



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

Chairperson's foreword



'We regularly consult on key issues to obtain information and advice, which we consider when making our decisions...'

One of our strategic goals over the past couple of years has been to improve the Council's relationship and engagement with the public and the profession, so that we can fulfil our role under the Health Practitioners Competence Assurance Act 2003 (HPCAA).

We regularly consult on key issues to obtain information and advice, which we consider when making our decisions.

Consultation for the Council has many benefits:

- enabling interested parties to contribute to policy development
- helping build an ongoing relationship with the profession and public
- helping early identification of potential problems and issues with proposed standards, guidelines, and related policies
- increasing understanding of the role and functions of Council.

To help our consultation process, we have developed a database of 400 organisations and individuals

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‘This year we are going to implement an engagement plan that will ensure ongoing formal and informal feedback from interested parties...’

with whom we regularly consult. Both Council and staff are delighted at the response we have received since the development of the database. We have received about 30 percent more submissions on each consultation document circulated.

We want to make it easier to respond to our consultation process. This year we are going to implement an engagement plan that will ensure ongoing formal and informal feedback from interested parties. We have for some time been publishing all our consultation documents on our website (www.mcnz.org.nz>>News and Issues>>Issues) and providing the opportunity for those people with an interest in a particular issue to make their views known to us online.

Once we have analysed the feedback, we intend to put it up on our website, together with the final version of the policy or document on which we have sought comment.

Decision-making principles

This year, Council has also made explicit the principles we follow when making decisions that affect individual doctors, or when developing a policy or statement.

The Council has two key roles.

First, the Council’s governance role is to set the strategic direction and oversee the management. Second, the Council also has a quasi-judicial function when making decisions about individual doctors seeking registration or referred to Council because of concerns about health, competence, or conduct. Both roles must be exercised within the Council’s powers and responsibilities under the HPCAA.

Our decision-making principles reflect these differences in Council’s roles. The key principles are discussed below.

Accountability

We are accountable for our decisions to the public, the Minister of Health and Parliament and, in relation to the efficient use of funds to achieve our purpose under the HPCAA, to the profession. This means we consider whether:

- the decision is consistent with our principal purpose – to protect the health and safety of the public
- the decision is consistent with the principles of the HPCAA; that is, setting standards, ensuring competence, promoting education and training, and promoting public awareness
- the decision is the most efficient means of meeting Council’s obligations under the HPCAA.

Independence

Council members are independent and do not represent the profession or any individual or group. Council decides governance and quasi-judicial matters independently of any stakeholder interest, personal interest or relationship, and professional interest or relationship.

Inquiry

We inquire into and assess all relevant and available information in deciding governance and quasi-judicial matters. This process includes examining critically all assumptions to determine opinion and fact.

Consistency

We aim to ensure consistency of decisions over time by giving consideration to earlier decisions in deciding governance and quasi-judicial matters.

Cultural competence

We respect the cultural diversity of the New Zealand public and the medical workforce.

Principles of natural justice

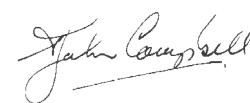
The Council applies the specific provisions of the HPCAA on providing relevant information and giving reasonable opportunity to make written submissions and be heard.

Council conducts proceedings so that they are fair to all parties.

The Council only takes into account relevant considerations and extenuating circumstances.

Applying the principles

The principles I have outlined here will help in providing a framework for Council when making decisions – either in its governance role or its quasi-judicial role. I would welcome your comments on our consultation processes, or decision-making principles and how they could be improved. 🗣️



John Campbell
Chairperson

Writing prescriptions – Best practice from a pharmacist perspective

Is prescription writing an art or a science? From the perspective of patient safety, it is perhaps best seen as both. Aside from concerns over the use of easily misconstrued abbreviations or indecipherable hand-written prescriptions, there are issues unique to writing prescriptions in New Zealand's healthcare environment. Pharmacists can spend an extraordinary amount of time following up on these issues, so your efforts in addressing any of them (or even just one of them) will reduce the calls that often interrupt your day.

The Council would like to thank the Pharmacy Council for contributing the following article and acknowledges Pharmacy Today for the 'mystery scripts'.

In no particular order, the following highlight some of the biggest frustrations pharmacists experience.

1. Computer-generated prescriptions should reduce errors, but before pressing the repeat button, check if the dose instructions are still relevant; for example, a patient prescribed a 'loading' dose of cholecalciferol every 3 months because computer records are not updated.
2. Make sure Special Authority (SA) numbers and Specialist endorsements are up to date and renewed as necessary. Remember, you can apply for or renew SA numbers on-line. For further information phone the Ministry of Health on-line help desk on 0800 505 125 or go to <http://www.pharmac.govt.nz/healthpros/ESA>
3. Advise the patient when a medicine is not subsidised but please don't use MIMS as a source when quoting prices – talk to your pharmacist instead.
4. Using outdated 'favourites' lists can often cause confusion when brands are no longer subsidised. Pharmacists purchase an updated
5. Computer-generated prescriptions make interpretation easier; however, pharmacists still occasionally receive scripts like the example below:

database of subsidised medicines on a monthly basis and ask that prescribers/medical practices do the same, or at least check for changes in the monthly schedule update. Alternatively:

- a. ensure you have generic substitution agreements with your local pharmacies or indicate your authority to substitute on the prescription itself
- b. prescribe generically unless brands are not interchangeable (for example, Marevan and Coumadin).



Mystery Script

Period	Quantity	Disp	Dispensing Date of Repeat	Pharmacist Initials
1st	30			
2nd	12			
3rd				
1st	1			
2nd	12			
3rd				
1st	30			
2nd	12			
3rd				

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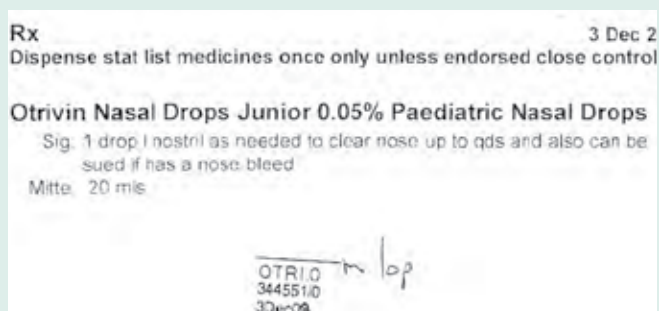
6. Note that 'cc' means 'close control' **not** certified condition or carbon copy. Close control can have some very practical benefits. Treatment change, often in the early phase of treatment, is one of the most common reasons for unused medications. Therefore, it may be prudent to prescribe a smaller initial amount of medication or 'close control' for the first month of a 3-month prescription if you anticipate that the dose may need to be changed.
7. Neither the Medicines Act 1981 nor the DHB Pharmacy Procedures Manual allows pharmacists to supply 2 x 3 months worth of medicines (that is, 6 months) at once just because the patient is going overseas. If you do write two prescriptions, please advise patients that only 3 months will be subsidised.
8. Legally the patient's address **must** be a street address, not a PO Box or Private Bag.
9. Make sure prescription co-payment codes are correct. The cost of a

prescription can influence whether or not it is picked up. The prescriber is responsible for ascertaining whether the patient is eligible for \$3 co-payments and for coding their prescriptions correctly. The pharmacist is entitled to rely on prescriber coding to indicate the correct level of co-payment that should be charged.

10. Additional best practice points:
 - a. Include the age **and** weight of a child under 5 years.
 - b. Make sure NHI numbers are correct.
 - c. Always include your Medical Council registration number.

These issues aside, pharmacists still enjoy prescriptions with additional tongue-in-cheek directions. 📞

Mystery Script



‘I have seen and examined...’

by Dr Steven Lillis, Medical Adviser to the Medical Council of New Zealand

Medical certificates provide a wealth of material for bringing a complaint against a doctor to the Medical Council. Several recent complaints exemplify some of the issues.

Certificate vaguely worded

A certificate was issued by a doctor working in general practice that indicated a patient could not be at work because of a medical problem. When further detail emerged, the employer realised that the medical condition was not as indicated by the employee. The certificate issued by the doctor was vague in its wording and contributed to the misunderstanding. Naturally, the employer was concerned that a certificate given by the doctor was used to support the employee position and believed that the doctor was complicit in misrepresenting the illness.

Certificate issued without seeing the patient

A vocationally registered general practitioner issued a certificate without seeing a patient. The patient was incapable of working because she had recently experienced a close relative having a life threatening medical problem. The general practitioner was intimately aware of the events and the traumatic effect on his patient and issued a medical certificate for her. The certificate was computer-generated (as most medical certificates are nowadays) and contained the phrase ‘...was seen and examined by me...’. Unfortunately the patient was neither seen nor examined at the time the medical certificate was issued. This left the doctor in a difficult situation when the employer questioned the validity of the certificate.

Certificate issued retrospectively

A doctor issued a medical certificate in retrospect for a patient whose mother had recently died from metastatic cancer. The certificate was written to cover the day of the funeral and the following day but was written and dated two weeks after the event. The argument that the employer took was that it is impossible for a doctor to know how incapacitated a person is for work when the doctor sees the patient 2 weeks later. The doctor was of the opinion that she was well aware of the emotional effect of the circumstances and the certificate was correctly dated so that its retrospective nature was transparent.

Results of the complaints

All three complaints were closed without action by the Council as they considered that the doctors involved did not intentionally mislead the complainant or the concern was minor. However, in each of the cases described, it is also apparent that the doctor was left in a vulnerable position and that such a position may have been avoided by careful attention to the intent and detail of writing a medical certificate.

Computerised certificates may be convenient, but the convenience lends itself to inadvertent statements. Vague wording and its associated multiplicity of meanings leaves ample room for differences in interpretation.

‘Medical certificates pose difficulties because they are written for a third party who may have an agenda quite different to that of the doctor and patient...’

Retrospective certificates create doubt over the accuracy of recollection.

Coles Medical Practice in New Zealand gives sound advice on signing medical certificates: ‘...you must take reasonable steps to verify any statement before you sign. You must not sign documents if you believe they are false or misleading, or if you are uncertain of the truth of any of the content.’

Medical certificates pose difficulties because they are written for a third party who may have an agenda quite different to that of the doctor and patient. Under such circumstances, the detail and accuracy of the certificate may come under unexpected and intense scrutiny. Taking an extra moment to consider how accurately the certificate reflects the clinical situation can spare the stress of dealing with complaints. 🧐

Supervision of international medical graduates by Philip Pigou, Chief Executive, Medical Council of New Zealand

Is it reasonable for an anaesthetist to start work in New Zealand with no immediately available on-site supervision from a vocationally registered anaesthetist? Would you be happy attending a general practitioner who had arrived in New Zealand the previous day and was working in an isolated rural general practice – alone? What conditions would you require where a general surgeon cannot be given on-site supervision because the other general surgeons in the department refuse to provide the supervision?

These are some of the recent scenarios the Council has managed.

Effective supervision

Effective supervision is one of three key processes the Council believes is critical to supporting doctors coming to work in New Zealand. Together with orientation and induction, and credentialling, supervision helps the doctor to fit into our health system. It also protects the health and safety of the public by assessing the doctor's competence to practise within their scope of practice.

New Zealand's health workforce relies heavily on international medical graduates (IMGs). Not only do IMGs constitute over 40 percent of our

medical workforce, they also make up about 80 percent (or 1,200 IMGs) of new registrations every year.

This places a significant burden on doctors to provide supervision, and the Council appreciates the contribution supervisors make to integrating IMGs into the profession.

Recognising the importance of these issues, the Council has designated medical migration as a critical strategic direction. One of the initiatives within this direction of work has been to develop and implement a new framework for the supervision of IMGs.

The Council has recently undertaken an extensive two-stage consultation process (including a national roadshow of meetings) with the profession and stakeholders about a new framework for the supervision of IMGs.

Key principles for supervision

The feedback from the consultation process has been considered by the Council and the following key principles have been finalised. A supervision proposal or plan:

- must be flexible, taking into account the merits of each situation
- must require an IMG to spend a period of time working at the same site as their primary supervisor

- will be part of a team model
- must include a credentialling process when employing IMGs
- will address issues of isolation and conflicts of interest
- will define supervisors' responsibilities clearly
- will include the Chief Medical Officer or their delegate in district health boards (DHBs), or practice manager or practice principal for general practice settings, as the person responsible to ensure appropriate supervision is provided.

The Council is now working on implementation of two supervision options. An employer or service may choose either option for supervision when employing a new IMG.

Supervision options

- DHBs, primary care organisations, and other employers / contractors may apply for a service to be accredited by the Council as an Approved Practice Setting (APS). Once a service has been recognised as an APS, it will **not** be necessary for individual supervision plans to be submitted to the Council for approval. An APS recognises that appropriate support and supervision are available and provided to IMGs.

'IMGs constitute over 40 percent of our medical workforce, they also make up about 80 percent ... of new registrations every year...'

- DHBs, primary care organisations, and other employers or contractors may submit a proposal for supervision. The proposal must meet the requirements of the Council's framework for an individual supervision plan for each IMG while the IMG is registered within a provisional general, provisional vocational or special purpose scope of practice. With some modifications following the consultation feedback, this option is based on the current supervision model.

Developing the APS concept

The Council has recently established a working group to assist us in developing the criteria for an APS. The group has Branch Advisory Body, DHB and Council members. As a minimum, an APS will have systems for:

- the effective support of doctors
- orientation, induction, and credentialling of doctors
- identifying and acting on concerns about doctors' fitness to practise
- supporting the provision of relevant training and continuing professional development
- providing regulatory assurance.

An APS is not required to be confined to one hospital service or primary care practice alone. The Council strongly supports greater clinical collaboration within the health sector and will look to accredit joint service or network arrangements as an APS.

The Council intends to consult on the APS criteria in early 2010.

More information

A new resource called *Supervision for international medical graduates* describes the Council's requirements for individual supervision plans and clearly sets out:



'This is crucial to helping IMGs integrate into New Zealand's health system and enabling the Council to achieve its primary purpose of protecting the health and safety of the public...'

- when supervision is required
- factors taken into account when assessing a supervision proposal
- the role of the supervisor
- an outline of the induction, orientation, and supervision process
- the reporting process on an IMG's performance to the Council.

This resource is a companion to *Induction and supervision for newly registered doctors*. Both of these resources are available from the Council's website www.mcnz.org.nz. The Council will release revised supervision guidelines including new information about the induction and orientation of IMGs and further details of the criteria and assessment process for APSs in mid-2010.

Next steps

In early 2010 the Council together with the Cognitive Institute will undertake two training sessions for supervisors – one in Auckland and one in Christchurch. The sessions will be coordinated by Dr Ian Brown, one of

the Council's Medical Advisers. On the completion of this training we will evaluate the value and need for further training and other support opportunities for supervisors.

We do hope that the new systems will make it simpler, easier and more effective for both IMGs and supervisors. We are also conscious that there is some discomfort with the term 'supervision'. If anyone can come up with a better term that covers both the mentoring and the quality assurance aspects of the task, we would be very grateful.

Finally, I wish to extend my and the Council's appreciation of the commitment and expertise shown by supervisors. This is crucial to helping IMGs integrate into New Zealand's health system and enabling the Council to achieve its primary purpose of protecting the health and safety of the public. 🙏

This article was first published in *New Zealand Doctor* on 16 December 2009. 🙏

Changes to your annual practising certificate

In the coming months, you will notice that your annual practising certificate has changed.

We are changing the name from annual practising certificate or APC to practising certificate. Currently we issue three different types of certificates:

- annual practising certificate
- certificate for less than a year
- interim certificate.

Rather than printing three types of certificate, we have decided to simplify our processes and have just one certificate, the practising certificate. This will result in considerable costs savings in printing and other resources.

Another significant change is that the practising certificate is no longer a tax invoice as in the past with an APC.

The Inland Revenue Department has recently accredited the Council to raise invoices on doctors' behalf, eliminating the need for us to obtain invoices with GST numbers from doctors. 🇳🇿

Lost doctors

In this issue of *Medical Council News*, we list several 'lost' doctors whom 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 [>>Registration>>Currently registered doctors>>Change your personal details.](http://www.mcnz.org.nz)

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 Sumedha Suriarachchi
Amarasekara
- Dr Jacqueline Loring Brivulis

- Dr Ian Keith Henderson
- Dr Shree Valli Krishna
- Dr Ian Robert Lange
- Dr Michael John Lannan
- Dr Ian Charles Winburn 🇳🇿



Order your free folder

In recent years, the Council has produced over 30 statements on topics such as:

- informed consent
- the responsibilities of doctors in management positions
- keeping patient records.

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 [>>Publications & guidance>>Statements.](http://www.mcnz.org.nz) 🇳🇿

Medical credentialling in New Zealand

by Dr Ian Brown, Medical Adviser to the Medical Council of New Zealand

History of credentialling in New Zealand

The concept of credentialling for senior medical officers was introduced in New Zealand in the mid-1990s, beginning in Counties Manukau District Health Board. By the late 1990s there were three hospitals with credentialling processes in place. The first national credentialling document, *Toward Clinical Excellence: A Framework for Credentialling in New Zealand* was published by the Ministry of Health in 2001. It defined credentialling in New Zealand as ‘a process used to assign specific clinical responsibilities (scopes of practice) to health professionals on the basis of their training, qualifications, experience and current practice within an organisational context’.

This definition preceded the Health Practitioners Competence Assurance Act 2003, which defined scopes of practice as ‘any health service that forms part of a health profession and that is for the time being described under section 11 and now equates to the vocational scopes of practice by the professional colleges and the Medical Council. The term no longer equates to credentialling where this term is replaced by “specific clinical responsibilities”.’

Process for credentialling

The four-step process for credentialling described in the 2001 document remains the basis of credentialling.

The process consists of:

1. verifying training, qualification, experience and registration status
2. determining the specific clinical responsibilities within the organisation
3. undertaking ongoing data collection to monitor practice and accumulate information for recredentialling
4. reviewing and redefining clinical responsibilities.

All district health boards (DHBs) have developed credentialling processes but there is no national credentialling standard. Some DHBs have shared their frameworks and have robust processes for confirming specific clinical responsibilities within their hospitals, but this is not universal. Private hospitals have been actively involved with credentialling and some have linked with DHBs to share processes.

Formal credentialling normally occurs every 3 to 5 years, but it is equally important to undertake individual credentialling on appointment.

The appointment process may involve recruitment agencies, human resources, Colleges, unions and the Medical Council. Credentialling is part of this process and can be linked with activities such as orientation and the development of supervision plans.

Efficient results require minimising the overlap between the processes of each of these bodies, and simplifying the processes as much as possible. Activities such as orientation and supervision planning also link to these processes.



Credentialling of locums presents specific issues, and can be difficult to arrange. However, it should be undertaken whenever possible.

New framework for credentialling

This issue, together with many others, has recently been addressed in the document led by the Ministry of Health *Credentialling Framework for New Zealand Health and Disability Service Providers*. The draft working document was released in late June 2009, but unfortunately has not progressed any further. The document related to all health professions, but there was a specific section for doctors.

The recommendations reinforce the importance of credentialling on appointment, and give guidance on regional credentialling and the credentialling of locums and visiting specialists.

The draft document also proposes an annual review of credentialling status that could be linked with annual performance appraisals when appropriate.

We hope that, the recommendations in the medical part of the new framework can be discussed and progressed without too much delay. (9)



Ethics 101 – Fringe medicine, some thoughts by Dr Barnett Bond

A medical degree is supposed to train the mind of the young doctor to focus on reason, rationality and critical thinking. Why is such training necessary? The reasons are not hard to find. Humans over the millennia have demonstrated an enduring propensity towards superstition and faith in irrational beliefs. The passage of time has shown these beliefs for what they were, with remarkable clarity. In spite of the lessons of the past, contemporary human minds continue to believe the unbelievable. The training of a doctor in the modern world is structured to inculcate in that doctor a critical faculty, and a demand for evidence of a certain standard, before she will adopt any new method of diagnosis or treatment.

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. 📖

Most of the non-doctor population however, have no such training. They have no way of knowing that all treatments are not equal. Unwell humans are particularly vulnerable to messages of cure regardless of the source. Quite apart from the abject misery of illness, the fear of death as a sequel to illness is a powerful and not always helpful emotion. Under the cloud of serious illness, the unwell human believes any number of claims to 'cure'. Most patients simply do not have the training nor the knowledge to make validity judgements. Cancer patients are especially vulnerable.

There has been much debate about the reasons why patients are increasingly

enamoured of fringe medicine. One popular hypothesis is that modern medicine has been 'captured' by the medical and allied professions. The argument goes that medicine has become so sophisticated and complex that it has had the unanticipated consequence of disempowering ordinary people from decision making about their own health.

There are other hypotheses. Whatever the reasons, contemporary attitudes of increasing numbers of people seem to be taking them resolutely down a path of equating the findings and treatments of modern medicine with any and all other forms of 'healing'. In other words, all forms of healing are equal and the patient (consumer) has simply to choose the method of diagnosis and treatment they prefer. It is assumed that the outcomes will also be equal (in fact better, safer and less toxic for fringe medicine treatments). This seems to be one of the fundamental tenets of fringe medicine.

Against this background, what should be the role of the modern doctor?

The answer seems obvious. The doctor's role is to protect the patient from false claims and from futile or harmful treatments. Further it is to promote the methods of diagnosis and treatment that work.

How then is it that a number of doctors reject the lessons of their training, join the ranks of the untrained 'fringe medicine' practitioners? They too engage in diagnostic methods that do not diagnose, and treatments that do not work. A cynic's view might go something like this:

1. They are in it for the money.
2. They were asleep through most of medical school.
3. They get gratification from being able to offer a diagnosis and/or treatment where conventional medical doctors have failed.
4. The notion of working in a 'special field' of medicine is attractive and results in enhanced self perceived status. ('I am not just an ordinary doctor, I am an expert').

5. They have placebo-effect-non-recognition disorder.
6. All of the above.

In the past the term 'quack' was attached to doctors who practiced fringe medicine.

If we were to look more closely at the cynic's view, it might help us understand the phenomenon a little better.

1. There is obvious support for the profit motive. Australians spent \$AUS2.3 billion on complementary and alternative medicines last year. New Zealanders probably about \$1 billion. It would seem that some doctors are unable to resist the temptation to participate in this extraordinarily profitable business. Fringe medical doctors, who come before the Health and Disability Commissioner and the Medical Council, almost invariably sell the products that they prescribe. One of the safeguards against patient exploitation and 'prescribing for profit' in conventional medical practice is that the dispenser is not the prescriber. This safeguard seems to not exist, at least among the fringe medical doctors whose practices are complained about.
2. Were the doctors who practice fringe medicine asleep during medical school? Fringe medicine practice is a society-wide public health problem. To understand these doctors better, an epidemiologic strategy is needed. To date there is little information on which doctors become quacks and why, the characteristics of people who do and do not turn to quackery, and factors that favour or discourage the proliferation of fringe medicine. Key statistics are needed on all of these things. (Now there is a PhD thesis for someone.)

3. Do doctors who practice on the fringe get gratification from being able to offer a diagnosis and/or treatment where conventional medical doctors have failed? This would seem to be a 'slam-dunk' conclusion. This type of gratification is probably universal. Nearly all doctors get gratification from making a diagnosis where others have failed. Patients identify such a doctor with 'excellence', and they report to other potential patients. Everyone wants to be good at their job and nearly everyone appreciates recognition for this.
4. 'I am a specialist in a field so specialised there is not a College'. This syndrome also is not unique to medicine. It affects people who have partially educated themselves in many fields. There is, alas, no medical claim so preposterous that a doctor cannot be found to vouch for it.
5. Placebo-effect-non-recognition disorder? Currently this disorder is not searchable as a READ Code.

How does one recognise a fringe medical practitioner? What should one advise one's patients who are struggling with the advice they receive? Help is at hand. Fringe medical practitioners are recognisable and they exhibit certain characteristic features:

1. The practitioner says that the medical establishment is trying to suppress his or her work. The idea is that the medical establishment is a cartel and addicted to power. Often, the practitioner describes mainstream medicine as part of a larger conspiracy that includes the pharmaceutical industry and government.
2. Most of the practitioner's recommendations to patients are based on anecdotes. If modern medicine has learned anything in the past century, it is to distrust anecdotal evidence. Because anecdotes have a

very strong emotional impact, they serve to keep irrational beliefs alive. The most important discovery of modern medicine is not vaccines nor antibiotics, it is the randomised double-blind controlled trial. There is much confusion among the public here, but the fringe practitioner thinks that 'data' is the plural of 'anecdote.'

3. The practitioner says that his treatment is sound because it is ancient. There is a persistent myth that hundreds or even thousands of years ago, our ancestors possessed remedies that modern medicine cannot understand. Much of what is termed 'alternative medicine' is part of that myth.
4. The doctor proposes new laws of diagnosis and treatment to explain why there may appear to be a conflict with existing rules around diagnosis and treatment. The practitioner needs to have credibility for an incredible method. Proposing that the medical establishment's rules have not taken the practitioner's methods into account, neatly sidesteps the need to explain the lack of evidence.

Fringe medicine has been around for a very long time. There was hope that the modern scientific method would rid us of dodgy practices. This has not happened. None-the-less a doctor's role is clear. That role is to protect the patient from false claims and from futile or harmful treatments. ❗



Seeking:

Assistant Examinations Director (part-time)

The Medical Council of New Zealand is looking to employ a vocationally registered doctor part-time to help run the NZREX Clinical Examination. NZREX is a 16 Station Objective Structured Clinical Examination for international medical graduates wanting to become registered as doctors in New Zealand.

Experience in medical education or assessment is preferred but not essential. Three examinations are scheduled for 2010, with the potential for a fourth depending on candidate numbers. Working hours will be variable month to month, but will increase in the weeks leading up to an examination.

Please submit your expression of interest and CV to

Valencia van Dyk, Business Services Manager, Medical Council of New Zealand, PO Box 11649, Wellington 6142 or by email to vvandyk@mcnz.org.nz.

For more information visit our website at www.mcnz.org.nz and go to our Vacancies page.

The closing date for submissions is 9 February 2010. 🇳🇿



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