

MEDICAL COUNCIL NEWS



Protecting the public, promoting good medical practice
Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

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NEWSLETTER OF THE MEDICAL COUNCIL OF NEW ZEALAND

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CHAIRPERSON'S FOREWORD

Council members



IN FEBRUARY, following Professor John Campbell's resignation as chairperson of the Council and as a Council member, I was elected by Council members as the next chair.

I would like to acknowledge the tremendous contribution that John has made to the profession and to the whole of the medical workforce. Since joining the Council eight years ago, John has been a part of or chaired Council's audit, education, examination, health, and issues committees.

The Council has been fortunate that John's wide range of experience, together with his clinical, academic, medical knowledge and appointments to various committees over the years have combined to give us the leadership and direction the profession has needed, particularly with the introduction of the Health Practitioners Competence Assurance Act 2003.

John's vision has always been for a strong, self-regulated medical profession of good doctors where the maintenance of professional standards protects public health and safety.

He has advocated for many years that New Zealand should train enough doctors to meet our health service needs, as well as the need to retain a higher proportion of those young doctors we train. Likewise, he has worked tirelessly to ►

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◀ improve the educational experience of medical graduates during their early postgraduate years.

REVIEWING THE INTERNSHIP

Here in New Zealand, we believe that the intern year is about growth as a doctor and about putting the attitudes, knowledge, and skills learnt at medical school into clinical practice. With this in mind, we are beginning to undertake a comprehensive review of the current content and structure of the intern year.

‘In the coming months, we will be considering how to better support more structured educational opportunities beyond the intern year...’

Specifically we will be looking into how the current internship is working to deliver doctors who reach the standard of competence required for registration in a general scope of practice. For some time now, we have thought the intern year could be improved with the addition of experiences in areas of medicine currently not available – such as community-based intern runs. We will also be clarifying the standards we expect for various intern runs to be accredited.

This thinking will take some time to develop as we will need to seek the views of stakeholders. It would also require significant up-front investment to create capacity and broaden current training settings.

We also recognise the need to further clarify those competencies we expect doctors to gain by the end of the intern year and what learning objectives are needed to specifically reflect these.

In the coming months, we will be considering how to better support more structured educational opportunities beyond the intern year and, in particular, in the second postgraduate year (PGY2). The Council recognises that this year currently provides a gap in the education and training continuum and is keen to develop frameworks to bolster the additional value of this year.

We hope this work will reinforce our philosophy that the early postgraduate years are based on a doctor being an apprentice on a team, receiving frequent real-time feedback and support, together with responsibility that is stimulating but safe.

For a glimpse of how we might achieve this, we can look across the Tasman at the Australian Curriculum Framework for Junior Doctors (ACF) and its focus on interns.

THE AUSTRALIAN CURRICULUM FRAMEWORK FOR JUNIOR DOCTORS

The pre-vocational phase of medical training and development encompasses the period between graduation and vocational training. The ACF is a template outlining the competencies required of pre-vocational doctors, to be achieved through their clinical rotations, education programmes, and individual learning, in order to promote safe, quality health care.

The ACF is built around three learning domains of knowledge, skills, and behaviour. These areas are divided into categories, each of which is further subdivided into learning topics. These topics have been identified in the literature and from supervisors' experiences as being critical to both safe pre-vocational practice and a basis for future training.

Work is also beginning in Australia as to how the ACF can be used in assessment of competencies and achieving national consistency on assessment and supervision.

Ideally, these learning outcomes will be achieved before starting vocational training; however, we recognise that proficiency may occur at different stages for different doctors.

More information on the ACF is available at:
www.cpmec.org.au

I would welcome any comments you may have on the ACF or how we may be able to improve intern runs in New Zealand.



John Adams
Chairperson 

Who are our Council members?

IN THIS ISSUE of *Medical Council News* we profile our Council members. Currently, the Council is made up of four doctors elected by the profession, four doctors appointed by the Minister of Health, and four lay members also appointed by the Minister of Health.



DR JOHN ADAMS

MB ChB, FRANZCP
Appointed to the Council
in August 2008

Dr Adams is chairperson.

Appointed Dean of the Dunedin School of Medicine in 2003, Dr Adams is a University of Otago graduate, who subsequently trained in psychiatry.

He gained his Fellowship of the Royal Australian and New Zealand College of Psychiatrists in 1984. He worked for many years at the Ashburn Clinic in Dunedin, where he was appointed Medical Director in 1988.

Dr Adams has had extensive involvement with the New Zealand Medical Association (NZMA), initially as a Council delegate, then as a board member, and later as NZMA chairperson from 2001 to 2003. A long-term interest in professionalism and ethics

led to him chairing the NZMA Ethics Committee during the recent review of the NZMA Code of Ethics.

Dr Adams teaches in the professional development programme in the undergraduate course in Dunedin. He is a trustee on the New Zealand Institute of Rural Health, the Ashburn Hall Board of Trustees, and the Alexander McMillan Trust.

Since joining the Council, he has participated as a member of the Health Committee and chairperson of the Education Committee. As chairperson, Dr Adams is ex-officio on all Council committees.



DR RICHARD ACLAND

MB ChB, FAFRM (RACP)
Elected member who was
reappointed to the Council
in June 2009

Dr Acland practises in rehabilitation medicine

at Burwood Hospital, Christchurch. He is a visiting consultant to the Auckland Spinal Unit and the Mercy Pain Service in Dunedin. He is a former Clinical Director of Anaesthesia and the Spinal Unit in Christchurch. He practised anaesthesia in Auckland from 1979 to 1994. Dr Acland was President of the New Zealand Pain Society from 2002 to 2003 and has been a member of the Medicines Assessment and Advisory Committee since 1996.



DR ANDREW CONNOLLY

MB ChB, FRACS
Appointed to the Council
in November 2009

Dr Connolly is a general and colorectal surgeon, employed fulltime by Counties Manukau District Health Board. Trained in Auckland, Dr Connolly had a formal 18-month period of surgical research under

Professor G L Hill before completing post-fellowship colorectal training in the United Kingdom, returning to Middlemore Hospital as a consultant surgeon in late 1997.

He has a strong interest in governance and clinical leadership and has been the Head of Department of General and Vascular Surgery for the last 6 years. He has served on the ministerial advisory group responsible for the *In Good Hands* document, which will help district health boards introduce greater clinical leadership into the public health system.

In addition, he has served on various district health boards and national committees including the National Guidelines Group for the screening of those with an increased risk of colorectal cancer. Dr Connolly also has a strong interest in surgical education and training and acute surgical care, as well as an active role in surgical research into enhanced recovery.

Dr Connolly is a member of the Council's Audit and Education Committees.



DR JONATHAN FOX

**MB BS, MRCS LRCP,
MRCGP, FRNZCGP**
Elected member who was
appointed to the Council in
June 2009

Dr Fox is a general practitioner from Auckland. He is the immediate Past President of the Royal New Zealand College of General Practitioners and chair of the Council of Medical Colleges in New Zealand. He is a board member of the NZMA and also ProCare, the Auckland Independent Practitioners Association (IPA). He is also a member of various charitable and research trusts in the Auckland region.

Previous positions held by Dr Fox include membership of the GP Council of the NZMA, and of the Competence Advisory Team of the Medical Council, Medical Officer to Kings College Auckland, and many RNZCGP Auckland Faculty positions.

Dr Fox qualified from Guys Hospital Medical School London in 1974. He then spent 7 years as a Medical Officer in the Royal Navy – including three and a half years as a submarine

medical officer and 2 years in Hong Kong before completing his vocational training in the United Kingdom. After leaving the navy, he spent 8 years as a general practitioner in Rugby in the United Kingdom, where he was also Medical Officer to Rugby School. He migrated to New Zealand in 1990 with his GP wife and their family. Over the last 19 years, their practice has grown and become established as a five-doctor practice in Meadowbank, Auckland.

He was recently awarded an Honorary Fellowship by the Royal Australian College of General Practitioners.

Dr Fox is a member of the Council's Audit and Health Committees.



DR ALLEN FRASER

**MB ChB, DPM,
MRCPsych, FRANZCP,
Dip Prof Ethics**
Appointed to the Council
in August 2008

Dr Fraser is a descendant of Scots who left Scotland for Nova Scotia before finally settling in Waipu in 1856. Medical school in Dunedin in the 1960s was followed by

training as a psychiatrist in Auckland and at St Thomas' Hospital in London. Dr Fraser was appointed as a consultant psychiatrist in South Auckland in 1977. He led the development of community-based mental health services, at the same time continuing his career-long commitment to the acute in-patient care of the seriously mentally ill.

He has been involved in many professional organisations (local, national and international), the first and most enduring being the Royal Australian and New Zealand College of Psychiatrists (RANZCP). Since 1980 he has been involved in College affairs in one way or another, including as chairperson of the New Zealand Committee for four and a half years. He has been a union leader (President of the Association of Salaried Medical Specialists (ASMS) for 4 years; he is now a life member of ASMS).

Dr Fraser has interests in philosophy, ethics, and law as they relate to medicine and particularly psychiatry. He has researched in this area, presented at international conferences, and assisted in the training of family court judges. He has an ongoing commitment to self-education and to the education and training of colleagues and those who will replace them.

His current clinical work is in private practice in Auckland where he concentrates

on mood disorders and medico-legal assessments.

Dr Fraser is chairperson of the Council's Education Committee and a member of its Health Committee.



MS JUDITH FYFE

LLB, ONZM
Appointed to the Council in
August 2008

Ms Fyfe is a lay member who has a background in research and communication. Before co-founding the New Zealand Oral History Archive with Hugo Manson, she worked in television as a journalist and in the film industry.

Ms Fyfe practises as a barrister specialising in forensic law. She lectures in oral history in New Zealand and the United States and is contracted by the Oral History Centre, Alexander Turnbull Library, to carry out contemporary oral history projects.

Ms Fyfe is also a partner in City Associates, a film production company, and a member of the Copyright Tribunal and the Film and Literature Board of Review.

In addition to involvement in several community organisations, she is a

long-time member of the Wellington Medico-Legal Society.

Ms Fyfe is a member of the Council's Audit and Education Committees.



MS LIZ HIRD

LLB (Hons)

Appointed to the Council in June 2005

Ms Hird is a lay member who has been a barrister since 1987 and has a wide-ranging commercial and administrative law practice. Ms Hird has had a long involvement in community health, beginning with the founding of the Otaki Women's Health Group in 1987. She was also an initial member of the Otaki community health committee of the area health board and founding trustee and chairperson of the Otaki Community Health Trust. The trust provides community grants for health projects. Ms Hird is the current chairperson of the trust.

Ms Hird was a member of the Otaki primary health organisations steering committee that established the Otaki Community PHO.

Ms Hird is also national contractual legal adviser to HealthCare Aotearoa (Inc), a network of community primary health providers PHOs.

In 2004, Ms Hird was appointed district inspector for intellectually disabled services for the lower half of the North Island. In 2005, she was reappointed district inspector of mental health services for MidCentral District Health Board.

Ms Hird is chairperson of the Council's Audit Committee and a member of its Education Committee.



MRS LAURA MUELLER

Juris Doctor (Calif), BA Psych (Calif)

Appointed to the Council in November 2009

Mrs Mueller is a lay member who was appointed as a judicial officer for the Ministry of Justice in 1999 and sits as a referee in the Disputes Tribunal at the Tauranga District Court. She has 20 years of business experience, including management of a large accounting and tax practice and experience as a medical insurance underwriter.

Mrs Mueller has a keen interest in governance and leadership. She serves on the Disputes Tribunal's National Education Committee, has served as treasurer on the Disputes Tribunal's Referees Association Executive, and is a peer reviewer for her fellow referees.

Mrs Mueller is an alternate member of the Council's Health Committee.



PROFESSOR JOHN NACEY

MB ChB, MBA, MD, FRACS

Appointed to the Council in March 2010

Professor Nacey graduated from the University of Otago in 1977. After completing specialist training in urology, which included an appointment as Chief Resident in Surgery at the Flinders University Medical Centre, he returned to New Zealand to take up a joint hospital/university position in Wellington. In 1998 he was appointed Dean and Head of Campus at the University of Otago's Wellington School of Medicine, a position he held for 10 years.

With a specialised interest in prostate disease, Professor Nacey has published extensively in this area. He is a member of the prestigious Urological Research Society and acts as referee for several major international journals. As past examiner for the Royal Australasian College of Surgeons he has maintained his interest in teaching both undergraduate medical students and postgraduate surgical trainees.

Professor Nacey holds the position of Professor of Urology at the Wellington School of Medicine. He has widespread community involvement including membership of the Board of Management of the Wellington Medical Research Foundation and the New Zealand Cancer Standards Institute. He remains a strong advocate for promoting men's health.



DR KATE O'CONNOR

BHB, MB ChB,
FRANZCR

Elected member who was
appointed to the Council in
June 2005

Dr O'Connor graduated from the University of Auckland in 1995 and completed her vocational training in diagnostic radiology in 2002. She worked as a house officer in Waikato and Tauranga Hospitals and as a registrar in all the public hospitals in Auckland.

During that time, she served on the national executive of the New Zealand Resident Doctors' Association for 6 years, including 2 years as national president.

Dr O'Connor is a radiologist at Auckland District Health Board and a partner at Auckland Radiology Group.

She is deputy chairperson of the Council and chairperson of the Council's Health Committee.



**PROFESSOR DICK
SAINSBURY**

MB ChB, FRACP,
G.DipArts

Elected member who was
appointed to the Council in
June 2009

After Professor Sainsbury graduated from the University of Otago, he completed 6 years as resident medical officer in Auckland before going to the United Kingdom for advanced training. Since 1982 he has worked as a consultant physician in geriatric medicine in Christchurch in dual university / hospital appointments. He has a particular interest in student teaching and has served a period as a trainee intern coordinator. He has also been involved in examining, mentoring, and supervising international medical graduates.

Professor Sainsbury is a member of the Council's Education Committee.



**MRS HEATHER
THOMSON**

Appointed to the Council in
September 1999

Mrs Thomson is in her third term as a lay member of the Council. She has been a public member on many boards including several of the Cartwright committees, the Public Health Commission, the Māori Health Commission, and the Bay of Plenty District Health Board.

Mrs Thomson is the manager of Rural Health Services Eastern Bay and lives in Whitianga Bay, 50 kilometres east of Opotiki. Her interest in health has been mainly in health management, the development of services for Māori, and community and rural development. Her hapu is Ngati Paeakau; her iwi te Whānau a Apanui.

Mrs Thomson is a member of the Council's Health Committee. 🌺

Response to Ethics 101 article by Dr Barnett Bond

BY DR TIM EWER, MB CHB, MRCP, FRACP, FRNZCGP

Ethics 101 has the objective of generating thoughtful discussion about the pros and cons of various issues. We hope it will create interest and generate further discussion among the profession about practical ethical and clinical issues. 🗨️

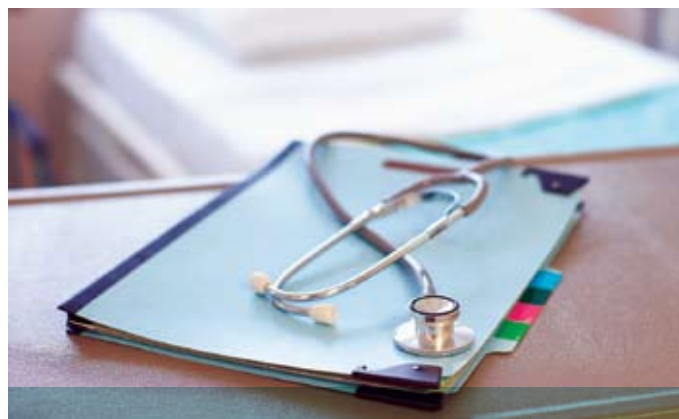
IN OUR DECEMBER 2009 ISSUE of *Medical Council News*, Dr Barnett Bond wrote an article in our Ethics 101 slot, entitled 'Fringe medicine, some thoughts'. In this issue, Dr Tim Ewer (from the Mapua Health Centre) responds.

It is not surprising that some doctors feel concerned about evolving and new areas in health care, particularly in the area of complementary and alternative medicine (CAM), which covers a whole spectrum of therapies – some of which are evidence-based, and others that are not.

It is for this reason that the term 'integrative medicine' (IM) has become more appropriate and has been defined as 'the blending of conventional and natural/complementary medicines and/or therapies with the aim of using the most appropriate of either or both modalities to care for the patient as a whole'.¹ A growing number of doctors in New Zealand and Australia, which is reflected throughout the world, are integrating various ethical, holistic, non-pharmaceutical modalities into their clinical practice, not to replace conventional medicine, but to expand its boundaries and build a scientific foundation for providing the best possible combination of care to patients.

Many patients are finding these therapies useful in improving health as they commonly aim to enhance a healthy lifestyle, work with the natural healing process, empower patients to be active participants in their own healing process, and nurture the body, mind, and spirit (as stated in the WHO definition of well-being²) to improve quality of life.

Integrative medicine describes a *style of practice* where the practitioner and patient will choose the appropriate therapy or medicine for the treatment of the condition. Acupuncture may be suitable for some patients but not for others; surgery may be



suitable for some patients but not for others. Herbs might be suitable for some conditions but not for others, and so on.

A review of the literature shows that the scientific evidence for some CAMs is growing, with positive systematic reviews and meta-analyses including Cochrane reviews. Examples of some of the treatments that may play a significantly effective role in treatment include cranberry to prevent recurrent urinary tract infections in young women,³ music therapy and St John's wort herb for depression,^{4, 5} various herbs for irritable bowel syndrome,⁶ yoga and exercise for menopausal symptoms,⁷ *Pygeum africanum* extract for benign prostatic hypertrophy,⁸ fish oils for hyperlipidemia,⁹ acupuncture for migraine and tension headaches,¹⁰ and garlic for hypertension.¹¹

As with any medical practice, including CAM, if the evidence is consistently negative and it comes with potential risks, then it is appropriate to remove the therapy. Publication bias is common to all trials,¹² and a lack of evidence for some CAMs does not necessarily mean that a therapy does not work, but that it warrants further testing.¹³ Even though the integration of CAM poses a variety of challenges to GPs and medical specialists, they may provide valid and safer options to health care for some patients.

Dr Richard Horton, FRCP, editor-in-chief of *The Lancet*, stated:

'We must act on facts and on the most accurate interpretation of them, using the best scientific information. That does not mean that we must sit back until we have 100 percent evidence about everything. When the state of health of the people is at stake ... we should be prepared to take action to diminish those risks even when the scientific knowledge is not conclusive...' ¹⁴

As also noted by some of the original authors of evidence-based medicine:

'External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be ►

◀ integrated into a clinical decision. Similarly, any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient's clinical state, predicament, and preferences, and thus whether it should be applied.¹⁵

In Australia, the Integrative Medicine Network was established in 2008 as a result of the positive relationship between the Royal Australian College of General Practitioners (RACGP) and the Australasian Integrative Medicine Association (AIMA). It represents medical practitioners who are interested in incorporating holistic, evidence-based integrative medicine into their clinical practice.¹⁶

The IM Network aims to uphold the highest standards of education and professional development, and to support medical professionals who choose to advance their knowledge in this important area. In New Zealand, in recognition of the evolving area of integrative medicine, the Ministry of Health appointed Dr David St George as Chief Advisor in Integrative Care in January 2008. The purpose of his role is to provide leadership, direction, and advice on the development of CAM in New Zealand, and on integrating CAM and mainstream health care.

The worldwide move towards patient-centred medicine indicates that the best way forward is to work together as health professionals, building bridges between different modalities and approaches, rather than resorting to the divisiveness of previous times.

The New Zealand branch of AIMA is discussing with the RNZCGP about developing policy and initiatives on evidence-based integrative medicine. Our aim is to work with the College on education, training, and setting standards for medical practitioners who choose to practise in this emerging style of medicine, particularly when the therapy has scientific evidence to support its use, with little risk, and with the aim of improving the health of the patient.

As stated by Professor Marc Cohen:

Ultimately, medicine has a single aim: to relieve human suffering. When measured against this benchmark, different therapies can be seen as either effective or ineffective rather than 'orthodox' or 'unorthodox'. No single professional group has ownership of health, and the best health care requires a multidisciplinary approach. Thus, there is an imperative for all health care professionals to work together for the benefit of their patients and the wider community.¹⁷

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Conditions on scopes of practice ... what they mean



CONDITIONS ON A DOCTOR'S SCOPE of practice may raise questions for patients, employers, media, colleagues and other health professionals alike.

Our publicly-available online medical register shows a doctor's name, qualifications, scope of practice, practising certificate status and any conditions on their practice. Many assume that conditions mean there are questions about the doctor's competence or conduct.

It is true that sometimes conditions are placed on a doctor's scope of practice as a result of concerns about their competence or conduct. These conditions are intended to ensure public safety. For example, the doctor may be required to work under supervision, or to have a Council-approved chaperone present during a consultation if the doctor is undertaking intimate examinations.

We emphasise that the doctor is considered to be safe to practise as long as they are working within the conditions on their scope of practice.

Conditions may be imposed in other circumstances too. For example, doctors coming into New Zealand to work from a comparable health system (such as Canada, the United States, and most West European countries) will have their scope of practice limited to the areas of medicine they have been assessed in while working under supervision in New Zealand. For example, the doctor may be limited to working in general practice, or psychiatry, anaesthesia, and so on. The Council has no concerns with the competence of these doctors working within their limited scope of practice. 🇳🇿

If you drink, then drive, you're a bloody idiot

'GOOD EVENING. State your name and address in the breathalyser please ... I'm afraid that's a failed result. You'll have to accompany me to the police station for a blood test.'

A drink-driving conviction will usually result in a fine and disqualification from driving. For doctors, the cost of such a lapse in judgement can be far greater. Why? Because doctors are answerable not only to the law for their actions; but also to the profession and to the public.

Medicine is arguably the profession held above all others when it comes to matters of integrity, ethics, and conduct. Doctors are at the raw end of alcohol-related incidents. They see and treat the injuries that result from motor vehicle accidents, domestic violence, and assault cases involving alcohol impairment. Surely they should lead by example?

Practising medicine takes an emotional and physical toll on doctors. It is totally understandable that lapses in judgement may happen. However, all doctors need to be aware of the consequences and the professional implications of any lapse in judgement. They should take steps to avoid driving under the influence of alcohol and prevent the stress and anxiety of a possible drink-driving conviction.

WHAT HAPPENS WHEN THE COUNCIL IS NOTIFIED OF A CONVICTION?

The Health Practitioners Competence Assurance Act 2003 (HPCAA) requires the registrar of a Court in New Zealand to notify the Council when a doctor is convicted of an offence that is punishable by imprisonment for a term of 3 months or longer. This includes drink-driving offences. When a notification is received by the Council, it is automatically referred, under the HPCAA, to a Professional Conduct Committee (PCC) for investigation.

WHAT IS A PROFESSIONAL CONDUCT COMMITTEE?

A PCC is a committee of three people, two doctors and one lay person, appointed by the Council to consider a complaint or conviction. The PCC's role is to establish if the matter under investigation relates to the doctor's competence or to discipline and to make one or more recommendations and/or a determination under the HPCAA. ►



PHOTO: THE NZ TRANSPORT AGENCY.

- ◀ Examples of determinations and recommendations a PCC can make include:
 - laying a charge against the doctor with the Health Practitioners Disciplinary Tribunal
 - recommending that the Council review the doctor's fitness to practise medicine
 - recommending that the Council review the doctor's competence to practise medicine.

THE COST OF DRINK-DRIVING

An increasing number of drink-driving-related convictions are being referred to the Council. However, our statistics currently do not indicate that any particular group of doctors are more vulnerable or susceptible than others. A drink-driving conviction has consequences beyond the requirement that Council establish a PCC. These convictions have an emotional impact on the doctor but, more than that, can also have professional impacts; for example, restricting travel (if you are disqualified from driving) and delaying or prohibiting registration with overseas authorities.

What does it cost in financial terms? In the past two years, PCC investigations of drink-driving convictions have cost the profession about \$143,000. This is paid for through disciplinary levies obtained from every doctor on an annual basis with their practising certificate fee. In addition, the profession meets the cost of any health assessments ordered by the Council in determining the safety of the doctor's drinking.

AN OPPORTUNITY TO TAKE STOCK

A PCC investigation into a drink-driving conviction doesn't have to be entirely stressful or without benefit for the doctor concerned. In fact, recent feedback from a doctor who underwent a PCC indicated that the process can be positive, as it helped 'open [their] eyes to the need to look after one's self, as well as each other'. They were 'thankful for the way [the PCC] handled the situation [they] had created for


[themselves] so sensitively', and were 'glad [they] were in a profession with people who do that'.

DOCTORS' HEALTH

Section 45 of the HPCAA requires doctors and other health professionals to report to the Council any doctor who may be unable to perform the functions required for the practice of medicine due to a mental or physical condition. A conviction for drink-driving can indicate a doctor has a problem. It is important that the Council is advised as soon as possible when you (or a doctor you know or work with) have been convicted, or sooner if there are other concerns about alcohol use. It is not in the individual's interest to be practising under a degree of impairment or illness, nor will it be in the interest of patients, the public (including employers), or the medical profession.

Council's Health Committee will obtain objective advice about the doctor's drinking, and will support the doctor if changes are required. If you are suffering from an alcohol-related problem, we can help you, and help protect those around you from the effects of your alcohol use.

GETTING HELP AND ADVICE

- If you would like to discuss any of the issues raised in this article please contact the Council's health manager on 0800 286 801.
- The Doctors Health Advisory Service (DHAS) helps doctors and their families with personal and health problems and can be contacted on 0800 471 2654 for a confidential discussion.
- The Medical Protection Society and Medical Assurance Society have joined together to offer a confidential helpline to doctors and can be contacted on 0800 225 5677. 

Is your email address the right one?

DURING THE NEXT COUPLE OF YEARS the Council will be moving to providing more of its services online, including using emails to communicate with doctors. Occasionally we may need to send an email containing confidential information to a doctor.

The email address you provide to the Council may be used to send confidential, personal, or private information about you or about other doctors. For this reason, you must give the Council an email address that is suitable for receiving confidential and private information.

If you would like to change the email address you have provided to us you can update it:

- during your next annual practising certificate renewal on the application form
- online at www.mcnz.org.nz Registration>>Currently registered doctors>>Change your personal details
- by emailing mcnz@mcnz.org.nz. 📧

Order your free folder

IN RECENT YEARS, the Council has produced over 30 statements on topics such as:

- informed consent
- best practices when providing care to Māori patients and their whānau
- unprofessional behaviour and the health care team. Protecting patient safety.

As new statements are produced, or others are updated, we will send them to you automatically with the Council newsletter. You can then file them in a folder for quick reference.

You can place your order at folder@mcnz.org.nz or phone 0800 286 801 extn 793.

Statements are also on our website at www.mcnz.org.nz>>Publications & guidance>>Statements. 📧

Changes to scopes of practice and prescribed qualifications

THE COUNCIL has recently reviewed its scopes of practice and prescribed qualifications.

Two new special purpose scopes of practice under the locum tenens pathway have been created. They are:

- assisting in a pandemic or disaster
- providing teleradiology services to New Zealand patients.

In addition, we have reduced the required period of supervision for doctors registered within a provisional general scope of practice in the competent authority and comparable health system pathways. This change will not affect New Zealand graduates or NZREX doctors, who will still need to complete their internships.

Over the next 3 months, Council staff will contact all doctors affected by these changes.

More detailed information on these changes and the scopes of practice has been published in the New Zealand Gazette, available at <http://www.mcnz.org.nz/portals/0/Publications/Gazette-A4.pdf>

If you would like more information on these changes, please email the Council at registration@mcnz.org.nz. 📧



Lost doctors

IN THIS ISSUE OF *Medical Council News*, we list several 'lost' doctors. These are doctors we cannot trace because they have not let us know their new addresses.

If you change your address, please let us know your new address within a month.

You can change your address online at www.mcnz.org.nz
>>Registration>>Currently registered doctors>>Change your personal details.

The following doctors will be removed from the medical register unless we receive their new addresses. If you know how to contact any of these doctors, please email apc@mcnz.org.nz or phone 0800 286 801 ext 785.

- Dr Abdullah Saad S Alhazmi
- Dr Niranthari Chinnaiah
- Dr Gye Yeun Lee (Claire)
- Dr Caroline Anne Ryan (Auckland)
- Dr Nicola Margaret Whittle 🇳🇿

THANKS FOR CONTRIBUTIONS TO FOCUS GROUPS

The Council would like to thank all those doctors who have contributed to its focus groups run by Sue Ineson of Karo Consulting on medical migration, orientation, and the retention of international medical graduates. In the next issue of *Medical Council News*, we will look at the issues raised and possible solutions. 🇳🇿



'Avoid exploiting the patient in any manner'

BY DR STEVEN LILLIS, MEDICAL ADVISER TO THE MEDICAL COUNCIL OF NEW ZEALAND

THE COUNCIL was recently notified of concerns related to doctors working in general practice who were involved in an initiative by a health funding organisation to expedite patient recovery from illness. The concerns arose because it appeared that the doctors involved would receive greater income from the funder for successful recovery that would be above and beyond the usual fee paid. While the detail of the arrangements between the funder and the doctors could be interpreted in many ways, the arrangement did raise important ethical issues that are relevant in a wider sense.

The extremes of unethical financial gain from patient exploitation are easy to identify and would raise the ire of the vast majority of doctors. No one would tolerate a fee being paid to a doctor by a laboratory based on the number of blood tests being ordered. Similarly, a specialist paying general practitioners per referral would be equally unpalatable with clear ethical violations. However, some ethical issues become much more ambiguous. When a third party is financing a consultation, the third party has a legitimate interest in the quality of care and the conclusions of the consultation. In the case described above, not only was the funder paying the consultation fee, it also could be inferred that the funder was attempting to influence the outcome of the consultation.

A useful guiding principle in such ambiguous circumstances is the question 'Could my actions have exploited this patient for my personal gain?' Alongside the Council's publication on *Good medical practice – a guide for doctors* and the New Zealand Medical Association's *Code of Ethics* statement on exploitation, The Code of Health and Disability Services Consumers' Rights clearly states that the consumer has the right to be free from exploitation. It defines exploitation as any abuse of a position of trust, breach of fiduciary duty, or exercise of undue influence. Of particular note in this case was the extra income that the doctors would derive from clinical decisions that were of benefit to the funder.

Much as we would like to think of our professional actions as always being above our own interests, the reality can be somewhat different. Placing ourselves in the position of personal gain for decisions involving complex and imprecise clinical information invites both the reality and appearance of biased judgement. This is not a comfortable place for a doctor to be in and is therefore best avoided.

- 1 New Zealand Medical Association Code of Ethics for the New Zealand medical profession. Revised 2008. 

Understanding our registration processes and proposals to decline

THE REGISTRATION OF DOCTORS is one way that Council fulfils its principal purpose under the Health Practitioners Competence Assurance Act 2003, 'to protect the public by providing mechanisms to ensure that doctors are competent and fit to practise'.

Registering doctors is an important part of the Council's work and in the past year we registered more than 1,500 doctors to work in New Zealand. The Council has been undertaking research with doctors to identify how well our registration processes work and what we can do better. One of the most informative comments we received was that how we manage registration applications is not well understood. Applicants do not always understand what a 'proposal to decline' means.

The Council has several pathways to registration. Most decision making within our registration policies is delegated to the registrar. The policies have been developed to ensure that the doctor has the right qualifications, training, and experience to work in New Zealand. Applications that fall within policy will normally be processed in the time frames described in the side bar on page 13.

A 'proposal to decline' means that the application is outside the Council's registration policy and the registrar's delegated authority to approve the application. A 'proposal to decline' does not reflect negatively on the doctor who has applied for registration.

The doctor will be advised of the 'proposal to decline' and given the opportunity to provide further information and to present a case to the full Council. The Council will then decide whether the doctor can be registered based on all the information. The doctor can be represented if they choose.

At the meeting, the Council will consider all the information submitted with the application, any additional information provided by the doctor, and our policies. A decision will be made on whether the doctor's qualifications, training, and experience are acceptable for registration. The legal test is 'equivalent to or as satisfactory as' the prescribed qualification for registration. We will provide further information on the legal test through our website (which we are currently reviewing to make it more user friendly) and in future issues of *Medical Council News* to help doctors understand this meaning.


PROCESSING TIME FOR REGISTRATION APPLICATIONS

Applications for registration within a provisional general and special purpose scope of practice

- Applications for registration within a provisional general and special purpose scope of practice take up to 20 working days from the date the completed application is received in the Council office.

Vocational applications

- Vocational applications can take up to 6 months because the registration process is much more complicated. The vocational process will be described in the next issue of *Medical Council News*.

Approval for registration applications that meet Council policy are generally made within these time frames. 

APPLICATIONS THAT DO NOT MEET POLICY

Completed applications that do not meet policy must be received in the Council office 2 months before the Council meets. This allows time for a fair process to be followed (including advising the doctor of a proposal to decline) and for staff to prepare and distribute the material to Council members to consider a couple of weeks before their meeting.

The schedule for this year's Council meetings and deadlines for completed applications to be received by Council staff has been distributed to recruiters and human resources departments on our mailing list. If you would like a copy of this schedule please email info@mcnz.org.nz. ►

◀ PROPOSAL TO DECLINE PROCESS ALSO APPLIES TO OTHER REGISTRATION APPLICATIONS

This proposal to decline process also applies to other types of applications submitted to the Council such as applications to change scopes of practice. 🐾

Council farewells 'Southern man'

BY LIANE TOPHAM-KINDLEY

RETIRING MEDICAL COUNCIL chairperson John Campbell is looking forward to spending a little more time getting closer to nature.

Together with wife Wendy – a secondary school English teacher by training – Professor Campbell owns and operates two sheep and beef farms: Arngibbon, a 1,300-acre property on north Taieri and a 1,100-acre block south of Dunedin at Waihola.

At first glance, one would little suspect the well-dressed, politely spoken University of Otago academic and consultant geriatrician is also a part-time shepherd and general farm labourer. But come the weekend, he swaps his suit and stethoscope for gumboots and a Swandri and can be found in the shearing shed penning up ewes or wandering the hills, with eye-dog Gyp close at hand.

'It's just beautiful up there on the hills with the dogs and the splendid views out over the Taieri,' he enthuses.

He joked at his farewell function last month that, unlike in the Council board room, on the north Taieri hills, politeness out can go by the wayside when he's bellowing at dogs while rounding up the sheep.

Since 1980, Professor Campbell has been a consultant physician with the Otago District Health Board. He has a particular clinical and research interest in geriatric medicine and has been Professor of Geriatric Medicine at the Otago Medical School since 1984. He was Dean of the University of Otago's Faculty of Medicine for a decade between 1995 and 2005.



PHOTO: LIANE TOPHAM-KINDLEY.

In 2001, Professor Campbell was appointed to the Council by the Hon Annette King, the then Minister of Health as the medical schools' representative. Two years later he took over the role of chairperson from Dr Tony Baird.

Now, having served almost seven years as chairperson, he admits to somewhat mixed feelings about leaving the Council and a role he has enjoyed so much, with developments such as regular performance reviews for doctors only partially finished.

However, he believes the time is right to leave the organisation, which he considers is in good heart.

'I will miss the Council; not only the work, but you build up a lot of friendships with staff and people you work with. But, like all jobs, you have to try and find a time when you feel the organisation needs someone new; you don't want to outstay your period of usefulness.'

The Council veteran believes the role of the Medical Council is sometimes under-estimated with outsiders wrongly assuming its work focuses on disciplinary issues. He admits to having been surprised himself when first joining to learn the breadth of work the Council undertakes.

Highlights have included helping to raise standards in New Zealand's medical schools and medical colleges by working with the Australian Medical Council in the accreditation process. Today, he believes, accreditation processes for medical schools and colleges in Australia and New Zealand are as robust as anywhere in the world.

The introduction of the Health Practitioners Competence Assurance Act 2003 was a significant and positive move during his time as chairperson, although he still sees room for improvement. Personally, he would like to see the professional organisations working much more closely together.

'One of the key tasks now that the Act is functioning is trying to bring the operational side of the different councils more in line.

'We need to increase the efficiencies at an operational level.'

Another highlight has been the development of scopes of practice and, for Professor Campbell particularly, rural hospital medicine being recognised as a specialty.

'We have many able people working in rural hospitals and it's good to see them develop a career structure with specialist recognition.'

One of the more difficult issues the Council has to deal with is the matters around doctors' competence and Professor Campbell admits this can be 'very stressful'. However, he notes that the Council's Health Committee provides a very important and valuable role in assisting doctors who need help.

Overall, Professor Campbell believes New Zealanders can have great faith in the competency levels of the country's doctors, due to a combination of sound medical schools and well-selected students, robust registration processes, and good professional support through the various colleges and continuing medical education.

Waiheke GP Barnett Bond worked alongside Professor Campbell on the Council for six years and says he was always impressed with how he handled matters as chairperson.

'He was extraordinary; I've never worked with anyone who was able to do that so skilfully before.'

'John had the ability to weigh up complex issues, listen to the debate as chairperson, and draw together all the key threads for the argument in a way which clarified the issue.'

At a farewell function in Professor Campbell's honour last month, new chairperson John Adams paid tribute to his predecessor who was recently voted 'top teacher' by his students. His ability to tackle large work volumes as lecturer and practitioner while juggling numerous national and international roles was 'in the style of Dr Seuss character Bartholomew Cubbins – wearer of 500 hats'.

'I really can't believe the series of hats is finished. I'm sure there's going to be another role.'

Already, his skills are being put to good use in a new national body, the expert panel on war veterans' health. Again Professor Campbell is wearing a familiar hat, that of panel chairperson. 🎩

Informed consent

THE ISSUE OF WHO should obtain consent for patients having procedures has been contentious.

Protagonists of expediency and efficiency hold that the transfer of information can be obtained by any suitably-trained health practitioner.

The converse view is that the consent process is an integral part of the doctor–patient relationship and is as much about the people involved as the information conveyed.

The occurrence of unforeseen or unusual complications has in some cases thrown a critical light on the consent process (as evidenced by the Health and Disability Commissioner's decisions 05HDC07699, 00HDC08358, 07HDC11318 and 99HDC08240). In such cases, where consent has been of concern, even the correct information conveyed by a health professional (rather than the doctor involved) but given in an inappropriate way can cause considerable difficulty.

From the patient's perspective, the consent process is their agreement to allow a doctor or team of doctors to undertake invasive procedures that could result in morbidity or mortality. Procedures that are commonplace for the medical profession are never routine undertakings for the patient. All procedures require patients to place considerable faith and trust in the doctor or team to undertake the procedure well and ensure the best outcome for the patient.

From the doctor's perspective, the doctor has the most comprehensive knowledge of the procedure and what complications, if any, could ensue. Should the consent process be undertaken by another health practitioner, this awareness may be diminished and so the patient's understanding of the procedure and its possible consequences may not be comprehensive.

The consent process, like all activities between doctors and patients, should occur within a trusting relationship. Getting another health professional to obtain consent does nothing to enhance that relationship. The process of obtaining consent is a demonstration to the patient that their trust is well placed. Therefore, the doctor responsible for the procedure is the correct person to obtain consent. 🎩

Interim pathway to Fellowship for general practitioners

THE ROYAL NEW ZEALAND COLLEGE of General Practitioners is offering an interim pathway to Fellowship and registration in the vocational scope of general practice. The Experiential Interim Pathway (EIP) has been developed for doctors who have considerable experience in general practice. The EIP is an interim pathway only, and is only available for a finite period of time. All doctors who meet the eligibility criteria are encouraged to take up the opportunity presented by this pathway to FRNZCGP and vocational registration.

The EIP will be available from 1 June 2010 until 31 May 2013.

It has been developed for doctors who have considerable experience in general practice but are not vocationally registered. The Medical Council wants doctors to be registered in a vocational scope of practice. The EIP provides an avenue for general registrants working in general practice to become vocationally registered. Vocational registration is for doctors who have appropriate qualifications, training and specialist experience, and who are competent to practise independently.

EIP ELIGIBILITY AND ASSESSMENT

Doctors applying to enter the EIP must meet all the following criteria:

1. The doctor has worked in general practice in New Zealand, or a comparable country, for a minimum of 8 years FTE from 1 June 1994 and prior to 01 January 2012.

2. The doctor can demonstrate that at the time of application they have worked in a general practice in New Zealand for 3 months (or more) FTE in the past 9 months.
3. The doctor can provide evidence of meeting the CPD requirements for MCNZ recertification for a minimum of 36 months prior to the date of the assessment visit taking place.
4. The doctor can provide a current certificate of good standing (one dated within the previous 3 months) from MCNZ.
5. The doctor must hold a resuscitation certificate to at least NZRC Level 5 (RNZCGP endorsed course), obtained within 3 years of the date of Fellowship;

Note that EIP applicants can apply to have up to a maximum of three years FTE practice recognised as part of the 8 years FTE general practice, from: student health, geriatric health, armed forces, A&M, rural hospital and/or after hours clinics.

Doctors who meet the eligibility criteria will have an assessment visit which must take place in a general practice in New Zealand where the doctor has worked for 3 months (or more) FTE in the past 9 months.

The assessment includes:

- Completion of a multisource 360 degree feedback, from colleagues and patients.
- Completion of the Personal Profile and Reflection.
- A practice assessment visit which will include: observation of at least 8 consultations; review of 15 patient records; review of practice systems and equipment; and up to 1 hour for clarification of issues raised from consultations and/or records viewed.

All Fellowship requirements must be completed by 1 December 2013, or within 18 months of the assessment visit, whichever occurs first.

Further information on the EIP pathway and for application contact:

Lana Henderson, Manager – Registry and Admissions, at the College: Email: lane.henderson@rnzcgp.org.nz; Telephone: 04 496 5999. ☎



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