

# 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

ISSUE 51 MAR 11

NEWSLETTER OF THE MEDICAL COUNCIL OF NEW ZEALAND

[www.mcnz.org.nz](http://www.mcnz.org.nz)

CHIEF EXECUTIVE'S FOREWORD

## The Medical Council's regulatory role

BY PHILIP PIGOU, CHIEF EXECUTIVE, MEDICAL COUNCIL  
OF NEW ZEALAND



THE COUNCIL last year surveyed the public, the profession, and key stakeholders. The survey was undertaken by an independent research company (TNS Global) and repeats the benchmark survey we undertook in 2007. The reports are available on our website at [www.mcnz.org.nz](http://www.mcnz.org.nz)>>News and Issues

A key focus of the survey was on the role and performance of the Council. From some feedback, it is clear that there is still uncertainty about the respective roles of the Council, the Health and Disability Commissioner (HDC), the Health Practitioners Disciplinary Tribunal (HPDT), and the various colleges. I think it would be useful to set out our different roles.

### THE ROLE OF THE COUNCIL

Two quotes from the TNS Global survey describe well the roles of the Council: 'Basically they're the authority whose core activity is to protect the health and safety of the public' ►

## WHAT'S INSIDE?

**04** Immunisation – a critical debate  
'...how to reconcile ... beliefs against a majority of opinion...'

**05** Ethics 101  
'...when it's inappropriate to accept a gift from a patient...'

**08** Revision of standards  
'Council has recently reviewed and revised a number of its older statements...'

**10** A reminder about doctors' obligations  
'...Complementary and alternative treatments hit the headlines...'

**11** Viewpoint – of visions, systems, and recurring themes  
'...6 months in, some of my thinking as I reflect on this first period of my tenure.'

**13** Viewpoint – engage, consult, and deliver  
'...December's newsletter, Professor Des Gorman, ... called for the medical profession to debate our health system's demand–supply–affordability challenges.'

◀ of New Zealand'. (Journalist); and 'They're the body responsible for ensuring that doctors are only registered if they're qualified and fit to practise and then keeping an eye on them and dealing with any concerns about competence, fitness, and conduct along the way'. (Stakeholder)

'We have two objectives. The first is to protect the health and safety of the public. The second is to ensure the competence and fitness to practise of doctors...'



Our role is set out in the *Health Practitioners Competence Assurance Act 2003*. Specifically, the Council's role includes:

- 1 Registering New Zealand and international medical graduates (IMGs) to practise in New Zealand.
- 2 Defining the qualifications and scopes of practice for doctors in New Zealand.
- 3 Managing competence, conduct, and/or health concerns about individual doctors.
- 4 Setting standards of clinical competence, cultural competence, and ethical conduct.
- 5 Promoting public awareness of medical regulation.
- 6 Issuing practising certificates if doctors meet all Council's requirements, including those related to continuing professional development and recertification.

We have two objectives. The first is to protect the health and safety of the public. The second is to ensure the competence and fitness to practise of doctors – and to continue enhancing these. We take these objectives very seriously and see them as complementary. While on occasions we will place conditions on a doctor's practising certificate, negotiate a voluntary agreement that a doctor change their practice (particularly in the health area), or in rare cases suspend the doctor, we will also always look to re-educate or rehabilitate the doctor back into competent and safe practice.

## DISCIPLINE – A MISUNDERSTOOD AREA

Our role in the discipline of doctors relates only to unethical or criminal conduct. Most disciplinary matters are instead dealt with by the HDC (see below) and the HPDT (see below). We have the power to, and do establish, professional conduct committees (PCCs). The PCC will investigate alleged misconduct about a doctor and may lay professional charges before the HPDT. However, once the PCC has been established, the Council has no further control or influence over its actions. It is only the PCC that can decide to lay charges – and it would then prosecute those charges. The PCC composition is always two doctors and one lay person.

## STAKEHOLDER INVOLVEMENT

Several questions were raised through the survey about our role in workforce planning and management. We have close links with Health Workforce New Zealand, the colleges, the New Zealand Medical Association, the Association of Salaried Medical Specialists, and many other stakeholders. We regularly engage and get involved in projects, including the review of the general practice training scheme, consideration of a postgraduate medical education programme, and the like. However, we also have to maintain an arms-length relationship to ensure that when we accredit these programmes, we are applying the principles of independent regulation.



Although we and our stakeholders have different interests, ultimately our shared objective is the same – the protection of public health and safety.

### THE HEALTH AND DISABILITY COMMISSIONER (HDC)

The HDC has the following key roles:

- 1 Establishing the *Code of Health and Disability Services Consumers' Rights* (the Code). This was first established in 1996, and although it has been reviewed, it remains largely unchanged today. The Code sets out patients' rights in New Zealand.
- 2 Investigation of complaints where a patient is involved. We have a statutory responsibility to refer all complaints where a patient is involved to the HDC for their initial consideration. Patients and their families can also complain directly to the Health and Disability Commissioner. The HDC has several options including full investigation, no further action, and referring the complaint back to the Council for consideration of a competence review or conduct inquiry.
- 3 Advocacy – promotion of the Code, low-level resolution of complaints, and helping complainants to make a complaint.
- 4 Professional prosecution – laying of charges before the HPDT. This is the specific responsibility of the Director of Proceedings.

The Council and the HDC have a close and excellent working relationship. We are in daily contact on complaints and concerns about doctors.

### THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL (HPDT)

The HPDT is a judicial body that hears all professional prosecutions and determines the guilt or otherwise of health practitioners; for example, doctors, nurses, and dentists. The Tribunal's composition when considering charges against a doctor is two doctors, two lay people, and an independent chair. The Council does not have any representation on the HPDT.

### THE COLLEGES

The colleges have the following key roles in relation to the Council.

- 1 Providing postgraduate education for trainees – in the scope of practice specialty which the college represents.
- 2 Assisting fellows and affiliates to meet their continuing professional development requirements as established by the Council.
- 3 Helping identify and re-educate the poorly performing doctor.
- 4 Advising us on the qualifications, training and experience of IMGs applying for vocational registration in New Zealand.

Colleges also work closely with their fellows to support implementation of Council's standards of ethical conduct and cultural competence.

### SUMMARY

New Zealand has a diverse medical regulatory environment where the Council, the HDC, and the colleges work together and share different but related medical regulatory roles. The HPDT, because of its judicial functions sits independently, although any conditions it imposes on a doctor's practising certificate are often enforced by the Council, and referred to on the Council's register.

**Philip Pigou**  
Chief Executive 

## Immunisation – a critical debate:

DR STEVEN LILLIS, MEDICAL ADVISOR TO THE  
MEDICAL COUNCIL OF NEW ZEALAND

ALTHOUGH THE MAJORITY OF PEOPLE believe in and take part in immunisation programmes, a small number of people hold very different ideas. Similarly, although the majority of doctors have a conventional medical stance on immunisation, some take a dissenting view. The difficult question for these doctors is how to reconcile their beliefs against a majority of opinion on what actions they should take when giving information to patients and caregivers.



‘From this wide critique, the consensus of opinion across the profession of medicine that includes academics, specialists, epidemiologists, and generalists has resulted in our current immunisation programme.’

It is likely that a reasonably informed patient would want to know some things about both the immunisation and the doctor who is giving advice. The patient would expect that the information given should be impartial, not selected or edited to support one particular view. The advice given concerning the doctor's opinion on the information should also conform to standards.

A useful guide to this comes from a decision from the Medical Practitioners Disciplinary Tribunal ruling on a doctor who offered a complementary therapy to a patient. The Tribunal wrote: ‘...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.’ If a doctor recommends a course of action over immunisation and that action (such as not immunising) is not supported by mainstream medical opinion, the patient, parent, or caregiver would expect to be told this.

A second question that arises for doctors who do not recommend or support immunisation is that of critical appraisal. A significant body of research exists about immunisation. The published research is peer reviewed and presented in journals to a broad audience and is therefore exposed to wide critique. From this wide critique, the consensus of opinion across the profession of medicine that includes academics, specialists, epidemiologists, and generalists has resulted in our current immunisation programme. It is important for those doctors who advise against immunisation to carefully consider their ability to critique research as well as the breadth and depth of the evidence base they use to support their position. 📖

# Ethics 101

Ethics 101 has the objective of generating thoughtful discussion about the pros and cons of various issues. We hope it will lead to further discussion among the profession about practical ethical and clinical issues 🌱

*DO YOU KNOW when it's inappropriate to accept a gift from a patient? What do you do if you hear that one of your colleagues is limiting patients to one medical complaint per visit? Can you refuse to accept a new patient if their medical history is complex?*

When faced with these types of dilemmas, doctors often contact the Council for guidance. Unfortunately, the response isn't always black and white. The details of each individual situation are unique and the advice to one doctor may not be the same as that to another doctor in a similar situation.

To encourage dialogue on these issues, the Council has introduced the Ethics 101 column, inspired by a column published by the College of Physicians and Surgeons of Alberta.

There will be no 'right' or 'wrong' answers. Rather we aim to hold a thoughtful discussion about the pros and cons of various approaches. This forum will allow doctors to benefit from the wisdom of their colleagues, and will also create interest among the profession about practical ethical issues.

## WHAT WOULD YOU DO?

The district health board (DHB) has proposed to close your department. You disagree with the rationale for the decision, and don't believe that it is in the interests of your community's health and safety. You have tried to reason with DHB management, but feel that they did not listen to your concerns. The debate has become very heated, with people writing to the local papers, elected officials grandstanding, and DHB management issuing media releases. You feel that much of the information being circulated in public is misleading or wrong. Some of your colleagues are quite angry about the situation, and one has shown you a letter he sent anonymously to a television programme in which he claims that closing the department will cost 'seven lives a year'. While you agree with his views on closing the department, you think that this particular claim is exaggerated and based on an unscientific analysis of the facts.

You feel a duty to the community to keep the department open, and working through official channels has not got you anywhere. Now a television journalist is on the phone. She has received the anonymous letter from your colleague and tells you that she hopes to run a story about it and the department's closure as the lead item on that night's news programme. You get the impression that she only thinks the story is newsworthy because of your colleague's claim about the closure costing 'seven lives a year'. She asks you for your comments.

What would you do? And more generally, when is it appropriate to talk to journalists and what is it appropriate to say to them?

Email your suggestions to Michael Thorn, Senior Policy Analyst at [mthorn@mcnz.org.nz](mailto:mthorn@mcnz.org.nz) (use the subject line 'Ethics 101'). If you have ideas for topics for future columns, please feel free to email them to Michael. 🌱





## Order your free statements pack

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
- cosmetic procedures.

As new standards and guidelines are produced, or others are updated, we will send them to you automatically with *Medical Council News*. A complete set of the Council's standards and guidelines can be obtained by emailing [folder@mcnz.org.nz](mailto:folder@mcnz.org.nz) or phoning 0800 286 801 extn 793.

Statements are also on our website at [www.mcnz.org.nz](http://www.mcnz.org.nz)>>Resources 📄

## Is your email address the right one?

DURING THE NEXT COUPLE OF YEARS the Council will be 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 given us, you can update it:

- during your next practising certificate renewal on the application form
- online at [www.mcnz.org.nz](http://www.mcnz.org.nz) Registration>>Currently registered doctors>>Change your personal details
- by emailing [mcnz@mcnz.org.nz](mailto:mcnz@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](http://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](mailto:apc@mcnz.org.nz) or phone 0800 286 801 ext 785.

- Jason Errol Burton
- Joanna Sarah Collins
- Gregory Douglas Clugston
- Samantha Jane Turnbull 📧

## New publications

### BEST HEALTH OUTCOMES FOR PACIFIC PEOPLES: PRACTICE IMPLICATIONS

In August 2010, the Minister of Pacific Island Affairs, the Hon Georgina te Heuheu launched the Council's new resource book *Best Health Outcomes for Pacific Peoples: Practice Implications* at a parliamentary function in Wellington.

The resource was written with assistance from Mauri Ora Associates and SAEJ Consultancy, with help from Panapa Ehau. It will help doctors and colleges meet the cultural competence requirements of both the Council and the HPCAA.

The booklet is designed to improve the health outcomes of all Pacific peoples. It also complements the *Council's Statement on Cultural Competence* and the *Best Health Outcomes for Māori: Practice Implications* resource.

Offering guidance on the cultural diversity of and cultural preferences for Pacific peoples in New Zealand, the booklet is of necessity generalised because there are at least 22 separate Pacific nations, each with their own culture and history. The booklet also tells the unrecognised story of vast health disparities between Pacific peoples and other ethnic groups in New Zealand. Importantly, it sets out a pathway of practical things we can do together as a profession to help redress these inequalities.

‘What is permitted now may have been unacceptable not long ago: what can be contemplated now was never imagined longer ago: there is a good deal in here to interest the established New Zealand doctor too...’

### COLE'S MEDICAL PRACTICE IN NEW ZEALAND

First published in 1988, *Cole's Medical practice in New Zealand* is now in its 10th edition. Editor Dr Ian St George in the book's preface notes:

‘Doctors do have special knowledge and skills, and thus inevitably, power, usually greater than that of their patients. Society allows them that power provided they use it for the common good.

Doctors therefore have ethical guidelines and legal duties to use power properly, within boundaries that dissuade them from taking advantage of patients sexually, financially, or emotionally by lending spurious authenticity to quack methods, or by allowing their performance to slip.

Although doctors are intelligent, well-motivated, self-regulating professionals on the whole, they must also work within sometimes quite austere moral and ethical boundaries defined by their colleagues. The chapters here traverse what may be quite complex law, and they refer to further guidelines and ethical statements made by the Medical Council and other bodies over recent years.

The book's main purpose is to introduce new entrants to medical practice in New Zealand to the main legislative and ethical standards and guidelines. Laws and even ethics change over time. What is permitted now may have been unacceptable not long ago: what can be contemplated now was never imagined longer ago: there is a good deal in here to interest the established New Zealand doctor too’.

To download or receive copies of these new publications at no cost, email [info@mcnz.org.nz](mailto:info@mcnz.org.nz) or go to [www.mcnz.org.nz](http://www.mcnz.org.nz)>> Resources>>Standards and guidelines. 📄



## Fortieth anniversary of the University of Otago, Christchurch

THE 40TH ANNIVERSARY of the University of Otago, Christchurch (formerly the Christchurch Medical School) will be celebrated in February 2012.


In 1973, the first intake of Fourth Year medical students enrolled at Otago University, Christchurch (then the Christchurch School of Medicine).

In February 2012, the school will celebrate 40 years of research and teaching. Events will be held in Christchurch 9–11 February 2012, beginning with a University of Otago Alumni evening on Thursday, 9 February 2012.

If you would like to be part of the celebrations register your interest by going to [www.otago.ac.nz/christchurch](http://www.otago.ac.nz/christchurch) and click on the 40th icon and the page for updates on anniversary celebrations.

Alternatively, call Kim Thomas, Senior Communications Advisor on 03 364 1199 ([kim.thomas@otago.ac.nz](mailto:kim.thomas@otago.ac.nz)) or Virginia Irvine on 03 364 0038 ([virginia.irvine@otago.ac.nz](mailto:virginia.irvine@otago.ac.nz)).

Other anniversary celebrations will include:

- A series of social functions in the second week of February 2012.
- The publication of a book covering the school's highlights and its future direction.
- The establishment of a research trust to fund fellowships and scholarships on the Christchurch campus. 



## Revision of standards

THE COUNCIL HAS RECENTLY reviewed and revised a number of its older statements, which outline the standards expected of doctors in a range of specific situations. As a result of its review, the Council resolved to withdraw from publication its statement on *Confidentiality and public safety*. This decision was made because since this statement was last reviewed in 2002, the Privacy Commissioner has published a copy of the Health Information Privacy Code 1994 that incorporates a helpful and comprehensive plain English summary. Doctors should refer to this resource if they have questions or concerns about the standards expected of them when collecting, storing or sharing information about patients. A copy can be downloaded from <http://privacy.org.nz/health-information-privacy-code-1994-with-commentary-link/>.

Enclosed with this issue of *Medical Council News* you should also find copies of four new editions of Council's statements on:

- *Responsibilities of doctors in management and governance* (this replaces the June 2001 statement of the same name)
- *Statement on complementary and alternative medicine* (this replaces the March 2005 statement of the same name)
- *Information, choice of treatment and informed consent* (this replaces both the April 2002 statement on *Information and consent* and the April 2002 statement on *Legislative requirements about patient rights and consent*)
- *Ending a doctor-patient relationship* (this replaces the March 2004 statement of the same name).

A number of changes have been made to all of these statements. Most of the changes are simply intended to simplify and improve the language. References to old legislation and other obsolete resources have also been updated. However, a few more substantive changes have also been made. In particular:

## RESPONSIBILITIES OF DOCTORS IN MANAGEMENT AND GOVERNANCE

- Updated to include more advice for doctors involved in governance.

## STATEMENT ON COMPLEMENTARY AND ALTERNATIVE MEDICINE

- The statement in paragraph 3 that Council 'supports' the use of complementary and alternative medicines 'in some circumstances has been replaced with a statement that Council does not oppose their use.' This change has been made because it is not Council policy to endorse any medical (or non-medical) treatments.

## INFORMATION, CHOICE OF TREATMENT AND INFORMED CONSENT

- Merged with the April 2002 statement on *Legislative requirements about patient rights and consent*.
- Includes a new requirement that 'You should pay careful attention to the process of informed consent when a proposed treatment is expensive or in any way innovative.'
- Includes a new clause to make clear that in certain cases specific legislation overrides general requirements, such as those set down in *The Code of Health and Disability Services Consumers' Rights (the Code)*.
- Includes a new sentence which states that Right 5 of the Code 'means that you should do your best to help your patient to understand any information you provide to them.'
- Includes a discussion about a patient's right to a competent interpreter.
- Includes a new paragraph that advises doctors to make themselves aware of all the reasonable alternatives to the treatment being provided.
- Includes a discussion about the patient's right to cooperation amongst providers, in particular cooperation in terms of obtaining informed consent.
- Includes a discussion about doctor's obligations when a patient waives their right to information.
- Clarifies the role of house surgeons and medical students in the consent process.
- Includes a new paragraph which suggests that, when a patient is not competent to consent and no family members are available to give advice, you seek the views of an experienced colleague and document that colleague's views before proceeding with treatment.
- Amends a paragraph discussing when to seek a legal opinion on obtaining authority from the High Court to proceed without consent, so that it supports lower level

resolution of disagreements. It also includes discussion of what you should do when you disagree with parents about the care to be provided to a child.

- Includes a new appendix containing the case studies considered by the HDC.

## ENDING A DOCTOR-PATIENT RELATIONSHIP

- Includes a new requirement relating to the referral you make when transferring care after a breakdown of the doctor-patient relationship. This new requirement states that the information you provide to your colleague should be clinical, relevant and objective.
- Includes a suggestion that patients who express a concern about the content of records to be transferred to another doctor be given the opportunity to review them. It is not appropriate to allow the patient to make or request changes to these records, but it may be useful to offer to forward their comments with the records. 📧



# A reminder about doctors' obligations

BY DR JOHN ADAMS, CHAIRPERSON, MEDICAL COUNCIL OF NEW ZEALAND

COMPLEMENTARY AND ALTERNATIVE treatments hit the headlines in October after a *60 Minutes* television programme about Waikato farmer Alan Smith's recovery from swine flu, which he and his family attributed to the administration of high-dose intravenous Vitamin C. Intensive care specialists involved in Mr Smith's treatment initially refused requests from Mr Smith's family that high-dose intravenous Vitamin C be administered.

Shortly after this incident, the Council received a letter from the College of Intensive Care Medicine outlining its concern about a number of doctors who have been championing the use of high-dose intravenous Vitamin C for treatment of the critically ill. This letter stated that, 'The care of critically ill patients lies outside [these doctors'] vocational scope of practice. The advice appears to be proffered even though these practitioners have failed to obtain a full history about the particulars of the individual patient's medical conditions, failed to examine the patient, and failed to consult the patient's primary clinician.'

Others have also raised concerns about doctors advising patients on the use of thermal imaging as a tool for the detection of breast cancer.

These incidents and the College's letter serve as a timely reminder about doctors' obligations to both patients and colleagues.

When discussing non-traditional treatments, the Council's *Statement on complementary and alternative medicine*<sup>1</sup> is a source of advice. The New Zealand Medical Association's Code of Ethics also contains guidance that will help avoid any sense of exploiting the patient, or creating difficulties in a patient's treatment for colleagues.

We should take care when talking to patients or their family members about any type of treatment when they are under the care of a colleague. Always keep in mind that the other doctor's conclusions and advice are based on the patient's full history, examination, and their analysis of investigation results.



'We should take care when talking to patients or their family members about any type of treatment when they are under the care of a colleague.'

*The Code of Health and Disability Services Consumers' Rights* tells us that 'every consumer has the right to co-operation among providers to ensure quality and continuity of services'. Patients have a right to be fully informed about all their treatment options, but there are appropriate steps that you should follow if you have concerns that a colleague's patient is not receiving the appropriate care. The first of those steps should usually be to discuss the treatment options with your colleague, and to seek their opinion on the suitability of the treatment for that particular patient. *Good medical practice* states that it is never appropriate to make malicious or unfounded criticisms of colleagues that may undermine patients' trust in the care or treatment they receive, or in the judgement of those treating them.<sup>2</sup> 🇳🇿

1 A copy of this statement can be found at [www.mcnz.org.nz](http://www.mcnz.org.nz) >>Resources >> Standards and guidelines.

2 *Good medical practice*, paragraph 61

# Viewpoint – Of visions, systems, and recurring themes

BY ANTHONY HILL, HEALTH AND DISABILITY  
COMMISSIONER VIEWPOINT



**GREETINGS.** It is a privilege to be the Health and Disability Commissioner. I appreciate this opportunity to share with you, 6 months in, some of my thinking as I reflect on this first period of my tenure.

In this note I will reflect on visions old and new for the health sector, some important themes arising in those visions and captured in our own Code of Health and Disability Services Consumers' Rights, and some recurring themes arising in the matters before my Office.

New Zealand has a health and disability system of which it can be rightly proud. Our system successfully treats or engages with health and disability consumers on millions of occasions every year.<sup>1</sup> Advocates assist with 3500 queries a year and this office receives some 1500 complaints.

These consumer stories provide us with important opportunities to learn, to improve system safety and quality, and thus to strengthen the system that serves us all.

## VISIONS OLD AND NEW

In 1988 Judge Cartwright advocated a system 'which will encourage better communication between patient and

1 'For example, acute hospital discharges exceed 660,000 per annum, primary care interactions exceed 18 million consults per annum'. Source: Ministry of Health

2 Cartwright, SR: *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters*. Auckland Government printing office 1988.

doctor, allow for structured negotiation and mediation, and raise awareness of patients' medical, cultural and family needs. The focus of attention must shift from the doctor to the patient.'<sup>2</sup> Judge Cartwright went on to say: 'Health professionals need to listen to their patients, communicate with them, protect them, offer them the best healthcare within their resources, and bravely confront colleagues if standards slip.'<sup>3</sup>

Twenty years on another voice speaking of a modern health care system articulated the following vision: 'We envision a culture that is open, transparent, supportive and committed to learning; where doctors, nurses and all health workers treat each other and their patients competently and with respect: where the patient's interest is always paramount; and where patients and families are fully engaged in their care. We envision a culture centred on team work, grounded in mission and purpose, in which organisational managers and boards hold themselves accountable for safety and learning to improve.'<sup>4</sup>

The similarities are striking. US thought leaders Leape Berwick et al go on to discuss five transforming concepts relevant to the delivery of that vision. Three of these – transparency, the integrated care platform, and consumer engagement – are themselves current themes in the New Zealand system and are echoes of our own Code.

A quality and safety approach rightly places 'what happened' before 'who did it'. It encourages the open disclosure of information and the genuine willingness to transparently disclose and discuss events that go wrong.

My approach will be first to seek the learning and to understand fully what happened in the consumer stories that come before me. Consumers commonly say to me that their purpose in complaining is to ensure that 'this does not happen to anyone else'.

There has been and will be no jurisprudential shift in the opinions being issued. Decision making will reflect the precedents set in the last 15 years. In resolving complaints I am interested to reduce repetition of errors – exploring system cause and context, and strengthening system delivery. The themes of resolution, protection, and learning continue, as do the themes of being fair and expecting professionals to take responsibility for their practice<sup>5</sup>.

## AVOIDING REPETITION – HOW WELL DO WE LEARN AS A SYSTEM?

If we can understand the systems within which events occur, we can also understand causation, learn, and avoid repetition. ►

3 Ibid

4 L.Leape, D Berwick et al; *Transforming Health Care: A Safety Imperative*, qual saf healthcare 2009: 18; 424-428

5 Opinion 08HDC04311

◀ Any conversation about a learning system connotes questions of culture. In a highly complex and busy system, learning is a challenge. One thought-provoking aspect of the stories before me in these last 6 months has been not that they occurred at all, but the frequency with which the same themes recur.

### GETTING THE BASICS RIGHT – RECURRING THEMES

Patient safety begins with getting the basics right. It is in the ordinary that we spend most of our time, and it is in the ordinary that issues arise. I group some of these under the rubric: 'Read the notes, ask the questions, talk to the patient'.

In this and other fora, I will be discussing these recurring themes. A broad series of issues fall within each area – some examples are outlined below.



### READ THE NOTES

Issues concerning notes appear frequently – are they comprehensive, accurate, contemporaneous? Do they quickly collect diagnostic results, do they support continuity of care, and are they read?

Consider the woman with shoulder pain who consulted five different doctors at a medical centre over a period of 7 months.<sup>6</sup> Each consultation was poorly documented and the notes provided little assistance to doctors at subsequent consultations. After a failure to follow up on referrals and test results, the woman was eventually diagnosed with cervical stenosis and myelopathy.

In another case, the notes were appropriate, but were not read by the next provider (who had them). Harm was avoided as a friend fortuitously advised the consumer to have a free mammogram independently of her GP practice. The mammogram confirmed the previously palpated lump was suspicious for cancer, subsequently confirmed.

### ASK THE QUESTIONS

Another recurring theme is omitting to ask questions about either history or what else may be going on. In one case a GP diagnosed his female patient, whom he saw on a series of visits, with iron deficiency, anaemia and gastritis, without performing an abdominal or rectal examination. When iron supplements failed to improve her health he undertook no further investigations. The woman eventually sought a second opinion, revealing a primary tumour in her caecum and secondary cancer in her liver.<sup>7</sup>

'Ask the questions' also raises cultural issues about our system – the ease with which we can ask questions and our comfort in doing so. Co-operation and teamwork ensure that the many different skill sets of individuals can be combined to provide more efficient, effective and safer care.<sup>8</sup>

Cases suggest team members can be hesitant to step out of the hierarchy, or to question decisions. The story of a 2½-year old boy illustrates this. The child was admitted to hospital with a moderately severe exacerbation of asthma. He was transferred to a paediatric ward later that day, initially improved but overnight experienced increasing respiratory distress. He suffered cardio respiratory arrest early the next morning and ultimately died. In that case, the attending house officer did not recognise the severity of the child's condition and failed to respond appropriately. Senior nurses present expressed concern; but even so, specialist assistance was not sought early enough.<sup>9</sup>

6 Opinion 08HDC06359.

7 Opinion 10HDC00253.

8 Weller J, Thwaites J, Nhoopatkar H, Hazell W., "Are doctors team players, and do they need to be?" New Zealand Medical Journal 2010: 123 (1310)

9 Opinion 08HDC04311.

‘...We have a strong system. It works well the vast majority of the time. Improving that system is a worthy challenge.’

The communication theme, in many forms, echoes through cases past and present. How effectively do we work, as teams, among providers, and is it easy to raise a concern or step up or outside the hierarchy when concerns grow?

### TALK TO THE PATIENT

It is important that consumers are equipped with information that a reasonable person in that consumer's circumstances might wish to know. Communication of risk is one recurring dimension of this.

A patient who was undergoing innovative robot-assisted surgery was not advised of the surgeon's limited experience and the time he had previously taken when carrying out this surgery. The patient was not aware of the risks should the operation be prolonged. The surgeon was found in breach as the patient did not give informed consent to the operation.<sup>10</sup>

In a case of a testicular torsion, incorrectly but reasonably diagnosed as infection, the patient was informed of the risk of the differential diagnosis of torsion. He chose to go back to work rather than walk into the room next door and have the free ultrasound, which was the only certain way to exclude the differential diagnosis. The consumer felt he wasn't given sufficiently clear information about the severity of the consequences of the differential diagnosis.

### CONCLUSION

Recurring themes within the 'getting the basics right' rubric will be the subject of ongoing discussion and engagement with the system. We have a strong system. It works well the vast majority of the time. Improving that system is a worthy challenge.

### CHRISTCHURCH EARTHQUAKE POSTSCRIPT

Within hours of the earthquake we began hearing the stories of people doing extraordinary things in extraordinary circumstances to help others. I am conscious that many reading this, in Christchurch and around New Zealand have been directly affected and involved, at first hand and in response to the devastation. We at HDC want to acknowledge such incredible care, and also to say that our hearts and thoughts are with the people of Canterbury and all those affected by this event. 🙏

<sup>10</sup> Opinion 08HDC20258

## Viewpoint – Engage, Consult, and Deliver

BY DR CURTIS WALKER, PRESIDENT, NEW ZEALAND RESIDENT DOCTORS' ASSOCIATION



In December's newsletter, Professor Des Gorman, Executive Chair of Health Workforce New Zealand (HWNZ), called for the medical profession to debate our health system's demand–supply–affordability challenges. Instead of debate, let me propose a better word – dialogue. As a fundamental first step in any change process – particularly changes as considerable and radical as those proposed – dialogue and engagement with the profession are essential.

Much has been written and said, but little done over the past decade with respect to the sustainability and affordability of New Zealand's health system. Numerous bodies and committees – including HWNZ – have been set up over this time, none of which have altered the fundamentals of our system. This may be no bad thing, as our health system is often acknowledged as one of the best bang-for-buck systems in the world.<sup>1</sup> This efficiency relies on the structures we have (educational, legislative, collegial, and so on) and the extraordinary goodwill of the thousands of committed health professionals working here.

Whatever the proposed (de)merits of changing our health system, presumably any change will aim to continue to deliver the good without unintended negative consequences – *primum non nocere*. It is up to us as a profession to scrutinise the evidence and challenge the assumptions that harm will not be done to the profession and our healthcare system. In this, drawing on the experiences of others is essential. ►

◀ The United Kingdom's Modernising Medical Careers (MMC) is a salient example familiar to hundreds of UK-trained doctors now working in New Zealand. What began as an attempt at reforming postgraduate medical training and workforce planning spiralled into a driver of mass-exodus of UK doctors. Ironically, this has aided New Zealand's own medical workforce shortages with an annual pilgrimage of disgruntled UK doctors staffing our hospitals.



‘...engagement must be with genuinely representative groups able to contribute to and best implement change at the coal face – not simply tokenism...’

Without real dialogue with the profession, HWNZ and the other newly minted and metastasising bureaucratic structures referred to by Professor Gorman run the real risk of repeating the mistakes made with MMC. One of the key findings of the Tooke inquiry into the ‘profound concerns’ and ‘distress caused [to doctors]’ by MMC, was the need for ‘medical and professional engagement’ when designing and implementing change.<sup>2</sup>

The RMO Commission Report in 2009 similarly recommended ‘best practice change management’ in order to achieve reforms. Professor Gorman, one of that report’s authors, wrote that solutions will need to be ‘intelligently informed ... and clinically led.’<sup>3</sup> Both statements imply and indeed require input from, and engagement of, the medical profession. Furthermore, engagement must be with genuinely representative groups able to contribute to and best implement change at the coal face – not simply tokenism involving non-representative supplicants. Writing as a resident doctor, who comprise a third of the medical workforce, the lack of engagement with our members or their representative organisation (New Zealand Resident Doctors Association) has been spectacular in its absence. This has led to the inevitable conclusion that changes to our working lives are to be imposed by decree and diktat rather than by agreement.

Failure to gain what could be termed ‘informed consent’ from the medical profession to reforms likely to affect our current and future careers is unconscionable, and is likely to succeed only in further disenfranchisement and disillusionment of doctors and the disappearance of another committee into obscurity. Given our already precarious medical workforce situation, our own version of an MMC-inspired exodus is the last thing New Zealand needs.

Turning to the two issues raised specifically: registration and the concept of a New Zealand College of Medicine. In the first instance, we agree that registration rightly remains the purview of the Medical Council. The reason for HWNZ’s ‘great interest’ in doctor registration is less clear, unless the plans of HWNZ are to be made compulsory through inextricable linkage with the practising certificate. Put more bluntly – if you want to be a doctor in New Zealand, here are our demands. Make those demands unreasonable and accompanied by non-transparent ulterior motives, and trust in the registration process itself is called to question. The Medical Council’s role is to maintain standards and ensure the safety of the public, and attempts to subvert the exercise of this role in order to serve other agendas must be resisted.

Restoring trainee interns as employees is a matter for their input, and may provide support to (or more work for) the Resident Medical Officer (RMO) workforce. It may well enhance the trainee intern experience, but this relies on

‘The creation of a doctor who is the equivalent of a 163-volt appliance is fine until you realise the rest of the world is on 240 or 110 volts, meaning we can’t function elsewhere.’

enhancing the current house officer experience to make it something worthwhile for trainee interns to participate in.

In commenting on provisional registration, it is important to note that this registration category applies only to first-year house officers (and possibly could be extended downwards to trainee interns). The laundry list of requirements to be inserted into the year of house officer provisional registration will make for fascinating discussion given the already crammed adjustment needed to commence work as a doctor.

Of the general registrants, there is no mention of the 3,000-plus RMOs who have this category of registration. Through RMOs, general registration provides two incredibly valuable components to the public health service: fully qualified and registered doctors delivering an incredible amount of clinical service while simultaneously working towards vocational registration. While the balance between the provision of service and the training experience for the RMOs has to be maintained appropriately, we see this as a ‘win-win’ scenario, and we tamper with it at our national peril.

The single New Zealand College of Medicine was first mooted in the 1980s, but was rejected at that time as representing a dangerous risk to standards of training and vocation. Given the advances in medicine that have occurred since that time, there is scant argument that a country of 4 million people should so distance itself from the scales of economy and knowledge across the Tasman. Further, what of the utility of general and vocationally registered doctors trained under such a system? The creation of a doctor who is the equivalent of a 163-volt appliance is fine until you realise the rest of the world is on 240 or 110 volts, meaning we can’t function elsewhere. What of the impact on the quality of care offered in New Zealand? The transportability of training programmes? Is this New Zealand College to be used to deliver a doctor workforce that is lesser trained (and therefore cheaper) than those trained by the Australasian Colleges?

Canada may neighbour the USA, but is itself a huge country with its own large economies of scale. The Canadian situation reveals no easy solutions and many of the same foibles as the Australasian relationship. One in nine Canadian-trained doctors work in the USA; they have increasing proportions of IMGs in their workforce; and pay and conditions are the top two drivers of physician migration flows.<sup>4</sup>

If change is obvious and unavoidable, so too is the need for genuine dialogue and engagement. In our recent bargaining with the district health boards it has been enlightening how much can be achieved once the parties’ misconceptions and misunderstandings are dealt with openly and honestly. We welcome the opportunity to continue this dialogue with our colleagues – and to begin it with HWNZ. 🇳🇿

#### References

1. Ashton T. New Zealand. In: Cost Containment and Efficiency in National Health Systems: A Global Comparison. Weinheim, Germany: Wiley-VCH Verlag GmbH & Co. KGaA; 2009. ch8.
2. Tooke J. Aspiring to excellence: Final report of the independent inquiry into modernising medical careers. London: MMC Inquiry. 2008.
3. Commission on the Resident Medical Officer Workforce. 2009. *Treating People Well: Report of the Director-General of Health's Commission on the Resident Medical Officer Workforce*. Wellington: Ministry of Health.
4. Phillips RL, Petterson S, Fryer GE, Rosser W. The Canadian contribution to the US physician workforce. CMAJ. 2007 Apr 10;176(8):1083-1087.



# Christchurch Earthquake



On behalf of Council members and staff,


I would to extend our sincere sympathy to all Christchurch people dealing with the immediate agony of grief, displacement and loss, in the wake of the earthquake. Our

thoughts go particularly to all those doctors affected, and we acknowledge the professionalism and skill with which the members of our profession have been doing all that they can, together with teams of other health professionals, to heal battered bodies and minds.

We know that this effort will need to continue well into the future.

With our best wishes in this time of need.  
Kia kaha.

**Dr John Adams**

Te manutaki o te kura whaiora o Ōtepoti  
(Dean, Dunedin School of Medicine) 



## Contact details

Medical Council of New Zealand  
Level 13  
139 Willis St  
PO Box 11649  
Manners Street  
Wellington 6142

**PHONE** 0064 4 384 7635

**FREephone** 0800 286 801

**FAX** 0064 4 385 8902

**EMAIL** [mcnz@mcnz.org.nz](mailto:mcnz@mcnz.org.nz)

**WEBSITE** [www.mcnz.org.nz](http://www.mcnz.org.nz)

March 2011