therapeutic intervention on a patient who lacks capacity to consent or to refuse participation.²⁷¹

In some situations, such as where there is treatment refusal or family conflict about the patient's interests, capacity can be difficult to assess and may not be clear cut. Where the decision involves significant risk or where there is conflict about the decision, it is a good idea to seek the advice of

271 See footnote 265, Chapter 6.

colleagues and members of the multi-disciplinary team. In more borderline or complex cases, a referral to a consultant psychiatrist or geriatrician may be necessary to undertake the assessment and/or provide a second opinion.

Key concepts of capacity

Deciding whether a person has capacity is a legal decision informed by medical and other evidence.

A capacity assessment is used to establish whether a person lacks capacity for making certain decisions.

The outcome of the assessment may have significant implications for a patient's autonomy and the legal decisions and processes that may follow. A capacity assessment may

be used, for example, to decide whether a patient has the right to refuse medical treatment or to support an application to the court appointing someone else, a welfare guardian, to make decisions for them.

Both the terms 'capacity' and 'competence' can be used. In a clinical context, competence often refers to the process of decision making and capacity to the legal term that is used.

In every assessment of capacity, the following key concepts need to be considered:

- There is a presumption that all adults have the capacity to make decisions on their own behalf. The starting point when assessing capacity is always to presume that the person has capacity to make the decision. However, the assessment will be taking place because a reason exists to question the presumption of capacity.

Deciding whether a person has capacity is a legal decision informed by medical and other evidence.

- A presumption of capacity does not diminish the duty of care owed to patients in the delivery of health care. There remains a duty to assess the person so that decisions can be made about the appropriate provision of health care.
- Capacity is decision and time specific. Someone who cannot make a complex decision may be able to make a simple one. A person whose capacity fluctuates may not be able to make a decision at one point in time, but they might be able to make that decision at a later time. The assessment must relate to the decision that needs to be made at the specific time that it needs to be made.
- A person cannot be deemed to lack capacity solely because they make an unwise decision. A capacity assessment is concerned with a person's decision-making ability, not the decision itself. There may be triggers for questioning a person's capacity – for example, where a person is at significant risk of harm or exploitation or the decision is obviously irrational or out of character for that person.
- A diagnosis is not the same as an assessment of capacity. As with many countries, New Zealand follows a functional approach to capacity not a status approach. A diagnosis or the fact that someone may have dementia, for example, does not necessarily mean that they lack capacity.
- Supported decision making is a human rights concept under the United Nations Convention on the Rights of Persons with Disabilities (CRPD). It emphasises that not only is it important that good judgements are made about whether or not a person has decision-making capacity, but it is equally important to provide ways in which a person can be supported so as to make their own decisions.²⁷² New Zealand law also reinforces that people with impaired capacity should participate as much as possible in decisions about them.

272 United Nations Convention on the Rights of Persons with Disabilities, art 12, ratified by the New Zealand Government in 2008.

Supported decision making in practice

Supported decision making involves doing everything possible to maximise the opportunity of a person to make a decision for themselves.

A capacity assessment can give guidance about the extent and nature of what a support person requires. For example, a patient may need more time to consider the information about the risks and benefits of the operation for which their consent is sought.

The doctor has a role in ensuring that the person to be assessed has already been given the best chance of making the decision – for example, by the existing health care team or service and/or with the assistance of the person's family. All reasonable attempts that have been made to support the person making a decision should be documented, including what these attempts have entailed. In practice, supported decision making may include:

- treating a medical condition that may be affecting the person's capacity (for example, delirium)
- using an alternative means of communication (for example, providing written material) or providing information in a more accessible form (for example, drawings)
- ensuring that discussions with the person about the decision have been conducted in an appropriate environment (for example, respecting the person's privacy and minimising distractions on a busy hospital ward or visiting the person in their own home)
- giving the person extra time to understand and reflect upon the decision.

Where necessary, arrange to have the assistance of a professional interpreter with appropriate accreditation and experience in health interpreting. It is not advisable to use a family member because of the potential for bias or a vested interest. Even with an interpreter available, a fully bilingual clinician, if available, may be a preferable option for undertaking the assessment (see Chapter 19 – Working with interpreters).

Consider the time and place for the interview. Ensure that enough time is available for the interview to be conducted at an easy pace and that the place chosen for the interview is comfortable and private. It is important to avoid interviewing later in the day for older persons when they may be suffering from fatigue or ‘sundowning’.

Hearing, visual and communication aids, where used, should be brought to the interview.

Tikanga Māori and cultural diversity

There is a need to recognise cultural diversity, and in particular the rights of Māori as tangata whenua, in all aspects of clinical practice in New Zealand (see Chapter 16 – Māori and health). This remains true when assessing capacity. Culture, language and religion are integral factors in how a person makes decisions and what decisions they make. For Māori, whakawhanaungatanga, the process of establishing connections through family and other social connections, can greatly enhance the assessment process, and provides a platform for supported decision making.²⁷³

In practice, carrying out capacity assessments requires clinicians to be culturally competent, especially if the person being assessed is from a different culture. This involves knowing when and how to enlist support or assistance from whānau and others to support the person through the assessment process.

The legal framework

There is a wide range of legislation (statutes) and common law (case law) that is relevant to people who may lack capacity for decision making. In New Zealand, the adult guardianship law, the Protection of Personal and Property Rights Act 1988 (PPPR Act) and the right to informed consent under the

273 Baxter J. Māori perspectives. In Douglass A, Young G, McMillan J. Assessment of mental capacity: A New Zealand guide for doctors and lawyers. Wellington: Victoria University Press; 2020.

Code of Health and Disability Services Consumers' Rights (Code of Rights) are the main legislation that applies to adults with impaired capacity.

Code of Health and Disability Services Consumers' Rights

Informed consent is the cornerstone of the Code of Health and Disability Services Consumers' Rights (Code of Rights). Under Right 5 (communication), Right 6 (information) and Right 7 (right to informed consent and choice), the essential components of the right to give or refuse consent to health care are:

- adequate information
- capacity to decide
- voluntariness.

Capacity is therefore an essential component to validating consent or refusal to consent to health care. However, there is no specific legal test for capacity set out in the Code of Rights itself. The person must be able to understand the nature, effects and purpose of the proposed treatment, the likelihood of success and any alternative forms of treatment. The possible consequence to the person of receiving or not receiving the proposed treatment should be explained. Even where there is an appointed decision maker, such as a welfare guardian or an attorney, every effort should be made to help the person participate as much as possible in the decision to be made.

Right 7(4) of the Code: justifying treatment decisions without consent

Doctors may find themselves in situations where they need to provide treatment without the patient's consent. In emergency or life-threatening situations, treatment can proceed without the patient's consent. Where the situation is not urgent and there is no authorised

Doctors may find themselves in situations where they need to provide treatment without the patient's consent. In emergency or life-threatening situations, treatment can proceed without the patient's consent.

decision maker, Right 7(4) of the Code of Rights provides a basis to treat if it is considered to be in the patient's best interests.

In making a decision to provide treatment under Right 7(4) – for example, carrying out a medical procedure – the following steps should be followed:

- Decide whether or not the patient has the capacity to make that particular decision.
- If not, check no one who is legally authorised to consent is available.
- Assess whether the decision to provide treatment or care is in the patient's best interests, taking into account the views of the patient or, where these are not possible to ascertain, the views of other suitable people interested in the welfare of the patient.

The third step may include consulting with the family as well as other health practitioners or social workers who know some background and are able to tell the doctor about the patient's preferences where the patient cannot speak for themselves. Family or next of kin are not legally authorised to make decisions for the patient unless they have been appointed into this role.

The use of Right 7(4) is most appropriate where decisions need to be made in the short term and should not be relied upon for ongoing decision making regarding longer-term health care and placements into residential care. In these circumstances, those involved in such decisions should consider making an application to the court for orders under the PPPR Act. A number of district health boards have policies for clinical staff that outline the circumstances where formal applications need to be made to the court and the role doctors have in assisting the court.

Protection of Personal and Property Rights Act (PPPR Act)

The Protection of Personal and Property Rights Act 1988 (PPPR Act) is the adult guardianship law that applies to people who lack capacity and who are 18 or older. The PPPR Act authorises the appointment of substitute

decision makers by the Family Court (welfare guardians and property managers) or one-off orders for care and treatment decisions (personal orders). It also sets out the procedures for making and activating enduring powers of attorney (EPOAs) when a person lacks capacity for decision making.

An EPOA is a legal document where the donor gives someone else (the attorney) the power to act for the donor if they become mentally incapable and lose the ability to make significant decisions for themselves.

Following changes to the PPPR Act in 2017, there are standard explanations and forms for the making and cancelling (revocation) of an EPOA. A doctor may be asked by a lawyer for a clinical opinion of capacity so that the witness to the EPOA is confident that the person “understands the nature of the instrument, potential risks and consequences” of making an EPOA.²⁷⁴

Under the PPPR Act, a substitute decision maker can include the following:

- An attorney appointed by the person for property and care and welfare decisions under an EPOA. Doctors may be asked to provide a medical certificate to activate the EPOA, confirming that the person lacks capacity for a significant health care decision.
- A welfare guardian or property manager appointed by the court. There is a medical report form that is usually completed by a doctor or other relevant health practitioner that is part of the evidence given to the court when deciding whether a decision maker should be appointed to make decisions on behalf of the person who lacks capacity. The reasons why a person is assessed as lacking capacity (or not) should be made clear in the report.

Where there is an application to the court, a lawyer will be appointed to represent the subject person and to report to the court. The lawyer may interview the doctor about the assessment. However, capacity assessments

274 Protection of Personal Property Rights Act 1988, section 94A(7).

are rarely contested in court. The lawyer will report on whether the court has the authority to make an order because of the person's incapacity and, if so, what intervention, such as a court order, may be necessary.

There are limitations placed on the appointed decision maker's powers so, for example, the decision maker cannot refuse life-saving treatment for the person or consent to medical experimentation on their behalf.

Assessing capacity

Although capacity involves a legal decision, the assessment of capacity is clinical. The purpose of assessing capacity is to determine by clinical interview the inability to make a legally effective decision. The clinical assessment aims to determine the extent, cause and possible reversibility of the patient's incapacity. In general, the outcomes of the assessment include that the patient has capacity to decide, they need support to make the decision, they are unable to make a particular decision or they are unable to make any decision.

A variety of methods of capacity assessment have been published internationally, but these mainly relate to other countries. The McArthur Competence Assessment Tool for Treatment (MacCAT-T), for example, is a clinical tool now widely used to assess capacity but requires some training and familiarity. There is growing recognition in New Zealand of the need to have a consistent approach for assessing capacity.²⁷⁵

It is important to be aware that brief tests of cognitive function, such as the Montreal Cognitive Assessment (MOCA) or the Mini Mental State Examination (MMSE), do not provide a measure of capacity. A functional test is used.

275 Astell H, Lee JH, Sankaran S. Review of capacity assessments and recommendations for examining capacity. *New Zealand Medical Journal*. 2013;126(1383):38–48.

Medical conditions affecting capacity

A range of conditions and disabilities can impair capacity. The most common of these, in the context of community care of older people is dementia. It is difficult to predict from the stage of dementia whether a person retains or has lost the capacity to make a particular decision. Measures of dementia severity correspond only approximately with capacity. It is important to recognise that different types of dementia may impair capacity in different ways. The most common form of dementia, Alzheimer's disease, affects memory in the first instance, whilst dementia secondary to vascular disease of the brain tends to impact on frontal and subcortical systems, causing problems with higher cognitive functions.

Delirium is a disorder that is seen more commonly in residential care and hospital settings and is characterised by a relatively sudden decline in cognitive function or fluctuations in such function and impaired condition. It occurs in the context of physical illness or toxic states and may present the first time a capacity assessment is required. Head injury (or acquired brain injury) and intellectual disability (also referred to as learning disability) are usually chronic, stable states where it is more likely the person's abilities will be understood and the focus should be on optimising the person's capacity.

Mental incapacity is not the same as mental disability. Mental disability, including mental illnesses such as depression, anxiety and psychosis, can impair capacity in a number of ways, including being forgetful or reducing the person's ability to think through complex issues, through inattention or by causing a bias in reasoning to the point of impairing capacity. In psychiatry, there are approaches for making self-binding directives (the Ulysses contract) by which patients with bipolar affective disorder commit themselves to treatment during episodes of mania, even if unwilling. For certain individuals, this can seem the most rational way to deal with their fluctuating condition.²⁷⁶

276 Gergel T, Owen G. Fluctuating capacity and advance decision-making in bipolar affective disorder – self-binding directives and self-determination. *International Journal of Law and Psychiatry*. 2015; 40:92–101.

The core legal test

When assessing capacity, it is necessary to identify the decision required to be made and the relevant test (legal threshold for capacity). The PPPR Act has five different tests for capacity depending on the kind of appointment or decision to be made. In general terms, a person is assessed as lacking capacity if they cannot understand the nature and foresee the consequences of decisions or are unable to communicate them.²⁷⁷

The core legal test set out below can be used to give a structure for the assessment interview.²⁷⁸ A person lacks capacity if they are unable to:

- **understand** the nature and purpose of a particular decision and appreciate its significance for them
- **retain** the relevant essential information for the time required to make the decision
- **use or weigh** the relevant information as part of the reasoning process of making the decision and to consider the consequences of the possible options (including the option of not making the decision)
- **communicate** their decision, either verbally, in writing or by some other means.

Only one of these elements needs to be present to establish that the person lacks capacity for the specific decision.

A checklist for assessing capacity

The toolkit for assessing capacity²⁷⁹ sets out a three-stage procedure for assessing capacity based on a semi-structured interview. Consider these questions when assessing capacity.

277 Protection of Personal and Property Rights Act 1988, section 6.

278 Mental Capacity Act 2005 (England and Wales), section 3. See also the capacity criterion for compulsory treatment under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017, section 9.

279 See footnote 264.

Stage 1: Preparing for the assessment

- **Triggers:** Why is this person's capacity being questioned now?
- **Decision:** What is the capacity decision to be assessed?
- **Legal test:** What is the legal test against which capacity is to be assessed under the PPPR Act or other laws?
- **Gathering Information:** Do you have all the relevant information about the decision, including the circumstances and details of the choices available?
- **Medical history:** Does the person have a medical condition that impairs their capacity, and does this need treatment before the assessment can be done?
- **Support measures:** What can be done to assist the person to make the decision?
- **Cultural considerations:** Is cultural support needed?
- **Where and when:** What is the best time and place for the assessment?

Stage 2: The assessment interview

- **Engagement:** Have you explained who you are and the purpose of the assessment?
- **General health and cognition:** What is the person's mental state? Is there a medical condition that is currently active and is impairing the person's cognitive function? If so, can you measure its severity using a cognitive screening test?
- **Legal test:** Have you asked questions to determine whether the person is able to understand, retain, use or weigh the information or communicate the decisions by any means?

Stage 3: After the interview

- **Decide:** Do you have enough information to decide if the person has capacity or not? Is a second interview necessary?
- **Communicate:** Have you told the person, and where appropriate their family, the outcome of the assessment?

- **Document:** Have you recorded your reasons in the person’s clinical records that the person has or lacks capacity for a particular decision? Is a medical certificate or report required?

Practice points

There are some additional practice points for the assessing clinician to consider.

Who should carry out the assessment?

If the assessment is about a medical decision, the clinician who is providing the treatment should assess the person’s capacity to consent to that treatment, although they may consult others for assistance.

Where the decision is about other matters such as personal welfare, living arrangements or property matters, it is usually best for a clinician who is well known to the person, for example, the family GP, to do the assessment. Where this is not the case, particular attention will need to be given to the process of engagement and, in the case of Māori, whakawhanaungatanga.

In cases of doubt or in relation to complex major decisions, it may be advisable to collaborate with other health practitioners with experience in relation to the needs of the person, such as a nurse, occupational therapist, psychologist or speech-language therapist.

Final responsibility for obtaining effective consent for treatment rests with the person intending to carry

Final responsibility for obtaining effective consent for treatment rests with the person intending to carry out the proposed medical procedure, not with other health practitioners advising about capacity.

out the proposed medical procedure, not with other health practitioners advising about capacity.

When a lawyer refers a client for a capacity assessment, the doctor should receive a written referral letter identifying the specific decision to be made, the relevant information, the applicable legal test and the form of certificate or report required to be completed.²⁸⁰

Form of assessment

It is important to apply a sense of proportionality to what might be involved with a capacity assessment and to allow for the best use of time within the time pressures inherent in clinical practice.

Informal assessments occur all the time in medical practice. These capacity assessments are often conducted intuitively by clinicians without recourse to courts or formal legal processes but may be documented in the medical notes. For example, if a residential care patient with dementia implicitly agrees to having a wound from a fall treated, an assessment is not necessary. However, if the same patient is refusing treatment and a decision needs to be made in their best interests, a capacity assessment will be necessary.

Formal assessments are assessments that are required to provide an opinion (often with a medical certificate) under the adult guardianship law (PPPR Act) or for other legal proceedings, or for some other legal purpose, such as a will. These capacity assessments are used to support, for example, the activation of an EPOA or an application to the Family Court to appoint a welfare guardian.

280 A template referral letter and forms for certifying capacity and incapacity may be found in appendices to Douglass A, Young G, McMillan J. *Assessment of mental capacity: A New Zealand guide for doctors and lawyers*. Wellington: Victoria University Press; 2020.

Refusal to undergo a capacity assessment

In circumstances where a person refuses to undergo a capacity assessment, it may be possible to persuade them to agree to an assessment if the consequences of refusal are carefully explained – for example, the implications of a medical procedure. However, in the face of an outright refusal (and in the absence of a court order), no one can be forced to undergo a capacity assessment. Refusal to cooperate with an assessment together with other available information may be relevant in the legal decision about the person's capacity.

Where there are serious concerns about the person's mental health, the Mental Health (Compulsory Assessment and Treatment) Act 1992 may be used only for the purpose of assessment or treatment of the mental disorder itself. It does not apply to physical treatments. A decision to admit a person to hospital and take them out of their home setting is a significant decision where that person is clearly expressing a refusal. Such decisions should not be made by a doctor without reference to the multi-disciplinary team.

Capacity is not the same as ‘best interests’

Where someone lacks capacity to make a particular decision, ‘best interests’ is the legal standard by which any action taken or decision made on that person’s behalf, that is, someone else (a substitute decision maker) will make the decision. Examples where a decision maker needs to decide what is in the person’s best interests include:

- an attorney appointed under an EPOA making a decision once the EPOA is activated
- a welfare guardian or property manager appointed by the court
- a doctor or other health practitioner justifying a decision to proceed with treatment under Right 7(4) of the Code of Rights.

Where someone lacks capacity to make a particular decision, ‘best interests’ is the legal standard by which any action is taken or decision made on that person’s behalf.

New Zealand legislation does not define how best interests should be applied or assessed as a standard for decision making. Instead, there are the principles of applying the least restrictive intervention and maximising a person’s participation in the decision(s) that need to be made.²⁸¹ English law, which is influential in New Zealand, has codified an approach to the assessment of a person’s best interests, including taking into account the person’s past and present wishes and feelings and their beliefs and values.²⁸² In reaching a ‘best interests’ decision, the law has substantially developed from the paternalistic notion of what the doctors think best to an approach that takes into account the person’s preferences – the patient’s point of view.²⁸³ This approach is more in keeping with the human rights concept of supported decision making and seeks to prevent professionals involved with a patient’s care from being overly protective.

281 Protection of Personal and Property Rights Act 1988, sections 8(a) and (b). See also Right 7(3) of the Code of Health and Disability Services Consumers’ Rights.

282 Mental Capacity Act 2005 (England and Wales), section 4.

283 *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67, Lady Hale at [45].

A doctor's opinion of what is the best or the most appropriate form of treatment may conflict with what the patient wants. There is a risk that professionals, including lawyers and judges, may conflate a capacity assessment with a 'best interests' analysis.²⁸⁴ It is tempting, but ethically and legally wrong, for the doctor to underestimate the capacity of a patient in order to achieve what they believe to be in that person's best interests.²⁸⁵

Undue Influence

Undue influence is a legal term most often used when considering whether a person had the capacity to make or change a will and who may have been vulnerable to improper pressure from others. There are also situations of elder abuse (psychological and financial) – for example, where there is pressure or coercion being placed on the person by family members or others. Social workers from agencies such as Age Concern may provide useful independent background information about a patient's family and their living circumstances.

A doctor's capacity assessment can provide information about the susceptibility of the person to undue influence and whether the person is freely making their decisions. The overpowering will of a third party is relevant to the 'use or weigh' aspect of the capacity test, especially where a person with borderline capacity may be less able to resist pressure from others.

Summary

Assessing a patient's capacity for decision making requires both legal and clinical knowledge, including knowing the key concepts and how to apply the elements of the core legal test: the person is unable to understand, retain, use or weigh or communicate information relevant to a specific

284 *CC v KK and STC* [2012] EWHC 2136 (COP), Baker J.

285 Ruck Keene A, editor. *Assessment of mental capacity: a practical guide for doctors and lawyers* (4th edition). London: British Medical Association and Law Society; 2015, at 207.

decision. A capacity assessment may have significant implications for a patient exercising their personal autonomy. Doctors have an important responsibility in this regard to ensure that the capacity assessment process is transparent and that all necessary support has been provided to a patient to enable them where possible to make decisions for themselves.

Resources

Douglass A, Young G, McMillan J. A toolkit for assessing capacity. In Douglass A, editor. Mental capacity: updating New Zealand's law and practice. Appendix D. Report for the New Zealand Law Foundation; 2016. <http://www.alisondouglass.co.nz/>

Douglass A, Young G, McMillan J. Assessment of mental capacity: A New Zealand guide for doctors and lawyers. Wellington: Victoria University Press; 2020. Available as an eBook. <https://vup.victoria.ac.nz/assessment-of-mental-capacity-a-new-zealand-guide-for-doctors-and-lawyers/>

Online course – Assessing decision-making capacity: the clinical basics (2018) <https://www.goodfellowunit.org/courses/assessing-decision-making-capacity-clinical-basics>

CHAPTER 15

Cultural safety and health equity in medical practice in Aotearoa New Zealand

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In 2019, in partnership with Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA), the Council issued a fully revised statement on cultural safety²⁸⁶ and an additional resource He Ara Hauora Māori: A Pathway to Māori Health Equity.²⁸⁷ We have adopted a cultural safety paradigm instead of the more simplistic previous approach of cultural competence. Council seeks to enhance the mana of te Tiriti o Waitangi at all times.

286 <https://www.mcnz.org.nz/assets/standards/b71d139dca/Statement-on-cultural-safety.pdf>

287 See footnote 193.

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Historical context in Aotearoa New Zealand

He ao, he aotea, he aotearoa.

It is a cloud, it is a white cloud, it is a long white cloud.

(Kuramārōtini, circa 950CE)

These are the words said to have been spoken in 950CE by Kuramārōtini, wife of the Polynesian navigator Kupe, on first sighting the landmass that would come to be known as Aotearoa New Zealand. Subsequent waves of Polynesian migration from the Cook and Society Islands over the next few centuries established Māori as the indigenous people or tangata whenua (people of the land) in Aotearoa by the 15th century.²⁸⁸

Dutch explorer Abel Tasman was the first European to discover Aotearoa in 1642. Englishman James Cook's visit aboard *Endeavour* in 1779 was followed by the arrival of sealers, whalers, traders and missionaries. In 1840, the Treaty of Waitangi was signed between the British Crown and Māori chiefs, which resulted in hundreds of thousands of mainly British migrants colonising Aotearoa New Zealand from 1840 onwards.

Colonisation had a despoiling and devastating effect on the Māori population, and the results of this are still manifested today in a multitude of poorer socioeconomic outcomes experienced by the Māori population compared with non-Māori.²⁸⁹ These disparities include health and health care provision.^{290,291}

In recent decades, there has been a prolonged and concerted effort across Aotearoa to address the effects of colonisation and reduce socioeconomic

288 Anderson A, Binney J, Harris A. Tangata whenua: an illustrated history. Wellington: Bridget Williams Books; 2014.

289 Bhopal R. Racism, socioeconomic deprivation, and health in New Zealand. *The Lancet*. 2006 Jun;367(9527):1958–1959.

290 Robson B, Harris R. Hauora: Māori standards of health IV. A study of the years 2000–2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare; 2007.

291 Penney L, Barnes HM, McCreanor T. The blame game: Constructions of Māori medical compliance. *AlterNative: An International Journal of Indigenous Peoples*. 2011;7(2).

disparities between Māori and non-Māori. One important aspect of this is reforming New Zealand’s health system to be more responsive to the needs of Māori.²⁹² Part of this effort is ensuring that all doctors working in Aotearoa New Zealand are culturally safe and practising safely in a cultural context. This includes that doctors are well versed in the historical and contemporary factors that result in present-day health inequities across Aotearoa

In addition to the predominantly bicultural origins of early New Zealand, over the course of the 20th century and to the present day, many other cultural and ethnic groups from Asia, Africa, Europe, the Middle East and the Pacific have continued to migrate to New Zealand, resulting in an ever more culturally diverse environment in which doctors are required to practise confidently, compassionately and effectively.

The challenge of Māori health equity

The Medical Council has adopted the Ministry of Health’s definition of health inequities as “differences in health that are not only avoidable but unfair and unjust” and that “equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.”²⁹³

Health inequities are avoidable or remediable health differences between groups of people, whether those groups are defined socially, economically, demographically or geographically. The Council sees all health inequities, including those that exist for Māori, as unacceptable, and therefore professional obligations arise to address health inequities where they exist.

The Medical Council particularly acknowledges the negative impacts of colonisation experienced by Māori in Aotearoa and acknowledges the specific rights of Māori as tangata whenua (indigenous people) under

292 <https://dpmc.govt.nz/sites/default/files/2021-04/health-reform-white-paper-summary-apr21.pdf>

293 <https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity>

te Tiriti o Waitangi. These have recently been defined in the Treaty of Waitangi Tribunal’s finding over the Wai 2575 claim as tino rangatiratanga (self-determination), equity, active protection, options and partnership.²⁹⁴ The Council believes that these principles must underpin health service design and delivery for Māori.

While the Council recognises that many of the causes of health inequity for Māori (such as colonisation, land and resource loss and environmental degradation) are outside the scope of the health system and its ability to influence them, it is nevertheless vital that the causes of health inequity that can be influenced are. Through its clear position statements on cultural safety and *He Ara Hauora Māori*, the Council is signalling the necessity of improvements in the quality and equity of health care delivery to Māori with the goal of achieving health equity. We encourage partnerships between health institutions and Māori organisations, support protection of Māori health as a taonga (treasure) and call on health institutions such as medical schools, specialist colleges and health care providers to engage Māori health consumers and practitioners in all aspects of their organisations, including governance.

In 2016, the number of Māori doctors graduating from Otago medical school (45) reflected the demographic proportion of Māori in the population at the time (15.7%), although overall, Māori still comprise just 3.6% of the medical workforce. Given the diversity of doctors practising in Aotearoa New Zealand, including the increasing numbers of Māori doctors, Council is accrediting institutions and health care providers to ensure they are culturally safe places for doctors to work and train.

The Medical Council sees all health inequities, including those that exist for Māori, as unacceptable, and therefore professional obligations arise to address health inequities where they exist.

294 See footnote 55.

It is recognised that, although cultural safety is necessary to realise the potential of the health system to respond to our diverse society and intersects with improving Māori health, cultural safety is not synonymous with Māori health, which is a broad and varied discipline in and of itself. Similarly, providing expert knowledge and training in cultural safety is not solely the responsibility of Māori health experts and providers but is a responsibility shared by the entire health system..

Definitions of culture and cultural safety

Cultural identity is not restricted to indigenous status or ethnicity but also includes age or generation, gender, sexual orientation, socioeconomic status, religious or spiritual beliefs. Culture also reflects the values, norms and behaviours that impact on decision making within population groups. Cultural safety is expected to benefit all patients and communities.

The diversity and plurality of cultures in modern day Aotearoa is reflected in the diversity of doctors practising in New Zealand, with 40.4% of registered doctors having trained overseas.²⁹⁵ As a result, cross-cultural interactions are an everyday reality in the doctor-patient relationship, and it is the doctor's responsibility to ensure that cultural differences are acknowledged and managed to allow effective clinical care.

The Council's statement on cultural safety²⁹⁶ defines cultural safety as:

The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.

Cultural identity is not restricted to indigenous status or ethnicity but also includes age or generation, gender, sexual orientation, socioeconomic status, religious or spiritual beliefs

295 <https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/6be731ea72/Workforce-Survey-Report-2019.pdf>

296 See footnote 286.

The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.

The awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities.

Understanding how one's own biases and those of the health care system itself affect patient care is vital to avoid 'othering', where the practitioner sees themselves and the culture of health care delivery normal and those being treated as outsiders required to fit into the system rather than ensuring the system is fit for the patient and their whānau.

The concept of cultural safety originated in New Zealand in the 1980s through the pioneering work of Irihapeti Ramsden, a Māori nurse educationalist.²⁹⁷ Cultural safety was adopted by the Nursing Council in 1992 and has been in the nursing profession's training curriculum since that time.²⁹⁸

In deliberately moving away from the term 'cultural competence' towards 'cultural safety', the Council has taken the view that cultural competence is frequently described as being more centred on the health professional's experience and knowledge about 'the other', while cultural safety centres on the experiences of the patient.^{299,300} Cultural safety involves a more

297 Papps E, Ramsden I. Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care*. 1996;8(5):491–497.

298 Nursing Council of New Zealand. *Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice*. Wellington: Nursing Council of New Zealand; 2011.

299 Paul D, Hill S, Ewen S. Revealing the (in) competency of 'cultural competency' in medical education. *AlterNative: An International Journal of Indigenous Peoples*. 2012;8(3):318–328.

300 Curtis E, et al. Why cultural safety rather than cultural competency is required to achieve health equity:

patient and whānau- centred approach to health care. In essence, the patient can and should determine what is culturally important to their needs, not the doctor.

Through this, health consumers are able to become full partners in health care interactions, be active participants in their treatment and are assisted to feel safe, respected and empowered. The development of culturally safe practice requires health practitioners to establish, maintain and develop cultural competency. It can be argued then that these terms are intertwined. Competency requires safety and safety requires competency.

Cultural safety also empowers culturally appropriate and respectful professional relationships with colleagues and staff and the responsibility health professionals have in challenging cultural bias in health care systems where this brings negative impacts for patients.

Finally, the Council recognises that cultural safety extends to health care organisations such as specialist medical colleges, training institutions and health care providers. Organisations need to ensure that they are providing culturally safe, supportive environments for trainees and staff and delivering culturally safe health services.

Cultural safety in practice

As a health practitioner, cultural safety is an essential and indivisible component of clinical competence and is therefore required in order to deliver effective, quality health care to all. There is ample evidence that a lack of cultural safety contributes to poorer health outcomes,^{301,302} although it is more difficult to ascertain that simply teaching cultural safety

a literature review and recommended definition. *International Journal for Equity in Health*. 2019; 18:174.

301 Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Racism and health: the relationship between experience of racial discrimination and health in New Zealand. *Social Science & Medicine*. 2006;63(6):1428–1441.

302 van Ryn M, et al. The impact of racism on clinician cognition, behaviour and clinical decision making. *Du Bois Review*. 2011 Apr 1;8(1):199–218.

results in improved health outcomes.³⁰³ Recognising health inequities and the harm that can be done by culturally unsafe practice, section 118(i) of the Health Practitioners Competency Assurance Act 2003 requires that health practitioner regulatory authorities, including the Medical Council, establish standards of cultural competence for practitioners.

The Council sets the overarching standards and expectations of medical practice through *Cole’s Medical Practice in New Zealand* and via its other resources and statements. An important theme throughout these resources is that of working in partnership with patients and families/whānau in the practice of patient-centred care. Practising in a culturally safe way is a key element of patient-centred care.

In addition to setting professional standards for individual doctors, the Medical Council accredits medical training providers such as medical schools and specialist medical colleges (in partnership with the Australian Medical Council) and intern training sites in hospitals and communities. Accordingly, accreditation standards require that cultural safety teaching and assessment is integrated into training programs and recertification programmes and are therefore accessible to doctors throughout their training and professional careers.^{304,305}

Assessing cultural safety and practising it proficiently are not without significant challenges. Culture is complex, and ascertaining safety as defined by the patient is complex. Cultural safety is not something that can be easily measured and signed off but is rather a lifelong journey of constant reflection, infinite learning and continuous expansion.

303 See footnote 299.

304 <https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-primary-medical-programs/>

305 <https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs-assessment-accreditation-specialist-medical-programs/>

A consumer perspective

Ms Jean Hera, the author of the chapter on cultural competence in the 12th edition of *Cole's*, provides an invaluable consumer perspective on the importance of cultural safety:³⁰⁶

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

We patients need you, our doctors, to develop a general and interconnected set of attitudes, behaviours, knowledge and skills that enable you, to be non-judgemental and show us respect and understanding, to be approachable, and to communicate well. We want you to behave in ways that make us feel safe, assist us to ask

306 Hera J. Cultural competence and patient-centred care. In: St George IM, editor. *Cole's medical practice in New Zealand*. 12th ed. Wellington: Medical Council of New Zealand; 2013. Note that this has been edited to reflect the term 'cultural safety'. Ngā mihi ki a Jean Hera nā ēnei kupu tino taonga, ngā kupu tino koi.

questions and give feedback about any concerns we have, and we want to be listened to. If our requests cannot be accommodated, we want you to be honest with us about why this is. It is helpful when you are friendly, and pronounce our name correctly or at least talk with us so that you can learn how to do this. We appreciate it when you show humility and assist us to tell you if there is any cultural need we may have that you are not aware of. If it is possible, help us to ensure that any important cultural requirements we have are accommodated. As a general rule, we want to be active partners in our health care decision-making however in some cultural contexts, we may not want this and we may not find it easy to communicate this to you. If we do not understand you, we may find it hard to tell you this and in some cultural contexts even nod as if we do understand. We hope that you do not label us as non-compliant or difficult, but work to find ways to understand our reality and adapt to this.

We also need doctors to engage well and in a culturally competent way with our family and other support people when this is appropriate. We hope that our doctors are culturally sensitive in all aspects of their work with us, not just to our face, and when we are conscious. Cultural safety also needs to extend beyond the patient to apply to interactions with colleagues and others encountered in the health environment to help ensure safe, collaborative and supportive health systems are in place around us. Cultural safety involves the heart as well as the intellect. We can teach you a lot if you are open to this.

Cultural safety must be recognised as significantly more important than developing a range of cross-cultural knowledge about specific ethnicities and cultures. If you manage to achieve this as well it could be very helpful unless you embarrass and undermine us by

knowing more about our culture than we do – but then this would not be our lived culture. If you are not able or are too busy to meet absolutely all these needs, we hope you will help to develop and support health systems that can. Is this too much to ask?

Acknowledgement

The contribution of Jean Hera as author of this chapter in previous editions is gratefully acknowledged.

CHAPTER 16

Māori and health

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Note that this chapter has not been updated from the 2017 edition.

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Introduction

Māori are indigenous to New Zealand and a significant proportion of our society, comprising some 850,500 people of Māori descent at 30 June 2020³⁰⁷ and growing at a faster rate than the overall population. Māori comprise approximately one in seven people usually living in New Zealand. Māori peoples are essentially a tribal society constructed from small family-based units (whānau) organised into subtribes (hapū), which contribute to larger tribal entities (iwi).

Providing culturally competent care for Māori increases the likelihood of Māori engaging with health professionals and health services, improves adherence to treatment plans and ultimately improves overall Māori health status.

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

Māori history and the Treaty

Traditional and modern scientific knowledge concur that Māori arrived in Aotearoa New Zealand from Hawaiki, the east Polynesian homeland, at least 500 years before contact with European explorers. After the late eighteenth

307 <https://www.stats.govt.nz/information-releases/maori-population-estimates-at-30-june-2020>

century, an increasing number of traders, whalers, sealers and settlers came to New Zealand. The British Government appointed James Busby as British Resident in 1833 to protect British trading interests and counter the increasing lawlessness amongst traders and settlers. By 1839, there were an estimated 2,000 Pākehā and 150,000 Māori living in New Zealand.

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

Consequently, in 1840, a treaty was drawn up and translated into Māori by Henry Williams, an English missionary, prior to being debated at Waitangi. After a single day of debate, the Treaty was signed on 6 February 1840 at Waitangi in the Bay of Islands by 43 Northland chiefs. Over the next 8 months, the Treaty was signed at more than 40 other locations by more than 400 Māori chiefs including some women. However, many important chiefs refused to sign the Treaty.

Both the English and Māori versions of the Treaty contain three articles, but the Māori translation differs significantly from the English version, resulting in two documents with different meanings and interpretation.

The first article covers sovereignty. The English version states that Māori give up 'sovereignty' to the British Crown, describing it as a complete transference of power to the Crown. By contrast, the Māori version implies a sharing of power and uses the word 'kawanatanga', an improvised word that did not mean a transfer of authority from Māori to British hands but implied the setting up of a government by the British. The nearest Māori equivalent to the English term would have been 'mana' or 'rangatiratanga'.

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

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

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

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

In 1896, the Māori population reached its lowest point, estimated at 42,000, while migration of non-Māori accelerated.³⁰⁸

The cultural and political structure of New Zealand in 1840 was still essentially Polynesian, and all European residents absorbed Māori values to some extent. During this period, Māori commercial enterprise prospered. For instance, in 1857, Te Arawa and Tūwharetoa Māori (connected tribes descended from the Te Arawa canoe and covering the Bay of Plenty, Taupō and Rotorua areas), consisting of approximately

308 Pool I. *Te iwi Māori: A New Zealand population past, present, and projected*. Auckland: Auckland University Press; 1991.

8,000 people, had an estimated 3,000 acres of land in wheat, 300 acres in potatoes, nearly 2,000 acres in maize and 1,000 acres of kumara. In addition, they owned some 100 horses, 200 cattle, 5,000 pigs, four water-powered mills, 96 ploughs and 43 coastal vessels averaging nearly 20 tonnes each.

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

During the twentieth century, the Māori population had recovered and, at over 500,000, is now larger than ever before. However, social and economic disparities continue to exist.

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

The Treaty and health

Editor's note: This paragraph has been updated by the editor for this 14th edition.

The principles of Te Tiriti o Waitangi, as articulated by the Courts and the Waitangi Tribunal, provide the framework for how we will meet our obligations under Te Tiriti in our day-to-day work. The 2019 Hauora report recommends the following principles for the primary health care system.

These principles are applicable to wider health and disability system. The principles that apply to our work are as follow:³⁰⁹

- **Tino rangatiratanga:** The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.
- **Equity:** The principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.
- **Active protection:** The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
- **Options:** The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
- **Partnership:** The principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.³¹⁰

The Treaty ensures that taonga, or precious possessions, would be protected and retained. In this context, health is sometimes considered a taonga.

309 These include the New Zealand Health Strategy, New Zealand Disability Strategy, Māori Health Strategy and Royal Commission on Social Policy.

310 <https://www.health.govt.nz/our-work/populations/maori-health/te-tiriti-o-waitangi>

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

Māori health and inequalities

Māori have the poorest health of any New Zealand group with a higher mortality rate than non-Māori^{311,312} as well as higher rates of illness.^{313,314} Māori infants die more frequently from SIDS and have lower birth weight than non-Māori children.³¹⁵

Avoidable death rates are almost double for Māori than for other New Zealanders, and Māori die, on average, 8–10 years earlier.^{316,317}

New Zealand has a higher rate of death from cancer than Australia, with Māori accounting for two-thirds of the excess male cancer deaths and one-quarter of the excess female cancer deaths.³¹⁸ Māori women have rates of

311 Ajwani S, Blakely T, Robson B, Tobias M, Bonne M. Decades of disparity: ethnic mortality trends in New Zealand 1980–1999. Wellington: Ministry of Health and University of Otago; 2003.

312 Blakely T, Fawcett J, Atkinson, J, Tobias M, Cheung J. Decades of disparity II: socioeconomic mortality trends in New Zealand 1981–1999. Public Health Intelligence Occasional Bulletin #25. Wellington: Ministry of Health; 2005.

313 <https://www.acc.co.nz/assets/provider/acc1625-maori-cultural-competency.pdf>

314 See 311.

315 Ministry of Health. Our health, our future. Hauora pakari, koiora roa. The health of New Zealanders 1999. Wellington: Ministry of Health; 1999.

316 Ring I, Brown N. The health status of indigenous peoples and others. *BMJ*. 2003;327:404–405.

317 McPherson K, Harwood M, McNaughton HK. Ethnicity, equity, and quality: lessons from New Zealand. *BMJ*. 2003;327:443–444.

318 Skegg DCG, McCredie MRE. Comparison of cancer mortality and incidence in New Zealand and Australia. *New Zealand Medical Journal*. 2002 May 10;115(1153):205–208.

breast, cervical and lung cancer that are several times those of non-Māori women.³¹⁹

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

This is compounded by lower rates of diagnosis and lesser access to effective treatment.³²⁰

In summary, Māori are sicker for longer periods but have less access to care and die earlier than Pākehā. These disparities in overall Māori health persist even when factors such as poverty, education and location are accounted for, demonstrating that culture is an independent determinant of health status.^{321,322} These lower standards of health lead to suboptimal outcomes for individual Māori and influence the Māori community's negative perceptions of the health system as a whole.^{323,324} These negative experiences can also reinforce stereotypes within the practitioner community if a provider does not understand a Māori patient's dissatisfaction and thus cannot prevent similar experiences with other patients.³²⁵

319 See 315.

320 Crengle S, Lay-Yee R, Davis P, Pearson JA. A comparison of Māori and non-Māori patient visits to doctors: The national primary medical care survey (NatMedCa): 2001/02. Report 6. Wellington: Ministry of Health; 2005.

321 Marwick JC, Scott KM, Crampton PR. Utilisation of general practitioner services in New Zealand and its relationship with income, ethnicity, and government subsidy. Presented at RNZCGP Annual Conference; 2000.

322 Smedley BD, Stith AY, Nelson AR. Unequal treatment: confronting racial and ethnic disparities in health care. Washington DC: Institute of Medicine; 2003.

323 Durie M. Māori attitudes to sickness, doctors, and hospitals. *New Zealand Medical Journal*. 1977;86(600):483–485.

324 Laveist TA, Nuru-Jeter A. Is doctor-patient race concordance associated with greater satisfaction with care? *Journal of Health and Social Behavior*. 2002;43:296–306.

325 Jansen P, Sorenson D. Culturally competent health care. *New Zealand Family Physician*. 2002 Oct;29(5):306–318.

Differential approaches to treatment

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

Once age is taken into account, Māori turn up for GP appointments at the same rate as non-Māori but obtain fewer diagnostic tests, less-effective treatment plans and are referred for secondary or tertiary procedures at lower rates than non-Māori patients.³²⁶

Analysis of the National Minimum Database over the period 1990–1999³²⁷ suggests bias against Māori receiving cardiac revascularisation procedures even though the clinical need is much greater. Similar evidence of bias is available for outcomes following stroke,³²⁸ obstetric intervention,³²⁹ heart failure³³⁰ and asthma.³³¹ These studies point to unconscious bias by providers rather than frank racism in health service delivery.

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

326 Gribben B. Ethnicity and resource use in general practice in West Auckland. *Experience in Practice*. 1999;1.

327 Tukuitonga CF, Bindman AB. Ethnic and gender differences in the use of coronary artery revascularisation procedures in New Zealand. *New Zealand Medical Journal*. 2002 Apr 26;115(1152):179–182.

328 McNaughton HK, Weatherall M, McPherson KM, Taylor WJ, Harwood, M. The comparability of resource utilisation for Europeans and non-Europeans following stroke in New Zealand. *New Zealand Medical Journal*. 2002 Mar 8;115(1149):101–103.

329 Sadler L, McCowan L, Stone P. Associations between ethnicity and obstetric intervention in New Zealand. *New Zealand Medical Journal*. 2002 Feb 8;115(1147):36–39.

330 Carr J, Robson BH, Reid P, Purdie GL, Workman P. Heart failure: ethnic disparities in morbidity and mortality in New Zealand. *New Zealand Medical Journal*. 2002 Jan 25;115(1146):15–17.

331 Ellison-Loschmann L, King R, Pearce N. Time trends and seasonal patterns of asthma deaths and hospitalisations among Māori and non-Māori. *New Zealand Medical Journal*. 2002 Jan 25;115(1146):6–9.

There is evidence too of the impact of racism on Māori health status. Harris et al.³³² reviewed the New Zealand Health survey data and made adjustments for sociodemographic factors and deprivation and identified that the remaining differences in self-perceived health status between Māori and non-Māori could be accounted for in terms of self-perceived experiences of racism. These effects appeared to be dose-related, that is, the greater the number of experiences of racial discrimination, the lesser was self-perceived health status.

The impact of culture on health

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

Culture of the doctor

Like other cultures, Māori value highly effective communications with health professionals.³³³

However cultural misunderstandings, unconscious bias and unfounded beliefs about Māori by practitioners contribute to problems in communication between non-Māori doctors

Cultural misunderstandings, unconscious bias and unfounded beliefs about Māori by practitioners contribute to problems in communication between non-Māori doctors and Māori patients.

332 Harris R, et al. Self-reported experience of racial discrimination and health care use in New Zealand: results from the 2006/07 New Zealand Health Survey. *American Journal of Public Health*. 2012;102(5):1012–1019.

333 Jansen P, Bacal K, Crengle S. He ritenga whakaaro: Māori experiences of health services. Auckland: Mauri Ora Associates; 2009.

and Māori patients. All these problems have been demonstrated in studies of general practitioners³³⁴ and psychiatrists in New Zealand.³³⁵

It is expected that improved integration of cultural and clinical competence should lead to better outcomes through improvements in communication, acceptability of treatment and adherence to treatment plans^{336,337,338} and through measurements of doctor performance in delivery of services to Māori .

Māori concepts and Māori health values

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

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

Tapu and noa

Although tapu is often described as a state of sacredness, it also has the more general meaning of being special or restricted. Noa is the absence of tapu and denotes the state of being normal, ordinary or safe. All things to

334 McCreanor T, Nairn R. Tauwi general practitioners' talk about Māori health: interpretative repertoires. *New Zealand Medical Journal*. 2002;115(1167).

335 Johnstone K, Read J. Psychiatrists' recommendations for improving bicultural training and Māori mental health services: A New Zealand survey. *Australian and New Zealand Journal of Psychiatry*. 2000 Feb;34(1):135–145.

336 Crengle S. The development of Māori primary care services. *Pacific Health Dialog*. 2000;7:48–53.

337 Baxter J. Barriers to health care for Māori with known diabetes. A literature review and summary of issues. Dunedin: Te Rōpū Rangahau Hauora a Ngāi Tahu; 2002.

338 Krupat E, Bell RA, Kravitz RL, Thom DH, Azari R. When physicians and patients think alike: patient-centered beliefs and their impact on satisfaction and trust. *Journal of Family Practice*. 2001 Dec;50(12):1057–1062.

do with death or the body are tapu, while anything related to cooked food is noa.

Many Māori feel that keeping tapu items separate from noa items is very important and find it distressing when this division is not observed. For example, in the case of a patient's death, the whānau will likely wish to spend time in the room with their loved one. The presence of the dead body (tūpāpaku) makes the room tapu and therefore food cannot be brought in. There will of course be wide variation in how strictly such controls are practised and how observance of the traditional practice might be amended for practical reasons.

Whanaungatanga

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

Tangihanga

The rituals and customary practices that surround death are regarded as very important within Māori communities. The familial and community obligations to the deceased and the bereaved family are extensive. The tangihanga is a coordinated set of formal procedures that recognise the relationships of the deceased with the ancestors and with the living relatives. Many Māori recognise very strong imperatives to attend tangihanga of anyone in their extended family and friends and will often travel great distances to fulfil their obligations in this regard. A person may be grieved over for 3 or more days at their home or at a marae and often

returned to their traditional tribal home for burial. Death itself, however, may not be feared so much as the manner and circumstances of dying, with many Māori preferring to die at home with the attention and support of their family.

Manaakitanga

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

There are many useful texts that can provide deeper insight into Māori customary practices,³³⁹ and Māori patients are generally happy to educate a provider who seeks guidance about their preferences.

Rongoā and traditional healers

Māori patients may seek assistance from traditional healers like people from other cultural backgrounds. For Māori, this may include consulting people with special skills (tohunga) in herbal preparations (rongoā rākau), massage therapies (mirimiri), prayers and incantations (karakia).³⁴⁰

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

339 Mead HM. *Tikanga Māori: Living by Māori values*. Wellington: Huia Publishers; 2003.

340 bpac^{nz}. *Demystifying rongoā Māori: traditional Māori healing*. *Best Practice Journal*. 2008;13:32–36.

Māori language

There are several general introductory Māori language courses and a small number of dedicated Māori language phrasebooks for the health sector.³⁴¹

Welcome everybody.	Kia ora tātou.
I would like to acknowledge the family.	Ka mihi atu ki te whānau.
Greetings all.	Tēnā koutou.
Let's introduce ourselves and get to know each other.	Tēnā, me whakamōhio atu ko wai rā tātou.
How can I help you?	Ka pēhea taku āwhina i a koe?
How can I help your family?	Ka pēhea taku āwhina i tō whānau?
Do you have pain anywhere?	He wāhi anō kei tō tinana e mamae ana?
How long have you had that pain?	Kua pēhea te roa e mamae ana?
Where did the pain start?	I tīmata mai tēnā mamae ki hea?
What were you doing when the pain started?	I te aha koe i te wā i tīmata ai te mamae?
What makes it worse?	Ka nui atu te mamae i te aha?
What makes it better?	Ka whakaeaeatia te mamae ki te aha? I te ruaki koe?
Have you been vomiting.	I te torohī koe?
Do you have diarrhoea?	
My name is Richard. I am a doctor.	Ko Richard ahau, he rata ahau.
My job is to listen to your concerns and support you.	Ko tāku, he whakarongo ki ō āwangawanga, he tautoko hoki i a koe.
What are the main issues for you?	He aha ngā tino take ki ōu whakaaro?
How would you like me to help?	Me pēhea taku āwhina atu?

341 Jansen D. He pukapuka reo hauora Māori. Whaingaroa: Ahuru Press; 2005.

Ngā whakahua/pronunciation guide

Vowel sounds

- a as in car, far
- e as in bed
- i as in eel
- o as in awe, saw
- u as in chew, moo

Consonants

- wh pronounced much like “f” (whā pronounced far)
- ng pronounced like the “ng” in singer

Macrons

The vowels may take a short or long form. This is indicated by the macron over the vowel – ā, ē, ī, ō, ū. This is the method preferred by the Taura Whiri i to Reo Māori – Māori Language Commission, although others occasionally use a double vowel to indicate the long form – aa, ee, ii, oo, uu.

The long vowel is pronounced in the same way as the short vowel but the length is extended and has a significant effect on the sound and meaning of a word. Knowing the length of each vowel is important in establishing correct pronunciation.

Ōtāhuhu Ō - tā - hu - hu
Waitematā Wai - te - ma - tā

Glossary

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

CHAPTER 17

Pacific people in New Zealand

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Introduction

This chapter describes Pacific people in New Zealand, their health status, health service usage and ethnic-specific factors that may affect the interactions between health professionals and their patients. This chapter will allow some insight into working with Pacific people, their families and communities to assist in providing high-quality health care, which will lead to improved health outcomes and reduced inequalities for Pacific people in New Zealand.

Background

The 2018 Census revealed that 8.1% (381,642) of the New Zealand population identify themselves as being of Pacific ethnicity. This is the fourth-largest ethnic group behind European, Māori and Asian populations.³⁴²

Initially, this population grew rapidly in the 1950s to 1970s due to work-related migration. These days, this rapidly growing population is due to births within New Zealand and is growing faster than the European population. The Pacific population has increased from 6.9% (2006) to 8.1% (2018) of the total New Zealand population. More than 60% of the current Pacific population were born in New Zealand. The Pacific population is projected to make up approximately 10% of the New Zealand population in 2026.³⁴³

The Pacific population is very young, with 46% being younger than 20 years of age compared to 27% of the total population. In fact, 54% of the Pacific population are less than 25 years of age. In 2018, the median age of people who identified with one Pacific ethnicity was 23.4 years (compared to 41.4 years for European).³⁴⁴

342 <https://www.stats.govt.nz/tools/2018-census-ethnic-group-summaries/pacific-peoples>

343 <https://www.mpp.govt.nz/about-us/pacific-aotearoa>

344 See footnote 342.

The term “Pacific” or “Pasifika” usually refers to people who identify as having heritage from one of the Pacific islands.

The term ‘Pacific’ or ‘Pasifika’ usually refers to people who identify as having heritage from one of the Pacific islands. This includes a large number of ethnicities (Samoan, Cook Island Māori, Rarotongan, Tongan, Niuean, Tokelauan, Fijian, Hawaiian, Kiribati, Nauruan, Papua New Guinean, Pitcairn Islander, Rotuman, Tahitian, Solomon Islander, Tuvaluan and Ni Vanuatu). Being called Pacific gives a false impression that this diverse group have a uniform culture when in fact there is diversity within and between

these groups. Inter-marriage amongst these ethnicities is adding to the mixing of the cultures as well as the influence of having been born and raised in New Zealand amongst Māori and European (Pākehā/palangi) cultures. It is important to be aware that each individual has a unique culture based on their background, and assumptions based on their ‘Pacific’ background can be misleading.

The Samoan people make up 48% of the total Pacific population with 22% Tongan, 21% Cook Island Māori and 8% Niuean.

The majority of the Pacific population live in the North Island with 64% living in the Auckland region and 12% in the Wellington region.³⁴⁵

Although less than 5% of the Pacific population are over 65 years of age, the cultural importance of the elderly in most Pacific societies often means that the needs of the elderly take precedence over the needs of younger people. Respect and care for the elderly is an important aspect of all Pacific societies in New Zealand, and this fact has a major influence on how Pacific families live.³⁴⁶

345 See footnote 342.

346 Tukuitonga C. Pacific people in New Zealand. In: St George IM, editor. *Cole’s medical practice in New Zealand*. 12th ed. Wellington: Medical Council of New Zealand; 2013.

Health and socioeconomic inequalities

Pacific people have some of the worst health and social indicators in New Zealand, and there are considerable unmet health needs in these communities.³⁴⁷

Examples of worse health outcomes of Pacific people compared to the general population in New Zealand include the following:

- **Lower life expectancy:** Based on death rates in New Zealand in 2017–2019, life expectancy was 79.0 years for Pacific females and 75.4 years for Pacific males, compared with 83.5 years for females and 80.0 years for males in the total New Zealand population.³⁴⁸
- **Higher rates of chronic disease:** Pacific people are three times more likely to have diabetes.³⁴⁹
- **Obesity:** Obesity is well documented as being associated with reduced quality of life and increased health care costs, is a major contributor to chronic disease and disability and is a major modifiable risk factor for many long-term conditions (cardiovascular disease, cancer and type 2 diabetes).^{350,351} Pacific people in New Zealand have the highest rate (67%) of obesity (BMI >30 kg/m²) compared to Māori (47%) and the general population (32%).³⁵²
- **Higher hospitalisation rates:** Pacific people have twice the rates of other New Zealanders in general, are five times more likely to have a hospital admission with cellulitis in children and are 2.5 times more likely to have a hospital admission with respiratory disease in children compared to the general population.³⁵³

347 See footnote 346.

348 <https://www.stats.govt.nz/information-releases/national-and-subnational-period-life-tables-2017-2019>

349 See footnote 346.

350 Haslam DW, James WPT. Obesity. *Lancet*. 2005; 366(9492):1197–1209.

351 Huxley R, Mendis S, Zheleznyakov E, Reddy S, Chan J. Body mass index, waist circumference and waist:hip ratio as predictors of cardiovascular risk – a review of the literature. *European Journal of Clinical Nutrition*. 2010; 61(1):16–22.

352 Ministry of Health. Annual update of key results 2015/16: New Zealand Health Survey. Wellington: Ministry of Health; 2016.

353 <https://members.mauriora.co.nz/wp-content/uploads/2015/03/Best-health-outcomes-for-Pacific-Peoples.pdf>

- **Premature disability:** Pacific people experience more severe disabilities in children and young adults compared to the general population.³⁵⁴
- **Higher incidence of mental disease:** Pacific people have higher incidence of mental disease than the general population but much lower access of mental health services.³⁵⁵

Pacific people are disproportionately represented in lower socioeconomic brackets.³⁵⁶ Socioeconomic disadvantage is closely correlated with poor health and poor access to health services.

Studies have shown that nine out of 10 Pacific people live in low-decile areas with significant social and economic disadvantage.³⁵⁷ The median income for Pacific people is \$24,300 compared to \$33,000 for the New Zealand European population.³⁵⁸

Despite being 8% of the general population of New Zealand, 27% of this population live in severe hardship, 15% in significant hardship and only 1% have very good living standards.

They are more likely to be living in overcrowded homes that are cold and damp, and rates of home ownership are much lower than the general population. Pacific people have twice the unemployment rates of the New Zealand population.^{359,360}

Health literacy is very poor amongst this population. This is apparent when statistics show that, despite Pacific people accessing the health system (high GP attendance, high PHO enrolment), they do not achieve the same benefits of preventive and primary care services as other population groups.

354 See footnote 353.

355 See footnote 353.

356 See footnote 353.

357 See footnote 346.

358 See footnote 342.

359 See footnote 342.

360 See footnote 353.

For example, Pacific women have much lower rates of cervical and breast screening, and Pacific people have disproportionately lower rates of referrals to specialists.

Current disease patterns amongst this population largely reflect the socioeconomic conditions under which they live, and poverty is a major contributor of ill health among Pacific families. Although socioeconomic factors are the main underlying factors contributing to poor health in Pacific people, there may be an effect of Pacific cultures and practices on the overall result, mainly due to delay in seeking health care. This, however, may be a direct result of low health literacy.

These health and social inequalities affect the individual, their family and the community as a whole in view of the family/community-oriented nature of Pacific cultures.

It is important to build rapport with these patients in order to understand their needs and address issues in a way that will help to reduce these health disparities.

Unfortunately, several reports show little improvement in the socioeconomic circumstances of Pacific people and little change in their overall health status.³⁶¹

It is important to build rapport with these patients in order to understand their needs and address issues in a way that will help to reduce these health disparities.

Morbidity and mortality

Pacific people experience significant premature mortality and preventable morbidity mainly due to chronic non-communicable diseases such as diabetes and heart disease. Cardiovascular diseases are the leading cause of death and disability in the adult population. Although coronary artery

³⁶¹ See footnote 346.

disease mortality rates are declining, the rate of decline is less rapid in this population compared to the total New Zealand population.

Stroke incidence and mortality has not declined in line with other New Zealanders, and stroke tends to affect younger adults in their most productive years in Pacific people. Ethnic differences in cardiovascular disease mortality and morbidity are attributable to differences in risk factor prevalence and access to health care services.^{362,363,364}

The prevalence of smoking has declined in the Pacific population but still remains higher (21.1%) than the smoking rate in other New Zealanders (15.7%) especially amongst youth, with Pacific girls smoking at much higher rates than their peers. Smoking remains one of the most important and preventable causes of morbidity and premature mortality among Pacific people in New Zealand.³⁶⁵

Type 2 diabetes is more prevalent among Pacific people in New Zealand. Prediabetes is especially elevated in Pacific people. Among youth aged 15–24 years, 13.6% have prediabetes (versus 7% in New Zealand Europeans), while among Pacific working-age adults (25–44 years), 29.6% (versus 16% in New Zealand Europeans) have prediabetes.³⁶⁶ High prevalence of obesity in Pacific people is attributable to the obesogenic environment (consumption of highly processed food and reduced physical activity) that exists in urban areas in New Zealand. Studies have shown that Pacific people are more likely to consume diets high in fats, sugar and salt, more likely to have takeaway meals and less likely to cook at home. Young Pacific boys consume sugar-sweetened soft drinks more often than their peers. Preventing and managing obesity in Pacific people is the most urgent priority for the New Zealand health system. Demand for services such as

362 See footnote 346.

363 https://www.health.govt.nz/system/files/documents/publications/tupu-ola-moui-pacific-health-chart-book_1.pdf

364 <https://www.stats.govt.nz/assets/Uploads/Reports/Health-and-Pacific-Peoples-in-New-Zealand/Health-and-Pacific-Peoples-in-New-Zealand-October-2011.pdf>

365 See footnote 342.

366 Coppel K, et al. Prevalence of diagnosed and undiagnosed diabetes and prediabetes in New Zealand: findings from the 2008/09 Adult Nutrition Survey. *New Zealand Medical Journal*. 2013;126(1370):23–42.

renal dialysis as a result of renal failure due to diabetes is already reaching a point where health services are struggling to meet demand.³⁶⁷

Pacific children experience significant preventable morbidity. Several studies have shown that respiratory disorders and skin infections are very common and hospital admissions are higher than other New Zealand children.³⁶⁸ Acute rheumatic fever and rheumatic heart disease are three times more common among Pacific children and young people compared with other New Zealand children and young people. Unless effective action is taken to address poverty, interventions directed at specific diseases are unlikely to be sustainable.

The 2006 New Zealand Mental Health Survey (Te Rau Hinengaro) showed that the prevalence of mental disorders among Pacific people in New Zealand is similar to Māori and other New Zealand populations, except psychotic disorders where the prevalence of schizophrenia is higher among young Pacific men.³⁶⁹ Survey findings showed that only one-quarter of Pacific people with severe mental disorders were receiving recommended care.³⁷⁰

Access to and quality of health care

Pacific people are known to have low uptake of preventive and primary health care services – for example, low uptake of cervical and breast cancer screening and low immunisation coverage rates. These observations are supported by high rates of ambulatory-sensitive hospitalisation (ASH) among Pacific people.³⁷¹ ASH admission rates are generally accepted as a reasonable indicator of the quality and effectiveness of primary health care services. A review of the primary health care for Pacific people in New Zealand showed a potential disconnect between primary health care providers and Pacific patients.

367 See footnote 346.

368 See footnote 353.

369 <https://www.health.govt.nz/system/files/documents/publications/mental-health-survey.pdf>

370 See footnote 346.

371 See footnote 363.

General practitioners were less likely to record high levels of rapport with Pacific patients, and Pacific patients had low uptake of subsidised care, high use of accident and medical clinics and lower levels of satisfaction with their experiences of primary health care.³⁷² The report also concluded that the top three barriers to primary health care for Pacific people were cost, transport and language.

Reforms of the health sector and changes to the funding and delivery of primary health care in New Zealand as part of the New Zealand Primary Health Care Strategy and the Pacific Health Strategy has resulted in some improvements for Pacific people. Information from primary health organisations has shown high enrolment rates for Pacific people. Furthermore, the New Zealand Health Surveys have shown that the per capita GP consultation rates for Pacific people is comparable to other New Zealanders, although the level of consultation may not be appropriate for the level of health needs in these communities.³⁷³ Immunisation coverage rates among Pacific children are now among the best in the country.

Despite these improvements, it is clear that Pacific people continue to receive variable quality of health care. Studies of almost all health conditions have shown that Pacific people continue to receive lower levels of care, especially at the primary health care level. Health practitioners who work in health settings in communities need to ensure that best practice is normal practice at all times. Additional support, education and information for patients and their families will assist in improving

Improvements in the quality of primary health care will reduce attendance rates at emergency departments and avoidable hospital admissions among Pacific people.

372 See footnote 346.

373 <https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey>

the consistency and impact of primary health care for Pacific people. Improvements in the quality of primary health care will reduce attendance rates at emergency departments and avoidable hospital admissions among Pacific people. It is also worth noting that 'free' health care in hospitals will continue to be a factor influencing Pacific people's decisions about where to seek health care services.

Community-controlled primary health care

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

Ethnic-specific considerations

The assumptions of being Pacific

A generalised grouping of Pacific people and cultures can be misleading to a health practitioner treating them. This population has different cultures with similar but unique cultural beliefs. However, this population

is changing as a result of being born and raised in the multicultural environment of New Zealand, intermarriage and mixing of cultures and increasing education. It is important for health practitioners to be aware that generalisation can be misleading. Treat patients as individuals and verify any assumptions you may have based on their ethnic background. It is also important to be aware that a patient's sense of identity and self-knowledge may change over time.

Family structure

Family rather than individuals are the basic unit of organisation in Pacific society. 'Family' more often than not refers to nuclear and extended family, which can affect the interaction that one has with a patient. It is common for a patient to be seen with family during consultations, they may defer to family for decisions and consent can often involve a group rather than an individual decision-making process.

Holistic concept of health

Pacific society has a holistic concept of health where a combination of physical, mental, social and spiritual wellbeing contributes to an individual's wellbeing. Being able to contribute fully to one's family and community is paramount.

Older Pacific people who were born in the islands have a socioecological approach to health with strong spiritual dimensions to their beliefs about illness, healing, death and dying. Death, disease and disability are often attributed to the will of God and/or superior being. Mental disorders in particular are often regarded as possession by evil spirits or deceased relatives as retribution for wrongdoing by the affected individual or members of their family. As a result, health care practitioners often have difficulty understanding the apparent fatalism that can be seen in some Pacific patients. These beliefs can lead to much 'shopping around' with different health care practitioners, including traditional healers.

Attitudes to health and illness among younger members of the Pacific communities are less clear. It is likely that young people are less likely to hold traditional attitudes and views about health and illness.³⁷⁴

Respect and religion

Respect is very important in the Pacific culture especially of elderly and those with authority such as church ministers, politicians and health care professionals. It is not unusual for a patient to defer to their health care provider or elders in the family or church for important decisions about their health.

Spirituality, especially the Christian faith, is very important in most Pacific cultures, and this may influence their decisions on their health. Many patients will defer to their God being in charge and accept whatever their God has planned for them. It is important not to see this as a fatalistic attitude, and all options for treatment or management should be fully discussed as many will see the doctor as an extension of God's healing hands to help them.

While most Pacific adults are regular church attendees, an increasing proportion of young people are less religious in their outlook compared with their parents. The 2018 Census found an increasing number have no religion (17.5% in 2013 and 22.9% in 2018). For most Pacific people (68% are Christian), the church remains a significant influence on their lives and attitudes to health, illness, death and dying.^{375,376}

Traditional medicine

Traditional medicine is still commonly used by the Pacific population. These treatments are based on individual need, and there is no prescriptive treatment for conditions – individuals with the same or similar

374 See footnote 346.

375 See footnote 342.

376 See footnote 346.

conditions may be treated differently according to the healer's perception of the patient's need.

Treatment can involve massage, plant-based balms or applications, herbal concoctions or baths. It is important to be open about the possibility that traditional treatment may be used and accept that individuals may have made a choice to seek this treatment. Patients are more likely to discuss it if their health care provider is receptive and accepting of this treatment modality.

It is acceptable to respectfully challenge a treatment (by explaining your concerns) if you see that it is dangerous or interferes with successful treatment of a condition. However, if you accept that a traditional treatment is not going to cause any harm, it is useful to acknowledge that you are aware and accept their use of traditional treatment but encourage them to ensure that the Western medicine you are advising be used in conjunction. Compliance with Western medicine is likely to be better if the patient is given the permission to use both rather than one over another. Work with the patient/family on the best way to help them use both if they prefer.

Care of the older and disabled

Pacific people generally prefer to provide care for the older and disabled patients themselves. This is seen as the right thing to do and often keeps problems within the family as part of respecting the elderly. This can cause significant carer stress, which may not be discussed openly due to respect of the person being cared for. It is important to discuss and offer assistance if available, as often knowledge is the issue and families may take up varying options of assistance according to their needs and acceptance amongst their family.

Kava

Drinking kava is still a common practice amongst certain Pacific communities in New Zealand. It is estimated that more than 20,000 people drink kava on a Friday and Saturday night.³⁷⁷ This is largely a male activity, but in some cultures (such as Fijian), women also consume kava. This traditional root drink acts as a sedative and anaesthetic, slowing reactions and causing euphoria. Kava is not addictive and does not cause dependency. Kava is not picked up by alcohol breathalysers and it is not unusual for people to drive after consuming kava. Significant consumption over prolonged periods can cause an ichthyosis of the skin. There is some anecdotal evidence that kava causes some hepatotoxicity, but there is no clear evidence. It is important to discuss this as a possible cause of abnormal liver function tests, particularly in Pacific males.

Non-residents

Due to close proximity to the Pacific islands, there are a large number of this population who are not eligible for publicly funded treatment due to immigration status (visitors, overstayers and those with short-term work visas). Family will often bring family members from the Pacific islands to New Zealand to seek medical treatment for conditions unable to be diagnosed or treated in their home island. This can cause issues for the health professional providing care to these individuals as they are dependent on the individual and family to fund any treatment required. It is best to provide all management options including recommended gold standard investigation and treatment options with these patients in order to fully inform them of their options. Assumptions on what the family is willing and able to afford can often be misleading.

If these individuals need urgent/acute care, an admission to hospital for stabilisation should be arranged before non-acute/ongoing care options can be discussed. It is important to advise family that payment will be required following discharge.

377 <https://www.1news.co.nz/2018/03/27/kava-circles-reduce-alcohol-consumption-gang-affiliations-in-new-zealand-pasifika-youth/>

Tropical disease

Due to frequent travel to and from the Pacific islands, the risk of tropical disease remains high, and one needs to be aware and open to this when seeing patients with unusual symptoms. Ask about travel to the Pacific and any knowledge of any local illnesses that may have been present while they were there. Dengue fever, malaria, chickungunya and typhoid outbreaks are examples of tropical diseases that have occurred amongst this population in New Zealand as a result of this frequently travelling population.

Getting assistance

The Ministry of Health has a well-developed strategy for improving the health of Pacific people and funds service delivery by selected district health boards that serve large numbers of Pacific people. The key Ministry strategy is 'Ala Mo'ui – Pathways to Pacific Health and Wellbeing 2014–2018, which outlines government priorities, programmes and major contributors to health.³⁷⁸ Much of the actual service delivery and support for health care providers is funded and coordinated by selected DHBs, mainly in urban centres. Pacific teams in DHBs are well placed to provide an overview of service delivery in their districts and advise on how best to support health care professionals. In addition, there are several Pacific-owned health care providers in most urban centres throughout New Zealand. These providers have well-developed networks that can assist with advice and support.

The Pasifika Medical Association (PMA)³⁷⁹ is the leading Pacific organisation dedicated to improving the health status of Pacific people, both in New Zealand and the Pacific region. PMA has close ties with individual medical associations of the Pacific countries. Membership includes doctors, nurses,

378 <https://www.health.govt.nz/system/files/documents/publications/ala-moui-pathways-to-pacific-health-and-wellbeing-2014-2018-jun14-v2.pdf>

379 <http://pacifichealth.org.nz/>

other health workers and community leaders. PMA provides professional support to its members, delivers health workforce development in schools and advocates for better policies and services for Pacific people. Most of the senior and experienced clinicians of Pacific descent in New Zealand are members of PMA. Most Pacific nations also have associations and community groups with an interest in health such as the Tongan Nurses Association, Samoan Nurses Association and the Cook Islands Health Network.

The Medical Council has produced an excellent resource for clinicians working with Pacific patients with an emphasis on supporting the best outcomes for patients. The resource includes information on key concepts in Pacific societies that impact on health and health care provision and specific advice on how best to manage Pacific patients.³⁸⁰

Pacific Heartbeat at the National Heart Foundation has been providing information and training for health and community workers for several years. Its focus is on improving nutrition and physical activity as well as smoking prevention and cessation information service. The New Zealand Stroke Foundation has also established a Pacific Stroke prevention project dedicated to preventing stroke in Pacific communities.

The Medical Council has produced an excellent resource for clinicians working with Pacific patients with an emphasis on supporting the best outcomes for patients. The resource includes information on key concepts in Pacific societies

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380 See footnote 353.

CHAPTER 18

Asian people in New Zealand

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Introduction

Asian people were the third-largest ethnic groups in New Zealand, making up 15.1% of the New Zealand population (707,598) in 2018, compared to 11.8% (471,708) in 2013.³⁸¹ The Asian population is projected to grow to 1.03–1.16 million in 2028 and to 1.44–1.72 million in 2043.³⁸² The increasingly diverse immigration to New Zealand built momentum following the changes to immigration legislation in 1987 and 1991.

According to the 2018 Census, Chinese made up the largest ethnic group with 35% of the total Asian population, followed by Indian (33.8%). Other ethnic groups included Filipino, Korean, Japanese, Sri Lankan, Cambodian and Vietnamese. Of the Asian people living in New Zealand, only 23% were born in New Zealand. Some do not speak English.

This rapidity and diversity of Asian ethnic growth in New Zealand will impact on the host population health delivery system due to possible language and cultural barriers between clients, health workers and health services. For discussion on the use of the term 'Asian', please refer to the work by Rasanathan, Craig and Perkins.³⁸³

381 <https://www.stats.govt.nz/tools/2018-census-ethnic-group-summaries>

382 <https://www.stats.govt.nz/information-releases/national-ethnic-population-projections-2018base-2043>

383 Rasanathan, K, Craig D, Perkins R. The novel use of 'Asian' as an ethnic category in the New Zealand health sector. *Ethnicity and Health*. 2006;11(3):211–227.

Specific health needs of Asian patients

Asian people in New Zealand are very diverse in religion, culture, language, education and socioeconomic experiences. It is therefore difficult to generalise the health needs of Asian people in New Zealand as a whole, although there is a selection of published reports on the health needs of Asian people in New Zealand.^{384,385,386,387,388}

Whilst the Asian people in New Zealand are relatively healthy overall, much of this result is due to the so-called healthy immigrant effect. Most migrants need to be in good health to be allowed to immigrate to a new host country, and many have high socioeconomic status in their country of origin. These migrant groups also have high levels of education, which are associated with better health status. However, this positive effect on health gradually disappears with increasing length of residency in the new host country. Many high-priority health issues and unmet health care needs were identified:^{389,390,391}

- Asian ethnic groups, compared to European/other category, had higher age-standardised prevalence of diabetes, were less likely to be physically active and had lower proportions of people eating the recommended daily number of servings of fruits and vegetables.
- Asian women had low rates of cervical screening coverage.

384 Zhu A. New Zealand Asian mental health & wellbeing report 2020 – a snapshot survey. Auckland: Asian Family Services; 2020.

385 Scragg R. Asian health in Aotearoa in 2011–2013: trends since 2002–2003 and 2006–2007. Auckland: Northern Regional Alliance Ltd; 2016.

386 Walker R. Auckland Region DHBs Asian & MELAA: 2013 Census demographic and health profile. Auckland: Northern Regional Alliance (NRA); 2014.

387 Mehta S. Health needs assessment of Asian people living in the Auckland region. Auckland: Northern DHB Support Agency; 2012.

388 Rasanathan K, et al. A health profile of young Asian New Zealanders who attend secondary school: findings from Youth2000. Auckland: The University of Auckland; 2006.

389 See footnote 385.

390 See footnote 387.

391 Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. (2006). Racism and health: the relationship between experience of racial discrimination and health in New Zealand. *Social Science and Medicine*. 2006;63(6):1428–1441.

- Asian ethnic groups had lower and delayed access to disability services due to stigma and lack of awareness of available service options.
- Asian people were more likely to think constantly about their ethnicity, to have ever been a victim of an ethnically motivated verbal attack and to have experience of being treated unfairly because of their ethnicity.

Mental health issues including depression and psychosomatic illness are frequently encountered among Asian people, and they often have a complex interplay among social isolation (from migration), language barriers, underemployment or unemployment.³⁹² Stigmatisation and taboo of psychiatric illness compound the problem further, resulting in a reluctance by Asian people and their families to seek early intervention or treatment. Other mental health issues identified in New Zealand include problem gambling and alcohol abuse. Furthermore, the New Zealand Mental Health Commission's report on Asian mental health mentioned several specific concerns:³⁹³

- The high mental health needs of women and refugees from smaller ethnic communities.
- Mental health needs of older people.
- Refugees' pre-migration traumas and post-migration stressors in adapting to a new culture.

Primary health organisations (PHOs) are playing a pivotal role in New Zealand health care system. Every Asian must be advised to register themselves and their families with these organisations through individual general practices. However, PHO enrolment rates and health service utilisation in primary care were low among Asian people.^{394,395}

392 Asian Public Health Project Team. Asian public health project report. Asian Public Health Project Team: Auckland; 2003.

393 Ho E, Au S, Bedford C, Cooper J. Mental health issues for Asians in New Zealand: a literature review. Wellington: Mental Health Commission; 2002.

394 See footnote 387.

395 See footnote 388.

There are many known barriers to explain the lower health service utilisation among Asian people:^{396,397}

- Language barriers during encounters with health professionals and brochures and health service facility signs written in English for people who are unable to read English.
- Lack of awareness and knowledge of the New Zealand health system, confusion of the referral system by primary care practitioners for hospital assessment and treatment and frustration of perceived long referral waiting times and tendency for ‘doctor shopping’.
- Stigma and perceived lack of confidentiality, especially for disability and mental health issues.
- Lack of cultural competency among health professionals.

Refugee health

Refugees enter New Zealand under three categories – refugee quota, family reunification members and asylum seekers. All of these categories are health screened for immigration purposes. Primary health care plays a significant role as individuals with a refugee background may have had very limited health care in their respective countries before arriving in New Zealand. Conditions prevalent in their respective geographical zones include tuberculosis, malaria, hepatitis B carrier state and gastrointestinal infections.³⁹⁸

396 See footnote 387.

397 Anderson A. Understanding migrants’ primary healthcare utilisation in New Zealand through an ethnographic approach. *Diversity in Health and Social Care*. 2008;5(4):291–301.

398 Ministry of Health. *Refugee health care: a handbook for health professionals*. Wellington: Ministry of Health; 2012.

Ways to engage Asian migrant patients

In order to provide practical suggestions to engage Asian migrant patients, the following material will be useful as examples for those working with Korean and Chinese patients.³⁹⁹

Appreciate health beliefs

Chinese patients in general are very health conscious. The fundamental belief of good health among Chinese people is the ability to maintain a peaceful state of mind and to be in harmony with the surroundings. It stems from the philosophy that everything in this universe is interrelated and is forever changing with the life force/energy (known as qi) flowing through all matter continuously. Qi is the fundamental substance, and its movements

Chinese patients in general are very health conscious even though they appear to be less knowledgeable in human anatomy or the scientific basis behind Western medicine.

produce everything that constitutes the universe. The concept of yin and yang describes the dynamic and oscillating relationship of the flow of qi between these two extreme states. Yin represents cold, dark, inactive, negative and female-like energy, whereas yang represents hot, bright, active and male-like energy. Everything in the universe has an element of both yin and yang. On an individual level, good health is about having a balanced flow of qi between the yin and yang.⁴⁰⁰

An example of misunderstanding resulting from differences in health

399 Tse S, Lloyd C, McKenna K. When clients are from diverse linguistic and cultural backgrounds. In: McKenna K, Tooth L, editors. Client education: A practical guide for clinical therapists. Sydney: UNSW Press; 2006.

400 Yu ECL. Essential traditional Chinese medicine: Western scientific medicine perspective. Hong Kong Practitioner. 2001;23:20–27.

beliefs is the Chinese patient who says, “I have too much heat in my body.” From a Western medicine perspective, most doctors would tend to think that the patient is implying that they have a fever. However, it is often not the case, as the patient is trying to say they have too much yang in their body.

Understand health practices

Chinese patients often use folk medicine in the early stages of illness. In addition, self-medicating with Chinese medicine and consultation with a traditional Chinese medicine (TCM) practitioner and concomitant use of both Chinese and Western medicine is not unusual. It is also common for both Chinese and Koreans to be taking regular daily supplements such as vitamins, propolis, calcium supplements, green-lipped mussels and royal jelly. Therefore, it is important to seek a full drug and medication history, especially enquiring about the use of TCM or alternative health supplements. Chinese and Korean patients may often request injections as a route of drug delivery as they perceive it as a more potent route of drug delivery than the oral route.

A perceived imbalance of the yin and yang forces can be influenced by many factors including dietary intake. It is therefore common for a Chinese patient to ask the health practitioner about food avoidance in times of illness. For those health practitioners who are not familiar with the yin and yang concept, it would be best to advise the Chinese patient to seek dietary advice from a TCM practitioner.

Realise Asian people’s use of medication

Non-compliance to medication is an issue with any group of patients, including in Asian patients. Until recently, many Koreans have been used to easy access to most medications from their local pharmacy in Korea. Medicines like antihypertensive drugs and oral antibiotics were freely available, which may lead to resistance and misuse problems. Doctors in

New Zealand need to reinforce the correct use of medication and check for compliance at each visit. It is helpful to use medication cards with the name of medicine, times to be taken and treatment duration clearly stated on them.

Be aware of patients' expectations

The family doctor is a rather foreign concept as it is not common practice in many Asian countries for a patient to have a family doctor. When Asian people are unwell in their country of origin, they tend to present to the first available doctor or whoever is the most reputable in treating the condition. Walk-ins and self-referral to specialists are the norm. Medical consultations in many Asian countries could be relatively short in duration and conducted in a doctor-centred manner. Some Chinese patients are used to doctors who give quick and authoritative diagnosis, whereas many are used to asking for medical investigations and medicines that they want.

Many Chinese and Koreans are familiar with total body checks, which are screening tests and investigations performed in many hospitals across Asia. They will often ask for the same in New Zealand. Many are used to being investigated extensively and regularly with a comprehensive batch of routine and screening tests, including blood tests, X-rays, ultrasounds, CT and endoscopy of the gastrointestinal tracts. Many patients may become anxious at the perceived long waiting time for specialist appointments or investigations in New Zealand so they often travel to their country of origin for specialist appointments or investigations. Many may return with abnormal test results, which they expect their doctor in New Zealand to follow up. This is a common scenario, so advising them to bring back medical certificates or clinical summaries in English will assist with their ongoing medical care.

Doctors in New Zealand need to reinforce the correct use of medication and check for compliance at each visit. It is helpful to use medication cards with the name of the medicine, times to be taken and treatment duration clearly stated on them.

Despite patients' various expectations, the practice of patient-centred care model is crucial in the provision of good medical services. In short, it is important to seek patients' ideas, concerns and treatment expectations of their illness regardless of their ethnicity.

Have effective communication

Simple tasks such as making an appointment with a general practitioner can be a huge obstacle for some Asian patients with limited English proficiency. For example, when answering phone calls from Asian patients, it helps to speak clearly and in short simple English. Offer appointment times that are easy to understand – for example, 2 o'clock rather than 20 to 4. Asian patients with limited English proficiency will often make appointments through friends or family members.

Know your patients' names and dates of birth

Getting this right is tricky. When Asian people come to New Zealand, they often take on an English name. For some women, it is further complicated by taking on the husband's surname. This results in a possibility of three different but similar name versions for the one person. It is recommended that medical practices use the official name on the patient's passport for registration purposes.

Getting the date of birth right could also be tricky because some Koreans and Chinese people use two dates of birth – one according to the solar calendar and the other according to the lunar calendar. Therefore, it is important to clarify the correct date of birth information.

Work with guardians/support persons

Many Asian patients are used to having a guardian or support person with them in consultations, similar to the whānau in Māori culture. It is appropriate to allow the guardian/support person to accompany the patient into the consultation room. Be aware that the guardian/support

person often speaks on behalf of the patient, so do try to encourage the patient to speak for themselves.

Deal with sensitive issues

It has been suggested that Confucian teaching, which discourages open displays of emotions in order to maintain social and family harmony, is contributing to the high rate of psychosomatic illness among Chinese patients. Regardless of the reason, sensitivity and tact are important when dealing with the psychosocial aspect and sensitive issues like suspected abuse. Marital status is another sensitive topic. Some Asian patients may feel uncomfortable answering questions on marital status if they are divorced. A useful question in a respectful manner may be “Who lives at home with you?” rather than “Are you married?”

Working with interpreters

For Asian people with limited English proficiency, this can be an anxiety-provoking experience. They are faced with putting their trust in a health professional with a different language and culture to their own. Thus, it is vital to employ a trained interpreter. In reality, the use of trained interpreters at every single health care encounter is often not possible due to lack of access and cost.^{401,402} Hence, friends and family members are frequently used as default interpreters.

Some doctors are more experienced than others at adjusting their consultation style in the presence of an interpreter. Some may feel uncomfortable when facing patients with little or no command of English. Many may feel less culturally competent in understanding the patient’s health beliefs.

401 Chan I, Lloyd T, Tong K. The use of interpreters by South Auckland GPs. *New Zealand Family Physician*. 1999;26:52–56.

402 Gray B, Hilder J, Stubbe M. How to use interpreters in general practice: the development of a New Zealand toolkit. *Journal of Primary Health Care*. 2012;4(1):52–61.

No doctor is expected to be fully competent in the many Asian cultures that exist in New Zealand. The key is to approach Asian patients with genuine concern and interest. Non-verbal messages and reassurance like smiles and good eye contact along with a clear tone of voice go a long way to establish good rapport. Sentences should be short, in simple English and not spoken too quickly. Longer consultation time may need to be considered when using an interpreter.

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

No doctor is expected to be fully competent in the many Asian cultures that exist in New Zealand. The key is to approach the Asian patients with genuine concern and interest.

Introductions/briefing

It is important for the interpreter to be briefed as to the problem or the context of the consultation. This will enhance the quality of the interpretation. In an ideal situation, the doctor might like to find out some do's and don'ts of the particular Asian culture before the consultation. For example, the colour red is good luck in China but bad luck in Korea. Number 4 is symbolic of misfortune and death in both cultures.

Agreement on type of interpreting

In the medical setting, it is recommended that the doctor speaks in one or two sentences followed by interpretation. Interpreting long sentences is less conducive to the flow and understanding of the consultation.

Seating arrangements

Where possible the doctor, patient and interpreter should be seated in a triangle formation with the doctor and the patient sitting in direct and full view of each other. The interpreter should be seated in between the doctor and the patient, slightly out of view from both. The doctor

should look and talk directly to the patient instead of talking through the interpreter.

Interpreter services are being made available to Asian migrants from non-English speaking backgrounds at PHO level. Further enquiries can be made at the local practices.

Conclusions

Asian people in New Zealand are very diverse in religion, culture, language, education and socioeconomic experiences. Whilst Asian people in New Zealand are relatively healthy overall, there are many important health issues and unmet health care needs. Mental health is a challenging area because of the degree of stigma attached to such illness in many Asian cultures. The cultural beliefs of Asian people's countries of origin still prevail in their initial settlement period. No doctor is expected to be fully competent in the many Asian cultures that exist in New Zealand. The key is to approach Asian patients with genuine concern and interest. The use of interpreters is important to communicate effectively with Asian people with limited English proficiency.

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CHAPTER 19

Working with interpreters

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Introduction

Increasing numbers of New Zealand residents are born overseas – the percentage has increased from 17% in 1996 to 27.4% in 2018 (41.6% in Auckland). The Asian ethnic group is now 15% of the population (28% in Auckland). The proportion of people from non-English-speaking backgrounds is also increasing. People of Chinese origin are the second-most common group of migrants after those of English origin, and Samoan, Mandarin and Hindi are the most widely spoken languages in New Zealand after English and Māori. New Zealand has three official languages – New Zealand Sign Language (23,500 users), English and Māori.⁴⁰³

Right to communication

Right 5 of the Code of Health and Disability Services Consumers' Rights 1996 (effective communication) includes a right to a competent interpreter.⁴⁰⁴ Without an interpreter, many of the other patient rights are not available to a person with limited English proficiency (LEP).

Right 5 of the Health and Disability Commission's Code of Patient Rights (effective communication) includes a right to a competent interpreter

Interpreting and translation

Language translation is the process of converting the written word from one language into another language in a way that is culturally and linguistically appropriate so it can be understood by its intended audience.

An interpreter's job is to facilitate communication between two people who speak different languages, whether the conversation takes place over the phone, in person or via video conference.

403 <https://www.stats.govt.nz/tools/2018-census-place-summaries/new-zealand>

404 See footnote 146.

Whilst both roles require bilingualism, they tend to be quite different professions. Interpreters work in the moment (at conferences, they interpret simultaneously) and need considerable skills to remember all that is said and to render it in the target language accurately. Translators have time and the ability to access many reference materials to develop the most accurate translation that conveys the intent and nuance of the subject language into the target language. Consultations are interpreted, while educational materials are translated.⁴⁰⁵

Is any interpreter satisfactory?

Accurate complete interpreting is a difficult professional job that requires significant training. In addition, good interpreting is founded on trust. The patient must trust the interpreter to hold any information confidential and trust them to accurately interpret their communication, and the doctor has to trust the interpreter to be accurate and to signal if there are any doubt as to how a phrase should be translated. The further apart culturally two languages are, the more likely that concepts do not translate. For example, there is no equivalent term to schizophrenia in Somali.⁴⁰⁶ It requires significant practice to be able to recall all that is said in English and then accurately translate it into another language.

It is common practice for clinicians to use ad hoc interpreters – family members, friends or bilingual colleagues – to aid communication with LEP patients. Table 2 lists the important linguistic and ethical problems with this approach. It is very hard for the clinician to judge the adequacy of interpretation.

405 <https://blog.languageline.com/explaining-the-difference-between-language-translation-and-interpretation>

406 Carroll JK. Murug, waali, and gini: Expressions of distress in refugees from Somalia. *Primary Care Companion to The Journal of Clinical Psychiatry*. 2004;6(3):119–125.

Table 2. Problems using ad hoc interpreters.

Linguistic problems	Ethical problems
<ul style="list-style-type: none">• Accuracy of interpreting• Degree of English fluency• Unfamiliarity with medical terms• Incomplete interpretation• Adding in advice or opinion of interpreter	<ul style="list-style-type: none">• Confidentiality• Difficulty with talking about sensitive matters• Role conflict (for example, abusing husband interpreting for abused wife)• Disrupting family dynamics – in particular, the use of young children as interpreters for their parents is unacceptable

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

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

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

- Complexity of anticipated clinical content.
- Language ability of the patient.
- Language ability of available ad hoc interpreter.
- Degree of ethical risk – for example, is the patient vulnerable with mental health issues? Is the available ad hoc interpreter a child? Does the available ad hoc interpreter have a position of power over the patient?

- Sensitivity of clinical content – for example, gynaecology, family discord.
- Legal need for informed consent.
- Urgency of presentation – in an emergency, use the best available.
- Wishes of the patient.
- Ability to pay for an interpreter.

Every doctor must have the ability to employ a professional interpreter if caring for an LEP patient.

If a patient has LEP, there will be times when adequate care cannot be provided without a professional interpreter.

Professional interpreter: telephone versus video versus in person

Many organisations preferentially use telephone interpreting and anecdotally some video rather than in person, predominantly because of cost issues.

Table 3 contrasts the risks and benefits of telephone and face to face interpreting.

Table 3. Comparing telephone and face-to-face interpreting.

	Telephone interpreter	Video	In-person interpreter
<ul style="list-style-type: none"> • Benefits 	<ul style="list-style-type: none"> • Anonymity of interpreter • Availability (for smaller language groups or at short notice) • Cheaper 	<ul style="list-style-type: none"> • Intermediate between phone and in-person interpreter in ease of communication • Not anonymous but can be from different city • Cheaper 	<ul style="list-style-type: none"> • Relative ease of communication including non-verbal • Easier if needing to consult with a family group • Easier if doing a psychiatric assessment
<ul style="list-style-type: none"> • Disadvantages/risks 	<ul style="list-style-type: none"> • Distancing effect of the phone • Possible background noise • Difficulty in gauging quality of interpreter • Lack of continuity (more likely) 	<ul style="list-style-type: none"> • Quality of connection can be a problem • Confidentiality harder to be sure of (other people in the patient’s room) 	<ul style="list-style-type: none"> • Possible issues with confidentiality/comfort if the patient and interpreter are socially acquainted or part of a small ethnic community • More costly

Computerised translation applications

Computerised translation (written language) and interpreting (spoken language) applications have the advantage of ready availability and no cost. Accuracy is better if the language pair are closely related (for example, French and English) but much worse if they are unrelated. In a recent study of translating medical phrases, only 60% overall were correct,

with 4% having serious errors.⁴⁰⁷ The field is developing quickly, and for some language pairs, there is significant improvement.⁴⁰⁸

Use of a computer application is better than nothing, but it is difficult to assess accuracy, and even slight discrepancies in translation can lead to important misunderstandings. Importantly, even the most accurate automated translation system can at best render only literal meanings – this technology cannot take account of meanings that could otherwise be inferred from aspects of the context or interaction or from knowledge of intercultural differences. Issues of confidentiality are not transparent, and of course using such applications requires typing or speaking language into a computer. The patient may not be literate in their own language.

Organisational systems required to care for LEP patients

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

- Routine collection of ethnicity, preferred language and need for interpreter data on registration.
- Organisational policy on use of interpreters.
- Provision of a budget for employing interpreters.
- Register kept of available interpreters or a contract with an interpreter service.
- Speaker phones available (telephone interpreters are commonly used and most available).
- Dual-screen computer stations to enable video consultation whilst using computer records.

407 Khoong EC, Steinbrook E, Brown C, Fernandez A. Assessing the use of Google Translate for Spanish and Chinese translations of emergency department discharge instructions. *JAMA Internal Medicine*. 2019;179(4):580–582.

408 <https://www.technologyreview.com/s/602480/googles-new-service-translates-languages-almost-as-well-as-humans-can/>

- Portable tablet computers/phones for video consultations on the wards.
- Staff training on managing LEP patients including reception and administration staff.
- Look at all communications from the organisation to patients through the eyes of an LEP patient. Do any of them need translating?
- Patient safety incident management system flagging when language barrier may have been a factor.

Skills required

Any clinician new to working with interpreters would benefit from basic training in the skills required for this. An online e-module ‘Working with interpreters for primary care practitioners’ is available at www.otago.ac.nz/working-with-interpreters.

Assessing English fluency

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

Even if someone has sufficient English for conversation at work, they may still have insufficient English for discussing or fully understanding complex health issues.

Working with an interpreter

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

- Speak as if you are talking to the patient – “How do you feel? not “How does she feel?”
- Sit in an equilateral triangle so the patient, doctor and interpreter can easily see each other.
- Speak in small chunks. The longer you speak without a break for interpreting, the harder it is to interpret accurately.
- Use illustrations where possible.
- Try to explain medical concepts in simple language, and avoid the use of jargon.
- Avoid colloquialisms. Jokes are often hard to explain and risk being misunderstood.

Working with a family member interpreter

There will be times when clinicians choose to work with a family member as an interpreter rather than a professional interpreter.⁴⁰⁹ This requires a number of additional skills to those needed for professional interpreters:

- You may need to coach the family member by explicitly asking them to interpret everything the patient says. This is more likely to happen if you speak in very short chunks.
- Simplifying the language is even more important, and you will need to continually assess whether the family member understands what you are saying in English.
- When working with a professional interpreter, the normal practice would be to face the patient as you speak (rather than the interpreter). This may require some adjustment when working with a family member.

409 Hilder J, Gray B, Dowell A, Macdonald L, Tester R, Stubbe M. ‘It depends on the consultation’: revisiting use of family members as interpreters for general practice consultations – when and why? *Australian Journal of Primary Health*. 2016; 23(3):257–262.

Communicating with deaf people

Past prohibition of the use of sign language in schools means that there are significant numbers of deaf people with low levels of literacy. Written communication in English (or another spoken language) is not a suitable or reliable substitute for communicating with many deaf people.

If you have deaf people in your practice, there is a detailed guide on managing this at www.odi.govt.nz/nzsl/tools-and-resources.

For details about finding an NZ Sign Language interpreter, go to www.healthnavigator.org.nz/languages/n/nz-sign-language-interpreters.

Funding for interpreters

All public hospitals in New Zealand have policies and a budget for the use of interpreters, although anecdotally the budgets are constrained.

Availability of professional interpreters

Any public sector organisation (does not include GP services) can join the subsidised New Zealand Government Telephone/Video Interpreting Service available 24/7 in over 180 languages and the Face-to-Face Interpreting Service – see www.mbie.govt.nz/cross-government-functions/language-assistance-services.

The three Auckland district health boards have a fully funded primary care interpreting service – see www.adhb.health.nz/patients/patient-support/interpreter-services (Auckland) or www.asianhealthservices.co.nz/Watis-Interpreting-Service (Waitemata).

Many PHOs provide some funding through Services to Improve Access funding and have contracts with interpreting providers.

Interpreting New Zealand provides interpreters in 80 languages from Wellington, Nelson, Christchurch and Dunedin face to face and by telephone to other regions – see www.interpret.org.nz.

Decypher provides interpreters in over 50 languages in Waikato – see www.hmstrust.org.nz/decypher-interpreting-and-translation.

The New Zealand Society of Translators and Interpreters keeps a database of interpreters – see www.nzsti.org.

Uptake of professional interpreters is poor

Two New Zealand studies document that the use of interpreters is inadequate and that clinical harm is likely to be happening as a result of impaired communication.^{410,411} Cost can be a significant barrier to using professional interpreters. Doctors working for organisations who care for LEP patients where there is no budget for interpreters have a responsibility to lobby for funding to be found.

However, even if the service is free, there can be a low uptake. This has particularly been noted in Australia where, despite the availability of a comprehensive free interpreting service, uptake is significantly lower than anticipated.⁴¹²

The main identified barriers to uptake identified were training of clinical staff and particularly training and attitudes of reception staff.⁴¹³ A toolkit has been developed for use in primary care in New Zealand to address this need.⁴¹⁴

410 Gray B, Hilder J, Donaldson H. Why do we not use trained interpreters for all patients with limited English proficiency? Is there a place for using family members? *Australian Journal of Primary Health*. 2011;17(3):240–249.

411 Gray B, Stanley J, Stubbe M, Hilder J. Communication difficulties with limited English proficiency patients: clinician perceptions of clinical risk and patterns of use of interpreters. *New Zealand Medical Journal*. 2011;124(1342):23.

412 Phillips CB, Travaglia J. Low levels of uptake of free interpreters by Australian doctors in private practice: secondary analysis of national data. *Australian Health Review*. 2011;35(4):475–479.

413 Huang Y-T, Phillips C. Telephone interpreters in general practice – bridging the barriers to their use. *Australian Family Physician*. 2009;38(6):443–446.

414 See footnote 402.

Summary

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

Acknowledgement

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CHAPTER 20

Assurance of fitness and competence to practice

David Dunbar is the Registrar of the Medical Council.

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The Council's role under the Health Practitioners Competence Assurance Act 2003

The regulation of health practitioners in New Zealand is governed by the Health Practitioners Competence Assurance Act 2003 (the Act). The principal purpose of the Act is to protect the health and safety of the public by establishing mechanisms to ensure that health practitioners are competent and fit to practise their professions. The Act provides the framework for the policies, procedures and standards applied by the Medical Council of New Zealand to the regulation of doctors.

The principal purpose of the Act is to protect the health and safety of the public by establishing mechanisms to ensure that health practitioners are competent and fit to practise medicine.

The intention of the Act is to ensure consistency, transparency and efficiency in the regulation of health practitioners. In establishing policy to give effect to the mechanisms in the Act, the Council ensures that the principles of natural justice are applied, with the Council striving to balance the need for standards-based regulation and accountability of doctors with the desire to maintain professional autonomy.

The Act sets out a number of important functions that the Council is required to perform. These, include:

- determining scopes of practice and qualifications required for registration
- accrediting colleges,⁴¹⁵ medical schools and clinical attachments (see Chapter 26 – Medical Council of New Zealand)
- registering doctors in a scope of practice
- requiring doctors applying for registration to satisfy the Council of their competence and fitness for registration before registration is granted

415 For each vocational scope of practice, the relevant medical college is accredited to provide a training programme resulting in the awarding of an approved postgraduate qualification.

- setting standards of ethical conduct, clinical competence and cultural competence (including competencies that will enable effective and respectful interaction with Māori)
- receiving information that raises concerns about a doctor’s practice, conduct or competence and, if appropriate, acting on that information
- conducting competence reviews (performance assessments) and requiring programmes for upskilling or retraining of doctors who are not practising at the required standard of competence
- receiving notifications of any mental or physical conditions affecting the fitness of a doctor to practise medicine (see Chapter 7 – Doctors’ health)
- promoting and facilitating inter-disciplinary collaboration and cooperation in the delivery of health services.

Registration

Under the Act, health practitioners must apply for registration in one or more scopes of practice defined by the relevant regulatory authority. For the Council, this has meant breaking down the practice of medicine in New Zealand into a number of scopes of practice – each scope defining specific aspects of the practice of medicine and the health services that a doctor registered in that scope are permitted to provide. Doctors practising in New Zealand are required to be registered with the Council in one or more relevant scopes of practice.

In addition, for each scope of practice it establishes, the Council must prescribe⁴¹⁶ the qualification(s) required to be held by a doctor wishing to be registered in that scope of practice. These prescribed qualifications vary across the different scopes of practice. In many cases, a prescribed

⁴¹⁶ Section 12(2) of the Act lists the aspects that may form part of a prescribed qualification, which include training, educational qualification and experience.

qualification is an identified medical degree or fellowship of a medical college. In other cases, the Council requires a combination of a medical degree and additional training or approved experience. Those elements, taken together, are treated as the qualification. In such cases, a doctor seeking registration will be required to satisfy all the required elements before they will be recognised as holding the prescribed qualification.

In summary, to qualify for registration, a doctor must:

- have a relevant prescribed qualification for the scope of practice in which they seek to be registered
- be competent to practise in that scope of practice
- satisfy a number of requirements relating to their fitness for registration.

In assessing an application, the Council may consider placing one or more conditions on a person's scope of practice. In the context of registration, such conditions are not a response to an identified competence, conduct or health concern. Rather, they are used to facilitate registration by allowing the Council to modify the scope of practice in that individual case and enable a doctor to be registered in a practice context that best corresponds to the areas that the doctor has previously worked in or been formally assessed in. Conditions may also record a requirement for a period of supervision in a specified position or identify an examination that must be passed to enable the removal of any limitations on the doctor's registration.

Once a doctor is registered, their authorised scope of practice is entered on the publicly available medical register, along with any conditions.

Practising certificates

A doctor must hold a practising certificate to work in New Zealand. The practising certificate is valid for a period of time up to 1 year. The certificate records the doctor's registered scope(s) of practice and any conditions (if applicable). The certificate will specify the period for which it has been issued and may also, on occasion, record the place of work and any supervision requirements.

A doctor must hold a practising certificate to work in New Zealand.

Scopes of practice

General scope of practice (and provisional general scope of practice)

New Zealand and Australian medical graduates who have completed their internships in New Zealand or Australia are eligible for registration in the general scope of practice.

International medical graduates who apply for registration within New Zealand in the general scope of practice must first obtain registration in the provisional general scope of practice and practise for a minimum period. This allows the Council to determine whether a doctor is able to work at the required standard in the New Zealand health system.

Doctors registered in the provisional general scope of practice are required to work satisfactorily under supervision in an approved position or positions for 6–12 consecutive months to qualify for registration in the general scope of practice. Once the doctor has satisfied the conditions required under their provisional general scope of practice, they can then apply for registration within the general scope of practice.

Vocational scopes of practice (and provisional vocational scopes of practice)

The vocational scopes of practice are the scopes for specialised medical practice. There are currently 35 different scopes of practice in the vocational pathway. Each scope has an associated accredited postgraduate training programme and postgraduate qualification.⁴¹⁷

Once they obtain general registration, doctors are able to enter a college training programme and work towards being awarded a postgraduate qualification – a college Fellowship.

An alternative route to vocational registration is available to international medical graduates who hold a postgraduate qualification and wish to apply for registration within a vocational scope practice. They must first be eligible or become registered within a provisional vocational scope of practice. The Council seeks advice from the branch advisory bodies when determining whether the doctor has training, qualifications and experience equivalent to or as satisfactory as that of a New Zealand trainee, and the Council considers this advice in making its final decision.

Special-purpose scopes of practice

The Council provides special-purpose scopes of practice for short-term registration. All of these pathways are limited in duration and are for defined purposes. The two most common special-purpose scopes of practice allow doctors to work in locum roles and to undertake postgraduate training.

Under the second of these, doctors may work as a postgraduate trainee registered in a special-purpose scope of practice for a maximum of 2 years. This pathway to registration is specifically designed to allow international medical graduates to work in New Zealand and gain skills and experience that they can take back to their country of origin.

⁴¹⁷ The Council has a system of accrediting and reaccrediting the postgraduate training and recertification programmes associated with each vocational scope.

Other special-purposes scopes of practice provide registration options for doctors wishing to teach, conduct research, provide teleradiology in New Zealand or assist in an emergency or pandemic scenario in New Zealand.

Recertification

While practising in New Zealand, all doctors must meet ongoing recertification requirements. These requirements broadly fall into two sets of requirements. For the general scope of practice, there are a range of requirements that include maintaining a collegial relationship, participation in clinical audit, peer review and continuing medical education. Within a vocational scope of practice, doctors must participate in an approved recertification programme.

While practising in New Zealand, all doctors must meet ongoing recertification requirements.

Professional standards

Competence and performance

The Act allows the Council to review the competence of a doctor to practise medicine at any time, whether or not there is a reason to believe the doctor's practice may be deficient. Commonly, however, such reviews follow formal notification to the Council of potential competence concerns. The Act refers to the "required standard of competence" as the standard reasonably to be expected of a doctor practising within the doctor's scope of practice. The assumed ability to practise well is not enough. The assessment also needs to show whether the doctor is actually practising well. A competence review (also known as a performance assessment) is a broad-based assessment of how the doctor is practising and is, as a minimum, intended to be educative. If, following the assessment, the Council has reason to believe that the doctor does not

meet the required standard of competence, the Council must make one or more of the following orders:

- That the doctor undertakes a competence programme.
- That conditions be placed on the doctor's scope of practice.
- That the doctor sits an examination or assessment.
- That the doctor is counselled or assisted by a named person.

Conduct

The Act enables the Council to appoint a professional conduct committee (PCC) to investigate a complaint or investigate the circumstances of offences committed by doctors. There are three sources for referrals to a PCC.

Convictions

If a doctor is convicted of an offence punishable by imprisonment for a term of 3 months or more, the Council will be notified. This is regardless of the actual sentence ordered by the Court. The Act provides the Council with two pathways to address the conviction. Where the Council considers the offence may reflect an underlying health condition, the Council is able to order that the doctor undergo an examination or course of treatment or therapy. The Council may, however, only make such an order if the doctor consents. If the doctor does not consent or if the Council chooses not to adopt this health-related option, the Council is required under the Act to refer the matter to the PCC for an investigation.

Referrals from the Health and Disability Commissioner

If the Health and Disability Commissioner⁴¹⁸ formally refers a notification to the Council, the Council must promptly assess the complaint and may decide to refer the complaint to a PCC.

418 The Office of the Health and Disability Commissioner was created under the Health and Disability Commissioner Act 1994 to promote the rights of health and disability services consumers and facilitate the fair, simple, speedy and efficient resolution of complaints.

Importantly, any “complaint alleging that the practice of conduct of a [doctor] has affected a health consumer” the Council receives directly must first be promptly forwarded to the Health and Disability Commissioner.⁴¹⁹ The Council is not able to consider referral of the matter to a PCC until the Commissioner informs the Council that:

- the matter is not being investigated by the Commissioner or
- the matter has been resolved by the Commissioner or
- the Director of Proceedings⁴²⁰ will not be considering or proceeding with the matter.

Concerns about conduct or safety of practice

The Council has residual power to refer the matter to a PCC if the Council considers that information in its possession raises one or more questions about the appropriateness of the conduct of the safety of the doctor’s practice. This can include breaches of standards of cultural and clinical competence and ethical conduct set by the Council. These standards may be used by the Health Practitioners Disciplinary Tribunal, the Council and the Health and Disability Commissioner as standards against which a doctor’s conduct is measured.

After considering a case, the PCC may make a number of recommendations to the Council, including recommending that the Council review a doctor’s competence or fitness to practise or scope of practice (including placing conditions on their scope of practice) and in some cases referral to Police. The PCC may, alternatively, make its own determinations, independent of the Council. These include laying a charge before the Health Practitioners Disciplinary Tribunal.

419 Health Practitioners Competence Assurance Act 2003, section 64(1).

420 The Director of Proceedings (DP) is a lawyer appointed under the Act. When the Commissioner has found a breach of consumer rights, they may refer the provider to the DP. The DP reviews the case and makes an independent decision on whether or not to take any further action.

Interim suspension or imposition of conditions

In association with a review of a doctor's competence or conduct, the Council has power, in more serious cases, to suspend a doctor's right to practise or impose conditions on a doctor's scope of practice for an interim period. The processes differ depending on whether the core concern relates to matters of competence or conduct.

However, in either situation, the Council adheres to natural justice principles and the specific provisions in the Act. The Council must first propose its decision and give the doctor the opportunity to provide submissions and be heard by the Council before finalising any proposed interim suspension or conditions. An exception to the requirement to give notice of a proposal exists where the Council considers the alleged conduct poses a risk of serious harm.

Competence

Where a doctor's competence is being or has been reviewed and the Council considers it has reasonable grounds for believing the doctor poses a risk of serious harm to the public by practising below the required standard of competence, the Council may impose conditions or suspension. The conditions or suspension will remain in effect until the performance assessment is completed or the doctor has passed an examination or assessment required by the Council.

Conduct

Where a matter has been referred to a PCC, the Council may also impose conditions or suspension where the Council believes on reasonable grounds that the alleged conduct casts doubt on the appropriateness of the doctor's conduct in their professional capacity. This power is not limited to matters referred to a PCC. The power also applies where the alleged conduct is being investigated by the Health and Disability Commissioner or is relevant to a criminal proceeding pending against the doctor.

As noted above, the Council must first give the doctor notice of any proposal to impose conditions or suspension on these grounds. In exceptional cases, however, the Council may act without notice to suspend a doctor's practice. Where questions over a doctor's conduct have been referred to a PCC or are subject to criminal proceedings or a Health and Disability Commissioner investigation and the Council believes the alleged conduct raises a risk of serious harm, the Council may, without notice, suspend the doctor's practice. The Council must, however, give the suspended doctor an opportunity to make submissions and be heard within 20 working days of the ordering of the suspension. The Council may, at that point, revoke the suspension but may choose alternatively to impose conditions on the doctor's practice.

Health Practitioners Disciplinary Tribunal

The Tribunal hears and determines charges brought by a PCC or by the Director of Proceedings. The main purpose of the Tribunal is to protect the health and safety of the public by ensuring that doctors conform to standards reasonably expected from them.

A doctor can be found guilty of professional misconduct or have a range of other findings made against them. Professional misconduct can be found to have arisen from an act or omission that the Tribunal considers amounts to malpractice or negligence in relation to the doctor's registered scope of practice or that the Tribunal concludes has brought or was likely to bring discredit to the medical profession. The Tribunal might also find that the doctor:

- has been convicted of an offence that reflects adversely on their fitness to practise
- has practised their profession while not holding a current practising certificate
- has performed a health service that forms part of a scope of practice of the profession in respect of which they are or were

registered without being permitted to perform that service by their scope of practice

- has failed to observe any conditions included in the practitioner's scope of practice
- has breached an order of the Tribunal under section 101 of the Act.

Should the doctor be found guilty, the gravity of the doctor's offence is reflected in the nature of the penalty imposed by the Tribunal.

Penalties could include the cancellation of a doctor's registration, suspension for a period of up to 3 years, imposition of conditions and a fine not exceeding \$30,000. If ordering cancellation of a doctor's registration, the Tribunal may fix a date before which the doctor may not apply for registration again. Under section 102 of the Act, the Tribunal may also impose one or more conditions that the doctor must satisfy before being able to apply for registration.

Decisions of the Tribunal may be appealed to the High Court. The High Court decision is final and can only be appealed to the Court of Appeal on points of law.

CHAPTER 21

How medical practice standards are set and maintained: other legislation

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Introduction

Every medical intervention, no matter how carefully conducted, has some level of risk including the possibility of error or complications. Where there is risk, governments tend to pass laws to protect the public. Many of these laws have a direct impact on how you practise medicine. Some grant you protections and powers, and others place limits on what you can do. It is important that you have a basic understanding of these laws and how they impact your practice.

Other chapters in this book deal with specific areas of medical law in detail. The Council also has a number of statements that discuss how aspects

If you are unsure about something, ask a colleague or an adviser from your indemnity insurer.

of the law apply in particular situations.⁴²¹ This chapter aims to provide a brief overview of laws not covered elsewhere in this book and discuss how they may be applicable to your practice. Law is complex, and this chapter is unlikely to answer all your questions. If you are unsure about something, ask a colleague or seek advice from your indemnity insurer.

The Acts and Regulations mentioned below can all be read online at www.legislation.govt.nz.

Prescribing medicines

The Medicines Act 1981, the Misuse of Drugs Act 1975 and the Medicines Regulations 1984 provide controls over the manufacture, storage, prescribing, dispensing and advertising of medicines. Medicines Control, a regulatory team within the Ministry of Health, oversees the local distribution chain of medicines and controlled drugs within New Zealand.⁴²² The Council has also issued a statement on good prescribing practice⁴²³ that references these laws and expectations when you prescribe.

Good prescribing practice

There are legal restrictions when you issue prescription medicines. In particular, while a doctor can generally prescribe from the full range of approved medicines, that doctor is only permitted to prescribe for a patient “under that doctor’s care” and “within and in accordance with all conditions (if any) stated in, [his or her] scope of practice...”.⁴²⁴

Your prescriptions must be “legibly and indelibly printed” and include:

- your signature (not a facsimile or stamp)
- the date

421 Refer to Appendix A.

422 Licensing enquiries – (04) 816 2579 or (04) 816 2444. Drug abuse containment enquiries – 0800 163 060 or (04) 496 2437.

423 See footnote 228.

424 Medicines Regulations 1984, regulation 39.

- your full name and your address
- the name and address of the person for whom the prescription is given (and date of birth if they are a child under 13 years)
- the name and strength of the medicine
- the total amount to be dispensed
- dose and frequency (and method of delivery in some cases)
- the number of occasions on which it may be supplied
- the interval between each date of supply
- the period of treatment.⁴²⁵

You should also include your contact phone number and medical registration number.

Prescriptions for some controlled drugs must be written on a prescribed form and require additional information.⁴²⁶

You must comply with these requirements unless under regulation 43 the Director-General of Health has formally issued a waiver relating to regulation 41. The waiver allows a prescription to be unsigned if:

- it has an NZePS (New Zealand ePrescription Service) barcode
- it is downloaded at the pharmacy
- it is for non-controlled drugs
- it is generated by a system authorised for signature exempt prescriptions by the Ministry of Health.

Ensure that your prescriptions include all the information needed for appropriate dispensing and compliance with subsidy requirements. Avoid using any abbreviations that could be misinterpreted. Mistakes, missing information or illegibility can have serious consequences. Unless there is a waiver or dispensation, prescriptions should not be issued by email or

⁴²⁵ Medicines Regulations 1984, regulation 41.

⁴²⁶ Misuse of Drugs Regulations 1977, regulation 29.

other electronic means.⁴²⁷ Prescriptions may be communicated orally to a pharmacist who knows the doctor, but only in cases where a medicine is needed urgently. In such cases, the written prescription confirming the oral communication must be forwarded to the pharmacist within 7 days.⁴²⁸

Approved medicines and their uses are outlined in MIMS New Ethicals.⁴²⁹ If you prescribe an unapproved medicine (or a medicine for a purpose that has not been approved), you should inform the patient of this and be honest about the evidence for that particular medicine and any safety concerns. You are also required to pass certain details relating to the supply of that medicine to the Director-General of Health.⁴³⁰

The Medicines Act and Regulations are currently under review, and the requirements could change under the new Therapeutic Products legislation. We will inform you of any relevant changes, and update Good Prescribing Practice to incorporate any change to prescribing laws.

Medication with a risk of addiction or misuse⁴³¹

The Misuse of Drugs Act classifies some medicines as controlled drugs and further classifies these according to the risk of harm they pose. Class A controlled drugs are very high risk (for example cocaine, heroin and methamphetamine), and these can only be prescribed in rare circumstances. Class B controlled drugs (high risk) include cannabis, methadone and morphine, while Class C controlled drugs (moderate risk) include codeine, diazepam and temazepam.

Inappropriate prescribing of medication with a risk of addiction or misuse is clinically and ethically unacceptable. It is usually also against the law. In

427 Unless special dispensation has been obtained. Contact the Ministry of Health for information on how to obtain such dispensation.

428 Medicines Regulations 1984, regulation 40A.

429 Subscription details are available from www.mims.co.nz or 0508 464 676.

430 Refer to Rights 6 and 7 of the Code of Health and Disability Services Consumers' Rights and to the advice provided by Medsafe at www.medsafe.govt.nz/profs/RISS/unapp.asp. See also footnote 228 – 'Prescribing unapproved medicines'.

431 See footnote 228 – 'Prescribing medication with a risk of addiction or misuse'.

particular, it is illegal to prescribe controlled drugs to a person deemed a “restricted person” by a medical officer of health.⁴³² If you prescribe medication that has the potential for addiction or misuse, be aware of any restricted persons living in your area. Lists of restricted persons are maintained through prescriber updates and peer-review processes. If you are unsure about the appropriateness of a request for certain medicines, especially controlled drugs, discuss your concerns with Medicines Control (0800 163 060).

Section 48 of the Medicines Act 1981, section 23 of the Misuse of Drugs Act 1975 and the Health Practitioners Competence Assurance Act 2003 empower the Medical Council to inquire into a doctor’s prescribing to determine whether that doctor is prescribing inappropriately.⁴³³ If the Council has concerns, it can recommend that the Minister of Health prohibit a doctor from prescribing all or specific classes of prescription medicines.

It is an offence to prescribe, administer or supply a controlled drug to a person you believe is reliant on that drug for the purpose of treating dependency, unless you are an authorised person (or working for an authorised facility).⁴³⁴

If you hold or dispense controlled drugs, you are required to keep a controlled drugs register. You are also required to keep Class A and Class B controlled drugs and your controlled drug prescription pad in a secure cupboard or compartment, which must be of metal or concrete construction or both.⁴³⁵

Standing orders

The Medicines (Standing Order) Regulations 2002 sets out the requirements for initiating and using standing orders. The Regulations

432 Misuse of Drugs Act 1975, section 25.

433 “Inappropriate prescribing” can include indiscriminate, excessive or reckless prescribing – see footnote 228.

434 Misuse of Drugs Act 1975, section 24

435 Misuse of Drugs Regulations 1977, regulation 28 and Schedule 1.

only allow medicines to be administered or supplied to patients through a standing order if certain conditions are met. If you delegate the administration or supply of medicines to another health professional through standing orders, you should familiarise yourself with these conditions⁴³⁶ and with the Ministry of Health’s Standing Order Guidelines.⁴³⁷ If you sign a standing order, you are responsible for the effects of the medicines administered or supplied under that standing order (see Appendix A – Good medical practice, paragraph 32). You must also countersign the medicines that are charted and have processes to monitor and review how the standing order is being used.⁴³⁸

Crimes Act 1961

The Crimes Act 1961 imposes a legal duty on those who “undertake ... to administer surgical or medical treatment” to have and to use reasonable knowledge, skill and care.⁴³⁹ You could be criminally responsible for the consequences if you omit or fail to discharge this duty without lawful excuse.

If you perform a surgical operation with reasonable care and skill, the Crimes Act protects you from criminal responsibility.⁴⁴⁰ This is provided that the operation was appropriate and took into account the patient’s state at the time of the operation and all the circumstances of the case. You are also protected if you perform a surgical

The Crimes Act 1961 section 155 imposes a legal duty on those who “undertake ... to administer surgical or medical treatment” to have and to use reasonable knowledge, skill and care.

436 Medicines (Standing Order) Regulations 2002, regulation 5.

437 <https://www.health.govt.nz/system/files/documents/publications/standing-order-guidelines-aug16-v2.pdf>

438 Medicines (Standing Order) Regulations 2002, regulation 8.

439 Crimes Act 1961, section 155.

440 Crimes Act 1961, section 61.

operation with reasonable care and skill when you have the patient's consent and the operation is for a lawful purpose.⁴⁴¹

You should familiarise yourself with relevant provisions in the Crimes Act 1961 and seek advice if you are unsure.

Withdrawal of care

Section 151 of the Crimes Act places legal duties on any person “who has actual care or charge of a person who is a vulnerable adult⁴⁴² to provide them with necessities where that adult is unable to do so themselves”. Under this section, you are required to supply a sick person in your charge with “the necessities” and to take reasonable steps to protect that person from injury. Although not defined, “necessaries” could include medical and hospital treatment. However, the law also recognises a distinction between “active killing” and merely allowing someone to die by the withdrawal of life support. The New Zealand Court of Appeal has upheld the withdrawal of treatment in circumstances where the Court was satisfied that treatment was futile and merely prolonging death.

Under the New Zealand Bill of Rights Act 1990, patients have the right to refuse any medical treatment.⁴⁴³ For some patients, this could mean that care is withdrawn in some circumstances or that they decline certain procedures or treatment. Be respectful of the patient's decisions even if you disagree with them.

Protecting vulnerable patients

You have a responsibility to report suspected child abuse or abuse of a vulnerable adult patient as part of your responsibility to patients and the community. A change to the Crimes Act in March 2012 made this

441 Crimes Act 1961, section 61A.

442 A “vulnerable adult” is defined in the Crimes Act as a “person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person”.

443 New Zealand Bill of Rights Act 1990, section 11.

ethical obligation a legal one. Section 195A states that a staff member of a hospital, institution or residence where a child or vulnerable adult resides commits an offence if they know that the person is at risk of death, grievous bodily harm or sexual assault as a result of another person's unlawful act or omission and fail to take reasonable steps to protect the person at risk.

Section 15 of the Oranga Tamariki Act 1989 allows you to report ill treatment or neglect of children and young persons to Police or a social worker. You do not need to seek authorisation from a child or parent before making this disclosure, and section 16 provides you with protection from civil, criminal or disciplinary proceedings for doing so (although this protection does not apply if the disclosure is made in bad faith).

Protecting vulnerable children

The Children's Act 2014 aims to protect and improve the wellbeing of vulnerable children. Under this Act, the heads of six government departments are accountable for protecting and improving the lives of vulnerable children – New Zealand Police, Ministry of Health, Ministry of Education, Ministry of Justice, Ministry of Social Development and Oranga Tamariki. The Children's Act introduces safety checking (screening and vetting) of every person in both central and local government children's workforce. Those with serious convictions are banned from working closely with children unless they are granted an exemption.

Part 3 of the Children's Act sets out the requirements for safety checks such as when those safety checks should take place and who is required to undergo a safety check. They include all new and existing employees and contractors who have regular and unsupervised contact with children ("children's workers"). Those who do unpaid work with children as part of an educational or vocational training course (for example, student doctors) are also required to undergo a safety check. The safety checks include identity verification, Police vetting, reference checks, checks

with professional registration bodies or licensing authorities and a risk assessment that considers the specific child safety-related risk. The aim of the safety check is to prevent those who are a risk to children from working with them as staff members or volunteers.

The employer is responsible for determining whether a particular role is a children’s worker role. Where it is, those making decisions about the children’s worker should be satisfied that the children’s worker does not pose any undue risk to the safety of children if employed or engaged. The employer should also have policies in place on child protection and safe recruitment practices.

Key timeframes have been set for completing the safety checks for all new and existing children’s workers.⁴⁴⁴ In addition, Part 2 of the Children’s (Requirement of Safety Checks of Children’s Workers) Regulations 2015 states that periodic safety checks have to be conducted every 3 years.

The Children’s Act applies to a wide range of government and community agencies who work with children to provide a regulated service (“specified organisations”).⁴⁴⁵ Regulated health services include:⁴⁴⁶

- services provided at a public hospital
- services provided at a publicly funded medical practice or facility, including blood and cancer centres, treatment centres, outreach clinics and mental health services
- services provided through medical practices belonging to primary health organisations
- services provided by health practitioners
- Well Child/Tamariki Ora services (for example, Plunket)
- home-based disability support services

444 <http://www.health.govt.nz/our-work/health-workforce/childrens-action-plan-childrens-worker-safety-checking-and-child-protection-policies>

445 Children’s Act 2014, section 24.

446 For more information on regulated health services and the Children’s Act 2014, see footnote 444.

- residential disability support services
- ambulance services
- maternity services, including lead maternity carers and midwives.

If you work with children in a regulated health service, you should be familiar with the requirements of this legislation including the need to undergo periodic safety checks.

Public health

The Health Act 1956 is intended to improve, promote and protect public health. It covers a range of issues such as ensuring the safety of drinking water and giving certain officials the power to quarantine ships or aircraft. It also outlines the statutory duties and responsibilities of medical officers of health and sets out when and how doctors must notify infectious and notifiable diseases.

Section 74 states that, if a doctor has a reason to believe that a patient is suffering from a notifiable disease, they must advise their local medical officer of health. The local authority must also be informed in some cases. If the notifiable disease is infectious, the doctor must also “inform the occupier of the premises and every person nursing or in immediate attendance on the patient of the infectious nature of the disease and the precautions to be taken”.

The list of diseases and infectious diseases that must be notified are set out in Schedule 1 and Schedule 2 of the Health Act.

Cervical screening

New Zealand has a National Cervical Screening Programme (NCSP),⁴⁴⁷ which aims to prevent cervical cancer by providing regular screening tests for all eligible women in New Zealand. NCSP is delivered by a large number

447 <https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme>

of providers across the country including primary care practices, Family Planning, marae-based or other Māori health centres and community health centres. The 20 district health boards are contracted by the National Screening Unit to provide colposcopy services. There is also the option to be seen privately for colposcopy.

You must tell a woman about the screening programme whenever you take a specimen from her for a screening test or perform a colposcopic procedure.⁴⁴⁸ If this is the woman's first screening test or you are performing a colposcopic procedure, you must also tell her about the importance of having regular screening, the objectives of the screening programme, who has access to information on the programme's register and how that information might be used. For colposcopic procedures, you must also tell the woman that she will be automatically enrolled on the programme but may withdraw at any time.

There have been recent changes to the NCSP laws. The Health (National Cervical Screening Programme) Amendment Bill will facilitate more direct look-up access of a person's screening history for health providers providing screening services. From July 2023, the primary test for cervical screening will change from cytology testing to human papillomavirus testing, with self-testing as an option.

The Bill also places restrictions on access to, use, retention and disclosure of NCSP information. For example, it introduces a penalty for amending information on the screening register without authorisation from the NCSP manager. The NCSP manager may also put conditions on access to the register to protect privacy and security.

448 Health Act 1956, sections 112L and 112M.

Contraception, sterilisation and abortion

The Contraception, Sterilisation and Abortion Act 1977⁴⁴⁹ and section 174 of the Health Practitioners Competence Assurance Act 2003 outline doctors' duties in respect of reproductive health services. If you are approached for contraception, sterilisation or abortion services, familiarise yourself with the requirements under these complex pieces of law. You should also consider seeking advice from your indemnity insurer.

Assisted human reproduction

The Human Assisted Reproductive Technology Act 2004 regulates assisted reproductive procedures, prohibits some unacceptable procedures (such as sex selection of human embryos) and prohibits commercial transactions relating to human reproduction. Organisations that wish to perform assisted reproductive procedures or conduct research into reproduction are required to obtain prior written approval from a specially designated ethics committee.⁴⁵⁰

The Act also establishes an information-keeping regime to allow people born from donated embryos or donated cells to find out about their genetic origins.⁴⁵¹

Advance directives and enduring powers of attorney

Advance directives and enduring powers of attorney are a means of ensuring that the care and treatment provided are consistent with a patient's wishes, even after a patient is no longer able to communicate those wishes to you.

449 A number of sections in this Act were repealed on 24 March 2020.

450 Human Assisted Reproductive Technology Act 2004, section 16.

451 Human Assisted Reproductive Technology Act 2004, Part 3.

An advance directive is sometimes referred to as a living will. Right 7(5) of the Code of Health and Disability Services Consumers' Rights says that "every consumer may use an advance directive in accordance with the common law". Clause 4 of the Code of Rights goes on to define an advance directive as:

... a written or oral directive—

- (a) by which a consumer makes a choice about a future health care procedure; and
- (b) that is intended to be effective only when that consumer is not competent.

This means that a person can make an advance choice about receiving or refusing services. Some countries have specific laws that set out requirements that must be met for an advance directive to be legally valid. There is no equivalent law in New Zealand, and it is unclear whether common law recognises the validity of an advance directive.

Although the law is not clear, there are steps you could take before you carry out the patient's wishes about their care and treatment based on their advance directive or living will. These include:

- ensuring that the advance directive was made without undue influence
- establishing that the patient was competent and fully informed about the consequences of their decisions
- being satisfied that the patient intended the advance directive to apply to the current situation and that they had recently reviewed their advance directive.

The Protection of Personal and Property Rights Act 1988 allows a patient formally to nominate someone else to make personal care and welfare decisions on their behalf should the patient become mentally incapable.

If a patient has appointed someone to act as an “enduring power of attorney” with respect to their personal care and welfare and that patient has been assessed as lacking capacity, their attorney should be who you look to for information about the patient and when consent is required.

However, section 18(1)(c) of the Act specifically forbids the attorney from refusing consent “to the administering ... of any standard medical treatment or procedure intended to save (the patient’s) life or to prevent serious damage to that person’s health”. When making decisions about the patient’s personal care and welfare, the attorney must consult, as much as possible, with the patient and with other people named and must have regard for any advance directive expressed by the patient. If you are concerned that an attorney has made a decision that is not in the patient’s interests, section 103 empowers you to ask a court to review that decision.

Fitness to drive motor vehicles

The Land Transport Act 1998 requires you to report to the Director of Land Transport when:

- in your judgement, a patient is not medically fit to drive
- you have advised the patient not to drive
- you believe or know that the patient is continuing to drive despite this advice.

Some drivers (for example, drivers over the age of 75 and bus drivers) are required to regularly obtain a medical certificate to state that they are medically fit to drive a motor vehicle. When assessing such a driver and completing a certificate, you are required to consider the information contained in the booklet *Medical aspects of fitness to drive: A guide for health practitioners* (see Chapter 29 – Doctors and the transport sector).⁴⁵²

452 Land Transport (Driver Licensing) Rule 1999, Part 7 and Part 13.

At some point, you might be asked to take a blood specimen for evidential purposes from a person who is suspected of an offence relating to alcohol or drug-involved driving. The Land Transport Act allows you to take a blood sample without a person's consent if they present as a result of a motor vehicle accident or when an enforcement officer asks you to.⁴⁵³ When taking a blood sample, you must be satisfied that doing so would not be prejudicial to the person's proper care or treatment and must tell them (unless they are unconscious) that the blood specimen is being taken for evidential purposes.

Deaths and medical certificates of causes of death

The requirements for the issuing of a medical certificate of causes of death are outlined in the Burial and Cremation Act 1964. This Act states that a doctor attending a patient who dies as a result of an illness must sign such a certificate "immediately after the doctor learns of the death".⁴⁵⁴ Such situations are often urgent because the body cannot be released for burial or cremation until you have issued the certificate.

If you were not the last doctor to attend the patient during the illness, you may only complete the certificate if you are satisfied that the death was a result of the illness and :

- the doctor or nurse practitioner who last attended the person during the illness is unavailable or
- less than 24 hours have passed since the death, and the doctor or nurse practitioner who last attended the person during the illness is unlikely to be able to complete a certificate within 24 hours after the death or
- 24 hours or a longer period has passed since the death and the doctor or nurse practitioner who last attended the person during the illness has not completed a certificate.⁴⁵⁵

453 Land Transport Act 1998, sections 72 and 73.

454 Burial and Cremation Act 1964, section 46B(2).

455 Burial and Cremation Act 1964, section 46B(3).

In these situations, you are required to review the medical records of the health practitioner who last attended the patient during their illness and the circumstances of their death and to examine the body before issuing a certificate of cause of death.⁴⁵⁶

You should be as precise and specific as possible when completing a certificate of causes of death. The information you provide not only appears on the official death certificate issued by the Births, Deaths, and Marriages Office but is also used in the national cause of death statistics that are reported to the World Health Organization.

You should pay particular attention when specifying the underlying cause of death. Often, it can be a combination of a number of serious conditions that leads to the death. In such cases, you should record the condition you believe is most likely to have led to the death. There are a range of specific provisions that apply to issuing death certificates in different circumstances – for example still-births or where an elderly patient dies as a result of an accident.

For further information, refer to the Ministry of Health’s online guidance on completing death documents.⁴⁵⁷

There are some circumstances when you should not issue a certificate and must instead report a death to Police. These circumstances are outlined in section 13 of the Coroners Act 2006 and include when:

- death appears to be unnatural or violent, self-inflicted or without a known cause
- death occurs during or apparently as a result of some medical, surgical, dental or similar operation or procedure
- death occurs while a person was affected by an anaesthetic or the result of the administration of the anaesthetic

456 Burial and Cremation Act 1964, section 46B(5).

457 <https://www.health.govt.nz/our-work/regulation-health-and-disability-system/burial-and-cremation-act-1964/completing-death-documents>

- death occurs while the woman was giving birth or appears to have been the result of the pregnancy or giving birth
- death occurs in certain types of institutions or custody, including Police or prison custody, or treatment facilities for mental illness or alcohol or drug addiction.

Once you have notified Police, they will usually make some enquiries and notify a coroner. The coroner might then contact you and, in some situations, might require you to complete a written report.⁴⁵⁸ If you are uncertain about your obligations in these circumstances or how to go about completing a report, contact Coronial Services on 0800 266 800 or email its National Initial Investigation Office on NIIO@justice.govt.nz.

458 Coroners Act 2006, section 40.

CHAPTER 22

Notifications and disciplinary processes

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Introduction

Part 4 of the Health Practitioners Competence Assurance Act 2003 (the Act) sets out the complaints procedures that apply to doctors and establishes the Health Practitioners Disciplinary Tribunal, which hears and determines disciplinary charges brought against doctors and other health practitioners.

The principal purpose of these processes is public protection – to protect the public and the profession from health practitioners who are unfit to practise. Another purpose is to enable the profession to ensure the conduct of its members conforms to the standards generally expected of them.

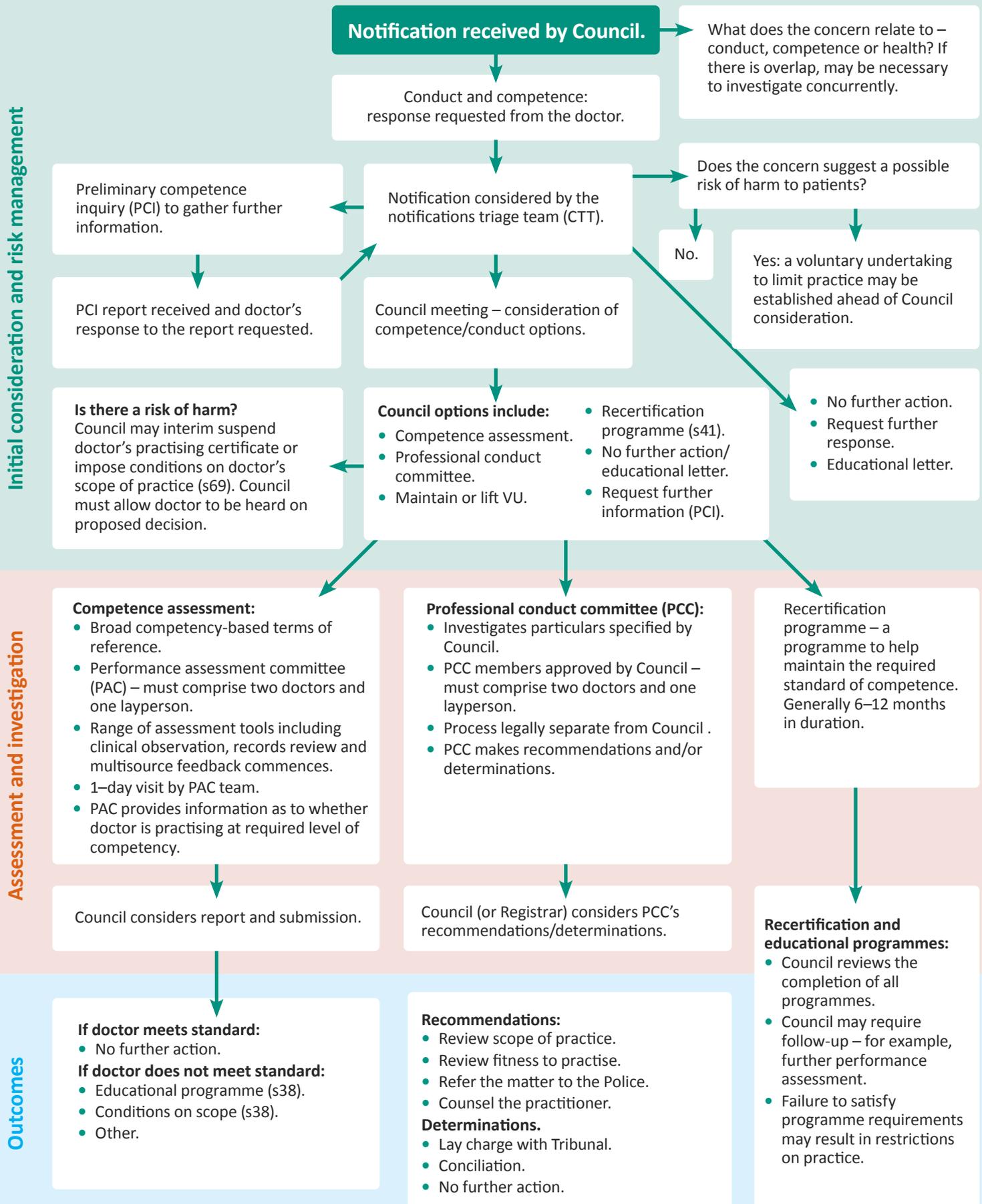
Notifications about doctors may be made to the Medical Council and/or the Health and Disability Commissioner. If the Council receives a notification alleging that the practice or conduct of a doctor has affected a health consumer, it must refer the notification to the Commissioner.

The Commissioner has the option to refer the notification back to the Council. If a notification is referred back, the Council must promptly assess the notification and consider whether any action is required.

The process the Council follows is set out in Figure 5.

The principal purpose of these processes is public protection - to protect the public and the profession from health practitioners who are unfit to practise

Figure 5. Notification process.



Notifications triage team (NTT)

The Council has a notifications triage team (NTT) to manage referrals made to the Council. The Council receives notifications from a number of sources – for example, the Health and Disability Commissioner, the Ministry of Health, ACC, the public or another medical practitioner. The NTT in the first instance will assess whether any action needs to be taken to protect the public. This may include asking the doctor to voluntarily agree to limitations on their practice, notifying other bodies of the notification and referring the notification to the full Council to consider interim suspension or the imposition of interim conditions.

The NTT considers the notification to assess that there is sufficient information and detail to allow careful consideration of the notification and more specifically whether the notification raises an issue of competence, conduct or health of the doctor referred. It is possible that a notification raises concerns that relate to more than just the one area, and if so, it may be necessary to investigate concurrently issues of competence, conduct and/or health.

In almost all cases, the doctor is asked to provide a response to the notification for the NTT to consider.

If the notification raises concerns around competence, the NTT may consider that there is still not sufficient information to make a decision on the next steps and can ask that a preliminary competence inquiry (PCI) be undertaken.

The NTT will also consider whether the notification raises a possible ongoing risk of harm to patients and seek a voluntary undertaking to limit practice pending full consideration by the Council.

The NTT may decide that no further action is needed, may request further information, may write an educational letter to the doctor or may refer the complaint for consideration by the full Council at the next Council meeting.

It can also recommend to the Council's Registrar to refer a matter to a professional conduct committee (PCC) under delegation.

Competence

If the notification raises concern about the doctor's competence, the Council may request that a preliminary competence inquiry (PCI) or a performance assessment is undertaken.

Preliminary competence inquiry (PCI)

A PCI involves a broad-based interview with the doctor by a Council-approved, vocationally registered practitioner. The interview includes a discussion of the doctor's circumstances and current practice. It also includes a random review of the doctor's patients' medical records. The purpose of the PCI is to provide more information about the doctor's practice.

All preliminary competence inquiries via Zoom and medical records are reviewed remotely.

Performance assessment committee (PAC)

A performance assessment is carried out by a performance assessment committee (PAC), which assesses whether a doctor is practising at the required standard for their registered scope of practice. The PAC's role is to objectively assess the doctor's current practice and provide the Council with a report on their observations and findings. The Council then makes the final decision on whether a doctor is practising at the required level of competence.

The assessment involves a review of the doctor's prescribing, clinical records and all other aspects of their practice, including interviews with the doctor and their colleagues and a practice visit with observations of patient consultations.

PAC membership

A PAC is made up of two doctors (one of whom practises in the same vocational scope of medicine as the doctor being assessed) and a layperson. A convenor is appointed and is the main point of contact between the doctor, their colleagues and practice/hospital staff. The convenor has overall responsibility for scheduling and timetabling of assessment visits, meetings and interviews (including leading these), along with facilitating PAC discussion, decision making and preparing and drafting the PAC report.

Assessment tools

A PAC uses a range of assessment tools including clinical observation, medical records review, multisource feedback from colleagues of the doctor being assessed and interviews with the doctor being assessed. The PAC also visits the doctor in their practice setting to observe their practice.

Report

The PAC provides a report to the Council that sets out their observations and supported conclusion as to whether the doctor meets, meets in part or does not meet the expected standard of competence for a doctor practising in that scope.

If a doctor meets the required standard, the options for the Council include taking no further action or an educational letter.

If a doctor does not meet the standard, options for the Council include an educational programme, imposing conditions on the doctor's scope of practice or other steps including removal from the register (in extreme cases).

Conduct

If the notification raises concerns about the doctor's conduct, the Council or the Council's Registrar under delegation may decide to refer the matter to a professional conduct committee (PCC) for investigation.

The Health and Disability Commissioner must notify the Council of any investigation under the Health and Disability Commissioner Act 1994 that directly involves a doctor.⁴⁵⁹ If the notification relates to conduct concerns, the Council must not take any action while the matter is under investigation by the Commissioner. However, if the concerns relate to competence, it is possible for both the Commissioner and Council to undertake dual processes.

If the notification raises concerns about the doctor's conduct, the Council or the Council's Registrar under delegation may decide to refer the matter to a professional conduct committee (PCC) for investigation

Professional conduct committee (PCC)

If the Council considers information in its possession raises questions about the conduct or the safety of a doctor's practice, it may refer those questions to a professional conduct committee (PCC). A PCC can be established to investigate notifications about the conduct of a doctor or where a doctor has been convicted of an offence punishable by a term of imprisonment of 3 months or more.

While a matter is under consideration by a PCC, if the Council thinks a further matter concerning that doctor should form part of the PCC's consideration, it may refer it to the existing PCC.

459 Hill A. The role of the Health and Disability Commissioner and the Code of Rights. In: Morris KA, editor. Cole's medical practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

A charge brought by the Director of Proceedings goes directly to the Tribunal and bypasses the PCC process.

PCC membership

A PCC comprises three members appointed by the Council. Two are doctors and one is a layperson. One member coordinates the investigation process and presides at PCC meetings. This member is known as the convenor. Both the doctor being investigated and the notifier are advised of the intended composition of a PCC and have an opportunity to request changes in membership.

Usually, where possible, one of the doctors on the PCC practises in the same vocational scope of medicine or a similar vocational scope as that in which the doctor being investigated practises. The other doctor is usually selected from a more general area (for example, general practice). This ensures there is an appropriate mix of general medical knowledge and specialised knowledge on the PCC.

If there are multiple notifiers involving one doctor, the same PCC generally deals with all the notifications.

Process

A PCC may investigate however it sees fit. It must ensure the parties are informed about the progress of the investigation and that the investigation is carried out fairly and in accordance with natural justice principles.

A PCC has wide powers to receive evidence and may receive any statement, document, information or matter that, in its opinion, may assist it to deal effectively with its investigation (even if the evidence would not be admissible in a court of law). A PCC has the power to

The PCC must give the doctor who is under investigation and the complainant a reasonable opportunity to be heard and to provide written submissions on each matter that is the subject of the PCC's investigation

call for information or documents from any person and, in the event of refusal or failure without reasonable excuse to comply with a request for information (or knowingly or recklessly providing false or misleading information), that person is liable to a fine not exceeding \$10,000.

A PCC must give the doctor who is under investigation and the notifier a reasonable opportunity to be heard and to provide written submissions on each matter that is the subject of the PCC's investigation.

Notifiers may bring a support person (patient advocate, family or whānau member, friend or counsellor) to a PCC meeting.

The PCC appoints a legal adviser to advise it on matters of law, procedure and evidence. It is also entitled to appoint an investigator to collect information and to investigate notifications. However, neither the legal adviser nor the investigator may be present during the PCC's deliberations.

Recommendations and determinations

Once the PCC has gathered all information relevant to its investigation, the PCC must recommend and/or determine an appropriate course of action. In accordance with section 80 of the Act, the PCC may make one or more of the following recommendations to the Council:

- Assess the doctor's performance.
- Review the doctor's fitness to practise medicine.
- Review the doctor's scope of practice.
- Refer the subject matter of the investigation to Police.
- Counsel the doctor.

The PCC may also make one of the following determinations:

- That no further steps be taken in relation to the notification or conviction.
- That a disciplinary charge should be brought against the doctor before the Tribunal.
- That the notification should be submitted to conciliation.

The PCC must make its recommendation(s) and/or determination within 14 days after the completion of its investigation. Written notice of any recommendation(s) and/or determination, and the reasons on which they are based must be given to the Council's Registrar, the doctor concerned and the notifier. The Council must promptly consider any recommendations.

It is not the responsibility of the PCC to reach a view on the guilt of the practitioner. If the PCC determines to lay a disciplinary charge, the Tribunal will determine the outcome and whether the conduct amounts to professional misconduct.

If the PCC decides to refer the notification to the Tribunal, it must frame an appropriate charge and lay it before the Tribunal in writing. Where a charge is laid against a doctor before the Tribunal, the chair of the Tribunal is required to convene a hearing of the Tribunal to consider the charge as soon as reasonably practicable.

If the PCC determines the notification should be the subject of conciliation, it must appoint an independent conciliator to help those concerned resolve the notification by agreement. If the notification has not been successfully resolved by agreement, the PCC must promptly decide whether it should lay a charge against the doctor before the Tribunal, whether to make any recommendations to the Council about the doctor or whether no further steps should be taken in relation to the notification.

Health Practitioners Disciplinary Tribunal

Function

The Tribunal's principal function is to hear and determine charges brought against doctors (and other health professionals) by the Director of Proceedings or by a PCC.

Membership

The Tribunal has a chair who has a law degree, one or more legal deputies and a panel of health practitioners and laypersons. The panel is maintained by the Minister of Health. For each hearing, the Tribunal must comprise a legal chair and four other persons selected by the chair or deputy from the panel, three of whom must be professional peers. One member must be a layperson.

Procedures

The Tribunal controls its own procedures in accordance with the Act and has wide powers to summon witnesses and records. Refusing to attend or cooperate or acting in contempt are offences punishable by a fine.

Charges

The Tribunal must notify the doctor in writing of the charge and ensure that the charge contains sufficient particulars to inform the doctor clearly of the substance of the allegations against them. A provisional hearing date is set between 20 and 60 working days from the date of the notice of the charge. In most cases, the hearing dates are rescheduled once the availability of the parties and their counsel has been ascertained at a directions conference. On occasion, hearings are adjourned.

Once a doctor has been notified of a charge, they must advise the Tribunal within 10 working days whether they wish to be heard by the Tribunal. Doctors can be heard personally or they may be (and usually are) represented by a lawyer.

Interim suspension

The Tribunal has the power, pending the hearing of a charge, to suspend the doctor or impose conditions on their practice if the Tribunal is satisfied that is necessary to protect the health or safety of the public. The Tribunal does not have to give notice to the doctor that it intends to make such an

order, but it must advise the doctor of the order once it has been made, the reasons for it and the doctor's right to apply for variation or revocation of the order. The Tribunal must also serve a copy of the order on the doctor's employer and on the Council. Any application for revocation must be heard within 10 working days after it is received by the Tribunal.

Public hearings

Although the Tribunal has the power to restrict publication and hold hearings in private, the majority of hearings are open to the public in accordance with the principle of open justice. The Tribunal can make various orders restricting the public nature of the hearing, including ordering that the whole or part of the hearing be heard in private and suppressing publication of the name or particulars of any person, including the doctor. Applications for private hearings are rarely granted. Applications for name suppression are usually supported by affidavit evidence of the reasons why an order is sought, and the Tribunal is required to balance the respective interests of the doctor, the notifier and the public interest before exercising its discretion.

Witnesses are given special protection if their evidence relates to a sexual matter or relates to another matter that may require the witness to give intimate or distressing evidence. Only certain people may be present during evidence of this nature, including a news media reporter, any person the witness chooses and any person the doctor chooses. The witness may object to the presence of a person of the doctor's choice.

The Tribunal has the power to order that a witness be permitted to give their evidence from behind a screen, if necessary.⁴⁶⁰

In cases that relate to a sexual matter, no person may publish the name of the notifier or any particulars likely to lead to the notifier's identification. However, if the notifier is 16 years or older and applies to the Tribunal

460 <https://www.hpdt.org.nz/portals/0/7Med0403P.pdf>.

for an order permitting the publication of their name and the Tribunal is satisfied the notifier understands the nature and effect of the application, the Tribunal must make the order. The Tribunal may restrict publication of any evidence relating to the sexual acts. If the Tribunal makes a non-publication order, any person can apply for it to be revoked, including representatives of the media.

Procedures

Hearings are generally held in person, but on occasion are held over video conference.

The Tribunal can regulate its own procedures, but these must accord with the rules of natural justice. Each party must be given a fair opportunity to put their evidence and call relevant witnesses. The Tribunal may receive as evidence any statement, document, information or matter that may help it deal effectively with the matters before it, whether it would be admissible as evidence in a court of law.

Witnesses usually read out their evidence from a written statement. They are then cross-examined by opposing legal counsel and questioned by members of the Tribunal. The evidence is recorded by a stenographer. The hearings are most often heard in the closest major centre to where the events that were the subject of the PCC's investigation occurred.

The prosecution has the burden of proving the charge. The Tribunal must be satisfied to the civil standard of proof (on the balance of probabilities rather than beyond reasonable doubt) that a doctor is guilty of the charge. The civil standard of proof is applied flexibly depending on the seriousness of the allegations.⁴⁶¹

461 *Z v Dental Complaints Assessment Committee* [2008] NZSC 55.

Findings

The Tribunal may find that the doctor has:

- been guilty of professional misconduct because of an act or omission that amounted to malpractice or negligence
- been guilty of professional misconduct because of an act or omission that has brought or was likely to bring discredit to the medical profession
- been convicted of an offence that reflects adversely on the doctor's fitness to practise
- practised their profession while not holding a current practising certificate
- performed a health service without being permitted to perform that service by their scope of practice
- failed to observe any conditions included in their scope of practice
- breached an order of the Tribunal.

Professional misconduct

The charge of professional misconduct has been part of New Zealand's medical disciplinary regime for many years.

A two-step process is involved in testing what constitutes professional misconduct under the Act.

The first step involves an objective assessment of whether the doctor's acts or omissions in relation to their practice can reasonably be regarded as constituting malpractice or negligence or otherwise meet the standard of having brought or been likely to bring discredit to the profession. The second step, often referred to as the threshold test, involves the Tribunal being satisfied that the doctor's acts or omissions require a disciplinary sanction for the purposes of protecting the public or maintaining professional standards (that is, that the conduct was sufficiently serious to justify the imposition of a sanction).

Malpractice involves immoral, illegal or unethical conduct or neglect of professional duty (improper professional conduct). Negligence generally involves breach of a doctor's duty in their professional setting. Bringing discredit to the profession involves bringing harm to the reputation of the profession and requires an objective assessment of whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the profession was lowered by the behaviour of the doctor concerned.

The threshold test recognises that not all acts or omissions that constitute a failure to adhere to the standards expected of a medical practitioner will constitute professional misconduct.

Who sets the standard?

In *Tizard v Medical Council of New Zealand*,⁴⁶² the Court stated:

Professional misconduct is behaviour in a professional capacity which would reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct. It ... is an objective test judged by the standards of the profession: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR, 369, 374. (p16)

However, when assessing a doctor's conduct, the Tribunal cannot lose sight of the fact that the Tribunal's role is partly one of setting standards (including the expectation that professional standards should not be permitted to lag) and that, in some cases, patient interests and community expectations may require the Tribunal to be critical of the usual standards of the profession.⁴⁶³ The Tribunal's deliberations now rely on both public as well as professional opinion, and it is that mix of opinion that sets the standard.

462 M2390/91 NZHC (Unreported, Barker, Thorp and Smellie JJ, 10 December 1992).

463 *B v The Medical Council of New Zealand* (Unreported, High Court, 11/96, Elias J).

The Tribunal issues a fully reasoned written decision once it has determined the charge. The Tribunal posts its decision on its website (www.hpdt.org.nz).

Penalties

When fixing a reasonable and proportionate penalty, the Tribunal balances the aggravating and mitigating factors in the case. To ensure there is consistency in the penalties imposed, the Tribunal also considers previous relevant cases.

The penalties available to the Tribunal if a doctor is found guilty are:

- cancellation of the doctor's registration
- suspension of the doctor for up to 3 years
- the imposition of conditions on practice for up to 3 years
- censure
- a fine of up to \$30,000.

The Tribunal cannot impose a fine when it is dealing with an offence for which the doctor has been convicted by a court. In all other cases, the full range of penalties (including cancellation of registration) is available. Before determining to cancel a doctor's registration, the Tribunal must consider the lesser alternatives available to it. If the Tribunal decides to order that the doctor's registration be cancelled, it must explain why any lesser options have not been adopted in the circumstances of the case.⁴⁶⁴

464 *Patel v PCC* (High Court, Auckland, CIV 2007—404—1818 Lang J, 13 August 2007).

After cancelling the doctor's registration, the Tribunal may impose one or more conditions that the doctor must satisfy before applying for registration again. The conditions may include any or all of the following:

- To undertake a specified course of education or training.
- To undergo a medical examination and treatment or a psychological or psychiatric examination, counselling or therapy.
- To attend a course of treatment or therapy for alcohol or drug abuse (the doctor must consent to this).
- Any other condition designed to address the matter that gave rise to the cancellation of the doctor's registration.

The Tribunal also has the power to order that the doctor pay a percentage of the reasonable costs and expenses incurred by the prosecution (either the Director of Proceedings or the PCC for the investigation and prosecution) and by the Tribunal (hearing costs).

There is no power to order costs be paid to a doctor acquitted of a charge. The Tribunal has no power to award compensation or costs to a notifier.

Appeals

Appeals must be filed within 20 working days from the date of the Tribunal's decision. Unless a court orders otherwise, the penalties imposed by the Tribunal stay in force pending the outcome of an appeal. Appeals against decisions of the Tribunal are to the High Court, whose decision is final on all matters except points of law, which may be appealed to the Court of Appeal. Instead of determining an appeal, the High Court may direct the Tribunal to reconsider the whole or any part of its decision or order. When reconsidering, the Tribunal must take the Court's reasons into account and give effect to the Court's directions.

Appeals are generally conducted by way of a rehearing on the record of the Tribunal.⁴⁶⁵ The High Court must form its own assessment of the merits of the case, having regard to the expertise of the Tribunal members who heard the charge but not approaching that expertise with undue deference. If the High Court is of a different view of the merits from the Tribunal and is, therefore, of the opinion that the Tribunal's decision is wrong, the High Court must act on its own view. The appellant bears the onus of satisfying the appeal court that its decision should differ from the decision under appeal.

465 Following the approach outlined in *Austin, Nicholls & Co Inc v Stichting Lodestar* [2007] NZSC 103. See, for example, *Harman v Director of Proceedings* (High Court, Auckland, CIV 2007—404—3732) and *Dr G v Director of Proceedings* (High Court, Auckland CIV 2009— 404—000951, 13 October 2009, Duffy J).

CHAPTER 23

The psychiatric patient and the law

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Introduction

In a typical day, a practitioner working in general practice and indeed in most areas of medicine can expect to assess and potentially manage several people presenting with psychological symptoms or distress. They may present with a clear psychological issue – for example, “I am depressed”) – or with other symptoms, which include psychological concerns – for example, “I haven’t been able to sleep properly for ages” or “I’ve got this pain in my guts and it’s really getting to me”. In most cases, their psychological issues can be assessed and treated in primary care, but some will require assessment and treatment from secondary (psychiatric) services.

Most of these referrals will be made with the agreement and consent of the patient and are made to their local district health board (DHB) community mental health service. A DHB’s mental health service is funded to provide assessment and treatment to 3% of the population experiencing the most serious mental distress at the time. These services are free to all New Zealanders and are mainly delivered through community mental health teams. Some people will elect to be seen in private by counsellors, clinical psychologists or psychiatrists. Private practice is less common in New Zealand than in some other countries. New Zealand private health insurance policies have very low rebates for mental health consultation and provide little cover for inpatient mental health care.

The standards of care required of providers seeing people in primary and secondary mental health services are the same as those required for all consumers of health and disability services. As such, they are afforded all the rights contained in the Code of Health and Disability Services Consumers’ Rights.⁴⁶⁶

466 See footnote 146.

Right 7(1) states:

Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

Right 7(7) states:

Every consumer has the right to refuse services and to withdraw consent to services.

As is the case in other countries, several of the exceptions referred to in Right 7(1) are enactments that can be triggered when somebody has serious concerns about another person's mental health. This chapter briefly reviews New Zealand's legislative provisions under which individuals with mental health difficulties can, in specific circumstances, be compulsorily detained and/or provided with care and treatment:⁴⁶⁷

- Mental Health (Compulsory Assessment and Treatment) Act 1992. This provides a legal framework for those who require compulsory psychiatric assessment and treatment for people experiencing a mental illness.
- Criminal Procedure (Mentally Impaired Persons) Act 2003. This provides the legislative framework within which the cases of individuals appearing before courts charged with criminal offending and who the court considers likely to be mentally impaired are progressed.
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003. This provides for the compulsory care and rehabilitation of certain individuals with a statutorily defined intellectual disability who have either been found unfit to stand trial on or convicted of imprisonable offences.

467 PDF copies of these Acts can be downloaded from <http://www.legislation.govt.nz/>.

- Substance Addiction (Compulsory Assessment and Treatment) Act 2017. This provides for the short-term compulsory assessment and treatment of certain individuals with serious substance addiction.
- Protection of Personal Property and Rights Act 1988. This provides the protective legislative framework available for individuals who the court decides have either lost or never had sufficient mental capacity to make competent informed decisions about their health and welfare and/or financial matters.

Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH CAT Act)

Why have a Mental Health Act?

People are usually assumed to be competent to make their own decisions and able to be accountable for the consequences of their actions. This framework extends to people's right to accept or reject offers of medical help when they are physically ill. However, a state of severe mental disturbance can temporarily, or in some cases permanently, deprive a person of their decision-making capacity and their ability to accurately assess their psychological state or the treatment options available. Mental health legislation provides the legal framework used to assess and, where necessary, treat people suspected of experiencing an episode of such serious mental disturbance that it may pose a risk of serious harm to themselves or others.

New Zealand's current iteration of compulsory mental health legislation is the MH CAT Act, which:

- defines mental disorder and related terms for the purposes of the MH CAT Act
- describes the statutory assessment and review processes.
- specifies the rights of and protections available for patients subject to the MH CAT Act
- provides the framework of accountability for their care.

How is ‘mental disorder’ defined in the MH CAT Act?

The MH CAT Act eschews the term ‘mental illness’. Instead, it defines ‘mental disorder’ in section 2 as follows:

mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—

(a) poses a serious risk of danger to the health or safety of that person or of others; or

(b) seriously diminishes the capacity of that person to take care of himself or herself;—

and **mentally disordered**, in relation to any such person, has a corresponding meaning.

The two parts of the definition – the requisite phenomena and associated risk – are often described as the first and second limb of the definition. A person is mentally disordered if their presentation meets/fulfils both the first and the second limbs of the definition.

The term ‘mental disorder’ is subject to section 4 (General rules relating to liability to assessment or treatment), which states that the process of assessment and treatment under the MH CAT Act:

... shall not be invoked in respect of any person by reason only of—

(a) a person’s political, religious, or cultural beliefs; or

(b) a person’s sexual preferences; or

(c) a person’s criminal or delinquent behaviour; or

(d) substance abuse; or

(e) intellectual disability.

However, if a person has the requisite phenomena and risk of a mental disorder, they are still mentally disordered even if they also meet one or more of these exclusory criteria. Information of how courts have interpreted the definition of mental disorder is contained in the Ministry of Health's guidelines to the MH CAT Act.⁴⁶⁸

Other definitions contained in section 2 of the MH CAT Act:

- A patient is defined as a person subject to compulsory assessment and/or treatment under the MH CAT Act.
- The Director of Area Mental Health Services (DAMHS) oversees the operation of the MH CAT Act in a particular area of the country.
- The responsible clinician (RC) is the health practitioner approved by the DAHMS as being competent in the assessment, treatment and care of persons with mental disorder who is the clinician in charge of a particular patient's treatment.
- A duly authorised officer (DAO) is a health professional authorised by the DAMHS to oversee the initial assessments conducted under the MH CAT Act.

468 <http://www.health.govt.nz/publication/guidelines-mental-health-compulsory-assessment-and-treatment-act-1992>

How is a process of committal under the MH CAT Act initiated?

A compulsory assessment can be initiated by anyone who has serious concerns about the mental health of another person contacting the Crisis Assessment and Treatment Team (CATT) or equivalent service. These teams always have a DAO available to respond to such calls.

If the DAO considers there are reasonable grounds for believing the person may be mentally disordered, they can then organise an initial assessment. The first step is ensuring a formal application for assessment is made to the DAMHS pursuant to section 8 of the MH CAT Act. This consists of two documents — a section 8A application and a section 8B certificate.

The section 8A application can be provided by anyone over the age of 18 who has seen the person in the past 3 days and “who believes that the person may be suffering from a mental disorder”. The applicant “states the grounds on which the applicant believes the person to be suffering from a mental disorder”. An initial application for assessment is completed when an appropriate health practitioner (a medical practitioner, a nurse practitioner or a registered nurse practising in mental health) who has assessed the person issues a section 8B certificate stating they have “reasonable grounds for believing that the person may be suffering from a mental disorder” and provides their reasons for that belief.

If a DAO receives only a section 8A application and they have reasonable grounds for believing the person the application concerns may be mentally disordered, they will organise a section 8B interview. When necessary, the DAO can request Police assistance to effect this interview.

A compulsory assessment is initiated by someone concerned about the mental health of another person through contacting the Crisis Assessment and Treatment Team (CATT) or equivalent service at their local DHB.

The health professional who provides a section 8B certificate can also provide a section 8A application in situations such as in general practice or hospital emergency rooms where there are serious concerns about a person's mental state but there is no one else willing or able to provide the section 8A application.

Once the DAO has both a section 8A application and a section 8B certificate, they arrange, pursuant to section 9, an assessment examination, also conducted under section 9 and undertaken by a psychiatrist or another approved health practitioner. They examine the person and issue a section 10 certificate recording whether or not “there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment”. Note that, while the initiating section 8B certificate requires the practitioner to have reasonable grounds for believing the person may have a mental disorder, the section 10 process requires the assessing clinician to decide whether they have reasonable grounds for believing the person is mentally disordered.

Establishing a compulsory treatment order

If an affirmative section 10 certificate is issued, a period of 5 days' compulsory assessment begins pursuant to section 11 of the MH CAT Act. This almost always happens in a mental health inpatient unit but may be undertaken in a community setting in some instances. During this first assessment period, the patient can be compulsorily treated, and their treatment is the responsibility of the RC.

The patient can be released before the end of the 5-day assessment if the RC concludes the patient is not mentally disordered. If, on the other hand, they reassess and certify, pursuant to section 12, that “there remain reasonable grounds for believing that the patient is mentally disordered and that it is desirable that the patient be required to undergo further assessment and treatment”, a further 14-day period of assessment is

commenced (section 13). Before the end of this period, the patient must be released or an application made for a compulsory treatment order (CTO). This application is heard by a Family Court Judge or District Court Judge within the following 14 days. At the hearing, the Judge examines the patient and hears evidence from the patient, the RC and at least one other health professional involved in the case as well as any other evidence the Judge considers relevant. The Court acts in an inquisitorial not an adversarial fashion, but the patient usually has a state-funded lawyer who can address the Judge on the patient's behalf and can question the RC and any other witness.

If the Judge determines the person is mentally disordered and a CTO is necessary, they first consider whether this can be a community CTO, and then only if this is not a safe option, an inpatient order is made. The initial CTO is for 6 months. If at any time during the order the RC concludes the patient is no longer mentally disordered, they are released, and the RC can also send the patient on leave from the hospital or convert the inpatient order to a compulsory community treatment order. Orders can be extended by the Family Court for another 6 months. Then, if there is a 12-month extension hearing and the Judge concludes the patient remains mentally disordered, the order is extended "indefinitely". Thereafter, throughout the currency of the order, 6-monthly statutory reviews are conducted by the RC. A copy of the review certificate is provided to the DAMHS, the patient and specified others interested in the care of the patient. If at any time during the tenure of the order, including at the statutory reviews, the RC concludes the patient is no longer mentally disordered, they must be released from this status under the MH CAT Act.

During the assessment phase and for the first month of a CTO, a patient is required to accept treatment as directed by the RC. Thereafter, the patient can still be required to accept treatment if it is considered to be in their interests by another psychiatrist appointed by the Mental Health Review Tribunal (MHRT) to review such matters. The primary role of the MHRT is

to review patients who have applied to the MHRT to have their detention under the MH CAT Act reviewed.

Issues in civil commitment

Part 6 of the MH CAT Act specifies the rights of the patient while undergoing compulsory treatment. These act in conjunction with the Code of Health and Disability Services Consumers' Rights, which also apply. District inspectors are lawyers appointed by the Minister of Health and tasked with informing patients of their rights and monitoring the care of patients against the rights specified in the MH CAT Act. They can conduct inquiries into the care of any patient either in response to complaints by or on behalf of the patient, on their own recognisance and also at the direction of the Ministry of Health's Director of Mental Health. Another of their roles is ensuring that patients are aware of the circumstances in which they can appeal their compulsory detention (to the High Court under section 16 of the MH CAT Act and to the MHRT) and assist them with the information they need to make such appeals.

The viewpoint of the family and other carers is important, and the MH CAT Act mandates consultation with the patient's family or whānau in section 7A. This must be undertaken unless the RC has good clinical reasons not to do so or it is not practicable to do so.⁴⁶⁹

Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP MIP Act)

The CP MIP Act was introduced in 2003 and updated the legislative framework under which the cases of individuals appearing before the criminal court who are suspected of having significant mental impairment are progressed. It was developed in tandem with the ID CCR Act.

469 For further reading, see Dawson J, Gledhill K, editors. *New Zealand's Mental Health Act in practice*. Wellington: Victoria University Press; 2013.

One of the drivers for developing the CP MIP Act and ID CCR Act was the difficulties courts had faced in dealing with defendants with an intellectual disability (ID) after the introduction of the MH CAT Act. Individuals with an ID alone appearing before the court could no longer be easily directed to hospital care as they were no longer considered to be mentally disordered. Another driver was the fact that, under the Criminal Justice Act 1985, an individual could be found unfit to stand trial and detained in hospital without an inquiry into whether they had actually offended as charged. The CP MIP Act provides for a process to establish the involvement of the defendant in the charge on which they might be found unfit and also provides the court with the option of sentencing an offender to a term of imprisonment while contemporaneously ordering they be held in a hospital or secure facility subject to an order under the MH CAT Act or the ID CCR Act.

The CP MIP Act, pursuant to section 38, provides for the preparation of psychiatric or psychological assessment of defendants suspected of being mentally impaired to assist the court in deciding whether the defendant is unfit to stand trial or was insane within the meaning of section 23 of the Crimes Act 1961 when they allegedly offended. Where a defendant has been found unfit to stand trial or found to be insane or convicted of imprisonable offences, the CP MIP Act mandates further assessments pursuant to sections 23 and 35 respectively to assist the court in making the most appropriate disposition. These can include orders under the MH CAT Act or the ID CCR Act. The terms ‘special patient’ and ‘special care recipients’ refer to those individuals who remain subject to the criminal justice system while subject to the MH CAT Act or ID CCR Act.

In most cases, these assessment reports are requested from forensic practitioners contracted to or working for the Regional Forensic Services or the Forensic Coordination Service (Intellectual Disability) and will not be further addressed in this chapter.

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID CCR Act)

The ID CCR Act provides for the compulsory care and rehabilitation within a health and disability framework of certain individuals with a statutorily defined ID who have been either found unfit to stand trial on or convicted of imprisonable offences and ordered into care. There is no other mechanism in New Zealand law for an individual with an ID alone to be detained purely based on risk they pose to others.

Most compulsory care orders are made as dispositions in criminal court under the terms of the CP MIP Act. An initial order of up to 3 years duration is made, and this can be extended by the Family Court depending on the risk the individual still poses. In addition, the ID CCR Act provides for the transfer into its regime of appropriately sentenced prisoners with an ID or certain individuals with an ID detained in a psychiatric facility under the MH CAT Act who would be more appropriately cared for within an ID service environment.

The structure and content of the ID CCR Act closely mirrors the MH CAT Act. Individuals detained under the ID CCR Act are defined as ‘care recipients’ instead of patients. Their care and rehabilitation is the responsibility of a care manager. Their role is broadly analogous to the RC’s role, and they are employed by the service detaining the care recipient. The care manager’s work is overseen by a care coordinator who is employed by the Forensic Coordination Service (Intellectual Disability) and has a role broadly analogous to that of the DAMHS.⁴⁷⁰

This Act provides for the compulsory care and rehabilitation within a health and disability framework of certain individuals with a statutorily defined ID who have been either found unfit to stand trial on or convicted of imprisonable offences and ordered into care under this Act.

470 Further information on the ID CCR Act is available at <https://www.health.govt.nz/our-work/disability->

Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SA CAT Act)

The SA CAT Act replaced the Alcoholism and Drug Addiction Act 1966 when it came into force on 21 February 2018. It provides for the compulsory assessment and treatment of individuals who have a severe substance addiction and do not have the capacity to consent to treatment for their addiction.

The SA CAT Act is focused on the small number of people with severe substance addiction and severely impaired capacity, both of which are defined in the legislation. Its aim is to enable people with a severe substance addiction and associated severely impaired decision-making capacity to receive compulsory treatment for their addiction. This is undertaken with the aim of protecting them from harm, stabilising their health, protecting and enhancing their mana and dignity and restoring their capacity to make informed decisions about further treatment and substance use.

In most cases, compulsory treatment under the SA CAT Act will be limited to less than 56 days. This reflects the importance of ensuring people with severe substance addiction are supported to engage with treatment on a voluntary basis wherever possible. In the case of individuals subject to the SA CAT Act who also have a substance-related brain injury impacting on their recovery, the compulsory treatment order can be extended by the court for a further 56 days. In some cases, this will be followed by arrangements being made for their ongoing care in a more specialised environment such as dementia-specific residential care.

The SA CAT Act also contains provisions to protect the rights of people subject to its compulsory assessment and treatment and provides for the investigation of alleged breaches of their rights.⁴⁷¹

[services/about-disability-support-services/intellectual-disability-compulsory-care-and-rehabilitation-act-2003](https://www.health.govt.nz/our-work/mental-services/about-disability-support-services/intellectual-disability-compulsory-care-and-rehabilitation-act-2003).

471 Further information on the SA CAT Act is available at <https://www.health.govt.nz/our-work/mental->

Protection of Personal and Property Rights Act 1988 (PPPR Act)

The PPPR Act provides for the protection and promotion of the personal and property rights of adults who are not fully able to manage their own affairs. The PPPR Act is predicated on a presumption of a person having the competence to manage themselves and their assets until and unless the contrary is proven.

Section 5 of the PPPR Act deals with personal rights:

For the purposes of this Part, every person shall be presumed, until the contrary is proved, to have the capacity—

- (a) to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare; and
- (b) to communicate decisions in respect of those matters.

Section 24 of the PPPR Act deals with property rights:

For the purposes of this Part, every person shall be presumed, until the contrary is proved, to be competent to manage his or her own affairs in relation to his or her property.

When “the contrary is proved” in the Family Court in relation to matters of personal care and welfare and/or property, the PPPR Act provides processes to establish alternative decision making for individuals who it has found to have significant impairment in their capacity. These orders can be because of lifelong impairment of capacity – mainly individuals with significant intellectual disability and when a person has developed

[health-and-addiction/mental-health-legislation/substance-addiction-compulsory-assessment-and-treatment-act-2017.](#)

impaired capacity due to brain injury, mental disorder or some other condition affecting brain function such as dementia.

The court can make one or more nuanced personal orders pursuant to section 10. These can include regulating where a person resides or what medical or other care they are to receive. These orders can only be made when the court considers the individual has either wholly or partially lost their capacity to make best-interests decisions in relation to particular or all aspects of their personal care and welfare.

There is also a power for the court to appoint a welfare guardian pursuant to section 12 to make ongoing welfare decisions in the areas where the court has determined the individual has wholly lost their decision-making capacity. In most cases, welfare guardianship is only sought where the individual has wholly lost their capacity to make decisions for all or virtually all aspects of their personal care and welfare. However, in New Zealand, there is no statutory body able to act as a welfare guardian, and in most cases, welfare guardianship is established by a concerned family member or close friend. In cases where there is no identified individual prepared to take on this role, the court may choose to make a number of personal orders to perform a similar function.

There is also a power to appoint a property manager pursuant to Part 3 of the PPPR Act. This can be a trustee corporation.

The PPPR Act prescribes a regime that, on the face of it, provides only for substitute decision making. However, the PPPR Act requires that anyone exercising a power under this

These powers are provided to a nominated attorney while the individual is still competent to make another person their enduring attorney. The attorney has no power to act on a person's behalf until that person has been certified to have lost the requisite capacities.

Act always acts to assist and encourage the subject person to exercise whatever decision-making capacity they retain.

The PPPR Act also provides the framework within which enduring powers of attorney for personal care and welfare and for property matters can be established. These powers are provided to a nominated attorney while the individual is still competent to make another person their enduring attorney. The attorney has no power to act on a person's behalf until they have been certified to have lost the requisite capacities. The certificates are provided by a health practitioner, often a medical practitioner whose scope of practice includes the assessment of a person's capacity.

With the increasing percentage of elderly in the population, medical practitioners in a variety of areas of practice are finding they are being increasingly asked to provide certificates in relation to the PPPR Act. These can be to support applications for appointment of a welfare guardianship and/or a property manager or in support of applications for personal orders. In addition, they may also be asked whether a person still the capacity to establish enduring powers of attorney or whether somebody has lost their capacity and the enduring attorney now needs to act for them. These certificates must be provided on specified templates.⁴⁷²

Acknowledgement

In closing, I wish to acknowledge my debt to the previous author of this chapter, Dr David Chaplow, whose work I have updated.

472 These templates and general information about the PPPR Act is available at <https://www.justice.govt.nz/family/powers-to-make-decisions/>.

CHAPTER 24

Overview of the New Zealand public health and disability system

Note that this chapter has not been updated from the 2017 edition. The New Zealand public health and disability system is to undergo significant reform in 2022.

The Ministry advises that they are fully engaged with a work programme across a number of critical health priorities, including maintaining an effective COVID-19 response. The Ministry directs readers to the following Ministry of Health website links for further information:

Ministry of Health 2019/20 Annual Report <https://www.health.govt.nz/publication/annual-report-year-ended-30-june-2020>

Briefing to the Incoming Minister of Health <https://www.health.govt.nz/system/files/documents/pages/nz-health-and-disability-system-priority-areas-july2020.pdf>

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Introduction

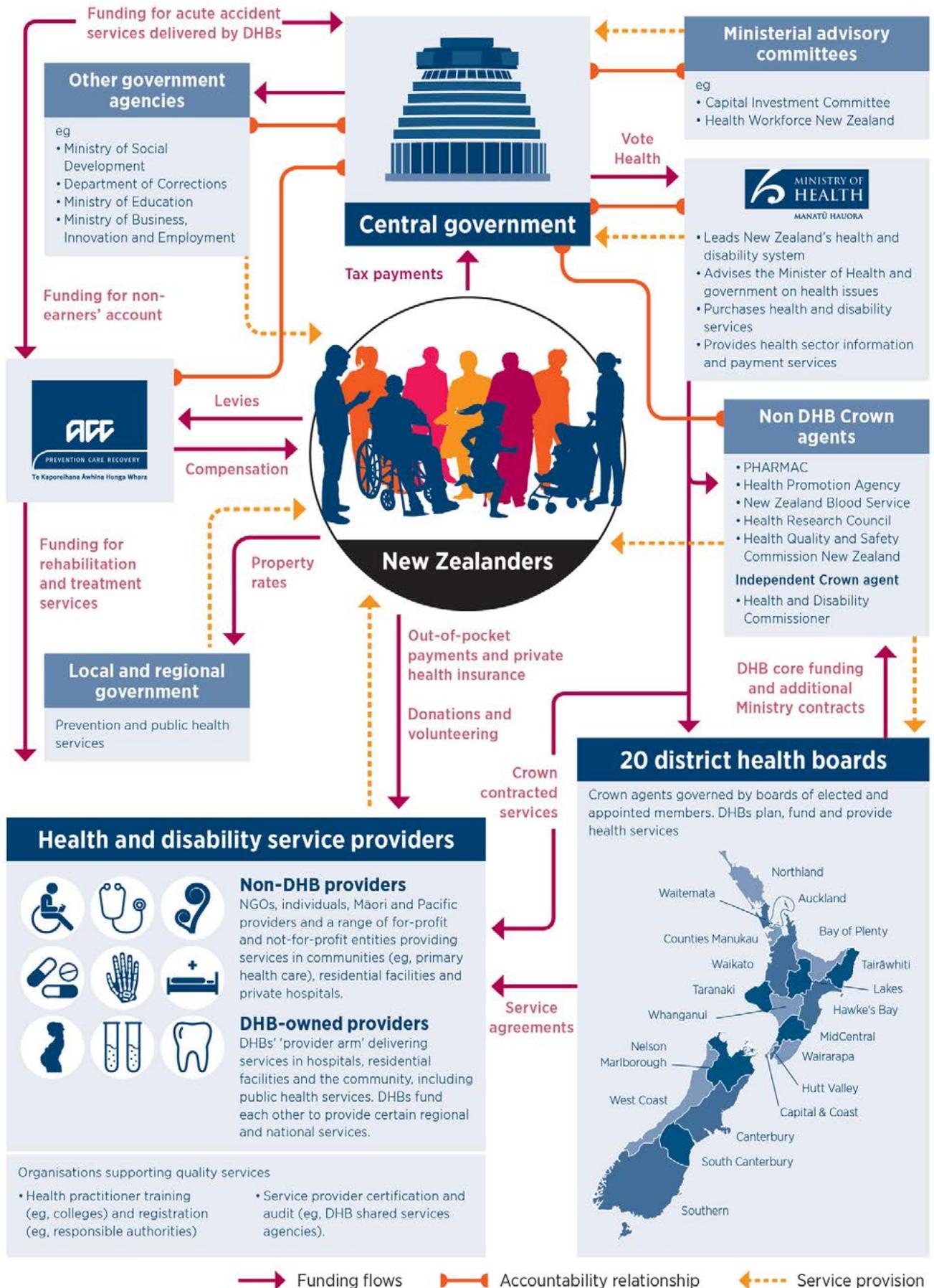
The Minister of Health, with Cabinet and the government, develops policy for the health and disability sector and provides leadership. The Minister is principally supported and advised by the Ministry of Health.

Most of the day-to-day business of the system and nearly three-quarters of the funding is administered by district health boards (DHBs). DHBs plan, manage, provide and purchase health services for the population of their district, implement government health and disability policy and ensure services are arranged effectively and efficiently for all of New Zealand. This includes funding for primary care, hospital services, public health services, aged care services and services provided by other non-government health providers, including Māori and Pacific providers. There are currently 20 DHBs across New Zealand.

The Ministry has a range of roles in the system in addition to being the principal adviser and support to the Minister. It funds an array of national services (including disability support and public health services), provides clinical and sector leadership and has a number of monitoring, regulatory and protection functions.

The entire system extends beyond the Ministry and DHBs to ministerial advisory committees, other health Crown entities, primary health organisations, public health units, private providers (including Māori and Pacific providers) and independent GPs. It includes professional and regulatory bodies for all health professionals, including medical and surgical specialities, nurses and allied health groups. There are also many non-government organisations (NGOs) and consumer bodies that provide services and advocate for the interests of various groups (see Figure 6).

Figure 6. Overview of the New Zealand health and disability system.



Vote Health

The health system's funding comes mainly from Vote Health, which is administered by the Ministry. For 2016/17, this totals \$16.142 billion.

Other significant funding sources include other government agencies (most notably the Accident Compensation Corporation – ACC), local government and private sources such as insurance and out-of-pocket payments.

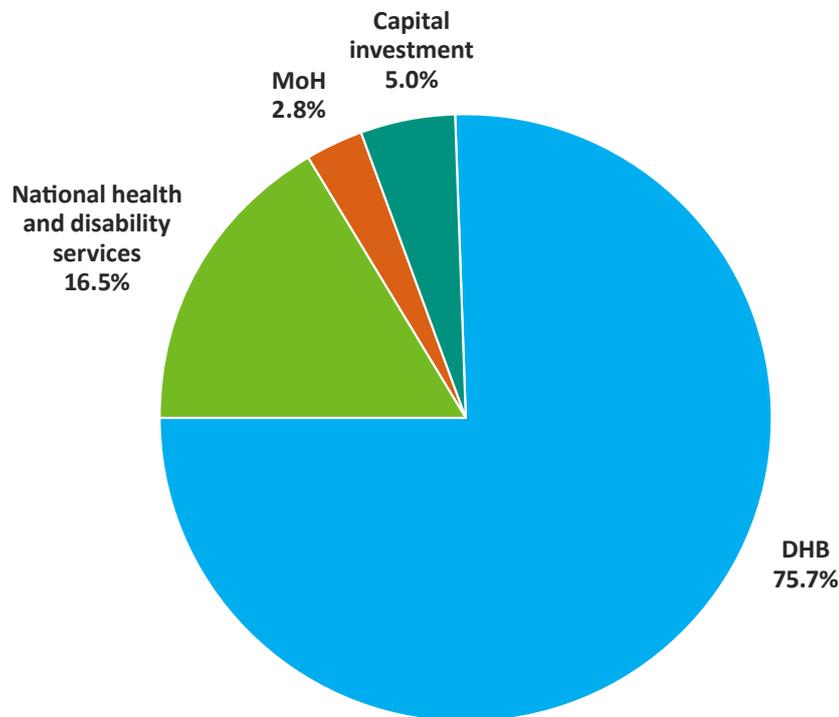
The majority of public funds managed through Vote Health are allocated to DHBs: \$12.220 billion in 2016/17 or 75.7% of Vote Health. DHBs use this funding to plan, purchase and provide health services for the population of their district so as to ensure effective and efficient services for all of New Zealand. DHBs oversee – but exercise varying control over – all levels of care, including hospital services, aged care services and primary care, such as GPs, nurses and pharmacists.

The Ministry will spend \$2.659 billion in 2016/17 (16.5% of Vote Health) to directly purchase a range of services, such as disability support services, public health services, specific screening programmes, elective services, Well Child and primary maternity services, Māori health services and postgraduate clinical education and training as well as Māori and Pacific provider development.

Capital funding comprises \$803 million in 2016/17 (5% of Vote Health). This includes provision of debt or equity for DHBs (and other health Crown entities and/or Public Finance Act Schedule 4A companies) to cover new investments or other purposes agreed by the Crown.

The final \$459 million in 2016/17 (2.8% of Vote Health) funds the Ministry's operating costs, health workforce training and development, national health information systems and other expenses (see Figure 7).

Figure 7. Allocation of \$16.142 billion Vote Health funding in 2016/17.



The Minister of Health

The Minister has overall responsibility for the health and disability system and for setting the sector’s strategic direction. The Minister’s functions, duties, responsibilities and powers are provided for in the New Zealand Public Health and Disability Act 2000, the Crown Entities Act 2004 and in other legislation. Some responsibilities may be delegated to one or more Associate Ministers of Health.

There are various ways the Minister, or the Ministry on the Minister’s behalf, can direct activity in the sector. Because it is a semi-devolved system, many day-to-day functions and detailed decisions happen at a local level. Due to the system’s complex set of governance, ownership, business and accountability models, the levers available to the Minister are varied and exert differing levels of control.

The Minister is responsible for strategies that provide a framework for the health and disability system such as the New Zealand Health Strategy, the New Zealand Disability Strategy and He Korowai Oranga: Māori Health Strategy.

The Minister is also responsible for the strategic direction of the Ministry through the statement of intent, 4-year plan, budgets and output plan.

Beyond setting the system's strategic direction, the Minister has an array of performance levers available. Given the Minister's legislative and financial responsibilities, specific levers are largely focused around ensuring strong performance from DHBs and other health Crown entities.

These levers can be broadly grouped into three categories:

- Setting entities' strategic direction and annual performance requirements (for example, through letters of expectation, statements of intent/statements of performance expectations, setting funding parameters and giving directions).
- Monitoring strategic direction and results (for example, through a monitoring agent, discussing results with entities, requesting information).
- Board appointments, remuneration and removals (for example, appointing chairs and members, setting terms and conditions of appointment, ensuring quality induction and review processes).

Other key roles of the Minister under legislation include the power to declare health emergencies and responsibility for decisions about extended leave from hospital and eventual change of legal status of special and restricted mental health patients.

Beyond setting the system's strategic direction, the Minister has an array of performance levers available. Given the Minister's legislative and financial responsibilities, specific levers are largely focused around ensuring strong performance from DHBs.

The Ministry of Health

The Ministry of Health is the government's principal agent in the New Zealand health and disability system and has overall responsibility for the stewardship of that system. The Ministry acts as the Minister's principal adviser on health policy, thereby playing an important role in supporting effective decision making. At the same time, the Ministry has a role within the health sector as a funder, monitor, purchaser and regulator of health and disability services.

In this way, the Ministry provides leadership across the system and is the government's primary agent for implementing the government's health priorities and policies within the system. The Ministry also has a wider role in coordinating action with other government agencies to deliver on the government's agenda across the spectrum of social sector services.

As well as its key relationships with the government and the health and disability system, the Ministry aspires to be a trusted and respected source of reliable and useful information about health and disability matters for all New Zealanders and the wider international community.

Purpose and role

The Ministry seeks to improve, promote and protect the health and wellbeing of New Zealanders through:

- its leadership of New Zealand's health and disability system
- advising the Minister and the government on health issues
- directly purchasing a range of national health and disability support services
- providing health sector information and payment services for the benefit of all New Zealanders.

The Ministry works in partnership with other public sector agencies and by engaging with people and their communities in carrying out these roles.

Leadership

The Ministry leads the health and disability system and has overall responsibility for the management and development of that system. It steers improvements that help New Zealanders live longer, healthier and more independent lives.

The Ministry ensures that the health system is delivering on the government's priorities and that health sector organisations are well governed and soundly managed from a financial perspective. To do this, the Ministry:

- funds, monitors and drives the performance improvements of DHBs and other health Crown entities
- supports the planning and accountability functions of DHBs and other health Crown entities
- regulates the sector and ensures legislative requirements are being met.

Advising the government

Health and disability policy choices are complex and challenging, and the Ministry has a responsibility to provide clear and practical advice to the Minister and Associate Ministers, supported by strong, evidence-informed analysis.

The Ministry provides expert clinical and technical advice to Ministers, organisations and individuals within the health and disability sector. Some Ministry functions (such as those that rest with the Director of Public Health) include clinical decision making or statutory responsibilities.

Buying health and disability services

The Ministry is a funder, purchaser and regulator of national health and disability services on behalf of the Crown. These services include:

- public health interventions (for example, immunisation)
- disability support services

- elective services
- screening services (for example, cervical screening)
- mental health services
- maternity services
- ambulance services.

Information and payments

The Ministry provides key infrastructure support to the health and disability system, especially through:

- the provision of national information systems
- a payments service to the health and disability sector (totalling \$8.7 billion of services funded by the Ministry and DHBs in 2015/16 from processing 108 million transactions).

Priority areas

The improved wellbeing and health of New Zealanders will be achieved by the delivery of services that are accessible, safe, individual and family-centred, clinically effective and cost-effective. The Ministry has a multi-faceted strategy, as is appropriate for a complex sector. As set out in the Ministry's Statement of Intent 2015–2019 (published June 2015):⁴⁷³

The Ministry will:

1. contribute to the Government's strategic priorities by:
 - delivering Better Public Services in a challenging fiscal environment
 - responsibly managing the Government's finances
 - supporting the Christchurch rebuild
 - building a more competitive and productive economy

473 <http://www.health.govt.nz/system/files/documents/publications/ministry-of-health-soi-2015-to-2019-aug15-v2.pdf>

2. deliver on the Government’s cross sector priorities in the health and social sector arena:
 - supporting vulnerable children, including reducing rheumatic fever cases and assaults on children
 - social sector trials
 - the Prime Minister’s Youth Mental Health project
 - health targets
 - Whānau Ora
 - National Drug Policy
3. implement the Minister’s objectives for the sector:
 - make services more accessible, including shifting services
 - maintain wellness for longer by improving prevention
 - reduce obesity – childhood obesity plan
 - implement a diabetes plan
 - improve the quality and safety of health services
 - support the health of older people
 - implement Rising to the Challenge
 - Smokefree 2025
 - therapeutic products regulatory regime
 - make the best use of information technology (IT) and ensure the security of patients’ records
 - strengthen the health and disability workforce
 - support regional and national collaboration.

Organisational structure

The Ministry is made up of 12 business units, each with its own functions and areas of responsibility.

Client Insights and Analytics

The Client Insights and Analytics business unit is responsible for ensuring that all of the Ministry's clients, especially the people of New Zealand, are front of mind in all that the Ministry does. The business unit manages national data collections and provides evidence-based insights and analytics relating to the health and wellbeing of New Zealanders. The business unit works closely with the Strategy and Policy and the Technology and Digital Services business units on information management and on the evidence base for service design.

Strategy and Policy

The Strategy and Policy business unit is responsible for the Ministry's advice on the health and disability system. It develops and enables implementation of strategy and policy, including advice on Māori health, technology and regulation.

Service Commissioning

The Service Commissioning business unit manages the relationships between the Ministry and health and disability service providers including DHBs. This includes funding, purchasing, performance management, commercial advice and contractual arrangements. The business unit works closely with the Strategy and Policy and the Finance and Performance business units to design, plan and fund health and disability initiatives.

Protection, Regulation and Assurance

The Protection, Regulation and Assurance business unit ensures the quality and safety of health and disability services, protects and promotes the health of New Zealanders and provides assurance and enforcement for both regulatory and contract compliance. The business unit works closely with the Service Commissioning business unit and DHBs to ensure service quality is a high standard.

Technology and Digital Services

The Technology and Digital Services business unit delivers technology and digital services to the Ministry and the health and disability sector. It also plays an important role in assessing the potential impact of existing and emerging health technology. The business unit works closely with the Strategy and Policy business unit, the Chief Medical Officer and the Chief Nursing Officer to develop and implement the technology and digital strategy for the health and disability sector.

Finance and Performance

The Finance and Performance business unit is the authority on the health and disability system's finance, financial and non-financial performance and risk. It is also responsible for managing and delivering the Ministry's finance functions, payments to the health and disability sector and an enterprise portfolio management office. The Finance and Performance business unit works closely with the Service Commissioning business unit supporting and advising the commissioning of services.

People and Transformation

The People and Transformation business unit is responsible for the sector workforce through Health Workforce New Zealand and managing and delivering the Ministry's human resources and internal organisational strategy. The unit is also the business owner for the Ministry's in-house information technology strategy and leads the Ministry's change programme and operating model.

Office of the Director-General

The Office of the Director-General of Health is responsible for government and ministerial services, internal and external communications, assurance and risk management and provides support to the Director-General of Health, Ministers and the Executive Leadership Team. The office also supports the Chief Science Officer.

Māori Leadership

Māori Leadership is a strategic role that leads the Ministry and sector in reducing Māori health inequalities. It is the pou tokomanawa (backbone) for the Ministry and health and disability sector in their efforts to promote, protect and partner with Māori. Māori Leadership has strong relationships within the health and disability sector, government agencies and with iwi Māori. Ministry business units support Māori Leadership and are jointly responsible for improving Māori health outcomes and reducing inequalities.

Chief Nursing Officer

The Chief Nursing Officer is the point of contact for clinical leadership and advice to the Ministry, Ministers and health and disability sector. The role supports professional development within the Ministry and the nursing workforce. The Chief Nursing Officer works in partnership with the Chief Medical Officer, DHBs and clinicians.

Chief Medical Officer

The Chief Medical Officer supports clinical leadership across the health and disability system and provides clinical advice to inform health policy and delivery. The role leads engagement with the medical profession and maintains links between New Zealand and the international medical community for the purpose of benchmarking New Zealand practice against international standards and ensuring that New Zealand medical practice is abreast of international developments. The Chief Medical Officer works in partnership with the Chief Nursing Officer, DHBs and clinicians.

Critical Projects

Critical Projects oversees and manages critical priority projects on behalf of the Director-General of Health. Critical Projects has been established for a fixed term of 2 years.

Statutory positions

Director-General of Health

The Director-General of Health is the Chief Executive of the Ministry and, like most public service chief executives, is appointed on a fixed-term contract by the State Services Commissioner under the State Sector Act 1988. In addition to responsibilities in the State Sector Act, the Director-General has a number of other statutory powers and responsibilities under various pieces of health legislation. These include:

- powers relating to the appointment and direction of statutory public health officers, oversight of the public health functions of local government and authorising the use of special powers for infectious disease control under the Health Act 1956
- certifying providers under the Health and Disability Services (Safety) Act 2001
- issuing guidelines under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and other Acts.

Director of Mental Health

The positions of Director and Deputy Director of Mental Health are both provided for in the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Director of Mental Health is responsible for the general administration of the Act under the direction of the Minister and Director-General. The Director is also the Chief Advisor of Mental Health and is responsible for advising the Minister on mental health issues.

The Director's functions and powers under the Act allow the Ministry to provide guidance to mental health services, supporting the strategic direction provided in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*⁴⁷⁴ and a recovery-based approach to mental health.

474 <https://www.health.govt.nz/system/files/documents/publications/rising-to-the-challenge-mental-health-addiction-service-development-plan-v2.pdf>

Director of Public Health

The Director of Public Health position is provided for in the Health Act 1956. The Director of Public Health has the authority to independently advise the Director-General and Minister on any matter relating to public health. The Director also provides national public health professional leadership and professional support and oversight for district medical officers of health.

Chief Financial Officer

The Public Finance Act 1989 requires all departments to have a chief financial officer responsible for the quality and completeness of the department's statement of intent and annual accounts. The Chief Financial Officer ensures that internal controls are effective and efficient and heads the Finance and Performance business unit.

Clinical leadership within the Ministry

The Ministry employs health practitioners from a variety of backgrounds in a range of clinical leadership roles. These staff provide clinical expertise and sector leadership and engagement and manage clinical areas of the Ministry's work programme. The Ministry's clinical leadership is jointly led by the Chief Medical Officer and the Chief Nursing Officer. This clinical leadership:

- provides strategic, clinical leadership across the health and disability system
- leads engagement with the medical profession and organisations
- provides clinical advice and input across the Ministry to help inform policy, programme development and legislative administration and to plan, fund and monitor health service delivery
- maintain links between New Zealand and the international medical community for the purpose of benchmarking New Zealand practice against international standards and ensuring that New Zealand medical practice is abreast of international developments.

District health boards

There are currently 20 district health boards (DHBs) in New Zealand. DHBs are responsible for implementing the health policies of the government and for providing or funding the provision of health services in their districts. DHBs fund primary health organisations to provide essential primary health care services to their populations. Public hospitals are owned and funded by DHBs.

The New Zealand Public Health and Disability Act 2000 created DHBs and sets out their objectives, which include:

- improving, promoting and protecting the health of people and communities
- promoting the integration of health services, especially primary and secondary care services
- seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional and national needs
- promoting effective care or support of those in need of personal health services or disability support.

DHBs are responsible for implementing the health policies of the government and for providing or funding the provision of health services in their districts.

DHBs fund primary health organisations to provide essential primary health care services to their populations.

Other DHB objectives include:

- promoting the inclusion and participation in society and the independence of people with disabilities
- reducing – with a view to eliminating – health disparities by improving health outcomes for Māori and other population groups.

DHBs are required to plan and deliver services regionally as well as in their own individual districts. To do this, DHBs are generally grouped into four regions. The DHBs of each region work together in order to find new and better ways of organising, funding, delivering and continuously improving health services to the people in their wider community. Agreed regional actions are approved by the Minister as part of a regional services plan.

The four regions are:

- Northern – Northland, Waitemata, Auckland and Counties Manukau DHBs
- Midland – Waikato, Lakes, Bay of Plenty, Tairāwhiti and Taranaki DHBs
- Central – Hawke’s Bay, Whanganui, MidCentral, Hutt Valley, Capital & Coast and Wairarapa DHBs
- South Island – Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs.

DHB appointments

For each of the 20 DHB boards, seven members are elected by the community every 3 years (concurrently with local elections), and up to four members are appointed by the Minister. The Minister also appoints each board’s chair and deputy chair from among the elected and appointed members. Should a vacancy arise, regardless of whether it is an elected or appointed position, the Minister can fill that vacancy at any time.

Members typically hold office for a 3-year term. All appointed members can be reappointed to the DHB at the end of their term, up to a maximum of 9 consecutive years. Elected members can be re-elected indefinitely.

At present, a number of DHB board positions are held jointly. Such cross-appointments are made to foster greater collaboration between DHBs. For example, there is a consistent chair across Auckland, Waitemata and Counties Manukau DHBs and also across Hutt Valley and Capital & Coast DHBs.

The Minister may appoint a Crown monitor or monitors to sit on a DHB's board if the Minister considers it desirable to do so to improve that DHB's performance. The Minister may also dismiss a DHB board and replace it with a commissioner if the Minister is seriously dissatisfied with that board's performance.

Funding and services

DHBs exist within a funding environment where:

- there is a mix of funding models (capitation, fee-for-service, pay-for-performance and individualised funding) and a range of financial and non-financial incentives – the Ministry also contracts directly with providers of some services, such as disability support and some maternity services
- a population-based funding formula (PBFF) determines the share of funding to be allocated to each DHB, based on the population living in the district – the formula includes adjustors for population age, sex, relative measures of deprivation status and ethnicity
- DHBs are responsible for making decisions on the mix, level and quality of health and disability services within the parameters of national strategies and nationwide minimum service coverage and safety standards

- the Ministry, as the Minister’s agent, defines nationwide service coverage, safety standards and the operating environment – the Minister enters into funding agreements with DHBs and may exercise reserve powers in the case of repeated performance failure (such as appointing a Crown monitor to the DHB board or dismissing the DHB board).

DHBs may provide services directly or contract with third parties. A DHB may also purchase certain specified services for their population from another DHB using a system known as ‘inter-district flows’. Where these services are provided by another DHB, a national agreed price is generally used or DHBs may agree on local arrangements between themselves. DHBs pay an additional lump sum to the tertiary hospitals to compensate them for the higher costs of maintaining specialist tertiary capability and access.

Accountability

As Crown agents, DHBs are accountable to the government through the Minister. The accountability documents that guide DHBs’ planning and performance can be broadly split into three groups: government expectations, planning documents and accountability documents.

Government expectations

The following documents set out the policies of the government of the day and the role DHBs are expected to play in implementing these policies.

- **Annual letter of expectations:** The Minister provides a letter of expectations to all DHBs and their subsidiaries annually. This letter sets out the strategic priorities of the government for the health and disability system. DHBs use this as a focus when they produce their annual plan, regional services plan, statement of intent and statement of performance expectations.
- **Enduring letter of expectations:** The Minister of Finance and the Minister of State Services issue an enduring letter of expectations

periodically to all Crown entities (including DHBs). This letter sets out more general expectations, including the need to achieve value for money and for strong entity performance.

Planning documents

The following documents set out the short-term course DHBs intend to follow to best meet the health needs of their populations.

- **Annual plan:** Each DHB agrees with the Minister on an annual plan. This plan sets out the best way of delivering health services locally, regionally and nationally and how this can be provided in a financially responsible manner and in line with the DHB's role and functions.
- **Regional services plan:** The regional services plan identifies a set of goals for a particular region and sets out how these goals will be achieved. Collaborating regionally has the potential to increase efficiency and provide a better standard of care across a greater area than if each DHB were to act alone. The Minister approves the regional services plan, and regions regularly report on their plan.
- **Māori health plan:** Māori health plans provide a summary of the health needs of a DHB's Māori population and set out the DHB's plan to meet these needs in order to reduce the health disparities between Māori and non-Māori. The plan is finalised by agreement between the DHB and the Ministry.

Accountability documents

The following documents allow Parliament and the public to measure the performance of DHBs and to hold them accountable.

- **Statement of intent:** Each DHB is required to publish a statement of intent (SOI) once every 3 years setting out the high-level objectives and strategic focus for the next 4 financial years (for example, an SOI published in the 2014/15 financial year will also cover

2015/16, 2016/17 and 2017/18). The DHB board prepares the SOI, with comment from the Minister. Once the board signs it off, the Minister tables the SOI in Parliament.

- **Statement of performance expectations:** DHBs include, as a component of the annual plan, a statement of performance expectations (SPE) containing the forecast financial statements for the current year. This document also sets out non-financial performance measures against which the DHB's performance can be assessed. The DHB board prepares the SPE, with comment from the Minister. Once the board signs it off, the Minister tables the SPE in Parliament.
- **Crown funding agreements:** Crown funding agreements (CFAs) are made between DHBs and the Minister. These set out the public funding the DHB will receive in return for providing services to its resident population. These agreements can also set out accountability requirements. CFA variations recognise changes in funding responsibilities for services or reporting requirements. The CFA variation process has four 'omnibus' rounds in the financial year. The execution date is the date on which the variation has been signed by both parties (the DHB's chief executive and the Director-General of Health).
- **Operational policy framework:** The operational policy framework is a set of business rules, policies and guideline principles that outline the operating functions of DHBs. The operational policy framework is incorporated as part of the CFA.
- **Annual report:** DHBs are required to report on their performance for the year against the measures set out in their SPE and their current SOI. Other information must be included in an annual report, such as:
 - › a statement of service performance
 - › an annual financial statement for the DHB

- › any direction given to the DHB by the Minister
- › the amount of remuneration paid to DHB board members and employees in the year
- › an audit report produced on behalf of the Auditor-General.

Annual reports must be signed off by two board members and provided to the Minister within 15 working days of the DHB receiving the audit report.

- **Quality accounts:** Quality accounts are a means by which health care providers account for the quality of the services they deliver, just as financial accounts show how an organisation uses its money. Quality accounts are produced annually by DHBs with guidance from the Health Quality & Safety Commission.

Performance

In addition to performance reported on in accountability documents, DHBs' progress towards achieving financial and non-financial performance targets is reported throughout the year.

The Ministry uses a monitoring and intervention framework (MIF) that allows it to influence DHB performance through increasingly intensive levels of monitoring and, where necessary, intervention to ensure that issues relating to poor performance are addressed.

Financial performance

DHBs provide financial data from financial templates after the end of each month. The information is analysed, and net results by DHB against plan are reported to the Minister. Following this, a further report presents an overview of the DHB sector as a whole (highlighting where the sector or an individual DHB reports a significant variance against plan or against comparable performance within the sector). Interpretation of the data provided by DHBs enables areas of financial pressure and risks as well as best practice within the DHB sector.

Non-financial performance

Health targets

Health targets are a set of national performance measures designed to improve the performance of health services that reflect significant public and government priorities. There are currently six health targets: three focus on patient access (shorter stays in emergency departments, improved access to elective surgery and shorter waits for cancer treatment), and three focus on prevention (increased immunisation, better help for smokers to quit and raising healthy kids). The health targets are reviewed annually to ensure they align with current health priorities, and performance is publicly reported on a quarterly basis.⁴⁷⁵

Patient experience survey

DHBs are expected to survey adult inpatients (aged 15 and older) on the experience of the care they received at least quarterly. The patient experience survey enables patients to provide feedback that can be used to monitor and improve the quality and safety of health services. Capturing, understanding and acting on patient experiences in a timely manner provides a vital contribution to improving health service delivery and to prioritising attention and resources.⁴⁷⁶

New Zealand Health Strategy

In April 2016, the Minister of Health, Hon Dr Jonathan Coleman, released a refreshed New Zealand Health Strategy.⁴⁷⁷

The strategy sets the framework for the health system to address the pressures and significant demands on its services and on the health

475 The current health targets and DHBs' results are on the Ministry's website – www.health.govt.nz/new-zealand-health-system/health-targets

476 Information about patient experience and current survey results are on the Health Quality & Safety Commission's website – <http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/health-quality-and-safety-indicators/patient-experience/>

477 See footnote 62.

budget. As the first refresh of this country's health strategy since 2000, it sets the direction New Zealand's health and disability system needs to take into the future.

Central to the strategy is the idea of all New Zealanders living well, staying well and getting well. This highlights the need for:

- a shift from treatment to prevention, improving people's lives and supporting greater financial sustainability
- overcoming the inequities in the health system so that it works for every New Zealander
- a deep understanding of what it's like to use the health system – so that services are customer-friendly and barriers to equity can be removed
- the Ministry, health providers, other government agencies, NGOs and communities working better together in recognition that a range of factors affect a person's health and wellbeing.

The health strategy has five strategic themes that summarise the overall thinking (see Figure 8):

- **People-powered** – providing services in different ways that reflect the varying needs of our diverse communities and providing information that helps people take control of their health and wellbeing.
- **Closer to home** – making it easier for people to access health services and working with local communities to provide tailored support on the ground.
- **Value and high performance** – making better use of data to understand all the factors that affect health outcomes and putting resources in the places they will make the most difference.
- **One team** – government agencies, health care providers, NGOs, experts, analysts and communities working together, designing and delivering services and support in a coordinated way.

- **Smart system** – using technology to improve services and make it easier to share information across the health system.

Figure 8. Five strategic themes of the New Zealand Health Strategy.



CHAPTER 25

The role of the Health and Disability Commissioner and the Code of Rights

Morag McDowell is New Zealand's Health and Disability Commissioner. Morag commenced the role in September 2020.

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Introduction

The Health and Disability Commissioner (HDC) is an independent Crown entity set up to promote and protect the rights of consumers who use health and disability services and, to that end, facilitate the fair, simple, speedy and efficient resolution of complaints relating to infringement of those rights.⁴⁷⁸

The office was established in 1996 following the Cartwright Inquiry, which investigated the withholding of conventional treatment from women found to have carcinoma in situ of the cervix, without the women's knowledge or consent. The 1988 Report of the Cervical Cancer Inquiry⁴⁷⁹ prompted sweeping changes around health consumers' rights, including the establishment of the Health and Disability Commissioner, the Code of Health and Disability Services Consumers' Rights with force of law and consumer advocacy services. It further led to changes in teaching practices (so as to conform to international standards), independent ethics committees and a national cervical cancer screening programme.

In accordance with its mandate, a significant proportion of the HDC's workload is the resolution of complaints. Everyone has the right to complain, and complaints are an inevitable part of health and disability service provision. There have been many studies showing what motivates consumers to complain. In general complainants want:

- communication – an explanation as to what happened and why
- corrective action – to prevent what happened to them or their loved one from happening again in the future
- an apology that is timely and authentic and acknowledgement of the harm caused.

478 Health and Disability Commissioner Act 1994, section 6.

479 [https://www.moh.govt.nz/notebook/nbbooks.nsf/0/64D0EE19BA628E4FCC256E450001CC21/\\$file/The%20Cartwright%20Inquiry%201988.pdf](https://www.moh.govt.nz/notebook/nbbooks.nsf/0/64D0EE19BA628E4FCC256E450001CC21/$file/The%20Cartwright%20Inquiry%201988.pdf)

A smaller proportion of complainants also seek sanctions and compensation.

The HDC strives to resolve complaints in an independent, fair and proportionate way while trying to maximise learning and quality improvement measures that may be revealed by inquiry into the circumstances that gave rise to the complaint. Promotion and protection of consumers' rights is therefore achieved by targeted, evidence-based recommendations as well as speaking into the sector where issues of concerns are noted.

In recent years, the Minister's Letters of Expectation have also directed the HDC to contribute to the improvement of health inequities prevalent in certain sectors of our community by drawing on intelligence from its dataset to feed and leverage quality improvement. To effect this properly, the HDC must itself ensure its complaints processes are accessible to and appropriate for consumers suffering such inequities.

This chapter focuses on the complaints process, including pathways of resolution.

The Code of Rights

The Code of Rights was drafted by the first Commissioner Robyn Stent and, after consultation, came into force as a regulation under the Health and Disability Commissioner Act 1994 on 1 July 1996. It confers legal rights on those who use health and disability services in New Zealand (consumers) and places corresponding responsibilities on providers of those services.

The Code of Health and Disability Services Consumers' Rights confers legal rights on those who use health and disability services in New Zealand (consumers) and places corresponding responsibilities on providers of those services.

Application of the Code is very wide and includes public and private services, paid and unpaid services, hospitals and individuals. The Code covers all registered health professionals, such as doctors, nurses and dentists, as well as unregulated providers such as naturopaths and caregivers. The Commissioner can consider systems issues as well as individual actions.

The Code does not override duties or obligations established in other legislation. For example, confidentiality of information about a consumer is affirmed in separate privacy legislation (see Chapter 4 – The purpose of medical records and notes).

Further, the Code does not extend to funding decisions or confer entitlement to any particular service, nor are the rights absolute. It is a defence for a provider to show that they took “reasonable actions in the circumstances to give effect to the rights, and comply with the duties in [the] Code”. The circumstances are defined to include the consumer’s clinical circumstances, the provider’s resource constraints and any other relevant circumstances.

In summary, there are 10 rights:.

- 1. Whakamana | Respect:** Consumers should always be treated with respect. This includes the right to be provided with services that take into account the needs, values and beliefs of different cultural, religious, social and ethnic groups, including the needs, values and beliefs of Māori.
- 2. Manaakitanga | Fair treatment:** Consumers have the right to be free from discrimination, coercion, harassment and exploitation.
- 3. Tu rangatira motuhake | Dignity and independence:** Consumers have the right to dignity and independence.
- 4. Tautikanga | Appropriate standard of care:** Consumers should be provided with services of an appropriate standard.

- 5. Whakawhiwhitinga whakaaro | Effective communication:**
Consumers have a right to effective communication in a form, language and manner that they can understand. The environment should enable open, honest and effective communication. This may require the services of an interpreter.
- 6. Whakamōhio | Full information:** Consumers should receive the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. That information includes an explanation of their condition, the options available, including an assessment of the expected risks, side effects, benefits and costs, and have any questions answered honestly. Consumers should be notified of any proposed participation in teaching and research and the results of tests and procedures.
- 7. Whakaritenga mōu ake | Informed choice and consent:** Consumers have the right to make informed choices and give informed consent. They have the right to refuse services and withdraw consent.
- 8. Tautoko | Support:** Consumers have a right to have a support person with them, except where safety may be compromised or another consumer's rights may be unreasonably infringed.
- 9. Ako me te rangahau | Teaching and research:** The Code rights apply if consumers are involved in research or teaching.
- 10. Mana to amuamu | Right to complain:** Consumers have a right to complain about a provider. The provider must facilitate the fair, simple and speedy resolution of complaints.

All doctors should be familiar with the Code and should take action to inform consumers about the rights in the Code and enable consumer to exercise their rights. Copies of the Code, as well as other educational materials, can be obtained from the Commissioner's website (www.hdc.org.nz) or by phoning 0800 11 22 33.

Complaints resolution

HDC is focused on the fair and early resolution of complaints. Each complaint received by HDC is carefully assessed and resolved at the lowest appropriate level, taking into account the issues raised and the evidence available. The Commissioner also supports early resolution at source, noting the very significant advantages to providers, consumers and quality improvement measures if complaints are addressed and resolved at the earliest opportunity.

Each complaint received by HDC is carefully assessed and resolved at the lowest appropriate level, taking into account the issues raised and the evidence available.

Complaints to HDC are increasing. In 2020/21, HDC received 2,721 complaints – a 14% increase on the previous year and a 23% increase over 5 years. This is consistent with what is being reported in overseas jurisdictions. There are likely to be multiple reasons for this increase in complaint volume, including a growing awareness among consumers of their rights and increases in health care service activity and complexity.

Any person (including the consumer, a family member or even another provider) may complain to the Commissioner alleging that any action of a provider is or appears to be in breach of the Code.

Complaints can be received by HDC in a number of ways:

- HDC's online complaints form or an email/letter/phone call directly from the complainant.
- A referral from another agency such as registration authorities (for example, the Medical Council), the Ombudsman or the Coroner. If the Medical Council receives a complaint alleging that the practice or conduct of a health practitioner has affected a health consumer, under the Health Practitioners Competence Assurance Act, it must refer the complaint to the Commissioner in the first instance.

- A referral from the Advocacy Service – either because the complainant has requested that their complaint be dealt with by HDC, or an advocate believes an issue affecting consumer rights needs to be brought to the attention of the Commissioner.

Under the End of Life Choice Act that comes into force in November 2021, complaints concerning assisted dying services may also be referred to HDC by the Registrar (Assisted Dying).

On receipt of a complaint, the Commissioner is required to undertake a preliminary assessment of the complaint to decide what course of action, if any, is appropriate. Each complaint is triaged on the day of its receipt (or as soon as possible thereafter) to determine the pathway of resolution.

The Commissioner may, among other things:

- refer the complaint to another agency or person, including a regulatory authority such as the Medical Council – complaints may also be referred to ACC and/or the Director-General of Health
- refer the complaint back to the provider for resolution
- refer the complaint to an advocate
- call a mediation conference
- formally investigate the complaint
- take no action on the complaint.

In all circumstances, the Commissioner may seek further information to assist the determination as to the best means of resolution including seeking a provider response to the complaint, comment from witnesses (including the complainant and provider) and obtaining independent clinical advice about the standard of care.

Complainants and providers receive a written explanation of any such decisions and actions taken by the Commissioner.

HDC makes many recommendations for change or educational comments in response to a number of complaints and in this way holds the provider and system to account for learning and taking preventive action as well as protecting consumer's rights. HDC's recommendations have a high compliance rate, with 99% of recommendations being complied with in 2020/21.

Doctors are complained about in relation to around 25% of complaints received by HDC each year. Recurring themes in those complaints, include:

- failure to communicate effectively with the patient and their family/whānau and/or a disrespectful manner/attitude
- failure to ensure continuity/coordination of care
- inadequate documentation
- missed/incorrect/delayed diagnosis
- inadequate/inappropriate examination/assessments
- inadequate follow-up
- issues regarding informed consent.

Resolution pathways

A number of resolution pathways are available to the Commissioner. A number of these are discussed below.

Decision to take no further action

At any time after completing a preliminary assessment of a complaint, the Commissioner may, at their discretion, decide to take no action on a complaint if the Commissioner considers that any action is unnecessary or inappropriate.

When considering whether or not to take no action on a complaint, the Commissioner may also take into account any of the following matters:⁴⁸⁰

- The length of time that has elapsed between the date when the issue(s) complained about arose and the date of the complaint.
- Whether the subject matter of the complaint is trivial.
- Whether the complaint is frivolous or vexatious.
- Whether the consumer does not want action to be taken.
- Whether there is an adequate remedy that it would be reasonable for the complainant to exercise.

In some circumstances, the Commissioner may decide to take no further action but will make recommendations for improvement to systems and practices. HDC will then follow up the recommendations to ensure any changes are appropriately implemented. In cases where the wider health sector may benefit from the learnings revealed by the assessment of the complaint, the Commissioner may publish an anonymised case note on the HDC website.

Case study

A consumer suffering from insomnia was prescribed zopiclone to help her sleep. She was given repeat prescriptions for the drug by several different GPs at the same medical practice over a period of 2 years. She became concerned about the lack of information provided to her about the risks of dependency from long-term use. Subsequently, she made a complaint to HDC.

After receiving the complaint, HDC obtained a response from the provider in question and sought advice from an expert. The expert advised that, although the treatment had been appropriate, the pattern of prescription was not consistent with best practice for

480 Health and Disability Commissioner Act 1994, section 38(2).

treating insomnia. After receiving the expert's advice, the provider told HDC that it had undertaken an audit of all patients on sleeping medication and held a clinical peer review meeting to discuss the particular case.

HDC considered that, given the actions taken by the provider to address the complaint and to prevent a similar case arising in the future, further action was unnecessary, and the complaint was closed. However, the case provided a valuable learning opportunity for the clinicians involved. In the interests of promoting consumer-centred care, the Deputy Commissioner recommended that the provider report back to HDC on the results of the audit and detail the steps it had taken to improve the process for reviewing long-term medication use to ensure that consumers understand the risks of treatment. In response to these recommendations, the provider told HDC that it had implemented an alert system for repeat prescriptions, with one doctor allocated to each patient, and it follows a policy of documenting that a consumer has understood the risks of treatment.

Referral to advocacy and the Advocacy Service

HDC contracts with the National Advocacy Trust to provide and operate the independent Nationwide Health and Disability Advocacy Service⁴⁸¹ – a free service that is available throughout New Zealand. The Advocacy Service plays an important role in resolving complaints that are suitable for resolution between the parties, with advocates assisting people to work with providers to achieve resolution. Promoting awareness of the rights of consumers is another key part of an advocate's role. To achieve this, advocates network extensively within their communities and provide community-based education to consumer groups and providers, with a particular focus on establishing contact with vulnerable people.

481 <https://advocacy.org.nz/> – the Advocacy Service can be contacted by freephone on 0800 555 050 or at advocacy@advocacy.org.nz.

Advocates do not make decisions on whether there has been a breach of the Code. Consumers are at the centre of the Advocacy Service complaints process. Advocates guide and support people to clarify their concerns and the outcomes they seek. This clarity enables the provider to write or speak effectively and directly to the complainant. Both complainants and providers provide positive feedback about the clarity advocates can bring to the process, not only identifying issues, but also providing guidance about what complainants need to help them resolve their concerns. Hearing each other's stories is an essential part of the advocacy and resolution process.

The Advocacy Service has a high resolution rate – 85% of complaints managed by the Advocacy Service are considered by the complainant to have been resolved or are withdrawn, and the majority are closed within 3 months. The Advocacy Service also achieves high satisfaction rates, with 93% of consumers and providers who responded to satisfaction surveys saying that they were satisfied or very satisfied with the service.

HDC will often refer complaints that are suitable for early resolution to the Advocacy Service to assist complainants to resolve the complaint directly with the provider. Advocates must report back to the Commissioner the results of a referral to advocacy.

Advocates will refer complaints to HDC where the advocate believes that an issue affecting consumer rights needs to be brought to the attention of the Commissioner. Advocates may also assist people to write a complaint to HDC where the complainant requests this support.

Case study

A woman complained about communication from a fertility services provider. She had received conflicting advice about the waiting time for services. She complained to HDC but subsequently indicated her willingness to use the Advocacy Service. Given this, the nature of the issues complained about and the need for an ongoing relationship,

HDC made a formal referral to advocacy. A teleconference was held with the woman and the provider during which the provider heard her concerns and agreed to a range of actions including provision of better information to consumers, reviewing ways of ensuring consumers received better information about waiting times and appointing a key person for each consumer to deal with. The complaint was thereby successfully resolved and the HDC complaint closed.

Referral for resolution between the parties

Often the quickest and most satisfactory way of dealing with complaints is for the consumer to deal directly with the provider. Where HDC considers that a complaint is suitable for resolution between the parties, the Commissioner may refer a complaint to the provider to resolve directly with the complainant or to the Advocacy Service to provide support to the complainant to resolve the complaint. Resolution between the parties can allow the provider and complainant to restore trust and can therefore be particularly helpful where there is an ongoing relationship between the provider and consumer.

A health or disability service provider who respects, listens to and involves the consumer (and family/whānau where appropriate) is more likely to resolve any concerns at an early stage. Right 10 of the Code requires providers to have a complaints procedure that facilitates the fair, simple, speedy and efficient resolution of complaints. Right 10 also sets out minimum requirements for complaints management, including timeframes for complaints management and information that should be provided to consumers in response to a complaint. Consumers are entitled to the assistance of a support person or an independent advocate when making a complaint.

All referrals to a provider or the Advocacy Service are accompanied by a requirement to report the outcome back to the Commissioner. This

enables the Commissioner to review the outcome of referrals to ensure the matter is adequately resolved, any compliance issues are addressed, and independent oversight is maintained. The Commissioner may take further action if not satisfied with the reported outcome.

Case study

A woman visited her GP clinic after she miscarried early in her pregnancy. She was told that she would need regular blood tests and to call the clinic to check her results but was given no explanation about why this was necessary. In subsequent interactions she had with the clinic, it was apparent that some staff did not know that the woman had miscarried. Given her ongoing relationship with her general practice, HDC decided to refer the matter to the practice for resolution. As a result, the provider met with the woman to apologise for the poor quality of care she received. The nurses involved were reminded about the importance of effective communication and empathy for patients in distress. The clinic also reviewed its processes to ensure that sufficient information about the reason for tests is given to patients who have suffered a miscarriage.

Referral to other agencies

The Commissioner has wide discretion to refer a matter to an appropriate person or authority. For example, a complaint of a breach of health information privacy will be referred to the Privacy Commissioner, and a complaint of discrimination may be referred to the Human Rights Commission. Concerns about the conduct or competence of a registered health practitioner may be referred to the appropriate registration authority such as the Medical Council.

The Commissioner must inform the appropriate authority or person if the Commissioner becomes aware that the practice or systems of a health care provider may pose a risk of harm to the public – for example,

complaints that raise concerns around the safety of medication or medical devices may be referred to MedSafe.

Working with other agencies is an important part of promoting and protecting the rights of consumers. The Commissioner regularly liaises with other agencies that have a responsibility for quality and safety in an effort to ensure that we all have a complete picture and to ensure that everyone is using their powers and functions effectively to identify public safety concerns and leverage change.

Other restorative justice pathways

The Commissioner may call a mediation conference of the parties at any stage. Mediation can be a very effective way of resolving complaints and provides an opportunity for the parties to agree to a fair outcome with minimum delay and cost.

This power has been rarely used in recent years. As a new Commissioner, Morag McDowell is keen to explore how HDC can make better use of restorative justice options, particularly for consumers whose cultural needs would favour a *kanohi-ki-te-kanohi* approach.

Case study

HDC received a complaint related to a man who had suffered a traumatic brain injury as a 9-year-old child. He was now an adult and had been residing in a residential facility. There were issues with his behaviour, and the family had removed him and organised a package of care themselves that was culturally appropriate for him. His behavioural issues had subsequently largely resolved. The whānau requested a hui, which was arranged and attended by the whānau, representatives from the provider facility and representatives from HDC.

The whānau wanted to explain the consumer's whakapapa, that he was a valued member of their whānau and the causes of the issues that had arisen. They agreed he had been aggressive but said that related to how he was treated by another resident at the facility. The provider accepted that changes needed to be made and apologised for the hurt experienced by the man and his whānau. Feedback after the hui was extremely positive.

Investigation

The Health and Disability Commissioner Act states that the Commissioner may investigate any action of a health or disability service provider if the action is or appears to the Commissioner to be in breach of the Code.⁴⁸² Some complaints – for example, those involving allegations of serious professional misconduct, sexual impropriety, complex systems issues or public safety issues – are not appropriate for low-level resolution and proceed to a formal investigation. The Commissioner may commence an investigation in response to a complaint or on the Commissioner's own initiative. The investigation process is independent and impartial.

It is through a formal investigation that the Commissioner determines whether there has been a breach of the Code.

The provider is given a copy of the letter of complaint and asked to respond to the complaint and provide information such as clinical records. The provider's response is very important in informing the Commissioner's understanding of what occurred and the Commissioner's opinion as to whether an investigation is appropriate. Where the appropriate standard of care is in issue, expert independent clinical advice from a peer of the provider is often obtained to assist the Commissioner. Relevant professional groups such as the Royal New Zealand College of General Practitioners nominate expert advisers, and the advisers are named in the Commissioner's reports.

482 Health and Disability Commissioner Act 1994, section 40.

If the Commissioner decides to commence a formal investigation, the provider and the relevant registration authority, such as the Medical Council, are notified of the investigation.

The Health and Disability Commissioner Act gives the Commissioner wide powers to gather relevant information. This includes the ability to summon witnesses, to take evidence under oath and to require the production of relevant documents. It is an offence to obstruct or hinder the Commissioner or any other person in the exercise of their powers under the Health and Disability Commissioner Act or to give false or misleading information. Once evidence has been collected, further expert advice may be required.

Most investigations result in a written report from the Commissioner where conclusions are drawn on the facts and an opinion reached on whether the Code has been breached. All the evidence gathered is assessed and analysed in reaching that opinion. Before forming a final opinion, the Commissioner sends a copy of the information gathered to the parties. If any adverse comment is proposed to be made about a person, that person is given an opportunity to respond to the adverse comment prior to the report being finalised. The Commissioner considers the responses to the provisional report and sometimes seeks further expert advice before issuing a final report. The reports are usually published in a partially anonymised form on the HDC website.

An investigation can be a lengthy process, depending on the complexity of the issues under consideration and the number of people involved.

Options where there is a breach of the Code

Where an investigation reveals a breach of the Code, the Commissioner has a number of options. The Commissioner will often make recommendations to improve systems or practices to help ensure that preventive action occurs and the chance of recurrence is reduced. For example, the Commissioner may recommend that the provider offer the consumer a written apology, review their practice in the light of the Commissioner's report, undertake further education or implement appropriate systems to prevent a recurrence. Where a wider systems issue is identified, the Commissioner may ask other agencies such as the Ministry of Health to take actions to address this issue.

The Commissioner cannot order compensation but occasionally may recommend that a provider refund money paid for substandard services.

The Commissioner's opinion is reported to the provider's relevant registration authority, and in the case of a doctor, the Medical Council may be asked to consider the need for a competence review. Copies of the report may also be sent to the Minister of Health, funders or any other appropriate agency to enable them to take further action if necessary.

Reports with significant educational value are distributed to the appropriate colleges and posted on the Commissioner's website (www.hdc.org.nz) in a partially anonymised form. The Commissioner is empowered to name providers publicly.⁴⁸³ While the Commissioner will usually name group providers such as a DHB or a rest home, individual providers are only named in exceptional circumstances (such as where the provider poses a risk of harm to the public).

The Commissioner uses individual complaints to promote wider systemic improvements. For example, in the case below, the Commissioner made sector-wide recommendations.

483 <https://www.hdc.org.nz/decisions/naming-policy/>

Case study

A woman required surgery for suspected endometriosis. She told the obstetrician and gynaecologist (O&G) at a public hospital that she did not want ablation used to treat any endometriosis found. The woman repeated her refusal for ablation at the pre-assessment clinic, and this was documented in her clinical notes.

On the day of surgery, a registrar obtained written consent for surgery but did not read the pre-assessment notes that recorded the refusal of ablation. When the O&G performed the surgery, endometriosis was found and removed using ablation.

The Commissioner found the O&G in breach of Right 7(7) of the Code for using ablation to treat the woman's endometriosis when she had specifically refused consent for this. Furthermore, the Commissioner was critical the O&G did not read the notes sufficiently to obtain the information he needed before commencing the surgery and did not keep adequate notes of information given to the woman or discussions in which the woman raised concern. The O&G was therefore found in breach of Rights 4(1) and 4(2) of the Code.

The Commissioner considered that staff at the DHB lacked clarity and guidance on the relevance of consent discussions, the escalation of pertinent information about consent and the reading of pre-operative assessment notes and found the DHB in breach of Right 4(1) of the Code.

The Commissioner recommended that the DHB report back to HDC on its corrective actions taken following this complaint, review staff training on informed consent, confirm the process for escalating important consent information at pre-assessment, clarify the expectation that an operating surgeon is responsible for reading the pre-operative assessments and provide a written apology.

Proceedings

Following a finding of a breach of the Code, the Commissioner may refer a provider to the independent Director of Proceedings to decide whether legal proceedings should be issued against that provider. Before referring a provider, the Commissioner must give the provider an opportunity to comment on the proposed referral. The Commissioner must also have regard to the wishes of the consumer and complainant and the public interest (including any public health or safety issues).

The Director of Proceedings may take proceedings before the Human Rights Review Tribunal and/or the Health Practitioners Disciplinary Tribunal or may decide to take no further action. An aggrieved person may themselves bring proceedings before the Human Rights Review Tribunal where the Commissioner, having found a breach of the Code, decides not to refer the matter to the Director of Proceedings or where the Director of Proceedings decides not to take proceedings.

The functions of the Health Practitioners Disciplinary Tribunal are outlined in Chapter 22 – Notifications and disciplinary processes.

Human Rights Review Tribunal

Where proceedings are brought before the Human Rights Review Tribunal, the Tribunal has the power to award a number of remedies, including:

- a declaration that the provider's action is in breach of the Code
- an order restraining the provider from continuing or repeating the breach

Following a finding of a breach of the Code of Rights, the Commissioner may refer a provider to the independent Director of Proceedings to decide whether legal proceedings will be issued against that provider

- an order that the provider perform any specified acts with a view to redressing any loss or damage suffered by the consumer as a result of the breach
- damages up to \$350,000 (including damages awarded in respect of loss suffered, expenses reasonably incurred, humiliation, loss of dignity, injury to the feelings of the consumer and punitive damages for any action that was in flagrant disregard of the consumer's rights)
- any other relief the Tribunal thinks fit.

Recent changes

There have been some recent legislative amendments and announcements that are expected to impact on the work of HDC.

The Code and the End of Life Choice Act 2019

The End of Life Choice Act 2019 (EOLC Act) comes into force on 6 November 2021. The EOLC Act enables a person who is competent and who has a terminal illness to request medical assistance to end their life.

Assisted dying services are health services that are subject to the Code. From 7 November 2021, HDC has the jurisdiction to hear complaints about services provided to a person who has requested assisted dying.

The EOLC Act operates to override some aspects of the Code as it relates to assisted dying services.

Informed consent and assisted dying

The EOLC Act prevents a health practitioner from initiating any discussion with a person that, in substance, is about assisted dying. They are also prevented from making any suggestion to a person regarding the option of receiving assisted dying services.

Rights 6(1)(b) and (c) of the Code provide consumers with the right to information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including an explanation of the options available and advice of the estimated time within which services will be provided. Right 6(2) similarly states that, before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent. A medical practitioner's obligations under these parts of Right 6 are overridden where a medical practitioner is complying with the EOLC Act's prohibition on initiating discussions or making suggestions about assisted dying.

Determining whether a person is competent to make a decision about assisted dying

If a person requests assisted dying services, the EOLC Act sets out a number of steps the medical practitioner must undertake, including determining whether the person is competent to make an informed decision about assisted dying. The assessment of competence required by the EOLC Act to make decisions about assisted dying differs to considerations of competence in Rights 7(2)–(5) of the Code. It is also not possible under the EOLC Act to make advance directives about assisted dying services. In situations where a person is seeking assisted dying services, these parts of Right 7 are overridden by the EOLC Act, and the EOLC Act's competence requirements must be complied with.

Mental Health and Wellbeing Commission Act 2020

On 9 February 2021, the functions of the previous Mental Health Commissioner at the HDC passed to the Mental Health and Wellbeing Commission. However, HDC will continue to look at complaints relating to mental health and addiction services. It will also continue to work with the Mental Health and Wellbeing Commission and the Ministry of Health on issues relating to mental health and addiction.

Aged Care Commissioner

An Aged Care Commissioner role has recently been established within HDC. The Aged Care Commissioner will be a Deputy Commissioner at HDC with existing functions and responsibilities including the resolution of complaints relating to aged care services. The role will also provide strategic oversight and stronger sector leadership to drive quality improvement, report on thematic improvements in aged care and provide enhanced advocacy on behalf of older consumers and their whānau and support the government's commitment to te Tiriti o Waitangi.

Conclusion

It is acknowledged that being on the receiving end of a complaint can be distressing and stressful for providers. This chapter has sought to demystify the complaints process and to emphasise that a key focus of the HDC is on systems and quality improvements and on seeking answers for consumers/complainants. Of course, from time to time, individual providers will be held to account (usually by way of breach finding), but only a very small proportion of cases are referred to the Director of Proceedings. Providers complained about are encouraged to seek professional and personal support if they require it.

CHAPTER 26

Medical Council of New Zealand

Joan Simeon is the CEO of the Medical Council of New Zealand.

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Introduction

Tā mātou kaupapa – our purpose – is to protect public health and safety in Aotearoa New Zealand through setting and promoting standards for the medical profession and ensuring doctors are competent and fit to practise.

We are governed by a Council, and our funding comes from the activities we carry out. In the most part, this is from the registration and practising fees paid by doctors in New Zealand.

Protecting the public

The Health Practitioners Competence Assurance Act 2003 (the Act) defines our role and purpose.

We are responsible for:

- registering doctors and maintaining a register of all registered doctors
- setting standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori) and ethical conduct
- promoting competence and lifelong learning for doctors
- assessing performance, investigating conduct and, when necessary, putting in place measures to ensure public safety when concerns are raised about a doctor's performance or professional conduct
- considering cases where doctors have a health condition that could impact on their ability to practise safely.

We also:

- set standards to ensure a high quality of medical education and accredit medical training institutions including medical schools, medical colleges and district health boards
- accredit and set programmes to ensure the ongoing competence of doctors.

We have effective legal powers that allow us to maintain the standards the public have a right to expect of doctors and these are laid out in the Act.

We are not here to protect doctors. Our role is firmly focused on protecting the health and safety of patients.

Independence and accountability

We believe patients' interests are best served by independent, open and accountable regulation. The principles of right-touch regulation guide our decision making:

- Proportionate – decisions will be proportionate to the risk posed.
- Consistent – our policies, standards and decisions will be based on the principles of fairness and consistency.
- Targeted – we focus on the problem and minimise side effects
- Transparent – we are open and transparent and keep our regulations simple and easy to understand.
- Accountable – we make sure our decisions and actions are robust and stand up to scrutiny.
- Agile – we are forward thinking and adapt to and anticipate change.

The Medical Council is accountable to the public and to the Minister of Health and Parliament but acts independently of government.

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The Council's role

Sometimes, members of the public notify us about a doctor's competence or professional conduct and would like us to investigate or to take disciplinary action. However, when we receive notifications that a doctor's practice of conduct has affected a health consumer, we must refer them to the Health and Disability Commissioner. This reflects the key role played by the Commissioner in protecting the rights of patients under the Code of Health and Disability Services Consumers' Rights.

The Health and Disability Commissioner deals with complaints about a doctor from patients, their families and other support people and from third parties such as concerned staff members in a health or disability service.

While we do not investigate the actual complaint, we are able to take action to assess that doctor's competence in order to protect the health and safety of the public. In addition, we are able to put conditions on the doctor's practice or suspend the doctor where there is a risk of serious harm to the public. This may be at the same time the Health and Disability Commissioner is investigating.

If the matter before the Commissioner relates to a doctor's conduct, the Council is not able to initiate its own investigation until the Commissioner has concluded. However, as with competence concerns, we are able to put conditions on the doctor's practice or potentially suspend the doctor if necessary to protect patients while the Commissioner investigation is under way.

The Health Practitioners Disciplinary Tribunal determines any disciplinary action to be brought against doctors and other health practitioners (see Chapter 22 – Notifications and disciplinary processes).

Our governance

We are governed by a 12-member council appointed by the Minister of Health.

The Council comprises:

- four doctors elected by the profession (who are then appointed by the Minister of Health)
- four doctors appointed directly by the Minister of Health
- four laypersons, also appointed by the Minister of Health – a layperson is someone who is not registered (or qualified to be registered) as a health practitioner.

The primary role of all Council members is to protect public safety.

Council members are usually appointed for a 3-year term and can be reappointed for additional terms to a maximum of 9 years.

The Council has six meetings scheduled each year. However, it may meet more frequently to consider any matters of urgency.

The Council has three committees that each report to the Council – the Health Committee, Education Committee and Audit and Risk Committee.

CHAPTER 27

Accident Compensation Corporation

Dr John Robson is the Chief Clinical Officer & Head of Health Partnerships for the Accident Compensation Corporation.

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Kia ora and welcome to this chapter on the Accident Compensation Corporation (ACC) – a no-fault accident insurance scheme unique to Aotearoa New Zealand. We've been here since 1 April 1974 and are an integral part of New Zealand society. We wrote this chapter to give a brief overview of the scheme to enable you to assist your patients with their ACC claims and support you with working in partnership with us.

We can assist with most enquiries, including cover, rehabilitation referrals, connecting you with the right teams and questions about invoices.

Phone [0800 222 070](tel:0800222070) (Monday to Friday, 8:30am - 5pm) Email providerhelp@acc.co.nz

For all other enquiries, such as locating the right recovery team, requesting information under the Official Information Act, finding a local site or reporting fraud, please visit www.acc.co.nz.

On behalf of the ACC team that put this together, thank you for taking the time to read and understand how we can support you to help your patients.

Ngāmihi nui

Dr John Robson, Chief Clinical Officer & Head of Health Partnerships

About ACC

Since 1974, ACC has provided a comprehensive, no-fault insurance scheme for people injured by accident. Levies from workers, employers and motor vehicle owners and funding from taxpayers are collected by ACC to fund injury prevention, rehabilitation and financial compensation.

ACC is a Crown entity, accountable to the Minister for ACC, and administers the scheme according to the Accident Compensation Act 2001 and Accident Compensation (Liability to Pay or Contribute to Cost of Treatment) Regulations 2003.

Cover is for everyone in New Zealand, including visitors. New Zealand citizens and residents who ordinarily live here and are injured while overseas may also be covered on their return.

Having ACC means that the right to take legal action for personal injury, including injury caused during treatment, is removed other than for exemplary damages.

Once a claim is accepted, the injured person has access to a range of appropriate supports such as treatment and rehabilitation as well as financial compensation, if they meet the relevant eligibility criteria.

Resources

- [About us – 2-minute introductory video](#)
- [How levies work](#)
- [About ACC](#)

Starting with ACC

To provide treatment for ACC patients, you will need to register with ACC and get an ACC provider number, even if you're a locum.

Resources

- [Register with us as a health provider](#)
- [Understanding your responsibilities](#)
- [Working together – a handbook for providers working under the Cost of Treatment Regulations](#) (PDF 703 KB)
- [How we support quality and resolve issues – explains how ACC provides feedback to health care providers and ensure quality and quantity of services](#)

Cover is for everyone in New Zealand, including visitors. New Zealand citizens and residents who ordinarily live here and are injured while overseas may also be covered on their return.

Injury prevention

ACC is committed to reducing the rates of accidents and injuries in New Zealand and encourages you to take the time to see how its initiatives can benefit you, your family/whānau and your patients.

Resources

- [Live Stronger for longer](#) – staying safe from trips and falls – programmes and resources for people over 65 years old
- [ACC SportSmart](#) – information about sport injury prevention, return to play and concussion resources
- [Keeping safe on the road](#) – programmes supporting young drivers, motorcyclists ([Ride Forever](#)) and scooter riders
- [Preventing injury](#)

Care and recovery from injury – covering claims

Each year, ACC accepts over 2 million claims. A claim is covered when it meets the criteria set out in the legislation. Most claims are easily lodged, and a cover decision is straightforward. For more complex claims, ACC may need to more information from you, other health providers, your patient and their employer to understand if the claim meets the legislative criteria.

Once a claim is accepted, ACC workd with health care providers and its contracted suppliers to make sure that the right supports are put in place to enable the best recovery practicable.

Cover criteria

ACC covers personal injury caused by:

- an accident
- a work-related gradual process, disease or infection
- treatment provided by or at the direction of a registered health professional (treatment injury)
- some criminal acts (sexual assault or abuse)
- traumatic event at work.

An injury is defined as:

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

The Accident Compensation Act describes an accident as a specific event (or series of events) that involves:

- the application of a force (including gravity) or resistance external to the human body or the sudden movement of the body to avoid such a force or resistance external to the human body
- inhalation or oral ingestion of any solid, liquid, gas or foreign object on a specific occasion, except for inhalation or ingestion of a virus, bacterium or protozoan, unless it is as a result of criminal conduct by another person
- a burn or exposure to radiation on a specific occasion (other than exposure to the elements)
- the absorption through the skin of any chemical for a period of not more than 1 month

- exposure to the elements or to extreme temperatures for a defined period (not exceeding 1 month) where the exposure results in death or incapacity of more than 1 month.

Accidents include those that are intentionally self-inflicted. However, ACC's ability to provide rehabilitation or financial support beyond acute care may be impacted. ACC will work with your patient to determine what support it can assist with.

Exclusions

Not considered accidents (unless work-related) or personal injuries are:

- any ectoparasitic infestation
- contraction of a disease through an arthropod as the active vector
- cardiovascular and cerebrovascular events
- conditions caused wholly or substantially by the ageing process
- gradual process diseases or infections.

ACC does not cover pre-existing conditions and 'wear and tear'. There are a few exceptions – for example, cover may be available for wear and tear for a work-related gradual process, disease or infection.

Resources

- [Understanding claims and cover](#) has practical examples of all claim types and a link to some specific resources on criteria for cover resources

Reviewing ACC decisions

A review application can be submitted to ACC within 3 months on all decisions ACC makes, including those for levy invoices. Once a review is requested, one of ACC's review specialists will work with the person to try to resolve the issue. If the issue can't be resolved, it may be referred to an independent reviewer or conciliator.

Resources

- [Review an ACC decision](#)
- [Get independent support](#)

Lodging a claim

All claims are initially lodged using an ACC45 form. Commonly, this form is completed via your practice management system (PMS) or by using ACC's online services. A paper-based ACC45 can be submitted if electronic lodgement is not possible.

Electronic and manual forms cover the same information and require you to identify a Read code or ICD code (in DHBs) that best describes the injury. If the injury diagnosis changes during treatment, you'll need to let ACC know so it can update what your patient has cover for.

Consent

The patient's consent is needed for you to lodge a claim and allows ACC to collect information about their injury from you and any other health providers involved.

For telehealth consults, a verbal approval will be accepted and must be recorded with the correlating clinical notes.

Accredited Employers Programme

Your patient may work for an accredited employer (AE) under the Accredited Employers Programme (AEP). Accredited employers 'stand in the shoes of ACC' and manage their own employees' workplace injury claims. If your patient is covered by an AE, you should complete the ACC45 as usual and send all forms and invoices to the AE contact or their third-party administrator (TPA). If you lodge the claim with us instead of the AE or TPA, there may be a delay in making a decision on your patient's cover.

When your patient is unsure if they work for an AE, you can call provider help on 0800 222 070.

Delayed lodgement

If you lodge a claim for a patient 12 months or more after the date of the accident, excluding sensitive claims, in addition to the ACC45, you should include:

- any supporting clinical records
- details of other health care services who have provided treatment.

Resources

- [Lodging a claim for a patient](#) – explains the process in detail, what supporting documentation is needed and the basic information you'll need to collect from your patient
- [Using the right Read code to lodge and update claims](#)
- [Patient consent for telehealth consults](#)

Lodging a claim for specific types of injuries

Most claims are straightforward – there is usually an easily identifiable accident and resulting injury. Once lodged, these can be quickly accepted.

ACC may require additional information or specialist assessment to establish cover where there is no clear link between the accident and the presenting condition. This is common for the specific injury types described below.

Treatment injuries

A treatment injury is a physical injury caused by treatment by a registered health professional. 'Treatment' means diagnosis, actual treatment and lack

A treatment injury is a physical injury caused as a result of treatment from a registered health professional, but some exclusions apply. There is no requirement to find fault, although in some cases, the cause of the injury will be treatment that is inappropriate in the circumstances.

of treatment. There is no need to find fault, although in some cases, the cause of the injury may be treatment that was inappropriate. Any underlying disease or pre-existing diseases can't be covered, although a significant worsening of disease that causes a new physical injury might be – for instance, metastatic cancer caused by delay in diagnosis, treatment or follow-up.

Exclusions are:

- a necessary part or the ordinary consequences of treatment – for example, hair loss following chemotherapy or radiotherapy burns would be unlikely to be covered
- injury caused solely by decisions about allocating health resources
- injury caused because a patient unreasonably delayed or refused to give consent for treatment.

Some examples of treatment injuries include some post-operative wound infections, pressure injuries, wrong side surgery and equipment failure causing a physical injury.

ACC reviews all treatment injury claims for risk of harm whether they are approved or declined. ACC must report to the relevant agencies responsible for patient safety where an investigation of the claim concludes that there is a belief of risk of harm to the public.

Lodging a treatment injury claim: If your patient's injury may have been caused by treatment, tick the 'Is this claim for treatment injury?' box on the ACC45, and complete an ACC2152 treatment injury claim form. ACC can contribute to the administrative costs of lodging a treatment injury claim – for example, recovering medical records. ACC will pay you if all the claim forms are filled out, even if ACC declines the claim.

Work-related gradual process, disease or infection

ACC can provide cover where your patient has been exposed at work to one of the substances or agents listed in the Accident Compensation Act⁴⁸⁴ and subsequently develops a listed occupational disease.

Other work-related gradual process injuries must meet a three-part test:

- There must be a particular property about the person's work task or work environment that has caused or contributed to the injury.
- The property or environment must not be found to any material extent outside the workplace.
- The risk of suffering the injury must be significantly greater for people who perform that task or work in that environment

Lodging a work-related gradual process, disease or infection claim: If you believe that the patient's condition has come on gradually because of their work, tick the 'Gradual process' box on the ACC45. ACC will contact your patient to find out more about their employment and work history. ACC will then send you an ACC271 medical practitioner cover questionnaire with a purchase order to contribute towards the cost of completion.

Mental injury

A mental injury is a clinically significant behavioural, cognitive or psychological dysfunction. It does not include hurt feelings, stress or loss of enjoyment.

Cover is for mental injuries that result from:

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

484 <https://www.legislation.govt.nz/act/public/2001/0049/latest/DLM105458.html>

Patients needing acute care should be referred to community mental health services.

Claims for work-related mental injury (WRMI) can be considered, when they:

- were caused by a single, sudden traumatic event
- were directly experienced, seen or heard whilst at work
- resulted from an event that could reasonably be expected to cause mental injury in people generally.

Lodging a mental injury claim: Use an ACC45 to lodge the claim and provide as much supporting information as possible. ACC will then usually refer your patient to a psychiatrist or psychologist (or other approved mental health specialist) for assessment and diagnosis.

Sensitive claims

Sensitive claims are those related to sexual assault or sexual abuse, caused by some criminal acts.⁴⁸⁵

The event may have happened many years ago. There does not need to be a physical injury, nor does it need to have been reported to Police or another authority.

ACC's fully funded Integrated Services for Sensitive Claims (ISSC) can provide some initial support for your patient and their whānau. It will support your patient to decide if they would like to then proceed to be assessed for cover for a mental injury.

Once covered, patients with mental injuries can access the full range of ACC's supports, although the main treatment offered is counselling or psychotherapy.

Lodging a sensitive claim: Your patient can lodge their claim through you, a nurse practitioner or one of ACC's registered therapists. Use an ACC45

485 <https://www.legislation.govt.nz/act/public/2001/0049/latest/DLM105476.html>

Read code SN571 (sexual abuse) or use 'Z' and add the relevant injury code. Write 'sensitive claim' in the accident description field. You should let your patient know that one of ACC's Recovery Partners will contact your patient for a 'welcome conversation'. This helps ACC to understand the situation, any barriers to accessing treatment and any additional information ACC may require.⁴⁸⁶

Hearing loss

ACC can provide cover for hearing loss where it is:

- a personal injury caused by accident
- the result of a work-related gradual process, disease or infection
- a treatment injury.

The person must have suffered at least a 6% hearing loss from accidental causes for the claim to be approved. For occupational noise-induced hearing loss to be covered, there must have been exposure for a considerable time to high levels of noise at work within New Zealand, and the hearing loss configuration must be consistent with noise-induced hearing loss.

Lodging a hearing loss claim: Use an ACC45 and as appropriate tick the 'Treatment injury' or 'Work-related gradual process, disease or infection' box. Once ACC receives the claim, it will arrange for assessments to be completed by an audiologist, and based on the information collected, ACC may then request an ORL specialist assessment. ORL specialists are engaged by ACC to assess claims to identify the apportionment of accidental causes for the hearing loss.

Resources

- [Treatment Injury – Claim Lodgement Guide.](#)
- [ACC2152 Treatment injury claim form \(DOC 183 KB\)](#)
- [Paying you for your services](#)

486 Further information can be found at www.findsupport.co.nz or by contacting ACC on 0800 735 566.

ACC-funded supports

Depending on your patient's injury and unique circumstances, once a claim is covered, they can access a range of treatment, rehabilitation and financial supports.

You can let ACC know that support is needed by ticking the 'Rehabilitation assistance required' box on an ACC45, via the ACC18 medical certificate, or by calling or emailing ACC.

Supports may be:

- treatment – including primary health, pharmaceuticals, imaging, elective surgery and pain management
- rehabilitation – services include home and community support, transport, equipment, housing modifications, education support and needs assessment
- compensation for lost earnings – called 'weekly compensation' for earnings lost as a result of the covered injury
- accidental death benefits, such as funeral grants and payments to dependants.

Resources

- [Referring a patient for rehabilitation](#) – includes information about pain management and concussion services
- [How we support clients throughout their recovery](#) – explains how ACC's recovery teams can assist you and your patient to find the right support
- [MyACC](#) – ACC's online service that enables some patients to self-manage and request the supports they need

Medical certification, financial compensation and recovery at work

Your patient will make the best recovery when the treating practitioner, employer and ACC work together to support a safe recovery at work as part of rehabilitation. Evidence indicates that the quicker we can all work to get a person back to work, the better it is for them. ACC knows that the sooner it can achieve a return to work, the better it is for its clients. New Zealand and Australian industry data demonstrates that the chances of returning to work reduce to 50% after just 5–6 weeks off work and that some people never return.

Assessing your patient

All patients should be assessed and examined in person each time they are issued with a medical certificate. It should be a clinical assessment of your patient's capacity to perform all or some of their pre-injury role or hours, regardless of the availability of suitable work or your patient's current employment status.

The ability, tolerance, risk model is a useful way to assess your patient.

Ability

- Specify what they can safely do — cognitively, physically, and interpersonally.
- Set out your diagnosis, treatment or rehabilitation recommendations and prognosis (if appropriate).

Tolerance

- Set out any appropriate adjustments to your patient's work such as hours, travel and tasks.
- Specify dates for staged return to activities at work.

Risk

- Specify what your patient must not do (to keep them and/or others safe).
- Describe what may be a risk to your patient – for example, certain activities or situations.
- Detail any specific actions that should be taken to reduce risk – for example, changes to the environment, seating or additional breaks.

There are only a few instances when your patient will be fully unfit for work because of their injury:

- Total inability to work – i.e. they are admitted and remain in hospital.
- The risks of returning to work are excessive and the work environment poses a risk of serious harm to your patient.
- Your patient is unable to travel to and from work (even with assistance).

You can certify your patient as fully fit, fit for selected work or fully unfit using the ACC45 for periods up to 14 days when the claim is first lodged and then the ACC18 for longer.

Both an ACC45 and an ACC18 medical certificate can be completed at the initial consultation and are usually submitted via your practice management system (PMS).

The ACC18 is also used to give medical clearance when your patient can do all their pre-injury work, activities or hours. This may occur when they are still undergoing treatment or awaiting a medical assessment for their injury.

You'll need to outline the activities, type of work and tolerances that your patient can do with their injury. Provide as much detail about your patient's injury as you can. This helps their employer and ACC work out what support is needed.

If weekly compensation is an appropriate support, ACC will pay up to 80% of a person's weekly income before the injury prevented them from being able to work. If your patient is able to work reduced hours or alternative duties while recovering from the injury, their employer can pay them for the hours they work. ACC can top up these wages with weekly compensation, so instead of getting 80% of their pre-injury income, they may earn up to 100%

Barriers or fears about returning to work

If your patient presents barriers or fears, you should explain to your patient that work is a valuable part of their rehabilitation by keeping them connected to the workplace and maintaining their income.

You can let ACC know about your patient's barriers or fears on the ACC18. Then ACC and the employer can work together to provide additional workplace support so that your patient stays on track with their recovery.

If your patient says that there are no light duties, please encourage them to be in regular contact with their employer. ACC has found that most employers are more than happy to support recovery at work and provide suitable alternative duties for their employee.

ACC has a range of supports and resources to help your patient and their employer to support a safe recovery at work. This includes Stay at Work (SAW) service providers, specialised equipment and technology, modifications to the workplace, transport to and from work, occupational workstation assessments, functional assessments and specialised health professionals.

Help with the medical certification process for your patient

If you need help:

- phone **0800 222 070** (Monday to Friday 8:30am – 5pm)
- email providerhelp@acc.co.nz

Resources

- [Certifying work capacity after injury](#) – this online course hosted by the Goodfellow Unit is intended to grow your skills and confidence in this area, there is no cost, it takes about 30 minutes and it contributes toward educational (CPD) credits
- [Issuing medical certificates and return to work](#) – comprehensive guidance on how to assess your patient and the value of maintaining connection with work.
- [Medical Council of New Zealand – Statement on medical certification](#)

What ACC can pay you

How much ACC can pay medical practitioners is either set out in the cost of treatment regulations or in ACC contract(s).

Resources

- [Paying you for your services](#)
- [Services we have contracts for](#)

Additional resources

Understanding how ACC works and makes decisions is important both for you and your patients. ACC has online resources, communications and independent organisations that can help.

Online learning modules

[Learning.acc.co.nz](https://learning.acc.co.nz)

These modules about ACC are free to complete and can be done at your own pace. To register, simply follow the instructions on the site and, when prompted, select 'Health provider' as your access point. Once your account has been created, you can select your profession. The modules include:

- what ACC does
- claim cover
- lodging claims.

Monthly updates for primary health

[Subscribe to our provider update emails](#)

ACC sends out a monthly provider e-newsletter with updates relevant to all providers. Keep up to date with information specific to your profession.

Independent organisations

[Get independent support](#)

Anyone with a claim-related question or issue or who would like support to navigate ACC's processes can get independent support from two independent organisations, Way Finders and Workplace Injury Advocacy Service.

CHAPTER 28

Doctors and the Ministry of Social Development

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The Ministry of Social Development (MSD) is the government department charged with providing support to members of the New Zealand population who currently have no income – including the unemployed, people limited by disabilities or health conditions, at-risk families and solo parents. Work and Income is the service delivery arm of MSD. The Ministry’s stated purpose is: “We help New Zealanders to be safe, strong and independent.”

But what has MSD got to do with health? A quick reminder of the widely accepted social determinants of health – income, employment, education, housing and access to health services – will give a clear indication of MSD’s importance to the health of New Zealand.

MSD has involvement in all of these determinants:

- **Income:** For those people who currently lack a source of income, MSD provides welfare benefits through Work and Income to working-age families, while those aged over 65 receive superannuation through Senior Services.
- **Employment:** Work and Income is a major provider of suitable employment opportunities for those out of work.
- **Education:** MSD administers student loans through StudyLink.
- **Housing:** Although MSD does not provide housing as such, it is responsible for the assessment of need for those seeking social housing including emergency housing.
- **Access to health services:** MSD can offset the financial barrier to accessing services through the Disability Allowance.

As this list clearly shows, MSD is a very large government department and is responsible for administering nearly a third of government expenditure through its various divisions – Work and Income, StudyLink, Seniors, Policy and Community Investment. Until 1 April 2017, it also included the child protection agency Child, Youth and Family. This is now a stand-alone ministry renamed Oranga Tamariki – Ministry for Children. Although a separate entity, it continues to work closely with MSD.

With such a large and complex organisation, it is neither practicable nor possible to know all the services that may be available for your patients. It is therefore valuable to establish a point of contact within the organisation. The most appropriate people for this role are the Regional Health and Disability teams who can ensure you have a direct-dial contact point for you to use (not your patients, please note). You may well be very surprised at just how many different services are available – particularly in terms of supporting people with disabilities or health conditions that impact on their work capacity to find suitable work. There are 11 such teams spread across New Zealand, and your local one should be known by your practice manager.

With one in eight working-age adults living on a welfare benefit and one in five New Zealand children growing up in households with no one in paid work, there is inevitably a significant number of your patients whose health will be affected by the absence of paid employment in their lives. The adverse health outcomes of worklessness have been well documented in recent years.⁴⁸⁷

The most common interaction between doctors and MSD is in the provision of work capacity medical certificates to support your patients being able to access appropriate support from MSD. While this support is often financial, it can also be to enable the person to consider suitable employment when and where this is possible. The professional responsibilities around medical certification are very well documented in the Medical Council's statement on medical certification,⁴⁸⁸ and this is essential reading. A medical certificate is a legal document and represents your best clinical assessment based on what you know and have observed. It is useful to consider all medical documents as prescriptions and to apply the same criteria:

A medical certificate is a legal document and represents your best clinical assessment based on what you know and have observed.

- Is this the best treatment for the condition?
- Is it evidence based?
- What are the potential side effects?
- What are the potential interactions?
- What are the potential adverse effects?

487 <https://www.racp.edu.au/docs/default-source/advocacy-library/realising-the-health-benefits-of-work.pdf>

488 <https://www.mcnz.org.nz/assets/standards/0541c585e7/Statement-on-medical-certification.pdf>

Doctors often find themselves taking the role of advocate on behalf of their patients in a wide variety of situations – be it to access particular health services or to clarify a person’s condition or situation. In advocacy, it is important to be both professional and responsible, ensuring the desired outcome is going to be the best one for your patient. For the working-age adult who is out of work, supporting a road to independence through suitable paid employment to the extent this is possible should be the outcome goal. It is important not to put a medical barrier in the form of a medical certificate indicating ‘no work capacity’ in the way unless this is clearly clinically indicated.

CHAPTER 29

Doctors and the transport sector

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Introduction

A number of safety-sensitive occupations require personnel to hold medical certificates of a statutory nature. Many of these occupations are in the transport sector because of the public safety implications of medical impairment or incapacitation while acting in those roles. There are a small number of doctors appointed to examine certain occupational groups in each transport sector, but every doctor working in New Zealand is obliged to consider the public safety implications of the physical and mental health of their patients. There are occasions when this may conflict with the imperative to maintain patient confidentiality. The Medical Council of New Zealand acknowledges that there will be times when doctors' fiducial duty to their patient of concern and their duty to the public of New Zealand are at odds and that difficult decisions occasionally need to be made. Guidance on certification can be found in the Medical Council of New Zealand's statement on medical certification.⁴⁸⁹

Every doctor working in New Zealand is obliged to consider the public safety implications of the physical and mental health of their patients employed in safety-critical roles.

These concerns relate to two aspects of the health of your patient – could your patient's illness, treatment or some other aspect of their health status render them vulnerable to being chronically impaired or liable to sudden loss of ability to perform the tasks that their safety-critical transport crew job requires and what effect may the transport activity have on their health?

The transport sector

Government agencies

There are a number of government agencies that are involved in health and safety issues in the transport sector, including the following.

489 See footnote 488.

Ministry of Transport/Te Manatū Waka

Ministry staff support and advise the Minister of Transport and draft policy and legislation related to transport with the goal of improving transport in New Zealand, enhancing and monitoring the performance of public sector agencies and local authorities responsible for transport and ensuring value for money in investment in public transport. There are no medical staff at the Ministry of Transport, but the Ministry does seek advice from medical staff at the appropriate transport safety authority.

Civil Aviation Authority of New Zealand/Te Mana Rererangi Tūmatanui o Aotearoa

Civil Aviation Authority (CAA) staff establish, maintain and monitor compliance with aviation safety standards, promote aviation safety and oversee the Aviation Security Service and Airways NZ. The CAA Medical Unit⁴⁹⁰ establishes medical systems and standards for pilots and air traffic controllers, monitors the performance of aviation medical examiners, and conducts accredited medical conclusions concerning the fitness of aviation licence holders who do not meet the statutory medical standards.

Medical standards are published in Civil Aviation Rule Part 67, which defines three tiers of medical fitness:

- Class 1 for professional aircrew.
- Class 2 for private pilots.
- Class 3 for air traffic controllers.

There are also detailed resources and the CAA Medical Manual⁴⁹¹ for the information of medical practitioners and the aviation industry. Medical examiners appointed by the CAA hold a delegation from the Director of Civil Aviation to assess the fitness of pilots and air traffic controllers and receive information on medical aspects of licence holders. Some

490 The CAA Medical Unit can be contacted at (04) 560 9400 or med@caa.govt.nz.

491 <https://www.aviation.govt.nz/licensing-and-certification/medical-certification/>

pilot medical certification is undertaken under delegation from the CAA by industry bodies such as Gliding New Zealand, Recreational Aircraft Association of New Zealand and Sport Aviation Corp. Each has its own medical adviser (see below for details). Medical practitioners provide certification independently to pilots and can seek amplification from the relevant medical adviser.

Maritime New Zealand/Nō te rere moana Aotearoa

Maritime New Zealand (MNZ) staff establish and maintain standards for ships, ports, marine operational environmental protection, seafarers, recreational boating and visiting vessels. Ships' crews, known as seafarers, have two levels of medical certification – national certificates, which can be completed by any doctor, and international STCW and STCW-F-aligned certificates, which must be completed by a Maritime New Zealand -approved doctor. The medical standards for the various classes of certificates are specified in Maritime Rules Part 34.⁴⁹²

Waka Kotahi NZ Transport Agency

Agency staff have a wide range of functions that support land transport network planning, safety issues such as fatigue and alcohol and driver medical certification. Waka Kotahi publishes a guide that deals with medical standards for commercial and public service drivers and the health assessment of older drivers.⁴⁹³ Waka Kotahi has retained medical advisers who can provide advice to doctors with concerns for drivers with health problems.⁴⁹⁴ Waka Kotahi has an experienced full time health team including clinical, medical and mental health specialists.⁴⁹⁵

492 <https://www.maritimenz.govt.nz/rules/part-34/>

493 <https://www.nzta.govt.nz/resources/medical-aspects/>

494 <https://www.nzta.govt.nz/driver-licences/getting-a-licence/medical-requirements/information-for-health-practitioners/guidance-on-unfit-driver-notifications/>

495 Information can be sent to the medical team by email (medical@nzta.govt.nz), fax (+64 6 953 6261) or post (Private Bag 11777, Palmerston North 4442).

Waka Kotahi also manages the issue of driver licence medical certificates (DL9) and eyesight certificates (DL12). The DL9 form can be used to validate a CAA private pilot licence subject to certain restrictions on the operational use of the licence from 5 April 2021, at which time the recreational pilot licence was suspended. The legal authority to use a CAA private pilot licence in this way is provided is contained in the Civil Aviation Rules Part 61 Subpart A – General 61.35(a)(1).⁴⁹⁶

Private pilot licence holders using a DL9 medical certificate can operate single and multi-engine aircraft up to 2,730 kg but may not engage in solo instrument flight rules, agricultural or unrestricted aerobatic flying or carriage of people for hire or reward or carry more than five passengers or fly without a radio without a colour vision deficiency test certificate. Any private pilot licence holder wanting to engage in these activities will need to obtain and hold a CAA class 2 medical certificate issued by a CAA-appointed medical examiner.⁴⁹⁷

The medical standards that apply to a private pilot licence using a DL9 medical certificate are prescribed in *Medical aspects of fitness to drive: A guide for health professionals*.⁴⁹⁸ Doctors requiring advice on the standards of medical fitness for a private pilot licence using a DL9 medical certificate should contact the Waka Kotahi Medical Team,⁴⁹⁹ not the CAA Medical Unit. If a doctor has a concern that a private pilot licence holder may be medically unfit to fly, the Waka Kotahi Medical Team should be notified as a section 18 notification under the Land Transport Act 1998, which provides protections to the health practitioner for any privacy or confidentiality breach.

However, if a treating health professional has concerns about the medical fitness of a CAA pilot licence holder using a DL9 medical certificate,

496 <https://www.aviation.govt.nz/rules/rule-part/show/61/1>

497 See <https://www.aviation.govt.nz/licensing-and-certification/pilots/pilot-licensing/#PPL-medical-updated-info> for more information.

498 See footnote 493.

499 See footnote 495.

the health professional must also notify the CAA Medical Unit⁵⁰⁰ and advise the licence holder to do the same. There are protections for the health professional for any privacy or confidentiality breach as this is a requirement under section 27C of the Civil Aviation Act 1990.

In addition, the private pilot licence holder using a DL9 medical certificate with a concern about medical fitness to fly must not fly until cleared to do so by a health professional under the Civil Aviation Rules Part 61 Subpart A – General 61.35D.⁵⁰¹

Rail certification

Waka Kotahi also has the principal objective of facilitating the safe operation of rail transport services across New Zealand. This is achieved through regulation of the rail industry in accordance with the Railways Act 2005 and basic regulatory functions of issuing licences to rail participants and a range of compliance functions to assess the safety approach and performance of rail participants. In order to obtain a rail safety licence, rail operators are required to submit a safety case to the Waka Kotahi detailing how they will manage the safety requirements prescribed by the Railways Act. One of these requirements is to detail the policies in place to ensure that the rail operator's rail personnel:

- are fit for duty
- are not suffering impairment or incapacity as a result of fatigue, illness, medication, drugs, alcohol or any other factor.

All train operators who operate on what is known as the National Rail System (the KiwiRail-owned rail network) use the Australian National Transport Commission (NTC) National Standard for Health Assessment of Rail Safety Workers 2017⁵⁰² as a key standard to manage health and fitness requirements for rail safety workers.

500 See footnote 490.

501 See footnote 496.

502 <https://www.ntc.gov.au/codes-and-guidelines/national-standard-health-assessment-rail-safety-workers>

The NTC standard has been approved by the National Rail Systems Standards Executive – the body used by KiwiRail to manage interoperability standards with train operators using its lines. Train operators are bound to these national standards through access agreements with KiwiRail. Waka Kotahi approves both KiwiRail's and TransDev's safety cases, which reference the use of the NTC standard. TransDev Auckland holds the contract to operate the Auckland Metro trains on behalf of Auckland Transport.

The requirements for rail safety worker health assessments are determined by a risk management approach. This aims to ensure that the level and frequency of health assessments conducted is commensurate with the risk associated with the tasks performed by rail safety workers. Train operators must establish systems and procedures to ensure that rail safety workers receive the appropriate level and frequency of health assessment that corresponds with the risks associated with the tasks they perform.

The risk categorisation applied is based on a consideration of a key question – for any aspect of the worker's tasks, could action or inaction on the part of the worker lead directly to a serious incident affecting the public or the rail network?

KiwiRail and TransDev require their train drivers to meet category 1 under the NTC standard. These are workers whose action or inaction may lead directly to a serious incident. Their vigilance and attentiveness to their task is critical, therefore they are the main focus of the NTC standard. Category 1 workers are the highest level of safety-critical worker. These workers require high levels of attentiveness to their tasks and for whom sudden incapacity or collapse (such as from a heart attack or blackout) may result in a serious incident. The standard cites single-operator train driving as an example of a category 1 task. Train controllers and other safety-critical staff are required to meet category 2, reflecting the slightly lower potential impact of health on rail safety.

Transport Accident Investigation Commission/Te Komihana Tirotiro Aitua Waka

A standing Commission of Inquiry employs investigatory staff to evaluate accidents and incidents where there are secondary prevention opportunities in the aviation, rail and commercial maritime sectors. The Commission has a dedicated medical consultant who evaluates the medical aspects of safety breaches with the aim of preventing medical and human factors causes or contributory factors in future potential accident and incidents.

Transport industry

There are a number of industry bodies that provide important resources and online/phone advice to medical practitioners who have concerns about the public safety aspects of their unwell patients working in transport.

New Zealand Gliding

Gliding is generally considered medically less demanding than many other flying environments as flight does not normally involve extended flights across multiple time zones or physiologically demanding high-G environments. However, the very high cabin altitudes in generally unpressurised cockpits that can be achieved by gliders and significant turbulence mean that the cardiorespiratory performance of glider pilots is a critical determinant of whether the patient is fit to fly. A medical declaration (OPS 1)⁵⁰³ is required, which has to be countersigned by the applicant's general practitioner or CAA medical examiner. This should not be signed unless the treating doctor is confident that the applicant meets the medical safety standard or appropriate operational limitations are imposed.

New Zealand Gliding publishes advice on medical standards⁵⁰⁴ and has a medical adviser.⁵⁰⁵

503 <http://www.gliding.co.nz/sites/gliding.co.nz/images/downloads/MOAP/Forms/OPS/OPS%201.pdf>

504 <https://gliding.co.nz/wp-content/uploads/2017/02/MOAP-AL-26.pdf>

505 They can be contacted via <https://gliding.co.nz/executive-contacts/>

Recreational Aircraft Association of New Zealand (RAANZ)

RAANZ uses the Waka Kotahi *Medical aspects of fitness to drive*⁵⁰⁶ class 1 private vehicle standard as its medical standard for the recreational pilot licence. The medical certificate can be issued by the recreational pilot licence holder's usual general practitioner or a CAA medical examiner. The medical declaration and medical certification form can be downloaded from www.raanz.org.nz. Contact information for the RAANZ medical adviser is on the back of the RAANZ form.

Sport Aviation Corp

Sport Aviation Corp is the primary organisation regulating microlight flying. The microlight pilot licence medical standard is based on the Waka Kotahi *Medical aspects of fitness to drive*⁵⁰⁷ class 1 private vehicle standard. Pilots must complete a medical certificate and declaration form.⁵⁰⁸ Medical fitness standards and procedures are specified in the Sport Aviation Corp Exposition Section 5.⁵⁰⁹ Sport Aviation Corp has a medical adviser who can be contacted via <https://www.sportflying.co.nz/contact-us.html>.

Balloon Aviation Association of New Zealand (BAANZ)

Commercial balloon companies must operate to similar safety standards as small airlines. For this reason, any balloon operator who carries fare-paying passengers must hold a CAA commercial pilot licence (balloon) and hold a class 1 medical certificate issued by a CAA medical examiner. Non-commercial balloon pilots require a CAA class 2 medical certificate.

Employers

Some employers have their own in-house medical services that deal with occupational health and safety and medical fitness for duty.

506 See footnote 493.

507 See footnote 493.

508 http://www.sportflying.co.nz/uploads/8/8/2/4/8824800/sacform_8.2_medical_form_rev_0.pdf

509 https://www.sportflying.co.nz/uploads/8/8/2/4/8824800/sac_expo_section_5.0_rev.0.pdf

Major airlines

Air New Zealand and comparable airlines have in-house aviation medicine and occupational health services that conduct CAA and other medical examinations and provide medical advice to the airline about the health and safety of their staff. They also deal with issues relating to possible mental health or substance use by personnel. The medical service also takes part in fatigue risk management system design, rehabilitation, medical clearance of impaired passengers to travel and occupational health. Concerns about an airline employee may be addressed in the first instance to the airline medical services.

Airways New Zealand

Airways New Zealand provides air navigation services including aviation systems engineering and air traffic control to New Zealand and the international airspace surrounding it. It also contracts to send experienced staff to provide expert and consultancy services worldwide, so some staff travel overseas extensively. Airways New Zealand has a dedicated corporate medical adviser who can be contacted via medicaladvisor@airways.co.nz. Medical standards and certification of air traffic controllers, who must meet the International Civil Aviation Organization (ICAO) class 3 standard, is conducted by the CAA. Medical standards for other staff are general pre-employment standards or standards for working at heights. Training for air traffic controllers does not require a medical certificate, but applicants are screened by the Airways Talent team and, where necessary, the Corporate Medical Adviser.

Any doctor who has a patient who wants to apply to be an air traffic controller but has a health problem that may render them unfit for a class 3 medical certificate is welcome to consult the Airways Corporate Medical Adviser (CMA). If there is some uncertainty that the CMA can't

give a definite opinion on, the applicant is best advised to undergo a full CAA class 3 medical certificate issue examination to obtain a clear decision from the CAA, even though the certificate will not be required until starting their on-the-job training.

Aviation Security Service

There are employment medical standards for Aviation Security Service personnel but no statutory medical certification process. Aviation Security has a dedicated medical adviser who can be contacted through the Human Resources section.

KiwiRail

KiwiRail sets its own medical standards for operating rail crew and has appointed regional medical officers (RMOs) to conduct medical examinations and surveillance and advise the company about the health and safety of its safety-sensitive employees. It has a chief medical officer and a devolved RMO service. A doctor who has concerns about a locomotive engineer, train controller or other safety-sensitive staff member should in the first instance contact the local RMO, who will be familiar with health issues and operating demands in their region, via the local manager.

Auckland Transport (AT)

AT oversees the provision of transport for the Auckland region, including the light rail system which is run by TransDev, bus services and wharf and ferry services.

Impairment versus incapacitation

The critical factor for the transport sector is that the decisions of one individual – whether a pilot, air traffic controller, truck driver, school bus driver or train driver – directly impact on the safety of others, mostly importantly the travelling public. This may arise either from progressive chronic impairment or sudden medical incapacitation. Chronic impairment may arise from chronic illness, such as cardiorespiratory disease, head injury or musculoskeletal problems, or mental illness such as depression.

Impairment is easier to assess unless the effect on performance is variable, as is often the case with mental illness or traumatic brain injury. However, a range of best and worst case scenarios can be evaluated, and decisions on whether someone is fit to work in the transport sector should be based on their performance on their worst day. Impaired performance is a hazard due to the risk of errors, impaired cognition, mishandling or misperception. Research shows that performance impairment in the transport sector is most likely to be due to the effects of drugs, whether prescribed medication, recreational drugs or alcohol.

Sudden incapacitation is much more complex to assess, as it relates to the probability of immediate loss of function occurring as the result of illness or injury or on the basis of risk factors for disease. Examples would be

The critical factor for the transport sector is that the decisions of one individual, whether a pilot, air traffic controller, truck driver, school bus driver or train driver, directly impact on the safety of others – most importantly, the travelling public.

a convulsion, loss of consciousness, collapse with myocardial infarction, renal colic or migraine. Many such conditions are specifically mentioned in the medical declarations that safety-sensitive transport workers have to submit for confirmation by a government-appointed medical examiner or sometimes their general practitioner. Paradoxically, quite serious chronic diseases like cancer and diabetes may carry a relatively low risk of sudden incapacitation, as they are only slowly progressive and unlikely to come on suddenly.

Assessing the probability of suddenly incapacitating symptoms requires a careful and expert risk assessment, and a doctor who does not feel capable of doing this should refer to the appropriate guidelines such as the *Medical aspects of fitness to drive*,⁵¹⁰ CAA Medical Manual⁵¹¹ or Maritime Rules Part 34.⁵¹² Sudden incapacitation is categorised as obvious or subtle, and some agencies add cognitive incapacitation. Obvious incapacitation is most commonly a pilot with diarrhoea and vomiting or ENT problems, less often acute myocardial infarction.

Examples of subtle incapacitation would include a pilot with a cerebrovascular accident who becomes vague and erratic. The ICAO has safety rules to protect a pilot not flying who takes over control from an incapacitated or impaired pilot in command if there is a concern about the safe operation of the aircraft.

510 See footnote 493.

511 See footnote 491.

512 See footnote 492.

What if I am asked to provide a medical certificate for a patient?

In some cases, such as pilots and air traffic controllers with CAA medical certificates, railway medicals and for SCTW international seafarers' licences, only approved medical practitioners can conduct medical examinations for medical certification of fitness to use a licence. Other pilots and national seafarer licence medicals can also be certificated by their normal general practitioner. If you are approached by a patient applying for a medical certificate who is unknown or unfamiliar to you, you should exercise caution because of the risk of 'doctor shopping'.

It pays to check whether the patient is registered with another GP, as there is a high risk that the patient's normal doctor is aware of a health problem that would be disqualifying. Using the 'Find My Patient' function may identify the normal treating doctor, and if your practice has electronic health records, you may be able to identify consultations suggestive of medical conditions, risk factors, substance use or prescribed medication that may mean that the patient is applying for a medical certificate for which they are unfit. If you believe that the patient's normal GP has been bypassed or has declined to issue a medical certificate, you should ask the patient for background on why they have come to you for a certificate, check your concerns with the normal GP, conduct the

If you believe that the patient's normal GP has been bypassed or has declined to issue a medical certificate, you should ask the patient for background on why they come to you for a certificate, check your concerns with the normal GP, conduct the requested examination if you think appropriate or notify the appropriate authority if you think the patient has a disqualifying health condition and/or you think the patient has been 'doctor shopping'.

requested examination if you think appropriate or notify the appropriate authority if you think the patient has a disqualifying health condition and/or you think the patient has been 'doctor shopping'. If you decline to issue a medical certificate, it is likely that the patient will continue to find a doctor who will.

Pilot with a health problem

CAA-appointed medical examiners have the CAA Medical Unit medical staff to give them advice on fitness of CAA medical certificate holders with a deviation from normal health. This includes airline transport pilot licence and commercial pilot licence holders who are required to meet the highest standards for a class 1 CAA medical certificate. It is a mistake to regard this as a homogeneous group, however. Airline pilots fly in a multicrew environment as a team of captain and a crew of one or more first or second officers. The captain rank is a measure of seniority rather than being synonymous with acting as pilot in command of the aircraft, which is the term used for the person assigned to operate and manage the aircraft. Non-operating crew on the flight are monitoring, cross-checking and supporting the pilot in command and are termed pilot not flying. Roles will often change in that the most senior pilot on type will often conduct the take-off and departure and the subsequent approach and landing, which are the crucial phases of flight.

During the cruise, the experienced pilot in a national airline may leave the flight deck on long flights for the crew rest area so that they are refreshed for arrival. Since the Germanwings murder-suicide by aircraft, there will always be two pilots on the flight deck as a safety measure. In two-crew operations involving long flights or time zone changes, one pilot may nonetheless deliberately take planned sleep on the flight deck, known as cockpit napping. The crucial thing is that there is always a second person on the flight deck, providing an additional level of safety but also redundancy in the event of a medical misadventure. An exception might

be in the event of an active medical incapacitation such as psychotic episode where other crew cannot maintain control. While this has caused catastrophic accidents, this is extremely rare. Some airline transport pilot licence medical certificates are endorsed with a multicrew only limitation, which provides protection in the event of some medical risk or limitation. Similar multicrew protection is in place for crews on regional airlines who fly smaller aircraft to smaller destinations from major hubs.

The most vulnerable area of flight safety is in the sphere of what is known as third-level operators – single-pilot scheduled or chartered air transport operations where safety standards are relaxed due to the smaller passenger loads. Reliance on the health and performance of a single pilot means that medical standards for class 1 CAA medical certificate holders operating in this sector have to be the most rigorous. Accidents involving impairment or incapacitation in these sectors are evidence of the importance of risks from poor health in such pilots.

Commercial pilot licence holders with class 1 CAA medical certificates also work in aerial work operations, such as firefighting, hunting, commercial helicopter flights, adventure flying, agricultural aviation, logging industry and so on. They are often involved in operations that are moving things rather than people, which reduces the public safety risk, but operations where groups of people are carried in sometimes demanding and unpredictable conditions make this an area of flying operations where public safety is most vulnerable to pilot impairment or incapacitation, and any concerns should be most carefully considered.

The high-G acceleration environment of agricultural aeroplane and aerobatic pilots requires greater attention to cardiovascular fitness. Helicopter flying is more demanding of pilot performance than fixed-wing flying, and the consequences of pilot incapacitation are more catastrophic due to the handling characteristics of helicopters. Flight instruction is another crucial group where high levels of fitness are paramount. The experience of the other pilot is also crucial to the outcome – instructional

flights where the student pilot is unable to recognise impairment of the instructor or effectively take over control in the event of sudden incapacitation of the instructor effectively renders instructional flying as a single-pilot operation.

Included in adventure aviation is commercial ballooning, requiring pilots to hold a commercial pilot licence (balloon) and a class 1 CAA medical certificate. As commercial ballooning involves high levels of mental, perceptual and physical performance, it is an area that is quite susceptible to pilot health risks. The 2012 Carterton balloon tragedy illustrates just how many passengers can be fatally injured in a single accident.

The private pilot licence requires a lower level of fitness due to the less-serious consequences of an impairment or incapacitation. A CAA private pilot licence can be validated with either a CAA class 2 medical certificate or a Waka Kotahi DL9 medical certificate, although the latter has a lower level of privileges.

Air traffic controllers are required to hold a class 3 CAA medical certificate. These standards recognise that mental and perceptual performance are more important than physical performance for controllers when compared to pilots. They also take into account the wider range of possible responses for controllers who become impaired or incapacitated. An affected controller can close the radar sector or airfield or call for an immediate substitute controller where one with suitable ratings is available or where another controller is available to be called in at short notice. This is important for conditions such as migraine and so on. Controllers work in three main operational environments – in airfield control towers around the country in airports that range in size, traffic and complexity,

As commercial ballooning involves high levels of mental, perceptual and physical performance, it is an area that is quite susceptible to pilot health risks.

in the Christchurch Radar Centre and in the long-reach Oceanic Centre in Auckland. Each has its specific demands, and any concerns can be discussed with the Airways Corporate Medical Adviser who is familiar with individual controller health concerns, operating environments and risk mitigation.

A student pilot licence, unlike other classes of CAA licence, does not require other experience or currency standards but primarily relies on a class 3 CAA medical certificate. These are usually based on an issue medical examination, which should be more extensive and rigorous than subsequent medical surveillance, as it is the primary entry point into the aviation system and where the highest proportion of applicants will be found unfit until advancing years take their toll.

Standards for CAA medical certificates are specified in Civil Aviation Rules Part 67,⁵¹³ and guidance on their applicability in a range of situations is given on the CAA website.⁵¹⁴ These standards are not absolute, and the CAA or one of its delegated medical examiners may exercise ‘flexibility’ – an ICAO term where the risks of any deviations from normal health can be mitigated with appropriate responses. This requires an accredited medical conclusion where a panel of experienced doctors and the medical examiner consider that a deviation does not impose an aeromedical risk or can be mitigated by appropriate limitations on the use of the licence.

Part 67 medical examinations can only be conducted by aviation medical examiners who have undergone academic (by Otago University) and procedural (by CAA) training in aviation medicine to a standard set by the ICAO. Medical examiners carry a range of delegations from the Director of Civil Aviation to act on CAA’s behalf to examine and receive information, and medical examiners can also conduct other medical examinations for pilot licences not administered by the CAA in lieu of the patient’s general practitioner. They are also a useful source of advice to other health

513 <https://www.aviation.govt.nz/rules/rule-part/show/67>

514 See footnote 491.

professionals on what might be a reasonable concern about the fitness of a pilot. A list of aviation medical examiners is published on the CAA website.⁵¹⁵

CAA pilot licence holders are required to hold an appropriate medical certificate valid for the flying privileges that they are exercising. This means undergoing appropriate medical examinations as a requirement of section 27 of the Civil Aviation Act, ensuring that the certificate has a validity period that extends up to or beyond the intended use of the licence, notification to the Director of Civil Aviation of any significant change in medical fitness and not using the licence when not fit to do so. The issue of non-CAA licences is made with an undertaking that the licence holder will not use the licence if unfit to do so.

Driver with a health problem

This may apply to a commercial or public service vehicle driver with a health problem, but most common dilemmas arise from older private vehicle licensed drivers who require regular medical examinations of their fitness to drive. Older drivers are more likely to develop illnesses that cause impairment or risk of sudden incapacitation and are also more likely to develop illness in between routine medical examinations. Where there is concern, a certifying

Older drivers are more likely to develop illnesses that cause impairment or risk of sudden incapacitation and are also more likely to develop illness in between routine medical examinations. Where there is concern, a certifying doctor can specify that the driver should undergo a road safety test or an occupational therapy test or have a range-restricted licence.

515 <https://www.aviation.govt.nz/licensing-and-certification/medical-certification/nz-medical-examiners/>

doctor can specify that the driver should undergo a road safety test or an occupational therapy test or have a range-restricted licence.

Section 44A of the Land Transport Act requires a medical practitioner to advise Waka Kotahi if a person is judged not fit to drive any motor vehicle. Section 18 states that a medical practitioner must advise Waka Kotahi if a person has been advised not to drive but is likely to do so or has been issued a DL9 medical certificate with specific restrictions with which the driver is expected not to comply. This will commonly apply in the event of cognitive impairment in older drivers or a driver with convulsions or following severe traumatic brain injury. Severe mental illness may also be a hazard that requires action. Section 19 requires that the person in charge of a hospital must notify Waka Kotahi if a licence holder becomes subject to a compulsory inpatient treatment order.

Guidance on fitness to drive safely is given in *Medical aspects of fitness to drive*.⁵¹⁶ The appropriate agency that can act where a doctor expresses concerns about the fitness of their patient to drive is the Waka Kotahi Medical Team.⁵¹⁷ It is unlikely that a referral where there is reasonable concern could be considered as inappropriate or a breach of health information privacy.

Locomotive engineer or train controller with a health problem

If you have a patient who has developed a disqualifying health problem, need for medication or substance use disorder who is a locomotive engineer or train controller, you should advise them to stop working immediately or within a reasonable timeframe, depending on the nature and likely effects of the problem. If you are in doubt, detailed medical standards are specified in the KiwiRail standard.⁵¹⁸

516 See footnote 493.

517 See footnote 495.

518 See footnote 502.

A locomotive engineer or train controller patient with a health problem that may have rail safety implications should be advised to consult the KiwiRail Regional Medical Officer (RMO) or TranzDev Medical Adviser for a determination. It may be that the RMO is already aware of the problem through regular routine medical examinations and will also be familiar with the safety-sensitive aspects of the patient's work role. If you have concerns that the patient is unlikely to disclose a safety-related health problem to the RMO, you should contact the RMO or national Corporate Medical Officer through 0800 801 070 or the TranzDev Medical Adviser on +64 (9) 969 7777. All of these doctors hold a part-time role with KiwiRail or TransDev but can call you back or email you to discuss your concerns.

Seafarer with a health problem

If you have concerns about the fitness of a patient to work as a seafarer,⁵¹⁹ you should refer to the Maritime New Zealand (MNZ) website for a patient who holds a national certificate. If you are concerned about the fitness of a patient holding a MLC or STCW Certificate, there is a reference ILO requirement guideline available.⁵²⁰

MNZ does not have dedicated medical adviser, but any doctor with concerns about the health implications of a seafarer can consult an MNZ-approved doctor,⁵²¹ who would advise on an appropriate course of action. Alternatively, there is an MNZ seafarers helpline at 0508 225 522 or email at seafarers@maritimenz.govt.nz and internationally at www.seafarerswelfare.org. The MNZ website also has information for seafarers with alcohol and other drug problems.⁵²²

519 The medical examination form for seafarers can be downloaded from <https://www.maritimenz.govt.nz/commercial/certification/documents/Medical-Examination-Form-Seafarers.pdf>.

520 https://www.ilo.org/wcmsp5/groups/public/@ed_dialogue/@sector/documents/normativeinstrument/wcms_174794.pdf

521 <https://www.maritimenz.govt.nz/commercial/certification/approved-medical-practitioners.asp>

522 <https://www.maritimenz.govt.nz/commercial/safety/health-and-safety/intoxication/wellbeing.aspx>

Privacy Act 2020

When you have concerns about a patient's health that might impact on transport safety and you don't have confidence that the patient will notify the appropriate authority or desist from transportation activity or you feel that it would be inappropriate or hazardous to raise your concerns directly with the patient, you should consider the balance between personal privacy and public safety.

There is specific and detailed guidance for when a medical practitioner may release personal information in the Privacy Act. Section 22 details the 12 information privacy principles (IPPs). IPP 11 permits discretion in the disclosure of private information.

Limits on disclosure of personal information

An agency that holds personal information must not disclose the information to any other agency or to any person unless the agency believes, on reasonable grounds,— ...

- (f) that the disclosure of the information is necessary to prevent or lessen a serious threat to—
 - (i) public health or public safety; or
 - (ii) the life or health of the individual concerned or another individual; ...

When evaluating the need to disclose information to an appropriate agency, there are a number of considerations:

- Is there a serious threat as defined by the Privacy Act? The seriousness of the threat is determined by the imminence of some adverse consequence of the threat, the likelihood that the adverse consequence might occur and the severity of that consequence.
- Is there a reasonable belief that the serious threat exists? It is vital to make sure that all reasonably available information is collected,

collated and taken into account when evaluating the reasonableness of your belief. It helps to check your objectivity by discussing this with a peer. If in doubt, the Office of the Privacy Commissioner is available to give expert advice. They can be contacted at <https://privacy.org.nz/further-resources/knowledge-base/> or 0800 803 909.

Caution needs to be exercised when considering the discretion to disclose. Section 24 of the Privacy Act states:

Relationships between IPPs and other New Zealand law

- (1) Nothing in IPP 6, 11, or 12 limits or affects—
 - (a) a provision contained in any New Zealand enactment that authorises or requires personal information to be made available; or
 - (b) a provision contained in any other New Zealand Act that—
 - (i) imposes a prohibition or restriction in relation to the availability of personal information; or
 - (ii) regulates the manner in which personal information may be obtained or made available.

If you have shown that you have considered all 12 Privacy Act principles and Health Information Privacy Code rules (vide *infra*), you would be considered to have taken all reasonably practicable steps.

This is particularly relevant when a medical practitioner (and, in future, all health professionals as defined by the Health Practitioners Competency Assurance Act) must notify the appropriate agency, as required by the Civil Aviation Act section 27C or the Land Transport Act.

The source of information may be relevant when personal information is collected for the purpose of obtaining a medical certificate. The application often contains an authorisation to disclose or obtain personal information as appropriate, which the applicant must sign as a condition of the application, and so access to information is appropriately transparent.

Health Information Privacy Code

The 12 privacy rules in the Health Information Privacy Code and its application are described in another Chapter 4 – The purpose of medical records and notes. You need to take into account these Health Information Privacy Code considerations when disclosing information about a patient to an agency that can act on your transport safety concerns:

- How was the information collected? Was the information provided voluntarily and in a normal doctor-patient relationship or for some other purpose?
- Why was the information being provided, and was there any discussion about the uses to which the information would be put?
- How transparent is the process that you followed when making a decision that you were obliged to disclose personal information to an appropriate agency? Good documentation is essential.
- Who did you consult about the decision to disclose? Peers? Medical Protection Society? Privacy Commission? A government agency?
- Did you evaluate the reasonable belief criteria against the information in your possession?
- How did you assess the seriousness of the concern? How imminent was it? What is the probability that your feared outcome might happen? Were the consequences of any concern of severe intensity to justify disclosure? How many people were involved? A smaller effect on many people might nonetheless be serious.
- Check out the consequences of your disclosure. Sometimes, the effects for your patient will not be as adverse as you fear. Revealing severe depression or substance use disorder may enable the initiation of treatment that eventually allows them back to their normal occupation safely.

- If you are able to discuss the necessity of notification with the patient, it is also helpful to discuss risk mitigation interventions available to them that might reduce the severity of a public safety threat. This includes seeking treatment, the availability of support from the airline or New Zealand Air Line Pilots Association (NZALPA) Pilot Advisory Group or, in the case of substance use disorder, the Human Intervention Motivation Study (HIMS) service. This service, which is available in New Zealand and can be contacted via the airline or CAA is an occupational substance use disorder treatment and rehabilitation programme specifically for aviation personnel, supported by NZALPA and CAA, with the goal of getting dependent pilots back on the flight deck.
- What was said to the patient about your concerns and your decision that health information needed to be disclosed? What was the patient's response when you suggested that they disclose important health information to the appropriate agency directly? What steps did you take to make sure that the patient followed through on an undertaking to self-disclose safety critical information? If you decided to make a disclosure without notifying the patient, you should document your reasons, on the grounds of their personal safety, why you did not do so.
- Did you take steps to limit the information you disclose to the absolute minimum relevant to the threat to personal or public safety?
- Did you ensure that the appropriate medium was used to minimise unintended consequences?

How to approach a patient who is unlikely or unwilling to voluntarily disclose a health problem with transport-related public safety implications

Follow these steps to make sure that we keep ourselves, our patients and the general public safe when confronted with a patient in a safety-sensitive role:

- Be vigilant to the work your patients do. If they are in a safety-critical occupation, consider whether there are serious wider health and safety concerns.
- Make sure of your facts. Document the facts about the patient's health, occupation, beliefs or behaviours that concern you, confirm your diagnosis and your reasoning on the background to your reasonable belief that serious harm might occur if you do not identify the appropriate agency that can act on your concerns.
- Discuss your concerns with the patient where it is safe for them (or you) to do so. Be honest and clear about your concerns and intentions. Discuss what you hope will happen following disclosure and what help might be available for them. NZALPA or the HIMS service can assist with substance use disorder to get them back on their feet, and the employer will usually fund an employee assistance programme.
- Seek advice – check the facts out with someone whom you trust and work with – even more importantly, anyone for whom you work.
- Seek professional advice – ring the Medical Protection Society on 0800 225 5677 or use the Privacy Commission Health Information Privacy Code Toolkit.⁵²³

523 <https://www.privacy.org.nz/news-and-publications/guidance-resources/health-privacy-toolkit/>

- Identify who is the appropriate person or appointee within the appropriate organisation who can act for you to approach to disclose information. If in doubt, contact the chief executive to find out who that person might be. It won't always be another doctor. Information on who to contact is available from the Medical Protection Society or Medical Council.
- Ensure that the tone, purpose, content and medium provide a balance between the need to act on public safety concerns and your desire to protect the medical confidentiality of personal information.
- Ensure that all envelopes, letters or emails are labelled 'Medical in Confidence'.

Conclusion

The dilemma faced by a medical practitioner when confronted with conflict between personal privacy and public health and safety arising from concerns about a patient who works in the transport sector is complex and intense. Taking a methodological approach to evaluation, seeking advice from peers, taking into account all relevant considerations and disclosure in an appropriate manner will help the practitioner to work through the issues and arrive at the correct solution.

CHAPTER 30

Doctors and the Department of Corrections: Ara Poutama Aotearoa

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Introduction

The Department of Corrections was formed in October 1995 when the Department of Justice was separated into two. There are 18 prisons across New Zealand, which include three prisons for women.

At any given time, up to 10,000 individuals are in prison and 30,000 people are serving a community-based sentence or order.

The majority of people in prison are serving short sentences of less than 2 years, and the Department works hard to address the reasons why people turn to crime, such as poverty, a lack of education, unemployment, drug and alcohol addiction, violence and trauma. To do this, the Department runs a number of programmes and specialist treatment units.

In New Zealand, 52% of our prison population are Māori. As outlined in our organisational strategy Hōkai Rangi,⁵²⁴ we work alongside Māori to achieve better outcomes for Māori and their whānau. It is fitting that we have returned to this whakataukī: Kotahai anō te kaupapa: ko te oranga o te iwi – There is only one purpose of our work: the wellness and the wellbeing of people.

We provide essential literacy and numeracy training to people in our care who have trouble reading and writing. We also increase people's chances of employment after release by teaching them relevant skills that are in the demand – for example, in the common trades or in horticulture.

Most people in prison will take part in work, education and rehabilitation programmes.

524 https://www.corrections.govt.nz/resources/strategic_reports/corrections_strategic_plans/hokai_rangi

Health and mental health need of the prison population

A high percentage of people in prison have needed mental health and addiction services at some point in the last 10 years and are also living with a long-term condition such as asthma or diabetes. People in prison are also less likely to have accessed appropriate health care in the community and overall experience poorer health than the general population. A recently developed health and equity outcomes report monitors a suite of clinical and other indicators to help address the health inequity that exists between Māori and non-Māori within the prison population.

A high percentage of people in prison have needed mental health and addiction services at some point in the last 10 years and are also living with a long-term condition such as asthma or diabetes.

The organisation of prison health services

The Department of Corrections provides an independent primary health care service to people in prison funded by Vote Corrections. Although we are running a separate health service, the Ministry of Health is recognised as the lead government agency, and we work closely with it across all aspects of health services provided inside prisons.

There are 18 prisons throughout New Zealand. Each prison has a health centre run by a health centre manager. The Department employs nurses who provide initial care and assessment of a person in prison and determine whether the person needs to see a doctor (medical officer). Medical officers are contracted to provide medical services to a certain prison and are all experienced general practitioners. Most medical officers working for the Department of Corrections also work as community general practitioners.

Medical officers are an essential part of our health service delivery model and provide medical care to our population through diagnosis, treatment, the ordering of special investigations and referrals to external health agencies when necessary. Although the role of a medical officer is similar to the role of a community-based general practitioner, there are some important differences and challenges based on our current operating policies, guidelines and procedures and the custodial environment.

Although patient confidentiality is very important, medical officers are kept safe by custodial officers when this necessary.

Medical officers refer patients to external health providers or hospitals when this is necessary as they would in the community. All prisoners who are referred to an external provider are accompanied by custodial officers, and it is important that all planned and unplanned referrals to hospitals are clinically appropriate. The Prison Director ultimately gives permission for a prisoner to be transported to a hospital, and sometimes when the need is not life-threatening, the transfer will be delayed in order to address any safety and security issues first.

The Department does not provide health care to people who are serving a community-based sentence or order. These people use mainstream community-based primary health care services.

Prisons also employ or contract with mental health nurses, counsellors and other professionals to address mental health and addiction conditions including running prison-based drug treatment programmes. District health board forensic health services focus on managing and giving advice on people who present with serious mental health conditions, and forensic psychiatrists are available to provide specialist advice to medical officers.

In the future, it is anticipated that rongoā Māori practitioners and practice will be introduced alongside the doctors and nurses who currently make up the prison primary care team. All medical officers are expected to take part in quality improvement work and cultural safety training to support the development of our kaupapa Māori model of care.

Relevant legislation and regulatory frameworks

The work of the Department of Corrections is underpinned by several major pieces of legislation:

- Sentencing Act 2002
- Parole Act 2002
- Crimes Act 1961
- Privacy Act 2020

Doctors' practice is also guided and regulated by several important Acts:

- Health Practitioners Competence Assurance Act 2003
- Health and Disability Commissioner Act 1994
- Accident Compensation Act 2001
- Corrections Act 2004
- Mental Health (Compulsory Assessment and Treatment) Act 1992
- End of Life Choice Act 2019
- Misuse of Drugs Act 1975
- Medicines Act 1981

Some important areas in the legislation guiding medical practice in prisons are outlined below.

Corrections Act 2004

It is worth reading the entire Act. However, some important sections regarding health services are summarised below.

Section 75 states that a prisoner is entitled to medical treatment that is reasonably necessary. The standard of health care that is available to prisoners must be reasonably equivalent to the standard of health care available to the public.

The Corrections Act requires every prison to have a health centre manager who must be a medical practitioner or nurse. The health centre manager is responsible for ensuring the provision of health care and treatment to prisoners. Every prison must also have a sufficient number of medical officers to meet prisoners' needs for medical care and medical treatment. Each medical officer must be a medical practitioner.

Section 60 outlines when segregation of a prisoner can occur for the purposes of medical oversight. Segregation means that a prisoner can have the opportunity of association with other prisoners restricted or denied. The reason for segregation for medical oversight is to assess and ensure a prisoner's physical or mental health. The health centre manager may consult with a medical practitioner when deciding about placing someone under medical oversight. Although the health centre manager must recommend segregation for medical oversight and also must recommend when it can end, the Prison Director directs that this should occur.

If a prisoner is deemed at risk of self-harm, they must be moved to an at-risk cell and observed at regular intervals by a custodial officer and visited twice a day by a registered health practitioner. These people are managed using an individually developed at-risk management plan.

Section 165 requires that medical officers must ensure that an adequate record of the health care or treatment provided by that officer to a prisoner at a prison is maintained and kept securely and not treated as part of the prison records for that prisoner or former prisoner, as the case may be.

Medical officers must ensure that an adequate record of the health care or treatment provided by that officer to a prisoner at a prison is maintained and kept securely and not treated as part of the prison records for that prisoner or former prisoner, as the case may be.

Mental Health (Compulsory Assessment and Treatment) Act 1992

Section 45 outlines when an assessment may be made in respect of persons detained in prisons. The application of assessment is made under section 8A where there are reasonable grounds to believe the person may be mentally disordered.

The application is accompanied by a certificate issued under section 8B relating to the person that states:

- a date of examination within the 3 days immediately before the date of the application
- that the applicant is 18 years or over
- that the applicant has personally seen the person within the 3 days immediately before the date of the application
- the relationship or association of the applicant with the person
- the grounds on which the applicant believes the person to be suffering from a mental disorder
- that the assessment examination shall take place either in the institution within 48 hours after the receipt of the application or, if that is not practicable, in a hospital within 72 hours after the receipt of the application.

Health Practitioners Competence Assurance Act 2003

This Act outlines the role of the Medical Council in:

- registering doctors
- setting practice standards for doctors
- reviewing doctors when performance, professional conduct or health is a concern.

The Department of Corrections has a close working relationship with the

Medical Council to ensure that doctors working for the Department are well supported and meet the required standards of practice as outlined in the Act.

Health and Disability Commissioner Act 2004

Prisoners and their whānau have the right to complain to the Health and Disability Commissioner if they feel that the health care provided by prison health services was substandard. Sometimes these complaints will lead to a doctor working at the Department of Corrections being the subject of an investigation to see whether there has been a breach of the Code of Health and Disability Services Consumers' Rights. A breach of the Code may lead to a Medical Council notification or a referral to the Health Practitioners Disciplinary Tribunal.

Doctors who are under investigation are supported by the Department's Chief Medical Officer.

Parole Act 2002

This Act describes the law relating to the release from detention of offenders serving sentences of imprisonment.

The Parole Board may, on referral by the chairperson, direct that an offender be released on compassionate release on either of the following grounds:

- The offender has given birth to a child.
- The offender is seriously ill and is unlikely to recover.

Every referral by the chairperson for consideration for compassionate release must be in writing and set out the reasons why the chairperson is making the referral.

The Parole Board may, as part of a direction for compassionate release, impose the standard release conditions and any special conditions on

the offender and may vary or waive the obligation to comply with any standard release conditions if necessary in the circumstances.

It is the right of all people in prison to apply for compassionate release. The decision on release is made by the Parole Board. If a doctor believes a person in prison may be eligible for compassionate release, they should discuss this with the health centre manager as soon as possible.

End of Life Choice Act 2019

The End of Life Choice Act 2019 (EOLC Act) gives people who experience unbearable suffering from a terminal illness the option of legally asking for medical assistance to end their lives.

The EOLC Act outlines the legal framework for assisted dying and includes controls, eligibility criteria and safeguards. A person who seeks assisted dying must be making an informed decision of their own accord.

The EOLC Act comes into force 12 months after the public referendum held at the 2020 General Election.

Assisted dying remains illegal until 7 November 2021.

People in prison need to be deemed competent to be able to make decisions around assisted dying.

If, at any time, the medical practitioner or nurse practitioner suspects a person is being pressured about their decision to receive assisted dying, they must immediately stop the process.

The Department of Corrections is currently working through how to make sure that people in prison can request assisted dying services. The risk of pressure and/or coercion is something that the Department is taking extremely seriously, and currently, it is unlikely that doctors providing medical services in our prisons will be directly involved in the provision of this service.

Deaths in custody

Confirmation of death is usually done by a nurse, doctor or attending ambulance staff.

Deaths in custody are caused by natural or medical causes or suicide. In the prison environment, all deaths in custody, even where the medical cause is known, are reported to the Coroner and Police. The prison health team will review all deaths. However, the Department must also notify all deaths to the:

- Inspector of Corrections who will independently investigate all deaths and produce recommendations
- Ombudsman
- Prison Chaplain
- Prison Cultural Advisor
- Victim Notification Coordinator.

The Chief Medical Officer will support all doctors who have been involved in the care of a person who dies in prison.

Ethical practice

Prisons are challenging places, and doctors will be exposed to situations and people that they are far less likely to come across in the community.

Professional behaviour should be consistent with the principles set out in the NZMA *Code of Ethics*. It is possible that you may be asked to do something that doesn't align to the *Code of Ethics*. It is important that you do not do anything that goes against the *Code of Ethics* even if you feel pressured to do so. If this happens, doctors are expected to discuss this with the health centre manager or Chief Medical Officer.

Informed consent in a custodial environment

There are three key elements for gaining informed consent from a person:

- **Competence:** The person must have the necessary capacity to consent to the intervention or refuse the treatment.
- **Information:** The person must be appropriately informed in order to make an informed choice about the proposed treatment.
- **Voluntariness:** The person's consent must be given voluntarily and without pressure from any other person.

Within a prison environment, informed consent isn't necessarily obtained when a patient asks for or agrees to a procedure. Sometimes, the person's consent in this situation is not given voluntarily as the setting or scenario may be coercive and the person may not be free from undue pressure.

This issue is illustrated below when a person in prison is suspected of internally concealing an item.

Informed consent when someone is suspected of internally concealing an item

The Corrections Act determines that under no circumstances are Corrections staff permitted to perform an internal examination or insert any object into any person's body orifice to determine whether or not an item is internally concealed. This includes when a person asks staff to retrieve an item. This does not apply to health procedures where a health need is evident and would normally be within the health practitioner's scope of practice.

Medical officers, however, must never internally examine a person in a prison specifically to find out whether they are concealing something such as contraband or not, even if the prisoner or another staff member asks them to. There is a risk that, in this situation any consent provided by the prisoner may not be free from undue pressure or coercion.

Voluntary refusal of food

The management of people who are refusing to eat or drink is very challenging.

The health centre manager and the Chief Medical Officer guide medical officers in the care of these people. It is likely that the doctor will be asked to attend a multidisciplinary team meeting to help plan the care and address any urgent issues.

When a person's health deteriorates to the point where the prison health service is not the appropriate place to be, the person is referred to hospital for assessment and treatment. It is common in this scenario for the person who is voluntarily refusing food or fluids to also be refusing assessment and observations by prison health staff.

Mental health and forensic teams are usually involved in the care of these people, particularly when determining whether they meet the criteria for compulsory assessment and treatment under the Mental Health Act.

The person may also request to sign an advanced directive outlining their wishes to not have medical interventions to save their life such as CPR or IV fluids should they become unconscious or incapacitated. Medical officers are expected to assess the capacity/competency or ability of the person to make and understand the implications of this decision at the time of signing the directive. When it is difficult to determine a person's capacity, particularly as starvation and malnutrition does affect a person's cognitive function, a psychiatrist must assess the person.

Management of test results and medical reports

Medical officers are expected to manage the tests that they have ordered according to the usual expectations as set out by the Medical Council and the Health and Disability Commission. Remote access to the patient management system is provided for this to occur.

Prescribing practice in New Zealand prisons

Non-pharmacological approaches to treatment are encouraged.

Prescribing medication is arguably the most challenging aspect of medical officer practice within our prisons. Full guidance is given within the Department of Corrections safer prescribing guidance. Prescribed medications may be misused or abused. Prescribed medications may be traded by some people, and some prisoners will have their legitimate medications taken off them by others. Some medications are recognised as currency within a prison environment.

Doctors can therefore come under considerable pressure to prescribe medications that are not clinically indicated. Sometimes specialist services are needed to make sure that medications are required. Full support to reduce or stop medications that are not needed is contained within the safer prescribing guidance and provided by the Chief Medical Officer if necessary.

Prescribed medications also have the potential to cause a lot of harm. The doctor works closely with the nursing staff to make sure that the medication is necessary and that the formulation supports safe administration.

New prisoners need to have their community-prescribed medication continued as soon as possible after arrival. It can be difficult to track down previous medical or pharmacy records to verify that medications are needed. The health centre manager will make sure that previous health records are sought in a timely fashion. Similarly, on release, it is important that people have enough medication to ensure there isn't an interruption in prescribed medication while the person looks to register with a community general practice.

Complaints and performance issues

If you are the subject of a complaint, the Department will guide you through the complaint process and you will be offered support by the Chief Medical Officer. If your clinical practice, conduct or competence is questioned, a meeting will be set up with the Chief Medical Officer to discuss and also to see what support or further training may be needed.

Serious issues of conduct or competence may be referred through to the Medical Council.

Quality improvement activities

From time to time, you may be asked to undertake a clinical audit, conduct a record review, take part in an adverse event review or attend a quality improvement meeting or national forum. Full support will be provided by the Chief Medical Officer.

CHAPTER 31

New Zealand Medical Association

Lesley Clarke is the CEO of the New Zealand Medical Association.

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Introduction

The New Zealand Medical Association (NZMA) (Te Hauora mō ngā iwi Katoa) is the professional medical organisation for all New Zealand doctors. Its members come from all disciplines within the medical profession, including specialists, general practitioners, doctors in training and medical students.

Key roles

The NZMA aims to provide leadership of the medical profession and to promote professional unity and values and the health of all New Zealanders. The NZMA is completely independent and receives no government funding but is fully owned by the profession. It provides a platform for doctors to come together to focus collectively on issues for the profession and for New Zealanders. It also provides professional connectivity, support and collegiality.

The NZMA's key roles are to:

- provide advocacy on behalf of doctors and their patients – the NZMA is a strong advocate on medico-political issues, with a strategic programme of advocacy with politicians and officials at the highest levels
- provide support and services to members and their practices
- publish and maintain the Code of Ethics for the profession (see Appendix B)
- publish the *New Zealand Medical Journal*.

The NZMA works closely with many other medical and health organisations – including the medical colleges – and provides forums that consider pan-professional issues and policies.

The NZMA aims to provide leadership of the medical profession and to promote professional unity and values and the health of all New Zealanders. The NZMA is completely independent and receives no government funding but is fully owned by the profession.

Values

As an organisation, the NZMA is committed to a strong set of values that guide the organisation's advocacy.

- **Integrity and honesty:** The NZMA models the highest standards of personal and professional behaviour in all its activities and interactions and is open and transparent in representations and in the way it works.
- **Respect:** NZMA members treat each other and all people with respect and dignity and value individual and cultural differences and diversity.
- **Fairness:** The NZMA upholds the principles of social justice and the creation of a fair and equitable society.
- **Inclusive:** The NZMA encourages the active participation and contribution of all members and seeks engagement and collaboration with the wider health sector and the communities it serves. The NZMA is guided by the Treaty of Waitangi in its obligations to Māori as tangata whenua and partners.
- **Quality and excellence:** The NZMA believes that quality is the foundation of good health policy, systems and delivery and is committed to developing, promoting and recognising excellence.
- **Caring and nurturing:** The NZMA shows concern for people's wellbeing and supports others in the pursuit of their goals.
- **Responsible:** NZMA members are accountable for their individual and collective actions, are conscientious in their work and use time, money and resources wisely.
- **Responsive:** The NZMA is proactive in meeting new challenges and is open to change.

Member services

As a membership organisation, the NZMA offers its members a range of services, including publications, advisory services (both online and over the phone) and financial benefits.

The member advisory service includes advice on the interpretation and practical application of legislation of key importance to doctors, such as the Privacy Act, the Employment Relations Act, the Code of Health and Disability Services Consumers' Rights and much more. It provides advice about managing staff, employee and employer rights and obligations, individual employment agreements, hiring locums, structuring a practice, retention of medical records plus much more.

The NZMA is also the employer advocate on behalf of general practices in negotiations with the New Zealand Nurses Organisation on the Primary Health Care Multi-employer Collective Agreement for primary care nurses and receptionists.

Members have access to the members-only section of the NZMA website (www.nzma.org.nz) and a subscription to the *New Zealand Medical Journal*, the New Zealand medical profession's leading scientific journal, which is published by the NZMA. Other publications include e-magazine *NZMJ Digest* (www.nzma.org.nz/publications/nzmjdigest) and *Vital Signs*, a weekly email bulletin with news and information about NZMA activities and medical issues and the opportunity for member feedback.

The NZMA also administers the New Zealand Medical Benevolent Fund, established in 1896 to provide aid to NZMA members and families of NZMA members who are in financial hardship or distress. Applications can come from any NZMA member or family of an NZMA member. NZMA members can also recommend applications from non-NZMA doctors and their families. Medical student members are not eligible.

History and structure

The New Zealand Medical Association was formed more than a century ago. Its inaugural meeting was held in Otago in 1886. Ten years later, the NZMA became affiliated with the British Medical Association (BMA) and remained a branch of the BMA until 1967. The NZMA's motto is *Scientia et Concordia: Knowledge and Accord*.

The NZMA retains strong links with the British, Australian and many other medical associations throughout the world and is also a member of the World Medical Association. Unlike many similar institutions worldwide, the NZMA is not a union but exists solely to provide leadership for the profession and support for its members and patients. The NZMA is a registered charity.

Members elect the NZMA Board, which provides governance and policy for the NZMA, as well as representatives for the three advisory councils: the General Practitioner Council, the Specialist Council and the Doctors-in-Training (DiT) Council. The Board comprises the Chair, Deputy Chair, up to five elected members and the chairs of the advisory councils. Elections for the NZMA Board and positions on the advisory councils are held at least every 2 years.

The NZMA Ethics Committee offers guidance on ethical issues and leads the review of the profession's *Code of Ethics*, which occurs every 5 years.

The NZMA also has a Council, which has the prime roles of providing advice to the Board and approving the *Code of Ethics*. The Council comprises the President, the NZMA Board, elected members of the GP Council, Specialist Council and DiT Council, delegates from local divisions, the immediate past-Chair, the Chair of the Ethics Committee, the NZMJ Editor and medical student representation.

The NZMA's National Office is in Wellington, and the business of the NZMA is carried out by National Office staff, which currently includes the Chief

Executive Officer, Operations Manager, Policy Manager, Communications Manager and support staff. Editor-in-chief of the *New Zealand Medical Journal* is Professor Frank Frizelle, based in Christchurch, while the journal's production is managed out of National Office.

Advocacy

The NZMA undertakes both proactive and reactive advocacy work, including participation in a wide range of consultation processes, making about 50 submissions annually. Proactively, the NZMA undertakes considerable policy work and produces regular position statements and policy briefings. The NZMA also has a substantial media presence and is frequently asked to comment on health-related matters in mainstream media as well as specialist publications.

As a strong voice for the medical profession, the NZMA advocates on range of issues. This includes population health and measures to improve health outcomes, particularly for disadvantaged communities. The NZMA has advocated strongly for strong and effective obesity, smokefree and alcohol reduction strategies. The NZMA regularly approaches and works with government on decisions regarding funding, policy, regulation, system design and workforce.

The advocacy function of the organisation is managed from National Office, with the Policy Manager seeking input from the Board and representative councils as appropriate, as well as from the wider membership. The NZMA Board approves and signs off submissions, which are issued under the Chair's name. The Chief Executive, NZMA Chair and council chairs meet regularly with representatives of other health sector organisations and other stakeholders as well as with government officials.

Leadership of the profession

Professionalism describes the skills, attitudes and behaviours expected from doctors during the practice of their profession. It includes concepts such as maintaining competence, ethical behaviour, integrity, honesty, altruism, compassion, service to others, adherence to professional standards, justice, respect for others and self-regulation. External challenges to professionalism include increasing bureaucratisation, commercialism and systems that erode clinical autonomy. On behalf of its members, the NZMA upholds the values and ideals of professionalism within the medical profession and promulgates these both to members and more widely to the general public.

Professionalism describes the skills, attitudes and behaviours expected from doctors during the practice of their profession.

The NZMA also advocates strongly on workforce issues and is represented on Ministry of Health governance and taskforce groups addressing workforce issues and inappropriate behaviour.

Doctor wellbeing is also a key concern for the NZMA. It has developed a website resource to assist doctors to monitor and take care of their own mental and physical wellbeing, which aligns with its position statement on doctors' health, wellbeing and vitality.⁵²⁵

Statement on the role of the doctor

As well as submissions, the NZMA also issues occasional position statements and policy briefings. Key among these is a consensus statement on the role of the doctor,⁵²⁶ formulated during an international seminar hosted by the NZMA. An important driver of its development

525 https://assets.website-files.com/5db26e2d55881e73a90f2b5d/5de5ac74f982a365c0463bd3_Doctors-Health-and-Wellbeing-2013.pdf

526 See footnote 162.

was to ensure that patient care was not compromised in a health sector undergoing significant change. The statement sought to identify the skills and attributes required of doctors to deliver quality health care and to reaffirm the medical profession's commitment to patients.

The statement was endorsed by the medical colleges and published in the *New Zealand Medical Journal*. It reflects the greater role of the patient in making decisions about their health care and considers the role of the doctor within the wider health care team. It reinforces the role and the responsibility of doctors as leaders of the health care team and as public health advocates.

The process for developing the statement was as important as the outcome. The seminar included key stakeholders such as Health Workforce New Zealand, the Medical Council, medical schools, medical colleges, district health boards, primary health organisations and health organisations such as the Association of Salaried Medical Specialists, the New Zealand Resident Doctors' Association, General Practice New Zealand and the New Zealand Nurses Organisation.

This collaborative approach highlighted what can be achieved with a collective, unified voice for the medical profession. Developing the statement gave the profession the opportunity to work cohesively towards a common goal that will positively affect both the profession of medicine and patients.

The statement places a strong emphasis on the importance of doctors advocating not only for individual patients but for population health and the health of all New Zealanders. It calls on doctors to be leaders in our communities to advance health outcomes.

Doctors are encouraged to embrace the concepts of clinical leadership and clinical governance and to take on leadership roles within health care teams and the broader health sector. Doctors must show leadership in making day-to-day clinical decisions and base these decisions on their

medical knowledge and training to apply their skills in the development of policy, strategy, service design, models of health care and clinical processes. As leaders, doctors must ensure patient safety and monitor the health outcomes of both the individual and wider health population.

The statement on the role of the doctor continues to serve as the foundation for ongoing discussions and advocacy with government and the wider health sector to deliver optimal health care to New Zealanders. It will guide future workforce planners. In terms of medical education, the statement will help to shape the selection and training of future doctors so that their skills match the needs of providing patient care in the 21st century.

As the professional organisation for all doctors, the NZMA has incorporated the statement on the role of the doctor in its advocacy, and it serves as a strong foundation when advocating on issues such as health equity, the medical and health workforce (particularly as it pertains to new health care roles and changes in existing health care roles), medical training, public health and clinical leadership.

The statement on the role of the doctor continues to serve as the foundation for ongoing discussions and advocacy with government and the wider health sector to deliver optimal health care to New Zealanders.

Health equity

In 2011, the NZMA published a statement on health equity.⁵²⁷ In health, equity is not about equal access or equal services but about equal outcomes. To achieve this, some individuals and families must receive more support to enjoy health status equal to others. New Zealand has long held on to the principles of universal health services, with everyone

527 https://assets-global.website-files.com/5e332a62c703f653182faf47/5e332a62c703f614c82fc548_Health-equity-2011.pdf

entitled to the same with no inclusion or exclusion criteria, because it is accepted that everyone will benefit.

Health inequities cannot be addressed by targeted health funding alone. Social determinants (housing, employment and so on) have a strong influence on health and require interdepartmental thinking and coordination. The principles of health equity are an important foundation for the NZMA's stand on public health issues.

In 2021, the NZMA adopted a position statement on admission to medical schools,⁵²⁸ strongly supporting affirmative action selection policies. The position statement recognises that the NZMA believes medical schools in New Zealand should select and train medical students who are representative of, appropriate for and sufficient in number for our population, taking into account current and future health and workforce needs. The NZMA strongly supports affirmative action selection policies to medical school that include but are not limited to increasing the numbers of Māori, Pacific people and those from rural communities, low socioeconomic and refugee backgrounds.

Public health issues

Public health issues such as smoking rates, reducing alcohol-related harm and tackling obesity are key areas of advocacy for the NZMA, as they are major drivers of poor health in New Zealand and have wider social impacts.

The NZMA is also a strong advocate on climate change and the effects of free trade agreements on health policy and outcomes.

Health literacy is another key area of focus, starting with understanding what health literacy is. Health literacy is not just about educating people about their treatment, their health conditions and how to live well and stay

528 https://assets-global.website-files.com/5e332a62c703f653182faf47/60b80a3af5fd000e5984f55d_Selection%20for%20Admission%20to%20Medical%20School%20%5BFINAL_June%202021%5D.pdf

well. It is also about system design and developing health professionals' skills to ensure that information and knowledge is imparted in a way that can be received.

As New Zealand undergoes extensive health sector reform, the NZMA expects to play a key role in shaping the new health care system.

International

The NZMA works with the World Medical Association and similar international organisations on issues of common ground such as ethics and the response to widespread health concerns such as the COVID-19 pandemic.

CHAPTER 32

A brief history of Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA)

Note that this chapter has not been updated from the 2017 edition.

Rawiri Jansen is a general practitioner and Clinical Director in Auckland. He is a past Chairperson of Te ORA (2006–2011, 2014–2016).

Donna Clarke is a psychiatrist and a founder of Te ORA.

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Pioneers

The history of Māori doctors begins over 100 years ago when Sir Maui Pōmare (Ngāti Mutunga, Te Āti Awa, KBE, CMG, 1875–1930) graduated from the medical programme at the American Missionary College in Chicago in 1899. Sir Peter Buck (also known as Te Rangi Hiroa, Ngāti Mutunga, KCMG, QSO, 1877–1951) was the first Māori graduate from the medical programme of the University of New Zealand in Otago. He was followed soon

after by Dr Tutere Wirepa (Te Whānau a Apanui, Ngāti Porou, 1877–1945) and Dr Pohau Ellison (Ngāi Tahu, Te Āti Awa, OBE, 1884–1963). The first Māori woman doctor was Dr Rina Moore (nee Ropiha, Ngāti Kahungunu, Te Whānau a Apanui, Ngāti Rangitāne, 1923–1975), graduating in 1946. They were the pioneer Māori medical practitioners, and each began remarkable efforts in public and community health to improve the health of their own peoples.

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Initial efforts to establish a national association of Māori doctors

The first attempt to establish a national Māori doctors' association was centred around Professor Eru Pōmare (Te Āti Awa, Ngāti Toa, Ngāti Kahungunu, Rongomaiwahine, Rongowhakaata, FRACP, MD, 1942–1995) at the Wellington Clinical School in the early 1980s. Eru, grandson of the first Māori doctor, was another Māori medical pioneer and mentor – “a quiet revolutionary”.⁵²⁹ Eru was a gastroenterologist and helped establish the Wellington Clinical School, later becoming Dean. He established the

529 https://www.eastonbh.ac.nz/1995/02/a_quiet_revolutionary_eru_woodbine_pomare/

Māori Health Research Unit that was later named in his honour, and in 1980, he published a foundation text for Māori health research.⁵³⁰ Hauora established patterns of mortality for Māori and non-Māori from 1955 to 1975 and that, for Māori, incidence and mortality from most of the common amenable diseases were appreciably higher compared with non-Māori. He went on to co-author two subsequent volumes in the series – Hauora II and Hauora III – that extended the time periods analysed and took a broader view of factors influencing health, including the Treaty of Waitangi and socioeconomic factors. The final volume⁵³¹ covers the years 2000–2005, with an exceptionally distinguished list of authors and contributors.

Dr Paratene (Pat) Ngata (Ngāti Porou, Te Aitanga a Hauiti, FRNZCGP Dist, LLD Hon, 1946–2009) was also based in Wellington at that time, and together, he and Eru created a stimulating, nurturing mentorship environment for Māori medical students coming through their clinical years in Wellington. Pat is well known for his significant contributions to Māori health nationally and directly in communities he served over decades. Pat was convinced to join the very first Māori group practice established by his great friend and colleague Dr Anthony (Tony) Ruakere (Taranaki, Te Āti Awa, FRNZCGP Dist, MNZM) in Opunake.

Eru and Pat joined with another Māori medical leader and psychiatrist Professor Sir Mason Durie (Rangitāne, Ngāti Kauwhata, Ngāti Raukawa, FRANCP, KNZM, FRSNZ) and others in initiating Hui Whakaoranga.⁵³² Hui Whakaoranga was held at Hoani Waititi Marae in West Auckland and was a watershed in terms of Māori aspirations for improved health outcomes. The hui recommendations include the call for ethnicity data collection, for involvement of Māori in all parts of the health system including health

530 Pōmare E, de Boer G. *Hauora: Māori standards of health: a study of the years 1970–1984*. Wellington: Department of Health; 1988.

531 Robson B, Harris R, editors. *Hauora: Māori standards of health IV: a study of the years 2000–2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare; 2007.

532 [http://www.moh.govt.nz/notebook/nbbooks.nsf/0/199037C1AB3E7B724C2565D700185DBD/\\$file/Hui%20Whakaoranga%20Māori%20Health.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/199037C1AB3E7B724C2565D700185DBD/$file/Hui%20Whakaoranga%20Māori%20Health.pdf)

professions and equitable resourcing for improved health outcomes. It was also an early venue for Mason in discussing and disseminating the Whare Tapa Whā model – the four cornerstones of Māori health.

In 1984, Eru called a meeting for Māori doctors and medical students, and the discussions at that hui included plans for future meetings and a potential work programme. Eru's untimely death while walking the Milford Track in 1995 was a very significant loss.

Māori Medical Practitioners Association

In 1995, two Auckland 6th year medical students, Elana Curtis (Te Arawa, FACP, FNZCPHM) and Donna Clarke (Te Arawa, Tainui, Ngāti Kahungunu, FANZCP) called a meeting for Māori doctors. Elana had recently returned from her elective in Hawai'i and had noticed the active association of Hawai'ian medical doctors.⁵³³ Elana and Donna had both experienced the supportive environment of the Māori and Pacific medical students' collective during their undergraduate studies, and they sought to emulate this for those moving into their medical careers. They recognised that a mentoring and networking approach would facilitate ongoing connection and support future cohorts of Māori doctors. They called on all of the senior Māori doctors they knew and recruited Māori medical students from the Auckland School of Medicine. The meeting was held at the Boyle Crescent villa then occupied by the Department of Māori and Pacific Health, Auckland School of Medicine (which has since been removed). The Department of Māori and Pacific Health at that time was led by Professor Colin Mantell (Ngāi Tahu, FRACOG) and Dr David Tipene-Leach⁵³⁴ (Ngāti Kahungunu, FRNZCGP Dist, FNZCPHM Hon). The Māori doctors and medical students filled the room, overflowing into the corridor, and demonstrated that a critical mass of Māori doctors existed sufficient to establish an association.

533 'Ahahui o nā Kauka, the Association of Native Hawaiian Physicians, is a non-profit organisation that was formally incorporated in 1998.

534 Currently Professor of Māori and Indigenous Research, Eastern Institute of Technology, Hastings.

Waipapa Marae at Auckland University was the venue for the first formal meeting of the association. The decisions that came out of that first meeting were pivotal in setting the foundations for the future. The name of the organisation⁵³⁵ and the key statements describing the purpose were contributed by Professor Sir Mason Durie. With those key decisions made, the assembly elected Dr Tipene-Leach as inaugural chairperson. Dr Tipene-Leach initiated the practice of holding a Scientific Conference in association with the annual meeting, and this practice continues to this day. The Scientific Meeting is an important platform for Māori doctors and medical students to publish and discuss their clinical, research, academic and education work.

Te ORA purpose

Te ORA has consistently maintained dual purposes. Supporting the development of the Māori medical workforce through the undergraduate years, early career and vocational training and continuing professional education is one pillar of Te ORA's vision. Leadership and influence to improve health outcomes for Māori is the other pillar, and Te ORA maintains an ambitious work programme. Māori medical practitioners contribute across the breadth of the New Zealand health system from community and primary care to public policy and population health.

A significant early project was an examination of expectations of the emerging Māori medical workforce Kōkiritia⁵³⁶ by Dr Joanne Baxter (Ngāi Tahu, FAFPHM). Kōkiritia covered a broad range of issues relevant to the training needs of Māori doctors and medical students and described the essential skill sets Māori doctors have identified in their work, including te reo Māori and tikanga Māori, peer support and peer review, gaining advanced Māori health knowledge and awareness of health policy.

535 The name translates roughly as 'the working group of doctors of Aotearoa', the acronym Te ORA cleverly signifies 'health and a state of wellness'.

536 Baxter J. Kōkiritia: An analysis of Māori doctors' training needs. A report prepared for Te Ohu Rata O Aotearoa. 2000. Kōkiritia means to thrust forward and to champion a cause.

Similarly, the establishment of the Henry Rongomau Bennett Foundation scholarships was an early achievement. Henry Bennett (Te Arawa, FRACP, QSO, CBE, 1918–2000) was the first Māori psychiatrist. He had a distinguished career over 50 years, and his contribution is honoured with the very successful Foundation scholarships that support Māori doctors to take up a career in psychiatry.

Growth in Māori in medical training

Professor Mantell initiated the remarkable growth in Māori inclusion in medical training in association with the then Dean of the Auckland School of Medicine, Professor Peter Gluckman.⁵³⁷ Vision 2020⁵³⁸ had the aspirational target for Māori to make up 10% of the medical workforce by 2020. The proposal had three components including an admissions scheme, a recruitment strategy and an academic bridging programme.⁵³⁹ The success is best seen in the record number of Māori medical graduates in recent years, with the world-leading result of achieving indigenous demographic proportionality in the New Zealand medical school graduates. That success has been constructed through the leadership of the Māori medical education teams at both Auckland and Otago Universities (Associate Professor Papaarangi Reid (Te Rarawa, FAFPHM, FNZCPHM) and Associate Professor Joanne Baxter) and the partnerships within those academic institutions.

The success is best seen in the record number of Māori medical graduates in recent years, with the world-leading result of achieving indigenous demographic proportionality in the New Zealand medical school graduates.

537 Professor Sir Peter Gluckman, KNZM FRSNZ FMedSci FRS, former Prime Minister's Chief Science Advisor – see <http://www.pmcsa.org.nz/a-short-biography-of-peter-gluckman/>

538 Gluckman P, Mantell CD. Vision 2020 proposal. Auckland: Faculty of Medicine and Health Science; 1997.

539 Ratima M, et al. Review of the Ministry of Health hauora Māori scholarship programme. Auckland: AUT University; 2007.

Indigenous health internationally

Māori and non-Māori medical educators are contributing significantly to and collaborating with LIME⁵⁴⁰ (Leaders in Indigenous Medical Education – an international network of medical educators). There are unique circumstances for vocational colleges in New Zealand – most medical colleges⁵⁴¹ are bi-national institutes that reach across both New Zealand and Australian jurisdictions. The exceptions are the Royal New Zealand College of General Practitioners, New Zealand College of Public Health Medicine and Royal New Zealand College of Urgent Care.

LIME led the development of an indigenous health curriculum, which has been endorsed by the Medical Deans of Australia and New Zealand and has been adopted by the Australian Medical Council (AMC). AMC has an accreditation role for both New Zealand medical schools and medical colleges that includes a focus on Māori health and training for Māori through undergraduate and vocational training pathways. Additionally, many medical colleges and the medical schools have developed their own position statements about Māori health, cultural competence and addressing inequity. Foremost in this is RNZCGP, which established the first indigenous faculty – Te Akoranga a Maui – in 2001.⁵⁴² NZCPHM, RACP and RACS have similarly established representational structures and policy positions for Māori membership and improving Māori health outcomes. This includes the establishment of awards, scholarships, committees and specific Māori academic or organisational positions. Te ORA is often consulted and provides advice about these developments, and given the increasing number of Māori medical graduates, most colleges are seeing a growth in the number of Māori fellows and trainees and beginning preparation for that increase.

540 <http://www.limenetwork.net.au/>

541 <http://www.cmc.org.nz/>

542 Additionally, RNZCGP has constitutionally adopted a Māori alternate name – Te Whare Tohu Rata o Aotearoa.

Te ORA has also been instrumental in establishing the Pacific Region Indigenous Doctors Congress (PRIDoC). This congress meets biennially and provides indigenous space for publication and collaboration across medical education, policy, research and clinical work.

Influential contributions to the medical profession

The Māori medical luminaries already mentioned in this chapter have provided a substantial body of writings to New Zealand and international audiences. The four volumes of *Hauora: Māori Standards of Health* are worthy of repetition. Māori medical practitioners have also contributed (along with many others) to the corpus that has been published by Te Kete Hauora (formerly the Māori division of the Ministry of Health) and the Māori health research centres including Te Rōpū Rangahau Hauora a Eru Pōmare (University of Otago, Wellington School of Medicine) and Tōmairora Māori Health Research Group (the research division of Te Kupenga Hauora Māori, Faculty of Medicine and Health Sciences, University of Auckland).

Consider just a single thread – Durie and others at Hui Whakaoranga in 1984 made a clear call for robust ethnicity data. Later, that call is revisited consistently by Te Kete Hauora and is then evidenced by Reid and others in publications such as *Ethnicity Matters*⁵⁴³ and *Mana Whakamārama – Equal Explanatory Power: Māori and non-Māori sample size in national health surveys*.⁵⁴⁴ This has been repeated across most clinical disciplines (especially general practice, psychiatry and population health) and across most health conditions.

543 Robson B, Reid P. Ethnicity matters: Review of the measurement of ethnicity in official statistics: Māori perspectives paper for consultation. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare for Statistics NZ; 2001.

544 Robson B. Mana whakamarama – equal explanatory power: Māori and non-Māori sample size in national health surveys. Wellington: Ministry of Health; 2002.

Near future

We are entering the era of ‘big data’, and questions about how Māori data is being collected, analysed and utilised are resurfacing. The narratives recorded at Hui Whakaoranga again resonate more than three decades on, albeit in the modern idiom of indigenous data sovereignty.⁵⁴⁵

Many doctors working in New Zealand will be involved in or affected by discussions and decisions about how Māori data is governed. Issues of data ownership, control, access and protection are discussed in several other chapters of *Good medical practice* (see Appendix A). For Māori, these issues have an additional dimension relating to how Māori collective rights may be expressed. Through Te ORA, Māori doctors are pursuing a Waitangi Tribunal claim⁵⁴⁶ beginning May 2017 that addresses the persistent disparities in Māori health outcomes and seeks comprehensive and constructive recommendations on actions for urgent remediation.

The growing Māori medical practitioner workforce along with growing capacity in other Māori health professions and in Māori health research are likely to precipitate some remarkable opportunities in the near future.

Te ORA has some critically important roles, firstly supporting the growing Māori medical workforce entering the profession, navigating their journeys through vocational training and supporting them in their professional contributions. Additionally, Te ORA will have a significant partnership role working with MCNZ, medical colleges and with Crown agencies involved in the broader health and social system. Te ORA has a contribution to make in supporting the cultural competency development of New Zealand’s health workforce.

The challenges have clearly been laid – kua takoto te mānuka.

545 Jansen R. Indigenous data sovereignty: a Māori health perspective. In: Kukutai T, Taylor J, editors. *Indigenous data sovereignty – toward an agenda* (pp. 193–211). Canberra: ANU Press; 2016.

546 Wai 2499 claimants include past Chairpersons of Te ORA and other leading Māori doctors. The claim is part of Wai 2575: Health Services and Outcomes Kaupapa Inquiry – see footnote 55.

APPENDIX A

Good medical practice

Medical Council of New Zealand, November 2021

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

<https://www.mcnz.org.nz/assets/standards/b3ad8bfba4/Good-Medical-Practice.pdf>

APPENDIX B

NZMA Code of Ethics

Te Hauora mō ngā Iwi Katoa *Code of Ethics*

NZMA *Code of Ethics*

The profession of medicine has a duty to maintain and improve the health and wellbeing of the people, and to reduce the impact of disease. Its knowledge and consciousness must be directed to these ends. The medical profession has a social contract with its community. In return for the trust patients and the community place in doctors, ethical codes are produced to guide the profession and protect patients. This document represents a further stage in that evolutionary process.

<https://www.nzma.org.nz/assets/Uploads/Documents/Code-of-Ethics-Redesign-2020-Version-4.pdf>

APPENDIX C

Current standards

The principal function of the Medical Council of New Zealand is to protect the health and safety of the public by ensuring that doctors are competent and fit to practise. We do this by setting standards of clinical and cultural competence and ethical conduct for doctors.

Our current standards set out the principles and values that define good medical practice, and outline what we expect from doctors in all aspects of their professional behaviour.

Our current standards are used by the Health Practitioners Disciplinary Tribunal, the Council and the Health and Disability Commissioner as benchmarks against which doctors are measured

<https://www.mcnz.org.nz/our-standards/current-standards/>



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2021: Edited by Kevin A Morris

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