



Cole's Medical Practice in New Zealand

2017: Edited by Kevin A Morris

Published by the Medical Council of New Zealand

Cole's Medical Practice in New Zealand

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First published in 1988 by the Medical Protection Society as Medical practice and professional conduct, in 1995 by the Medical Council of New Zealand as Medical practice in New Zealand: *a guide to doctors entering practice* and in 1999, 2001, 2003, 2004, 2006, 2007, 2008, 2009, 2011 and 2013 as Cole's Medical practice in New Zealand.

This revised and updated 13th edition published electronically by the Medical Council of New Zealand, Level 28, Plimmer Towers, 2–6 Gilmer Terrace, Wellington 6011.

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ISBN 978-0-473-41704-8

Preface to the 13th (2017) edition

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

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

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

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

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

Kevin A Morris, November 2017

Contents

Chapter 1	Good medical practice	6
Chapter 2	New Zealand Medical Association <i>Code of Ethics</i>	46
Chapter 3	The doctor-patient relationship	66
Chapter 4	Interdisciplinary collaboration: working in teams for patient care	81
Chapter 5	End-of-life issues	100
Chapter 6	The purpose of medical records and notes	113
Chapter 7	The management of clinical investigations	122
Chapter 8	Doctors in other roles	126
Chapter 9	Doctors' health	137
Chapter 10	Maintaining competence	153
Chapter 11	Credentialling	160
Chapter 12	Doctors who use complementary and alternative medicine	165
Chapter 13	eHealth	177
Chapter 14	Choosing Wisely – more isn't always better	196
Chapter 15	Informed consent	208
Chapter 16	Mental capacity	225
Chapter 17	Cultural competence, cultural safety and health equity in medical practice in Aotearoa/New Zealand	246
Chapter 18	Māori and health	258
Chapter 19	Pacific people in New Zealand	274
Chapter 20	Asian people in New Zealand	290

Chapter 21	Working with interpreters	303
Chapter 22	How medical practice standards are set and maintained: the Health Practitioners Competence Assurance Act 2003	315
Chapter 23	How medical practice standards are set and maintained: other legislation	327
Chapter 24	The complaints and disciplinary process	345
Chapter 25	The psychiatric patient and the law	362
Chapter 26	The organisation of medical services in New Zealand	379
Chapter 27	Overview of the New Zealand public health and disability system	389
Chapter 28	The role of the Health and Disability Commissioner and the Code of Rights	416
Chapter 29	Medical Council of New Zealand	440
Chapter 30	Accident compensation	445
Chapter 31	Doctors and the Ministry of Social Development	459
Chapter 32	Doctors and the transport sector	463
Chapter 33	New Zealand Medical Association	495
Chapter 34	A brief history of Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA)	505
	Statements – standards for doctors	515

CHAPTER 1

Good medical practice

The principal purpose of the Medical Council of New Zealand is to protect the health and safety of the public by providing mechanisms to ensure doctors are competent and fit to practise.

About Good Medical Practice	7
How Good Medical Practice applies to you	8
Professionalism	9
Areas of professionalism	11
Caring for patients	12
Respecting patients	16
Working in partnership with patients and colleagues	22
Acting honestly and ethically	32
Accepting the obligation to maintain and improve standards	39
Related documents	42

The Council has the following key functions:

- registering doctors
- determining qualifications
- prescribing scopes of practice
- setting standards and supporting doctors to uphold these standards
- recertifying and promoting lifelong learning for doctors
- reviewing the practice of doctors if there is a concern about performance, professional conduct or health
- accrediting training institutions – including medical schools, colleges of medicine and hospitals.

About *Good Medical Practice*

Under section 118(i) of the Health Practitioners Competence Assurance Act 2003, a function of the Medical Council is to set standards of clinical competence, cultural competence and ethical conduct for doctors. Under Right 4 of the *Code of Health and Disability Service Consumers' Rights* patients also have “the right to have services provided that comply with legal, professional, ethical and other relevant standards.” The Council has developed *Good Medical Practice* to be the foundation document for these standards.

The standards detailed in *Good Medical Practice*, and in other Council statements, are those which the public and the profession expect a competent doctor to meet and have been developed through discussion with the public and the profession. Where relevant, *Good Medical Practice* also provides guidance to assist doctors understand, and comply with, the requirements of legislation.

Good Medical Practice is not intended to be exhaustive. There may be obligations or situations that are not expressly provided for. In such circumstances, a doctor's first priority should always be the care of his or her patient.

Good Medical Practice is not a *Code of Ethics* – it does not seek to describe all the ethical values of the profession or to provide specific advice on ethical issues, ethical frameworks and ethical decision-making. This type of advice is provided by the New Zealand Medical Association.

Good Medical Practice is addressed to doctors, but is also intended to let the public know what they can expect from doctors.

How *Good Medical Practice* applies to you

- For medical students, *Good Medical Practice* identifies the basic duties of a good doctor and serves as a source of education and reflection.
- For doctors, *Good Medical Practice* serves as a basis for you to monitor, and reflect on, your own conduct and that of your colleagues. The Health Practitioners Disciplinary Tribunal, the Council's Professional Conduct Committees and the Health and Disability Commissioner may use *Good Medical Practice* as a standard by which to measure your professional conduct.
- For patients, *Good Medical Practice* provides guidance for assessing the minimum ethical and clinical conduct expected of doctors.

The directives outlined in *Good Medical Practice* are usually duties and must be followed. However, we recognise that not all duties will apply in all situations. Sometimes there are factors outside a doctor's control that affect whether or not, or how, he or she can comply with some standards. Throughout this resource we have used the term "you should" (rather than a more directive term such as "you must") to indicate where this is the case.

If you believe that a doctor is not meeting standards outlined in *Good Medical Practice*, you should raise your concerns with the doctor, draw that matter to the attention of the doctor's employer, or report your concerns to the Registrar of the Medical Council¹ or the Office of the Health and Disability Commissioner², or in the event of matters related to health information privacy and security – the Office of the Privacy Commissioner³.

Professionalism

Patients trust their doctors with their health and wellbeing, and sometimes their lives. To justify your patients' trust, follow the principles outlined below and the duties outlined in the rest of this document.

Caring for patients

Make the care of patients your first concern.

Protect and promote the health of patients and the public.

Respecting patients

Aim to establish a relationship of trust with each of your patients.

Be aware of cultural diversity, and function effectively and respectfully when working with and treating people of different cultural backgrounds.

Treat patients as individuals and respect their dignity by:

- treating them with respect
- respecting their right to confidentiality and privacy.

1 Telephone 0800 286 801 or email complaints@mcnz.org.nz. For more information, refer to the "Fitness to Practice" page of the Council's website, www.mcnz.org.nz

2 Telephone 0800 11 22 33 or email hdc@hdc.org.nz. For more information, refer to www.hdc.org.nz

3 Telephone 0800 80 39 09, or email enquiries@privacy.org.nz. For more information, refer to www.privacy.org.nz

Working in partnership with patients and colleagues

Work in partnership with patients by:

- listening to them and responding to their concerns and preferences
- giving them the information they want or need in a way they can understand and ensuring they understand it
- respecting their right to reach decisions with you about their treatment and care
- supporting them in caring for themselves to improve and maintain their health.

Maintain the trust of colleagues, and treat them respectfully.

Work with colleagues in ways that best serve patients' interests

Acting honestly and ethically

Be honest and open when working with patients; act ethically and with integrity by:

- acting without delay to prevent risk to patients
- acting without delay if you have good reason to believe that a colleague may be putting patients at risk
- never discriminating unfairly against patients or colleagues
- never abusing your patients' trust in you or the public's trust of the profession.

Work cooperatively with, and be honest, open and constructive in your dealings with managers, employers, the Medical Council, and other authorities.

Accepting the obligation to maintain and improve standards

Act in accordance with relevant standards.

Keep your professional knowledge and skills up to date

Recognise, and work within, the limits of your competence.

Be committed to autonomous maintenance and improvement in your clinical standards in line with best evidence-based practice.

Demonstrate reflectiveness, personal awareness, the ability to seek and respond constructively to feedback and the willingness to share your knowledge and to learn from others.

Accept a responsibility for maintaining the standards of the profession.

Remember that you are personally accountable for your professional practice – you must always be prepared to explain your decisions and actions.

Areas of professionalism

1. The Council expects doctors to be competent in:

- caring for patients
- respecting patients
- working in partnership with patients and colleagues
- acting honestly and ethically
- accepting the obligation to maintain and improve standards

In the sections that follow, we outline the requirements of each of these areas of professionalism.

Caring for patients

Principles

Make the care of patients your first concern.

Protect and promote the health of patients and the public.

Providing good clinical care

2. When you assess, diagnose or treat patients you must provide a good standard of clinical care. This includes:
 - adequately assessing the patient's condition, taking account of the patient's history and his or her views, reading the patient's notes and examining the patient as appropriate⁴
 - providing or arranging investigations or treatment when needed
 - taking suitable and prompt action when needed, and referring the patient to another practitioner or service when this is in the patient's best interests.
3. In providing care you are expected to⁵:
 - provide effective treatments based on the best available evidence
 - consult and take advice from colleagues when appropriate
 - take steps to alleviate pain and distress whether or not a cure is possible.

4 See the Council's statement on *Non-treating doctors performing medical assessments of patients for third parties*, which outlines the specific requirements for non-treating doctors performing medical assessments for other parties.

5 See the Council's statement on *Telehealth* for information about providing services electronically or from a distance.

Safe practice in an environment of resource limitation

4. Strive to use resources efficiently, consistent with good evidence based patient care, and balance your duty of care to each patient with your duty of care to the community and wider population⁶.

Keeping records⁷

5. You must keep clear and accurate patient records that report:
 - relevant clinical information
 - options discussed
 - decisions made and the reasons for them
 - information given to patients
 - the proposed management plan
 - any medication or other treatment prescribed.
6. Make these records at the same time as the events you are recording or as soon as possible afterwards.
7. Take all reasonable steps to ensure that records containing personal data about patients, colleagues or others are kept securely.

Administrative systems

8. Your administrative systems must support the principles and standards contained within *Good Medical Practice*.

6 For more information, see the Council's statement on *Safe practice in an environment of resource limitation*.

7 See the Council's statement on *The maintenance and retention of patient records*.

Prescribing medication or treatment⁸

9. You may prescribe medication or treatment, including repeat prescriptions, only when you:
- have adequate knowledge of the patient's health
 - are satisfied that the medication or treatment are in the patient's best interests.
10. Before prescribing any medicine for the first time to a patient, Council expects you to have an in-person consultation with the patient. If that is not possible because of exceptional circumstances,⁹ consider a video consultation¹⁰ with the patient¹¹ or discuss the patient's treatment with another New Zealand registered health practitioner who can verify the patient's physical data and identity. When these options are not possible or practical, it may be reasonable practice to:
- Complete a prescription for a patient if you are providing cover for an absent colleague or are discharging a patient from hospital and have reviewed the patient's notes.

Before prescribing any medicine for the first time to a patient, Council expects you to have an in-person consultation with the patient.

8 See the Council's statement on *Good prescribing practice*.

9 Examples of exceptional circumstances include the urgency of the clinical situation or the unavailability of a doctor. It is good practice to document in the patient's clinical notes, the mode of the consultation and the reasons for not conducting an in-person consultation before prescribing any medication for the first time to a patient.

10 Video consultation refers to situations where the doctor and patient use information and video conferencing technologies to communicate with each other and visual and audio information are exchanged in real time but the doctor and patient are not physically present in the same consultation room. Video consultations can be conducted between a doctor and patient in the presence of their general practitioner or other health practitioner or it can be conducted with no medical support at the patient's end.

11 If you conduct a video consultation, you must take extra care to ensure that a physical examination of the patient is not necessary. If in the course of a video consultation it becomes clear that a physical examination is required, you must inform the patient and arrange for a physical examination. In instances where the physical examination is to be conducted by another health practitioner, you must ensure that you outline clearly what follow-up is required.

- Renew a prescription of a patient you, or a colleague in the same practice, have seen previously, following a review of its appropriateness for the patient. When the prescription has potentially serious adverse effects, you should regularly assess the patient.
- Complete a prescription when you have a relevant history and there is an urgent clinical need to prescribe, provided that you inform the patient's regular doctor as soon as possible¹².

Providing care to yourself or those close to you¹³

11. Other than in exceptional circumstances you should not provide medical care to yourself or anyone with whom you have a close personal relationship.

Treating people in emergencies¹⁴

12. In an emergency, offer to help, taking account of your own safety, your competence, and the availability of other options for care.

Treating patients who present a risk of harm

13. If a patient poses a risk to your own health and safety or that of other patients or staff, you should take all reasonable steps to minimise the risk before providing treatment or making suitable arrangements for treatment.

12 For example, when a public health physician prescribes prophylactic medicines for family members of a patient, after that patient has been diagnosed with a serious communicable disease.

13 See the Council's statement on *Providing care to yourself and those close to you*.

14 See the Council's statement on *The doctor's duties in an emergency*.

Respecting patients

Principles

Aim to establish a relationship of trust with each of your patients.

Be aware of cultural diversity, and function effectively and respectfully when working with and treating people of different cultural backgrounds.

Treat patients as individuals and respect their dignity by:

- treating them respectfully
- respecting their right to confidentiality and privacy.

Establishing and maintaining trust

14. You should aim to establish and maintain trust with your patients. Relationships based on openness, trust and good communication will enable you to work in partnership with them to address their individual needs.
15. Make sure you treat patients as individuals and respect their dignity and privacy.
16. Be courteous, respectful and reasonable.

Relationships based on openness, trust and good communication will enable you to work in partnership with them to address their individual needs

Cultural competence¹⁵

- 17.** New Zealand has as its founding document the Treaty of Waitangi. You should acknowledge the place of the Treaty, and apply the principles of partnership, participation and protection in the delivery of medical care. You must also be aware of cultural diversity and function effectively and respectfully when working with and treating people of all cultural backgrounds. You should acknowledge:
- that New Zealand has a culturally diverse population
 - that each patient has cultural needs specific to him/her
 - that a doctor's culture and belief systems influence his or her interactions with patients
 - that one's culture may impact on the doctor-patient relationship
 - that a positive outcome for patient and doctor is achieved when they have mutual respect and understanding
- 18.** You must consider and respond to the needs of all patients. You should make reasonable adjustments to your practice to enable them to receive care that meets their needs¹⁶.

¹⁵ See the Council's *Statement on cultural competence*. For specific guidance on providing care to Māori patients, see the Council's *Statement on best practices when providing care to Māori patients and their whānau* and *Best health outcomes for Māori: Practice implications*. For advice on providing care to Pacific patients, see *Best health outcomes for Pacific peoples: Practice implications*. See also *Cole's Medical Practice in New Zealand* for advice on providing care to Asian people in New Zealand.

¹⁶ New Zealand is a signatory to the United Nations Convention on Persons with Disabilities. This convention is intended to protect the rights and dignity of persons with disabilities. The convention includes provisions to ensure that persons with disabilities receive care appropriate to their needs, and at the same standard as others.

Personal beliefs and the patient

19. You must not refuse or delay treatment because you believe that a patient's actions have contributed to their condition. Nor should you unfairly discriminate against patients by allowing your personal views to affect your relationship with them.
20. Your personal beliefs, including political, religious and moral beliefs, should not affect your advice or treatment. If you feel your beliefs might affect the advice or treatment you provide, you must explain this to patients and tell them about their right to see another doctor. You must be satisfied that the patient has sufficient information to enable them to exercise that right.
21. Do not express your personal beliefs to your patients in ways that exploit their vulnerability or that are likely to cause them distress.

Treating information as confidential¹⁷

22. Treat all information about patients as confidential and sensitive¹⁸.

Supplementary guidance – Sharing information in public

- When sharing information in any public forum (including, for example, chatting in a hospital cafeteria or posting to a social networking site), do not disclose information about yourself that might undermine your relationship with patients. Similarly, do not disclose information that might identify and cause distress to colleagues, patients or their families.

17 See the Health Information Privacy Code.

18 Rule 10 (1)(d) of the Health Information Privacy Code, allows you to disclose information about a patient in a limited range of circumstances, including when “disclosure [is] necessary to prevent or lessen a serious and imminent threat to public health or public safety or the life and health of an individual.”

Supplementary guidance – Sharing information with parents, caregivers or next of kin

When working with patients under 16 years, you should determine their competence to understand their condition and make decisions about their treatment. If they are competent, they are entitled to confidentiality. In the absence of a concern that the young person is at risk of harm, you should only share information with parents and caregivers with the patient's consent.

When working with adult patients who have an intellectual disability or communication difficulties you should make a judgement as to whether you are acting in the patient's best interests by sharing information with family or caregivers. Whenever possible you should seek the permission of the vulnerable adult to share information about their condition and treatment with others.

When an adult patient has died, advise the patient's partner or next of kin, unless you know that the patient would have objected. When a patient under 16 has died, explain to the parents or caregivers to the best of your knowledge why and how the patient died.

Involving relatives, carers and partners

23. Actively involving relatives, carers and partners in a patient's care is inherent to cultural competence and a positive doctor-patient relationship, and is often part of good clinical care. When appropriate you should seek the patient's permission to involve relatives, carers and / or partners in their care. You must always be courteous, respectful and reasonable to relatives, carers, partners and others close to the patient. Make sure you are sensitive and responsive in providing information and support, for example, after a patient has died.

Supplementary guidance – End of life care

As a doctor you play an important role in assisting patients, families/whānau and the community in dealing with the reality of dying and death. In caring for patients at the end of life, you share with others the responsibility to take care that the patient dies with dignity, in comfort and with as little suffering as possible.

You should take care to communicate effectively and sensitively with patients, their families and support people so that they have a clear understanding of what can and cannot be achieved. You should offer advice on other treatment or palliative care options that may be available. You should ensure that support is provided to patients and their families, particularly when the outcome is likely to be distressing to them.

Supplementary guidance – Euthanasia

You must not participate in the deliberate killing of a patient by active means. Euthanasia is an offence under the Crimes Act 1961 and illegal in New Zealand.

Dealing with adverse outcomes¹⁹

24. If a patient under your care has suffered serious harm or distress you should act immediately to put matters right. You should express regret at the outcome, apologise if appropriate, and explain fully and without delay to the patient:
- what has happened
 - the likely short-term and long-term effects
 - what you and your health service can do to alleviate the problem

19 Refer to the Council's statement on *Disclosure of harm*.

- what steps have been or will be taken to investigate what happened and (if possible) prevent it from happening again.
 - how to make a complaint.
25. Patients who have a complaint about the care or treatment they have received have a right to a prompt, constructive and honest response, including an explanation and, if appropriate, an apology.
26. Do not allow a patient's complaint to prejudice the care or treatment you provide or arrange for that patient.

Reporting of alleged abuse

27. If you have any concerns about alleged or suspected sexual, physical or emotional abuse or neglect of vulnerable patients, you should report this to the appropriate authorities without delay. You should inform the patient, and if the patient is under the care of another person, his or her caregivers of your intention to report your concerns, taking into account that such action might endanger you or the patient. Giving information to others for the protection of a patient may be a justifiable breach of confidentiality²⁰ and, where a vulnerable adult is at risk of injury, is a legal duty²¹.

Ending a professional relationship²²

28. In some rare cases, because of a lack of trust and confidence, you may need to end a professional relationship with a patient. If you do so, you must be prepared to justify your decision. You should tell the patient – in writing if possible – why you have made this decision. You should also arrange for the patient's continuing care and forward the patient's records without delay.

20 As outlined in the Privacy Act and the Health Information Privacy Code.

21 As outlined in s.151 of the Crimes Act 1961.

22 See the Council's statement on *Ending a doctor-patient relationship*.

Working in partnership with patients and colleagues

Principles

Work in partnership with patients by:

- listening to them and responding to their concerns and preferences
- giving them the information they want or need in a way they can understand and ensuring they understand it
- respecting their right to reach decisions with you about their treatment and care
- supporting them in caring for themselves to improve and maintain their health.

Maintain the trust of colleagues, and treat them politely and considerately.

Work with colleagues in ways that best serve patients' interests.

Assessing patients' needs and priorities

29. The care or treatment you provide or arrange must be made on the assessment you and the patient make of his or her needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options.

Supporting self care

30. Encourage your patients and the public to take an interest in their health and to take action to improve and maintain their health. Depending on the circumstances, this may include:
- advising patients on the effects their life choices may have on their health and wellbeing and the outcome of treatments

- offering patients appropriate preventative measures, such as screening tests and immunisations, that are appropriate to their particular health status and consistent with guidelines and best practice
- encouraging patients to stay in, or return to, work or engage in other purposeful activities²³

Information, choice of treatment and informed consent²⁴

31. You must familiarise yourself with the:

- Code of Health and Disability Services Consumers' Rights²⁵
- Health Information Privacy Code²⁶.

32. With rare and specific exceptions you should not provide treatment unless:

- the patient has received all the information that a reasonable patient, in that patient's circumstances, would expect to receive about their condition and treatment options, including the expected risks, side effects, costs and benefits of each option; and
- you have determined that he or she has an adequate understanding of that information; and
- you have provided the patient with an opportunity to consider and discuss the information with you; and

23 The Royal Australasian College of Physicians' *Consensus Statement on the Health Benefits of Work* outlines the evidence that work is generally good for health and wellbeing, and that long-term work absence and unemployment generally have a negative impact on health and wellbeing. A copy of this paper can be downloaded from <http://www.racp.edu.au/page/policy-and-advocacy/occupational-and-environmental-medicine>.

24 See the Council's statement on *Information, choice of treatment and informed consent*.

25 For a copy of the *Code of Health and Disability Services Consumers' Rights* go to <http://www.hdc.org.nz/the-act--code/the-code-of-rights>

26 For a copy of the Health Information Privacy Code go to <http://privacy.org.nz/health-information-privacy-code/>

- the patient has made an informed choice; and
 - the patient consents to treatment.
- 33.** In order that you can appropriately advise patients on their treatment options, you should have a reasonable knowledge of the range of evidence based treatments that are available to treat their condition, and of how patients can access those that you yourself do not provide.
- 34.** You must respect and support the patient's right to seek a second opinion or to decline treatment, or to decline involvement in education or research.

Supplementary guidance – Informed consent in specific situations²⁷

You should obtain separate written consent for research, experimental procedures, general or regional anaesthesia, blood transfusion or any procedure with a significant risk of adverse effects.

You should pay careful attention to the process of informed choice and consent when a proposed treatment is expensive or in any way innovative. If a patient is choosing between evidence based medicine and innovative treatments for which there is no scientific evidence, you should attempt to present to the patient a clear and balanced summary of the scientific information available.

²⁷ Additional requirements apply in certain circumstances, such as where the patient is a minor or not competent to make an informed decision. In addition, there are several pieces of law that can override the requirements of the Code of Rights. The Council's statement on *Information, choice of treatment and informed consent* outlines these requirements.

Before providing treatment you should seek the advice of a senior colleague, or obtain legal advice, if you are unsure whether the patient is competent to make a particular decision, and:

- the patient's wishes, or the wishes of a parent, guardian or caregiver, conflict with your assessment of the patient's best interests; or
- the treatment is risky or controversial.

Supplementary guidance – Use of interpreters

When treating patients whose English language ability is limited, you should arrange to use a competent interpreter. When an interpreter has been used to assist in obtaining the patient's informed consent you should note this in the records, along with the interpreter's name and status (professional interpreter, family member etc) and, if possible, a note signed by the interpreter to certify that they believe the patient understands the information provided.

Advance directives

- 35.** An advance directive is a formal document that clearly and specifically outlines or describes the patient's wishes. Advance directives have legal standing in the *Code of Health and Disability Services Consumers' Rights*. There may be exceptional circumstances in which it may not be appropriate to comply with the wishes outlined in an advance directive²⁸, however you must always respect and consider those wishes. If a patient has an advance directive that is relevant to their care you should, where possible, confirm that it is consistent with their current views before providing treatment.

28 For example, where the patient is being treated under specific legislation such as the Mental Health (Compulsory Assessment and Treatment) Amendment Act 1992 or when significant changes in the patient's circumstances or condition or available treatments arising since the advance directive was made appear to counteract its validity or relevance.

Support persons

36. Patients have the right to have one or more support persons of their choice present²⁹, except where safety may be compromised or another patient's rights unreasonably infringed.

Advertising³⁰

37. Make sure that any information you publish or broadcast about your medical services is factual and verifiable. It must not put undue pressure on people to use a service, for example by arousing ill-founded fear for their future health or by fostering unrealistic expectations. The information must conform to the requirements of the Council's *Statement on advertising*, the Fair Trading Act 1986 and the Advertising Standards Authority guidelines.

Use of titles

38. Patients can find medical titles confusing. To reduce confusion, you should not use a title such as "specialist" or "consultant" that refers to an area of expertise unless you are registered with the Council in an appropriate vocational scope.

Working with colleagues³¹

39. You must be aware of the impact of your conduct on members of your practice team and colleagues, and how that may affect quality care and treatment for patients³².
40. You should respect the skills and contributions of your colleagues.

29 This right is outlined in Right 8 of the Health and Disability Services Consumers' Rights.

30 See the Council's *Statement on advertising*.

31 Colleagues are those you work with, including doctors and other health professionals.

32 For more information, refer to the Council's statement on *Unprofessional behavior in the healthcare team*.

41. Treat your colleagues courteously, respectfully and reasonably . Do not bully or harass them. You must not discriminate against colleagues.
42. Do not 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.

Management

43. You must always strive to work with managers and administrators in a constructive manner to create and sustain an environment that upholds good medical practice. If you are working in a managerial or leadership role you should adhere to the guidance contained in the Council's statement on *Responsibilities of doctors in management and governance*.

Being accessible

44. Be readily accessible when you are on duty. Depending on the situation, this may mean you are accessible to patients, or it may mean that you are accessible to colleagues or a triage service.

Going off duty

45. When you are going off duty, make suitable arrangements for your patients' medical care. Use effective handover procedures and communicate clearly with colleagues.

Supplementary guidance – Shift handover

In an environment where doctors work in rotating shifts, you should insist that time is set aside for the sole purpose of organising appropriate handover.

Supplementary guidance – Arranging a locum

Whether in private or public practice, you must take particular care when arranging locum cover. You must be sure that the locum has the qualifications, experience, knowledge and skills to perform the duties he or she will be responsible for.

Sharing information with colleagues

46. You should ensure that patients know how information is shared among those who provide their care.
47. You should seek the patient's permission to, and explain the benefits of, sharing relevant information with other health practitioners and agencies involved in their care, including their principal health provider (who will usually be their general practitioner).
48. Once you have the patient's permission to share information, you must provide your colleagues with the information they need to ensure that the patient receives appropriate care without delay.
49. In most situations you should not pass on information if the patient does not agree. Some situations exist in which colleagues should be informed even if the patient does not agree (for example where disclosure is necessary to ensure appropriate ongoing care). Under the Health Act 1956 you may share information in these situations when a colleague is providing ongoing care and has asked for the information.

Continuity of care

50. Work collaboratively with colleagues to improve care, or maintain good care for patients, and to ensure continuity of care wherever possible.

51. Make sure that your patients and colleagues understand your responsibilities in the team and who is responsible for each aspect of patient care.
52. If you are the patient's principal health provider, you are responsible for maintaining continuity of care.

Supplementary guidance – Transferring patients

Transfer of care involves transferring some or all of the responsibility for the patient's ongoing care. When you transfer care of a patient to another practitioner, you must ensure that the patient remains under the care of one of you at all times. You should also provide your colleague with appropriate information about the patient and his or her care, and must ensure that the chain of responsibility is clear throughout the transfer. Where the transfer is for acute care, you should provide this information in person or in a telephone discussion with the admitting doctor.

You must appropriately document all transfers.

You should ensure that the patient is aware of who is responsible for their care throughout the transfer, and how information about them is being shared.

When you transfer care of a patient to another practitioner, you must ensure that the patient remains under the care of one of you at all times. You should also provide your colleague with appropriate information about the patient and his or her care

Supplementary guidance – Referring patients³³

Referring involves transferring some or all of the responsibility for some aspects of the patient's care. Referring the patient is usually temporary and for a particular purpose, such as additional investigation, or treatment that is outside your scope of practice. When you refer a patient, you should provide all relevant information about the patient's history and present condition.

You must appropriately document all referrals.

When you order a test and expect that the result may mean urgent care is needed, your referral must include one of the following:

- your out-of-hours contact details
- the contact details of another health practitioner who will be providing after-hours cover in your absence.

You must also have a process for identifying and following up on overdue results.

You should ensure that the patient is aware of how information about them is being shared and who is responsible for providing treatment, undertaking an investigation and reporting results.

Supplementary guidance – Delegating patient care to colleagues

Delegating involves asking a colleague to provide treatment or care on your behalf. When you delegate care to a colleague, you must make sure that they have the appropriate qualifications, skill and experience to provide care for the patient.

33 *Cole's Medical Practice in New Zealand* contains some useful advice in the chapter on *The management of clinical investigations*.

Although you are not responsible for the decisions and actions of those to whom you delegate, you remain responsible for your decision to delegate and for the overall management of the patient.

You should pass on complete, relevant information about patients and the treatment they need.

You should ensure that the patient is aware of who is responsible for all aspects of their care, and how information about them is being shared.

Supplementary guidance – Prescribing and administering of medicines by other health practitioners

You should support any non-doctor colleagues who are involved in prescribing or administering medicines as outlined below.

When other health professionals have prescribing rights

Some other health professionals have legal and independent prescribing rights. If you are working in a team with other health professionals who have prescribing rights, you should offer appropriate advice when needed to help ensure patient safety.

When non-doctor colleagues are supplying or administering medicines

Some teams delegate to non-doctors the responsibility for initiating and/or changing medication therapy. If a colleague is working from standing orders³⁴ that have been issued under your authority, then you are responsible for the effects of the medicine being supplied or administered. You should be available to give them advice, and should regularly review how the standing order arrangement is working.

34 Refer to the Ministry of Health's *Standing Order Guidelines*. You can view or download a copy of these guidelines at <http://www.health.govt.nz/publication/standing-order-guidelines>

Supplementary guidance – Planning for transfer of care

You should have a plan in place to ensure continuity of care if you become unexpectedly ill.

If you are thinking of retiring or reducing your patient list, you should put transfer arrangements in place and let your patients know before these arrangements take effect. With the patient's consent, all relevant medical records should be sent to the health practitioner taking over the care of the patient.

Acting honestly and ethically

Principles

Be honest and open when working with patients; act ethically and with integrity by:

- acting without delay to prevent risk to patients
- acting without delay if you have good reason to believe that a colleague may be putting patients at risk
- never discriminating unfairly against patients or colleagues
- never abusing your patients' trust in you or the public's trust of the profession.

Work cooperatively with, and be honest, open and constructive in your dealings with managers, employers, the Medical Council, and other authorities.

Integrity in professional practice

- 53.** You must be honest and trustworthy in your professional practice and in all communications with patients.

Sexual and emotional boundaries³⁵

54. Do not become involved in any sexual or inappropriate emotional relationship with a patient. In most circumstances you should also avoid becoming sexually or inappropriately emotionally involved with someone close to a patient, or a former patient.

Writing reports, giving evidence and signing documents³⁶

55. If you have agreed or are required to write reports, complete or sign documents or give evidence, you should do so promptly, honestly, accurately, objectively and based on clear and relevant evidence.

Supplementary guidance – Providing objective assessments of performance

Be honest and objective when appraising or assessing the performance of colleagues, including those whom you have supervised or trained. Patients may be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practice.

Supplementary guidance – Writing references and reports

Provide only honest, justifiable and accurate comments when giving references for, or writing reports about, colleagues. When providing references do so promptly and include all relevant information about your colleagues' competence, performance and conduct.

35 See the Council's guidance on *Sexual boundaries in the doctor-patient relationship*.

36 See the Council's statement on *Medical certification*.

Financial and commercial dealings³⁷

56. Be honest and open in any financial or commercial dealings with patients, employers, insurers or other organisations or individuals.
57. Act in your patients' best interests when making referrals and providing or arranging treatment or care. You must not allow any financial or commercial interests to affect the way you prescribe for, treat or refer patients. In particular:
 - do not ask for or accept any inducement, gift, or hospitality that may affect, or be perceived to have the capacity to affect, the way you prescribe for, treat or refer patients. The same applies to offering such inducements.
 - do not exploit patients' vulnerability or lack of medical knowledge when making charges for treatment or services
 - do not encourage patients to give, lend or bequeath money or gifts that will benefit you
 - do not put pressure on patients or their families to make donations to other people or organisations
 - do not put inappropriate pressure on patients to accept private treatment.

37 See also the Council's statement on *Doctors and health related commercial organisations*.

Conflicts of interest³⁸

58. If you have a conflict of interest, you must be open about the conflict, declaring your interest. You should also be prepared to exclude yourself from related decision making.

Openness and investigatory or legal processes

59. You must cooperate fully with any formal inquiry or inquest (although you have the right not to give evidence that may lead to criminal proceedings being taken against you). When you provide information you must be honest, accurate, objective and the information provided must be based on clear and relevant clinical evidence.
60. You must not withhold relevant information from any formal inquiry or inquest, or attempt to contact or influence complainants or witnesses except where directed by the relevant authority.

Supplementary guidance – Giving evidence

If you are asked to give evidence or act as a witness in litigation or formal proceedings, be honest in all your spoken and written statements. Make clear the limits of your knowledge or competence.

61. You have additional responsibilities if you are involved in management or governance³⁹. In particular, you must ensure that procedures are in place for raising and responding to concerns.

Raising concerns about patient safety⁴⁰

62. Protect patients from risk of harm posed by a colleague's conduct, performance or health.

38 See also the Council's statement on *Doctors and health related commercial organisations*.

39 See the Council's statement on *Responsibilities of doctors in management and governance*.

40 See the Council's statement on *Raising concerns about a colleague*.

63. If a colleague behaves in a manner which is inappropriate or unprofessional you should speak to them and raise your concerns in a constructive manner.
64. If your colleague does not respond to your concerns and continues to act inappropriately or unprofessionally, raise your concerns with a manager, appropriate senior colleague or the relevant external authority. Your comments about colleagues must be made honestly and in good faith. If you are not sure how to raise your concerns, ask an experienced colleague for advice.
65. If a colleague is concerned about the conduct, competence or health of another practitioner, or about a problem in the workplace, you should treat their concerns with respect and support them in taking action to address the concerns and in notifying the relevant authorities. You may need to provide less experienced colleagues with additional support to ensure that they have the confidence to raise concerns.
66. If you have reasonable grounds to believe that patients are, or may be, at risk of harm for any reason, do your best to find out the facts. Then you should follow your employer's procedures or policies, or tell an appropriate person or organisation straight away. Do not delay taking action because you yourself are not in a position to put the matter right.
67. Under the Health Practitioners Competence Assurance Act 2003 you must tell the Council if you have reason to believe that a doctor's ill-health is adversely affecting patient care.
68. You should also tell the Council about:
 - concerns you have that another doctor is not fit to practise or is not providing an appropriate standard of care
 - behaviour by another doctor that risks causing harm to patients.

- 69.** If a colleague raises concerns about your practice, you should respond constructively.

Concerns about premises, equipment, resources, policies and systems

- 70.** If you are concerned that patient safety may be at risk from inadequate premises, equipment or other resources, policies or systems, put the matter right if possible. In all other cases you should record your concerns and tell the appropriate body.

Your health

- 71.** You should register with an independent general practitioner so that you have access to objective medical care. You should not treat yourself⁴¹.
- 72.** Protect your patients, your colleagues and yourself by:
- following standard precautions and infection control practices
 - undergoing appropriate screening
 - being immunised against common serious communicable diseases where vaccines are available.
- 73.** You must tell the Council's Health Committee if you have a condition that may affect your practice, judgement or performance. The Committee will help you decide how to change your practice if needed. You should not rely on your own assessment of the risk you may pose to patients.⁴²

⁴¹ Refer to the Council's statement on *Providing care to yourself and those close to you*.

⁴² See *The HRANZ joint guidelines for registered healthcare workers on transmissible major viral infections* (a statement developed by the Council with other regulatory bodies).

- 74.** If you think you have a condition that you could pass on to patients, you must consult a suitably qualified colleague. Ask for and follow their advice about investigations, treatment and changes to your practice that they consider necessary.

Disclosing concerns to the Council

- 75.** You must inform the Council without delay if, anywhere in the world:
- you have been charged with or found guilty of a criminal offence
 - you have been suspended or dismissed from duties by your employer
 - you have resigned for reasons relating to competence
 - another professional body has made a finding against you as a result of 'fitness to practise' procedures.

Being open about concerns and restrictions on your practice

- 76.** If you are suspended from working, or have restrictions or conditions placed on your practice because of a concern about your competence, conduct or health, you must inform without delay:
- any other persons, or organisations, in which you are in partnership or association, or for whom you undertake medical work
 - any patients who would have a reasonable expectation to receive that information.
- 77.** You must also give patients honest and accurate answers to any questions they have about restrictions or conditions on your practice.

Supporting colleagues

- 78.** You should support colleagues who have problems with performance, conduct or health.

Accepting the obligation to maintain and improve standards

Principles

Act in accordance with relevant standards.

Keep your professional knowledge and skills up to date

Recognise, and work within, the limits of your competence.

Be committed to autonomous maintenance and improvement in your clinical standards.

Demonstrate reflectiveness, personal awareness, the ability to seek and respond constructively to feedback and the willingness to share your knowledge and to learn from others.

Accept a responsibility for maintaining the standards of the profession.

Applying your knowledge and experience to practice

79. You must be competent in each professional role you hold. You must follow relevant guidance, including the guidance published by the Council, and continue to develop your knowledge and skills. This applies to all doctors, and to all aspects of your medical practice including management, research and teaching.

80. Recognise and work within the limits of your competence.

Research

81. When designing, organising or carrying out research:

- make sure that a properly accredited research ethics committee has approved the research protocol, and that the research meets all regulatory and ethical requirements
- do not allow payments or gifts to influence your conduct
- do not make unjustified claims for authorship when publishing results
- report any concerns to an appropriate person or authority
- be honest and accurate in reporting the results of your research.

Maintaining and improving your professional performance⁴³

82. Work with patients and colleagues to maintain and improve the quality of your work and promote patient safety. In particular:

- take part in clinical audit, peer review and continuing medical education
- respond constructively to the outcome of audit, appraisals and performance reviews, undertaking further training where necessary
- contribute to inquiries and sentinel event recognition, analysis and reporting
- report suspected drug reactions using the relevant reporting scheme

43 See the Council's guidelines on *Continuing professional development and recertification*

- cooperate with legitimate requests for information from organisations monitoring public health
- participate in regular reviews and audit of the standards and performance of any teams of group in which you are a member, taking steps to remedy any deficiencies identified.

Keeping up to date

83. Keep your knowledge and skills up to date throughout your working life:

- familiarise yourself with relevant guidelines and developments that affect your work
- take part regularly in professional development activities that maintain and further develop your competence and performance
- adhere to and keep up to date with all laws and codes of practice relevant to your work.

Mentoring, teaching, training, appraising and assessing doctors and students⁴⁴

84. Teaching and the passing on of knowledge is a professional responsibility. When you are involved in teaching you should demonstrate the attitudes, awareness, knowledge, skills and practices of a competent teacher.

Supplementary guidance – Providing supervision⁴⁵

Make sure that all staff for whom you are responsible and who require supervision, including locums, less experienced colleagues, and international medical graduates who are new to practice in New Zealand are properly supervised. If you are responsible for supervising staff, you should make sure you supervise at an appropriate level taking into account the work situation and the level of competence of those being supervised.

44 See the Council's publication *Education and supervision for interns*.

45 See the Council's booklet on *Induction and supervision for newly registered doctors*.

Related documents

The guidelines contained in *Good Medical Practice* do not cover all forms of professional practice or discuss all types of misconduct that may bring your registration into question.

You should familiarise yourself with the series of statements and other publications produced by the Council. The Council's statements expand on points raised in this document. Some statements also cover issues not addressed in this document, such as internet medicine and alternative medicine.

Standards set by the Council⁴⁶

Below we list relevant Council statements and other publications.

Definitions

Clinical practice and non-clinical practice

Fitness to practise

Practice of medicine

Administrative practice

Non-treating doctors performing medical assessments of patients for third parties

Raising concerns about a colleague

Responsibilities of doctors in management and governance

Safe practice in an environment of resource limitation

⁴⁶ For the most recent versions of the statements, go to www.mcnz.org.nz under the heading News and Publications. New and updated statements are sent to all doctors with the Council's newsletter.

General subjects

Advertising

Complementary and alternative medicine

Cosmetic procedures

Disclosure of harm following an adverse event

A doctor's duty to help in a medical emergency

Ending a doctor-patient relationship

Good prescribing practice

Information, choice of treatment and informed consent

The maintenance and retention of patient records

Medical certification

Doctors and health related commercial organisations

Use of the internet and electronic communication

Telehealth

When another person is present during a consultation

Sexual boundaries in the doctor-patient relationship, a resource for doctors

Health

HRANZ Joint guidelines for registered health care workers on transmissible major viral infections

Providing care to yourself and those close to you

Cultural competence

Best practices when providing care to Māori patients and their whānau

Cultural competence

Other Council publications

Best health outcomes for Māori: Practice implications

Best health outcomes for Pacific peoples: Practice implications

Cole's Medical Practice in New Zealand

Continuing professional development and recertification

Deciding whether to make a competence referral

Doctors' health, a guide to how the Council manages doctors with health conditions

Education and supervision for interns, a resource for new registrants and their supervisors

Induction and supervision for newly registered doctors

The importance of clear sexual boundaries in the patient-doctor relationship, a guide for patients

Medical registration in New Zealand

What you can expect. The performance assessment

You and your doctor, guidance and advice for patients

Legislation and standards set by other agencies

The Code of Health and Disability Services Consumers' Rights gives rights to consumers, and places obligations on all people and organisations providing health and disability services, including doctors.

Traditionally the *Code of Ethics* for the medical profession in New Zealand is that of the New Zealand Medical Association.

The Health Information Privacy Code 1994 governs the collection and use of health information. A plain English edition has been published by the Office of the Privacy Commissioner and is available from www.privacy.org.nz

New Zealand is a signatory to the United Nations Convention on Persons with Disabilities. This convention is intended to protect the rights and dignity of persons with disabilities. The convention includes provisions to ensure that persons with disabilities enjoy full equality under the law, and have their rights and dignities protected.

Legislation places further legal obligations on doctors – consult your lawyer if you need advice about your legal obligations.

CHAPTER 2

New Zealand Medical Association Code of Ethics

CODE OF ETHICS FOR THE NEW ZEALAND MEDICAL PROFESSION

Preliminary Statement	47
Principles	49
Recommendations	50
RESPONSIBILITIES TO THE PATIENT (recommendations 1-30)	51
PROFESSIONAL RESPONSIBILITIES (recommendations 31-45)	56
RESEARCH (recommendations 46-53)	58
TEACHING (recommendations 54-57)	61
MEDICINE AND COMMERCE (recommendations 58-66)	62
MEDICINE AND INDUSTRIAL ACTION (recommendation 67)	64
DOCTORS IN A JUST AND CARING SOCIETY (recommendations 68-74)	64

Preliminary Statement

The profession of medicine has a duty to maintain and improve the health and wellbeing of the people, and to reduce the impact of disease. Its knowledge and consciousness must be directed to these ends. The medical profession has a social contract with its community. In return for the trust patients and the community place in doctors, ethical codes are produced to guide the profession and protect patients. This document represents a further stage in that evolutionary process.

This document does not purport to set out rigid, immutable rules. It revises the *Code of Ethics* and provides guidelines endorsed by the Council of the New Zealand Medical Association. The Code will be reviewed at regular intervals and, to this end, comment and feedback is invited.⁴⁷

The basis of the moral framework for medical practice has been developed gradually over several thousand years, and is therefore well established, whereas guidelines for professional behaviour must reflect the changing social and cultural environment in which doctors practise. The moral basis for practice has its expression through what is commonly termed medical ethics. Integral to an ethical basis for professional practice is the overriding acceptance of an obligation to patients,⁴⁸ and recognition of their autonomy.⁴⁹

47 Comments should be sent to: New Zealand Medical Association, PO Box 156, Wellington.

48 The NZMA strongly favours retention of the word “patient” because it reflects accurately the nature of the relationship between a doctor and the person seeking help.

49 The NZMA recognises no distinction, in terms of accountability, between conventional and alternative medicine when practised by a registered medical practitioner. All treatments should be subject to the same standards in respect of the rigour with which they are subjected to scientific testing and the ethics applicable to their use.

Standard treatises on medical ethics cite four moral principles: autonomy, beneficence, non-maleficence and justice. Autonomy recognises the rights of patients to make decisions for themselves. Beneficence requires a doctor to achieve the best possible outcome for an individual patient, while recognising resource constraints. Non-maleficence implies a duty to do no harm. (This principle involves consideration of risks versus benefits from particular procedures.) Justice incorporates notions of equity and of the fair distribution of resources. In New Zealand today, there is also an increasingly wide recognition of the principle of partnership – between doctor and patient; profession and society; and different cultures – as an important aspect of the ethos of professional practice.

The concept of the autonomy of doctors also needs to be considered, although this principle has always been tempered with common sense and recognition of the duty to act within the limits of one's own capabilities. Some ethicists are beginning to argue for a fifth principle, namely, the duty of doctors in some circumstances to recognise the need to work in collaborative groups, sharing their skills, experience and judgement with others. In today's world, doctors have an increased ethical responsibility to participate in reviewing formally their own and others' work to maintain standards of practice.

The concept of accountability, as applied to the medical profession, needs to encompass a widening set of relationships and contexts. An increasing number of statutory and commercial organisations interact with doctors in relation to issues of accountability. Increasingly, doctors are experiencing difficulty in balancing the requirements of their primary obligation to individual patients and families/whānau with their responsibilities to the wider community. Many commercial concepts, including that of intellectual property and that of contracting with various funding bodies, are challenging aspects of medical organisation and professional practice.⁵⁰

50 The concept of intellectual property and its protection is relatively recent. The patenting of inventions based on an individual's thinking and research is becoming widespread. The ethical issues related to this are at present being defined and the present code cannot encapsulate any established pattern.

Changes in the context of medical practice are reflected in a new section on Doctors in a Just and Caring Society to address the wider social responsibilities of doctors.

Faced with this complex and changing situation, the New Zealand Medical Association affirms its adherence to certain ethical principles. Patients have a legal right (under the Code of Health and Disability Services Consumers' Rights) to services that comply with ethical standards such as this *Code of Ethics*. While the Medical Council of New Zealand has developed *Good Medical Practice* as a foundation document for professional and legal standards, the Council recognises the New Zealand Medical Association's *Code of Ethics* as the key source of advice on ethics for the medical profession. The Association accepts responsibility for delineating standards of ethical behaviour expected of doctors in New Zealand and has consulted widely in the development of this Code.

The NZMA urges Members and all doctors to follow the standards set out below:

Principles

All medical practitioners, including those who may not be engaged directly in clinical practice, will acknowledge and accept the following Principles of Ethical Behaviour:

1. Consider the health and well being of the patient to be your first priority.
2. Respect the rights, autonomy and freedom of choice of the patient.
3. Avoid exploiting the patient in any manner.
4. Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity.
5. Protect the patient's private information throughout his/her lifetime, and following death, unless there are overriding considerations in terms of public interest or patient safety.

6. Strive to improve your knowledge and skills so that the best possible advice and treatment can be offered to the patient.
7. Adhere to the scientific basis for medical practice while acknowledging the limits of current knowledge and contributing responsibly to innovation and research.
8. Honour the profession, its values and its principles in the ways that best serve the interests of patients.
9. Recognise your own limitations and the special skills of others in the diagnosis, prevention and treatment of disease.
10. Accept a responsibility to assist in the protection and improvement of the health of the community.
11. Accept a responsibility to advocate for adequate resourcing of medical services and assist in maximising equitable access to them across the community.
12. Accept a responsibility for maintaining and improving the standards of the profession.

Recommendations

Given the complexities of doctor-patient relationships, and the increasing difficulties brought about by the need for rationing of resources and direct intervention of third-party providers of funding, no set of guidelines can cover all situations. The following set of recommendations is designed to convey an overall pattern of professional behaviour consistent with the principles set out above in the *Code of Ethics*.

RESPONSIBILITIES TO THE PATIENT

1. Doctors should ensure that all conduct in the practice of their profession is above reproach. Exploitation of any patient, whether it be physical, sexual, emotional or financial, is unacceptable and the trust embodied in the doctor-patient relationship must be respected.
2. Doctors, like a number of other professionals, are involved in relationships in which there is a potential or actual imbalance of power. Relationships between doctors and their patients or students fall within this category. The NZMA expects doctors to be familiar with Medical Council policy in relation to sexual boundaries in doctor-patient relationships. It is the responsibility of the doctor to maintain appropriate sexual boundaries with their patients.
3. The NZMA considers that breaching sexual boundaries with a current patient is unethical and that, in most instances, a breach of sexual boundaries with a former patient would be regarded as unethical. It is acknowledged that in some cases the patient-doctor relationship may be brief, minor in nature, or in the distant past. In such circumstances and where a sexual relationship has developed from social contact away from the professional environment, impropriety would not necessarily be inferred. Any complaints about a sexual relationship with a former patient therefore need to be considered on an individual basis before being regarded as unethical.
4. Doctors should ensure that patients are involved, as far as possible, in understanding the nature of their problems, the range of possible solutions, and the likely benefits, risks and costs, to assist them in making informed choices.

5. Doctors should, within reason, provide adequate information to their patients about their assessment and treatment options, including those not readily available.
6. Doctors should take reasonable steps to ensure that each patient receives appropriate available investigation into their complaint or condition, including adequate collation of information for optimal management.
7. Doctors should recommend only those diagnostic or screening procedures and treatments which seem necessary to assist in the care of the patient or the management of public health risks.
8. Doctors should ensure that patients are promptly informed of any adverse event that occurs during care for which the doctor has individual or direct overall responsibility.
9. Doctors should access patient health records only when there is an appropriate reason.
10. Doctors should ensure that information is recorded in an accurate and timely manner.
11. Doctors have an obligation to guard against unauthorised access to any health information they have collected pertaining to identifiable patients, including when transferring data.
12. Doctors should keep in confidence information derived from a patient, or from a colleague regarding a patient, and divulge it only with the permission of the patient or in those unusual circumstances when it is clearly in the patient's best interests or there is an overriding public good, including the risk of serious harm to another person. If there is any doubt, doctors should seek guidance from colleagues or an appropriate ethics committee.

- 13.** When appropriate, doctors should communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information. Patients should be made aware of this information sharing, which enables the delivery of good quality medical care. Where a patient expressly limits possession of particular information to one practitioner, this must ordinarily be respected. Patients should be made aware in advance, if possible, where there are limits to the confidentiality that can be provided.
- 14.** When it is necessary to divulge confidential patient information without patient consent, this must be done only to the proper authorities, and a record kept of when reporting occurred and its significance. Whenever possible, the patient should be informed this has occurred.
- 15.** Where a doctor is performing an assessment on behalf of a third party, the patient must be clearly informed of the identity of the third party, the purpose of the assessment and the limits of confidentiality. Where the assessment occurs in the context of a treating relationship, the patient should be made aware that the doctor is ethically obliged to provide a complete and professional report.
- 16.** Doctors should recognise the right of patients to choose their doctors freely.
- 17.** Doctors have the right, except in an emergency, to refuse to care for a particular patient. In any situation which is not an emergency, doctors may withdraw from or decline to provide care as long as an alternative source of care is available and the appropriate avenue for securing this is known to the patient. Where a doctor does withdraw care from a patient, reasonable notice should be given and an orderly transfer of care facilitated.

- 18.** When a patient is accepted for care, doctors should render medical service to that person without discrimination (as defined by the Human Rights Act).
- 19.** Doctors should recognise the needs of patients to receive culturally sensitive and competent care.
- 20.** Doctors should ensure that continuity of care is available to all patients, whether seen urgently or unexpectedly, or within a long-term contractual setting, and should assure themselves that appropriate arrangements are available to cover absence from practice or hours off duty, informing patients of these.
- 21.** Doctors should respect the right of a patient to have access to further management in situations where there is a moral or clinical disagreement about the most appropriate course to take.
- 22.** Doctors should recognise their own professional limitations and, when indicated, recommend to patients that additional opinions and services be obtained, and accept a patient's right to request other opinions. In making a referral to another health professional, so far as practical, the doctor should have a basis for confidence in the competence of that practitioner.
- 23.** When requested or when need is apparent, doctors should provide patients with information required to enable them to receive benefits to which they may be entitled.
- 24.** When undertaking remote consultation, a doctor should always exercise their judgement as to whether diagnosis and treatment by this means is appropriate. It is essential that the doctor and patient be able to reliably identify each other when engaging in remote consultation. The interaction should be documented in the patient's clinical record.

25. Doctors must be aware of statutory provisions and the codes of the Privacy Commissioner, the Human Rights Commissioner and the Health and Disability Commissioner, and the requirements of the Medical Council of New Zealand.
26. Doctors should accept that autonomy of patients remains important in childhood, chronic illness, ageing and in the process of dying.
27. When patients are not capable of making an informed choice or giving informed consent, doctors should consider any previously expressed preferences from the patient, the wishes of the family/whānau, guardian or other appropriate person, and consult colleagues before making management decisions, which may include recourse to the courts for determination.
28. Doctors should always bear in mind the obligation of preserving life wherever possible and justifiable, while allowing death to occur with dignity and comfort when it appears to be inevitable. In such inevitable terminal situations, treatment applied with the primary aim of relieving patient distress is ethically acceptable, even when it may have the secondary effect of shortening life.
29. Doctors should be prepared to discuss and contribute to the content of advance directives and give effect to them. In the case of conflicts concerning management, doctors should consult widely within the profession, with the family/whānau and, if indicated, with ethicists and legal authorities.
30. In relation to transplantation and requests for organ donation, doctors should accept that when death of the brain has occurred, the cellular life of the body may be supported if some parts of the body might be used to prolong or improve the health of others. They should recognise their responsibilities to the donor of organs that will be transplanted by disclosing fully to the donor or relatives the intent and purpose of the procedure.

In the case of a living donor, the risks of the donation procedures must be fully explained. Doctors are obliged to provide reassurance and support to all donors and/or their family/whānau members (in the case of a deceased donor). Doctors should ensure that the determination of death of any donor patient is made by doctors who are in no way concerned with the transplant procedure or associated with the proposed recipient in a way that might exert any influence upon any decisions made.

PROFESSIONAL RESPONSIBILITIES

- 31.** Doctors have both a right and a responsibility to maintain their own health and well being at a standard that ensures that they are fit to practise.
- 32.** Doctors should seek guidance and assistance from colleagues and professional or healthcare organisations whenever they are unable to function in a competent, safe and ethical manner. When approached in this way, doctors should provide or facilitate such assistance.
- 33.** Doctors should ensure that their personal conduct does not risk adversely affecting their reputation or that of the profession.
- 34.** Doctors have a responsibility to assist colleagues who are unwell or under stress. Doctors have a general responsibility for the safety of patients and should therefore take appropriate steps to ensure unsafe or unethical practices on the part of colleagues are curtailed and/or reported to relevant authorities without delay.
- 35.** Doctors should seek to improve their standards of medical care through continuing self-education and thoughtful interaction with appropriate colleagues.

36. Doctors have a responsibility to participate in reviewing their own practice and that of others, and to develop a critical attitude towards accepted and traditional practice.
37. When appropriate, doctors should make available to colleagues, with the knowledge of the patient, a report or summary of their findings and treatment relating to that patient.
38. When working in a team environment, doctors have a responsibility to behave co-operatively and respectfully towards team members.
39. Doctors should recognise that the doctor/patient relationship has a value and should not be disturbed without compelling reasons. Disruption of such a relationship should, wherever possible, be discussed in advance with an independent colleague.
40. Doctors should avoid impugning the reputations of colleagues. In normal circumstances, information about colleagues divulged as a part of quality assurance exercises (including peer groups) should remain confidential.
41. Doctors have an obligation to draw the attention of relevant bodies to inadequate or unsafe services. Where doctors are working within a health service they should first raise issues in respect of that service through appropriate channels, including the organisation responsible for the service, and consult with colleagues before speaking publicly.
42. Doctors should not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, no matter what offence the victim of such procedures is suspected, accused or guilty of.
43. Doctors should not use secret remedies.

- 44.** Advances and innovative approaches to medical practice should be subject to review and promulgation through professional channels (including ethics committees) and medical scientific literature. Doctors should accept responsibility for providing the public with carefully considered, generally accepted opinions when presenting scientific knowledge. In presenting any personal opinion contrary to a generally held viewpoint of the profession, doctors must indicate that such is the case and present information fairly.
- 45.** Doctors should exercise caution when using social media in a professional or private capacity. The risk of boundary violations in this area is considerable. All the ethical obligations set out in this Code, such as confidentiality and appropriate doctor-patient relationships, are applicable to social media.

RESEARCH

- 46.** Before initiating or participating in any clinical research, doctors should assure themselves that the particular investigation is justified in the light of previous research and knowledge. Any proposed study should reasonably be expected to provide the answers to the questions raised. There must be an assessment of predictable risks and burdens in comparison with foreseeable benefits to the participants or to others. All studies involving patients should be subject to the scrutiny of an appropriately constituted ethics committee, which must be independent of the investigator and the sponsor and of any kind of undue influence.
- 47.** Doctors should be assured that the planning and conduct of any particular study is such that it minimises the risk of harm to participants. When comparing active treatments, the control group should receive the best currently available and accepted treatment, in accordance with a reasonable body of medical opinion.

- 48.** A placebo-controlled trial may be ethically acceptable, even if an established therapy is available for a certain condition, under the following circumstances:
- › The established treatment has never been demonstrated to be effective by evidence-based criteria; or
 - › Where for compelling and scientifically sound methodological reasons its use is necessary to determine the efficacy or safety of a prophylactic, diagnostic or therapeutic method; or
 - › Where a prophylactic, diagnostic or therapeutic method is being investigated for a minor condition and the patients who receive placebo will not be subject to any additional risk of serious or irreversible harm; and
 - › There must be a robust mechanism for curtailing the trial if at any stage the treatment group is demonstrated (by adequate statistical methods) to be different from the placebo group.
- 49.** Patient consent for participating in clinical research (or permission of those authorised to act on their behalf) should be obtained in writing only after a full written explanation of the purpose of that research has been made, and any foreseeable health hazards outlined. Opportunity must be given for questioning and withdrawal at any time. When indicated, an explanation of the theory and justification for double-blind procedures should be given. Acceptance or refusal to participate in, or withdrawal from, a clinical study must never interfere with the doctor-patient relationship or access to appropriate treatment. No degree of coercion is acceptable.

- 50.** Boundaries between formalised clinical research and various types of innovation have become blurred to an increasing extent. Doctors retain the right to recommend, and any patient has the right to receive, any new drug or treatment which, in the doctor's considered judgement, offers hope of saving life, re-establishing health or alleviating suffering. Doctors are advised to document carefully the basis for any such decisions and also to record the patient's perception and basis for a decision. In all such cases the doctors must fully inform the patient about the drug or treatment, including the fact that such treatment is new or unorthodox, if that is so.
- 51.** In situations where a doctor is undertaking an innovative or unusual treatment on his or her own initiative, he or she should consult suitably qualified colleagues before discussing it with, or offering it to, patients. Doctors should carefully consider whether such treatments should be subject to formal research protocols.
- 52.** It is the duty of doctors to ensure that the first communication of research results is through recognised scientific channels, including journals and meetings of professional bodies, to ensure appropriate peer review. Participants in the research should also be informed of the results as soon as is practicable after completion.
- 53.** Doctors should not participate in clinical research involving control by the funder over the release of information or results, and should retain the right to publish or otherwise release any findings they have made. Doctors involved as principals in research should not participate if they do not have access to the base data. Negative as well as positive results should be published or otherwise made publicly available. Any dispute or ethical issue that may arise in respect of the research should be considered openly, eg, by consultation with the appropriate ethics committee.

TEACHING

54. Clinical teaching is the basis on which sound clinical practice is based. It is the duty of doctors to share information and promote education within the profession. Education of colleagues and medical students should be regarded as an ethical responsibility for all doctors.
55. Teaching involving direct patient contact should be undertaken with sensitivity, compassion, respect for privacy, and, whenever possible, with the consent of the patient, guardian or appropriate agent. Particular sensitivity is required when patients are disabled or disempowered, eg, children or those with impaired states of consciousness.
56. Whenever possible, patients should be given sufficient information on the form and content of the teaching, and adequate time for consideration, before consenting or declining to participate in clinical teaching. Refusal by a patient to participate in a study or teaching session must not interfere with other aspects of the doctor-patient relationship or access to appropriate treatment.
57. Patients' understanding of, or perspective on, their medical problems may be influenced by involvement in clinical teaching. Doctors should be sensitive to this possibility and ensure that information is provided in an unbiased manner, and that any questions receive adequate answers. It may be appropriate for the doctor to return later to address these issues.

MEDICINE AND COMMERCE

- 58.** Doctors should not allow their standing as medical practitioners to be used inappropriately in the endorsement of commercial products. When doctors are acting as agents for, or have a financial or other interest in, commercial organisations or products, their interest should be declared. If endorsing a product, doctors should use only the proper chemical name for drugs, vaccines and specific ingredients, rather than the trade or commercial name. Any endorsement should be based on specific independent scientific evidence, and that evidence should be clearly outlined.
- 59.** Doctors should accept that their professional reputation must be based upon their ability, technical skills and integrity. Doctors should advertise professional services or make professional announcements only in circumstances where the primary purpose of any notification is factual presentation of information reasonably needed by any person wishing to make an informed decision about the appropriateness and availability of services that may meet his or her medical needs. Any such announcement or advertisement must be demonstrably true in all respects and contain no testimonial material or endorsement of clinical skills. Qualifications not recognised by appropriate New Zealand statutory bodies should not be quoted.
- 60.** Doctors should exercise careful judgement before accepting any gift, hospitality or gratuity which could be interpreted as an inducement to use or endorse any product, equipment or policy. Doctors must not allow any gifts to influence clinical judgement. In all cases of doubt, advice should be sought from relevant professional organisations.

- 61.** Commercial interests of an employer, health provider or doctor must not interfere with the free exercise of clinical judgement in determining the best ways of meeting the needs of individual patients or the community, nor with the capacities of individual doctors to co-operate with other health providers in the interests of their patients, nor compromise standards of care or autonomy of patients in order to meet financial or commercial targets.
- 62.** Where potential conflict arises between the best interests of particular patients and commercial or rationing prerogatives, doctors have a duty to explain the issues and dilemmas to their patients. Doctors should state quite clearly what their intentions are and why they advocate particular patterns of diagnosis, treatment, referral or resource use. Commercial arrangements that have the potential to impinge on the patient's care should be declared to the patient.
- 63.** Doctors who provide capital towards health services in the private sector are entitled to expect a reasonable return on investment. Where there may be a conflict of interests, the circumstances should be disclosed and open to scrutiny.
- 64.** Like all professionals, doctors have the right to fair recompense for the use of their skills and experience. However, motives of profit must not be permitted to influence clinical judgement.
- 65.** Doctors should insist that any contracts into which they enter, including those involving patients, be written in clear language such that all parties have a clear understanding of the intentions and rules.
- 66.** Doctors who find themselves in a potentially controversial contractual or commercial situation should seek the advice of a suitable colleague or organisation.

MEDICINE AND INDUSTRIAL ACTION

- 67.** It is recognised that certain extreme circumstances may lead to consideration of industrial action by doctors. Such action may compromise care to individual patients, which is contrary to one of the ethical principles, so a decision to take industrial action must be based on a reasonable expectation that the desired outcome will result in improved patient care and safety. A doctor's primary duty is to their patient, but the secondary duty to all other patients may mean that action has to be considered. In the case of industrial action, doctors should take care to minimise any detrimental effect on patient care. Services to preserve life and prevent permanent disability must always be provided. Self interest alone, by individuals or the profession, is not an ethical basis on which to take action.

DOCTORS IN A JUST AND CARING SOCIETY

- 68.** Doctors should accept a share of the profession's responsibility toward society in matters relating to the health and safety of the public, health promotion and education, and legislation affecting the health or well being of the community.
- 69.** Doctors have a role in ongoing efforts to achieve health equity. This includes working collaboratively with public health and other colleagues to shape services and programmes that address health inequities and the broader social and environmental factors that influence health and well being.
- 70.** While doctors have a primary responsibility to the individual patient, they have a concurrent responsibility to all other patients and the community. Doctors therefore have an ethical responsibility to manage available resources equitably and efficiently. Wherever possible, doctors should use their influence to advocate for appropriate resources to improve health outcomes for their patients and populations.

- 71.** Rationing of resources must be open to public scrutiny and points of conflict identified and presented in a rational, non-biased manner to the public.
- 72.** In an environment of resource constraint, priorities need to be assigned to achieve the wisest use of limited resources. Doctors have a duty to work with others in developing rules to set priorities. Doctors also have a duty to abide by such rules, provided the rules conform to ethical principles. The rules should be just, open, valid and reliable.
- 73.** Doctors should recognise the responsibility to assist courts, commissioners, commissions and disciplinary bodies, in arriving at just decisions. When doctors are providing expert opinions, the doctor has a duty to assist the body impartially on relevant matters and to confine such opinion within their area of expertise.
- 74.** Doctors should certify or give in evidence only that which has been personally verified when they are testifying as to circumstances of fact.

This Code will undergo major review by May 2019.

However, minor changes may be introduced before then in response to further alterations in the environment in which medicine is practised. To this end, the NZMA welcomes feedback and comment on this Code at any time.

CHAPTER 3

The doctor-patient relationship

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Cite this as Hawken SJ, Wilson H. The doctor-patient relationship. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	67
Qualities of an effective doctor-patient relationship	68
Modern undergraduate training	69
Skills in the doctor-patient relationship	70
The importance of listening	71
Patient-centred clinical medicine	71
Monitoring your consultation style	73
Challenging clinical interactions	74
Sexual boundaries	78
Use of chaperones	79
Ending a relationship	79

Introduction

Professional relationships are central to the practice of medicine and to achieving good clinical outcomes. The doctor-patient relationship is the felt experience of the patient and doctor; their ongoing thoughts, feelings and behaviours in response to each other. Most practitioners derive a deep sense of satisfaction through respectful and effective relationships with their patients.⁵¹ Many relationship skills can be learned through role modelling, but specific educational interventions are required for higher levels of competence.⁵² Clinical relationships need to be understood and developed effectively, as they can also be a source of great discomfort and even harm to both patients and doctors.

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

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

51 Mendoza MD, Smith SG, Eder MM, Hickner J. The seventh element of quality: the doctor-patient relationship. *Family Medicine*. 2011;43(2):83–9.

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

Qualities of an effective doctor-patient relationship

Professionalism is the basis of medicine's relationship to society and can be viewed as a social contract.⁵³ As part of this contract, doctors have an obligation to maintain their competence. In addition, doctors are expected to be trustworthy, moral, honest, accountable and compassionate. They need to work in the best interest of the patient and to maintain their own professional standards.

Although the clinical context is rapidly changing, what patients want from their doctor is clear – caring, kindness, courtesy and compassion.⁵⁴ General practitioners often focus on a 'holding relationship', which aims to maintain a trusting, reliable and supportive relationship, often without the expectation of a cure.⁵⁵

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

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

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

53 Cruess RL, Cruess SR. Expectations and obligations: professionalism and medicine's social contract with society. *Perspectives in Biology & Medicine*. 2008;51(4):579–98.

54 Youngson R. *Time to Care: How to love your patients and your job*. Raglan: Rebelheart Publishers; 2012.

55 Cocksedge S, Greenfield R, Nugent GK, Chew-Graham C. Holding relationships in primary care: a qualitative exploration of doctors' and patients' perceptions. *British Journal of General Practice*. 2011;61(589):e484–91.

Trust is an important quality in the therapeutic relationship. Usually, however, trust is not explicitly negotiated with the patient. Given their clinical situation, many patients are quite vulnerable. Their decision to trust their doctor is sometimes based on only a brief interaction. However, trust can be developed and deepened if doctors show an early interest in the patient, display sensitivity to patient emotion, give time, build alliances and for short periods of time step outside their prescribed role (for example, using shared humour).⁵⁶ Doctors who encourage patients to talk, check understanding, provide information and use humour are less likely to receive complaints.⁵⁷

Modern undergraduate training

Older doctors usually have their own particular style of consulting, largely learned through trial and error. While many have an effective bedside manner, the research on consulting skills indicates that good communication can be taught and learned and that it is not necessarily an innate or intuitive skill.⁵⁸ For these reasons, most medical schools now include consultation training as part of their clinical skills programmes. Students are taught about the structure of each consultation and how to use ‘micro-communication’ skills (introductions, open and closed questions, exploring the patient’s ideas, mini-summaries and so on).⁵⁹

Further, many medical schools are now also focusing more specifically on particular skills and competencies within the doctor-patient relationship.

56 Skirbekk H, Middelthon A-L, Hjortdahl P, Finset A. Mandates of trust in the doctor-patient relationship. *Qualitative Health Research*. 2011;21(9):1182–90.

57 Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. Physician-patient communication. The relationship with malpractice claims among primary care physicians and surgeons. *JAMA*. 1997;277(7):553–9.

58 Kurtz S, Silverman J, Benson J, Draper J. Marrying content and process in clinical method teaching: Enhancing the Calgary-Cambridge guides. *Academic Medicine*. 2003;78(8):802–9.

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

Undergraduate training is now more explicit that students need to be able to attend effectively to the emotional content of each doctor-patient relationship, are aware of their own feelings and the links between their feelings and clinical decisions, can review and reflect effectively on their interactions with various patients including biomedical and relationship aspects and can learn and grow from interpersonal issues and challenges within modern clinical practice.

Skills in the doctor-patient relationship

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

These competencies include the capacity to:

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

A benchmark competency for doctors is their capacity for effective listening. This is a sentinel skill that reflects the doctor's underlying values and skills as listed above.

The importance of listening

The three major functions of listening are to make an accurate diagnosis, to develop and maintain a high-quality doctor-patient relationship and to act as a healing and therapeutic agent.⁶⁰ Adler, for example, has researched the “socio-physiology of caring”, where empathic listening can physiologically improve patients' muscle tension and blood pressure.⁶¹ It can be profoundly helpful if the doctor is fully present and engages with the patient's story and situation. ‘Being heard’ in this way can help the patient make better sense of their illness.

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

Patient-centred clinical medicine

Modern undergraduate training programmes are based on what is known as a ‘patient-centred’ approach to clinical practice. In brief, the underlying knowledge basis of modern practice is known as biomedicine, a relatively new approach to individual illness that emerged in the sixteenth and seventeenth centuries. This particular medical model has, of course, been very powerful, affording an advanced understanding of the problems of the human body.

60 Jagosh J, Boudreau J, Steinert Y, MacDonald M, Ingram L. The importance of physician listening from the patients' perspective: enhancing diagnosis, healing and the doctor-patient relationship. *Patient Education and Counseling*. 2011;85 (3):369–74.

61 Adler HM. The sociophysiology of caring in the doctor patient relationship. *Journal of General Internal Medicine*. 2002;17(11):883–90.

In the last 50 or so years, there is also increasing evidence that communication skills within each consultation will improve the health outcomes of patients.⁶² Such evidence is the rationale for emerging models of clinical practice such as the patient-centred clinical method.⁶³

This clinical model differentiates between the ‘disease’ (symptoms, pathophysiology, diagnosis, investigations and treatment) and the ‘illness’ (the patient’s ideas, feelings, effect on daily life, the meaning of being unwell, any anguish or suffering), or in other words, the personal experience of illness.⁶⁴ While the patient’s disease is never really ‘separate’ to that person, this conceptual differentiation is useful as it affords some objectivity for both doctor and patient. The doctor has a body of knowledge about each disease that usually helps to predict the clinical course. The patient’s concerns are validated and justified as their problem is now legitimised.

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

Being patient-centred does not imply giving patients what they want; instead, the name emerged as a reaction against older more paternalistic styles of biomedical practice where doctors made unilateral decisions. The patient-centred model of consulting has been very influential, even if most senior doctors have not been explicitly trained in its use.

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

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

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

Monitoring your consultation style

Another feature of modern undergraduate medical training is the emphasis on careful review of clinical work. Reflection involves “thoughtfully considering one’s own experiences in applying knowledge to clinical practice, while being coached by professionals within the discipline”.⁶⁵ Most medical students are now required to analyse and review their consulting skills as well as to write about or discuss their seminal learning experiences. These activities are known as ‘reflection on action’, as they usually occur after the event. The overall goal is ‘reflection in action’, the capacity for increased awareness of the ebb and flow within each consultation, whether in hospital practice or in primary care.

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

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

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

Balint groups emerged in the UK in the 1950s when Dr Michael Balint developed groups for general practitioners to discuss their more ‘difficult’ or troubling patients.⁶⁶ The method itself has since evolved considerably, and Balint groups are now becoming more popular, especially using multi-disciplinary groups.⁶⁷ Some medical schools in the UK and Europe now use these groups within undergraduate training for medical students.

Mentoring and supervision are one-to-one methods of clinical review and support. Mentoring is usually with a more senior colleague who can help a junior enter their chosen field, provide support when doctors are under stress or help a doctor start work in a new country.⁶⁸ Supervision is usually with a psychotherapist and is more focused on the nuances of the doctor-patient relationship. Because the therapist does not have medical training, there is less chance of becoming side-tracked by biomedical details. Doctors can also improve their psychological understanding of patients through this ongoing method of professional support.⁶⁹ All these methods are aimed at better understanding of quite diverse doctor-patient relationships within modern clinical practice.

Challenging clinical interactions

These methods of reflective practice are useful when clinical interactions are challenging to the doctor. Historically, such interactions were usually attributed to the patient. For example, there is a thread of literature from the UK about the ‘heartsink’ patient, where the doctor’s heart ‘sinks’ to the floor when consulting with, or even thinking about, a particular patient.⁷⁰

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

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

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

69 Wilson H. Self-care for GPs: The role of supervision. *New Zealand Family Physician*. 2000;27(5):51–7.

70 Mathers NJ, Gask L. Surviving the ‘heartsink’ experience. *Family Practice*. 1995;12(2):176–83.

While a few patients will prove problematic for almost all doctors, most patients who are labelled in this way illustrate specific problems within the doctor-patient relationship.

There are links between doctors' perception of their numbers of 'difficult' patients and an increased incidence of burnout.⁷¹

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

'Challenging' patients tend to confront the doctor's assumed authority, while 'clinging' patients make unrealistic demands on the doctor's time or potential effectiveness. 'Self-destructive' patients include those with alcohol, drug and gambling problems; many doctors find it difficult to acknowledge that they are relatively powerless to intervene.⁷² Cultural barriers or other factors preventing adequate communication can also induce feelings of frustration and impotence.

Doctors can find such patients to be 'troublesome', perhaps because the patient is not behaving in the 'proper way' as a patient or because the doctor's internalised expectations of being competent and effective are not being met or realised.

71 An P, Rabatin J, Manwell L. Burden of difficult encounters in primary care: data from the minimizing error, maximizing outcomes study. *Arch Intern Med.* 2009;169:410–14.

72 Clark R, Croft P. Heartsink patients. In: Clark R, Croft P, editors. *Critical reading for the reflective practitioner.* Oxford: Butterworth-Heinemann; 1998. pp. 267–91.

Identifying and analysing why each interaction is perceived to be ‘challenging’ or ‘heartsink’ can be extraordinarily helpful, both for the doctor and for the patient.⁷³ In brief, challenging interactions are due therefore to a complex interaction of factors involving:

- the doctor – being less experienced, burnout, depression, low job satisfaction
- the patient – personal attitudes, illness behaviour and culture
- the illness – complexity, chronic illness and whether the disease is treatable
- social factors – isolation, relationships, economic and health system issues.

Balint groups and supervision are particularly useful methods of reflection and support, as they focus directly on the doctor-patient relationship. Acknowledging that some patients are challenging and disruptive to the doctor’s self-esteem and equilibrium is helpful, as without the benefit of such insight, some doctors will avoid engagement with the patient. While this can lead to poor outcomes for patients, the doctor also misses out on their usual sense of purpose and meaning that emerges from productive therapeutic relationships.⁷⁴ In this way, reflective practice about these challenging or ‘heartsink’ patients can also help to avoid burnout and compassion fatigue.

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

74 Suchman AL, Matthews DA. What makes the patient-doctor relationship therapeutic? Exploring the connexional dimension of medical care. *Annals of Internal Medicine*. 1988;108(1):125–30.

A recent randomised prospective study reported on doctors' use of the BREATHE OUT model (Table 1), an efficient and effective method of improving their clinical satisfaction.⁷⁵

Table 1. The BREATHE OUT model.

Pre-consultation check list: BREATHE

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

Post-consultation check list: OUT

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

75 Edgoose J, Regner C, L Z. BREATHE OUT: A randomized controlled trial of a structured intervention to improve clinician satisfaction with 'difficult' visits. J Am Board Fam Med 2015;28:13–20.

Patients with stress-related symptoms can be particularly challenging to doctors and to the therapeutic relationship. Such patients usually present with multiple somatic complaints; despite investigations, no organic pathology is found. While many patients can be educated about links between their stress and their symptoms, most doctors have a small group of patients whose management is more difficult.⁷⁶

Unnecessary investigations often emerge from these unsatisfactory consultations, illustrating what is known as ‘somatic fixation’ where both doctor and patient collude in avoiding possible links between symptoms and the patient’s personal and social context. Learning how to approach the ‘somatising’ patient is an important clinical skill in all areas of medical practice. Despite initiatives now in medical schools to better equip students with particular skills, most doctors require specific postgraduate training on strategies to manage the consultation if they are to function effectively for these patients.⁷⁷

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

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

Sexual boundaries

Given the power imbalance between doctor and patient, setting and maintaining appropriate professional boundaries is the responsibility of the doctor. A sexual relationship with a patient is never acceptable, as it violates the trust in the relationship and is harmful to both parties.

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

77 Stone L, Clarke DM. Somatising disorders: untangling the pathology. *Australian Family Physician* 2007;36(3):234–9.

The Medical Council provides clear guidelines about sexual boundaries,⁷⁸ and any doctor who is sexually attracted to a patient is strongly advised to admit to the problem and to seek help from a trusted colleague. As professional role boundaries are complex, both medical students and doctors need ongoing education and support in this area of professional practice.^{79, 80}

Use of chaperones

It is recommended best practice to offer a chaperone for all intimate examinations. A chaperone acts as an independent person within the consultation, for both the safety of the doctor and of the patient. Patients may also request their support person to be present, and they can provide practical and emotional support to the patient. Many colleges now recommend that a notice is placed in clinic rooms informing patients of their right to have a chaperone present. All medical students and some doctors are required, as a condition of their practising certificate, to have a chaperone present at all times when intimate examinations are conducted.⁸¹

Ending a relationship

Occasionally, the therapeutic relationship may become too damaged to continue. The patient and the doctor must be clear about the reasons for ending the relationship, and the transfer of care needs to be managed carefully.

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

78 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Importance-of-boundaries.pdf>

79 White GE. Setting and maintaining professional role boundaries: an educational strategy. Medical Education. 2004;38(8):903–10.

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

81 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/When-another-person-is-present-during-a-consultation.pdf>

In some situations, expert medical and legal advice is helpful, but cessation of care cannot occur if the patient needs acute or emergency medical help. Further models around ending a relationship in the general practice setting are described by Stokes.⁸² In-depth guidance is outlined by the Medical Council.⁸³

More commonly, however, doctors end their therapeutic relationships with their patients when they sell or pass on their practice to another doctor, whether in specialist or general practice. The process of ending a practice needs to be respectful of the mutual investment in the medical relationship from both doctor and patient. This implies that the doctor carefully advises their patients about what is happening and introduces their replacement.

In summary, the doctor-patient relationship is central to the practice of medicine. Clinical relationships require as much focus and attention as technical competence and biomedical details. The outcomes of this focus on relationship are improved clinical outcomes, enhanced practitioner satisfaction and a greater sense of professional wellbeing.

82 Stokes T, Dixon-Woods M, McKinley RK. Ending the doctor-patient relationship in general practice: a proposed model. *Family Practice*. 2004;21(5):507-14.

83 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Ending-a-doctor-patient-relationship.pdf>

CHAPTER 4

Interdisciplinary collaboration: working in teams for patient care

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Cite this as McKinlay E, Bycroft J, Darlow B, Gray B, Morris C, Pullon S. Interdisciplinary collaboration: working in teams for patient care. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	83
Collaboration – always needed?	84
What is collaboration?	85
Collaborative teamwork	86
The patient as a member of the care team	88
Leading and following: roles in collaborative teams	89
Benefits of collaboration	92
Interdisciplinary collaboration in primary care	95
Measures to increase interdisciplinary collaboration	96
Tools and enablers for collaborative interdisciplinary care	97
Conclusion	98

Introduction

New Zealand health care relies on the skills of many health and other professionals. For those with long-term or complex needs, a culturally safe focus on the patient (and family and whānau) is needed along with collaborative care provided by a range of health disciplines. This dual focus leads to patient-centred, person-focused care.^{84,85} Doctors have a key role in enabling a coordinated and collaborative approach,⁸⁶ because interdisciplinary models of team care result in safer, higher-quality care for patients, providers and systems.^{87,88}

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

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

85 Starfield B. Is patient-centered care the same as person-focused care? *Perm J* 2011;15:63–7

86 Cohen DJ, Davis M, Balasubramanian BA, Gunn R, Hall J, Peek C, et al. Integrating behavioral health and primary care: consulting, coordinating and collaborating among professionals. *J Am Board Fam Pract* 2015;28:S21–S31.

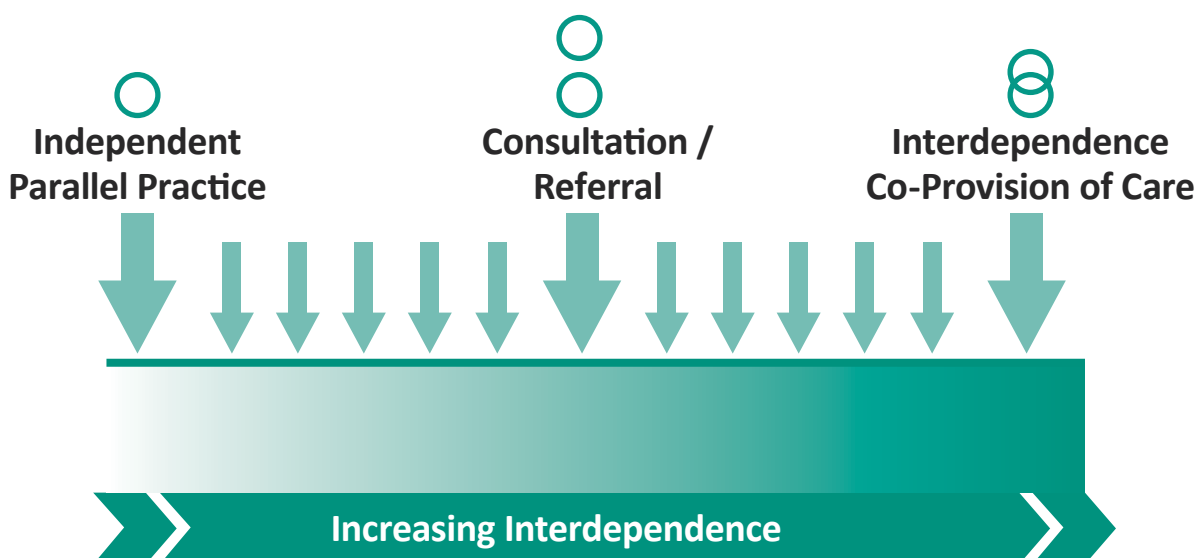
87 Gawande A. How do we heal medicine? *Ted Talks* 2012; [http://www.ted.com/talks/atul_gawande_how_do_we_heal_medicine.html]. cited 29/4/17]

88 Paterson R. Lessons from complaints: implications for medical education. *NZ Med J* 2010;123:6–11.

Collaboration – always needed?

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

Figure 1. The spectrum of collaboration.⁸⁹



89 Oandasan I, Baker G, Barker K, Bosco C, D'Amour D, Jones L, et al. Teamwork in healthcare: promoting effective teamwork in healthcare in Canada. Ottawa, Ontario: Canadian Health Services Research Foundation; 2006.

What is collaboration?

While the terms ‘team work’ and ‘collaboration’ are often used in the same breath, they are not the same. Individuals of different disciplines may provide care to the same patient and consider themselves as part of a team. However, for teamwork to be effective, there must be collaboration. The following definition of interdisciplinary collaboration describes partnership and mutual decision making within a working relationship: “An active and ongoing partnership often between people from diverse backgrounds with distinctive professional cultures and possibly representing different organisations or sectors, who work together to solve problems or provide services.”⁹⁰

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

Collaborative interdisciplinary care aligns with New Zealand models of health care delivery, notably Te Whare Tapa Whā, with the four cornerstones of health encompassing all facets of wellbeing: taha tinana (physical health), taha wairua (spiritual health), taha whānau (family health) and taha hinengaro (mental health).⁹¹ This is particularly important when clinicians work in partnership with individuals and communities to enable improved Māori health outcomes (see [Chapter 17 – Cultural competence, cultural safety and health equity in medical practice in Aotearoa/New Zealand](#) and [Chapter 18 – Māori and health](#)). Collaborative interdisciplinary care is also supported in the 2016 refresh of the New Zealand Health Strategy, which defines five strategic themes including the theme of one team. One team means “operating as a team in a high-trust system that works together with the person and their family and whānau at the centre of care”.⁹²

90 Morgan S, Pullon S, McKinlay E. Observation of interprofessional collaborative practice in primary care teams: an integrative literature review. *Int J Nurs Stud* 2015;52:1217–1230.

91 Durie M. A Maori perspective of health. *Soc Sci Med* 1985;20:483–486.

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

The focus on the person and their family and whānau is also a key aspect of collaboration and includes shared decision making between all parties and a consensus regarding goals of treatment and care.^{93,94}

The concept of collaborative interdisciplinary care is enshrined in the Code of Health and Disability Services Consumers' Rights in Right 4: Right to Services of an Appropriate Standard, which requires in point 5 that "Every consumer has the right to co-operation among providers to ensure quality and continuity of services".⁹⁵

Collaborative teamwork

Collaborative interdisciplinary teams explicitly commit to cooperate in order to meet shared goals, including those of the patient and family and whānau. Members allow their activity to be directed through shared decision making or by the team leader.⁹⁶ These types of teams are "characterised by a greater interdependence, jointly defined goals and client-centred plans"⁹⁷ giving recognition and value to the expertise and perspectives of other disciplines.⁹⁸ All are reliant on the skills of others to achieve the necessary goals of treatment or care. This means the unique skills of each discipline are best utilised and common values and skills affirmed by all. Communication equity means all disciplines are able to contribute to care and speak up about quality and safety concerns.

93 Stiggelbout A, Weijden T, Wit MD, Frosch D, Légaré F, Montori V, et al. Shared decision making: really putting patients at the centre of healthcare. *BMJ* 2012;344:e256.

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

95 [http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-\(full\)](http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full))

96 See footnote 89.

97 Solheim K, McElmurry BJ, Kim MJ. Multidisciplinary teamwork in US primary health care. *Soc Sci Med* 2007;65:622–634.

98 Drinka T, Clark P. Health care teamwork: interdisciplinary practice and teaching. Westport, Connecticut: Auburn House; 2000.

We all recognise collaborative team work when it's working well. Here are two examples:

- The Emergency Department team is undertaking resuscitation. The team of health professionals (most often doctors and nurses) train together and know and trust each other. Each person has a particular role and yet there is flexibility, with some skills able to be undertaken by a range of health professionals (for example, chest compressions, cannulation) and others that are discipline specific (for example, intubation). The team measures success by the delivery of timely, competent and appropriate resuscitation procedures undertaken by a team who each undertook their roles in a seamless, coordinated manner, irrespective of the outcome.
- The community-based team is working with an older person with arthritis, type 2 diabetes and obesity who has pain and immobility and is struggling to remain independent at home. The team might include a mix of the following: diabetes nurse educator, dietitian, general practitioner, pharmacist, physiotherapist, primary health care nurse and possibly an endocrinologist, exercise or sports instructor, occupational therapist and rheumatologist. Ideally, it would include the patient and the family, whānau or close supporters in the patient's social network. Roles may be organised by skills, possibly performed by one of several disciplines (prescribing, home assessment) or by the support or care able to be provided by a particular discipline (physiotherapy for maximising mobility and function, occupational therapy for home modification, nursing for mobilising family support). The team measures their success by effectively forming a partnership with the patient (and family and whānau) in order to meet their goals and, when possible, to appropriately self-manage. If this is not possible, the team will continue to support the patient by putting other measures in place.⁹⁹

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

In contrast, in some so-called multi-disciplinary teams, clinicians from different disciplines are each involved in the patient's care but report back on referrals solely to the senior doctor leader, who then unilaterally directs patient care. The limitation of this model is not that the senior doctor is the team leader per se – they may indeed be the best person to lead the team at a particular time – but that there is little or no opportunity for sharing wisdom or shared decision making. This might be appropriate in some settings (perhaps in the consultation/referral stage in the spectrum of collaboration), but the multi-disciplinary team process has significant limitations wherever ongoing complex care is needed. Not only does it inadvertently restrict possible alternative quality options for patients, but it can also sideline or ignore members of other disciplines or disempower junior staff, making it hard for them to contribute to care or speak up, even about issues of basic safety.¹⁰⁰

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

The patient as a member of the care team

There are many benefits of involving patients within the care team. Partnering with the patient includes undertaking joint decision making leading to an increased likelihood of behaviour change, concordance with health care decisions,

patient activation (skills knowledge and confidence to manage one's own health) and greater adoption of self-management skills.^{101,102,103,104}

100 Lingard L, Espin S, Whyte S, Regehr G, Baker G, Reznick R, et al. Communication failures in the operating room: an observational classification of recurrent types and effects. *Qual Saf Health Care* 2004;13:330–334.

101 See footnotes [94](#) and [99](#).

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

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

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

The Health Quality & Safety Commission New Zealand actively endorses patients and family and whānau as members of the health care team. They state: “enabling consumers/patients to become equal partners in care requires support that builds consumers’/patients’ self-efficacy, self-awareness, confidence and coping skills”.¹⁰⁵ Wherever possible, patients need to be able to both establish and revisit their role within the team; some may choose at some times to be passive receivers of proffered treatment but at other times to reject or substantially alter management recommendations.

That is not to say that patients either need or should be expected to take sole responsibility for all care decisions, especially when wellbeing and ability to self-manage fluctuates (for example, with multi-morbidity, mental health conditions and palliative care).^{106,107} Patients and families are entitled to hear clearly expressed, thoughtfully considered recommendations for care from health professionals, particularly in complex situations where there is no single right answer.

Leading and following: roles in collaborative teams

Different disciplines can take the lead or share leadership within a distributed model that acknowledges “no one leader can provide all the leadership in any complex situation”.¹⁰⁸ Teams need good leaders, and teams need good followers.

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

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

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

108 See footnote [98](#).

Knowing when it is appropriate to take the leader role and when it is time to be a supporting member of a team is a key skill in being a good team player and ensures effective communication and that good team processes are followed by everyone.

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

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

Knowing what your own role is in a team (such as leader or the person responsible for a particular task) is just as important as knowing what others' roles are, and this is particularly so when the composition of teams change or teams form for time-limited periods. Roles may be defined by the specific skill sets disciplines possess, but where skills are held in common (communication or common procedural skills), roles need to be negotiated.¹⁰⁹

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

109 Hall P, Weaver L. Interdisciplinary education and teamwork: a long and winding road. *Med Educ* 2001;35:867–875.

It is only by discussing and practising how the different team members each contribute to patient care that role clarification is achieved. Role clarification is one of the most important requirements of a well-functioning team. Once it is achieved, the team is well placed to swing into action in any given situation, often with just a few well-chosen words, as each member anticipates and trusts in each other's respective roles.¹¹⁰

A common concern when a team of disciplines is involved is the issue of who is ultimately responsible for the patient's care. In the past, doctors have assumed varying degrees of responsibility for the practice of other clinicians involved in patient care. The regulatory framework is now clear that each professional is responsible for their work within their scope of practice.¹¹¹

Student health professionals (including medical students) hold a limited responsibility for patient care, as they are working under the direct supervision of a more experienced colleague. However, they can be included within the team for the purposes of learning.^{112,113,114} Once junior staff are registered, they must work within a scope of practice commensurate with their qualification and level of experience, reporting to more senior colleagues but still responsible for their own practice within their expected scope. Adequate communication and collaboration with all health professional colleagues is also expected and essential practice. The Health and Disability Commission reports more frequently on a breakdown of collaboration between professionals than on the responsibility of the individual clinicians being deficient.¹¹⁵

110 Vyt A. Interprofessional and transdisciplinary teamwork in health care. *Diabetes Metab Res Rev* 2008;24:S106–S109.

111 Health Practitioners Competence Assurance Act 2003, No. 48 (18 Sept 2003).

112 Young J, Egan T, Williamson M, Jaye C, Kenrick K, Ross J, et al. An exercise to map patient-centred care networks. *Clin Teach* 2016;13:1–3.

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

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

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

Benefits of collaboration

The Health Quality & Safety Commission New Zealand supports collaboration by naming teamwork and communication as one of seven domains of the New Zealand Health and Safety Capability Framework. This domain is defined as “working with others across professional, organisational and cultural boundaries to achieve shared quality and safety goals”.¹¹⁶ The Commission has found that interdisciplinary collaboration reduces clinical error as well-functioning teams make fewer mistakes than individuals.¹¹⁷ It also leads to more timely referrals, more effective resource allocation, better use of disciplinary skill sets and more holistic care provision, and patients are less likely to fall between services. Taken together, patients have higher levels of satisfaction and are more likely to have better access to health care and improved self-management skills.^{118,119} Staff also enjoy higher levels of work satisfaction, and efficiency savings are likely to occur.¹²⁰ This approach benefits not only our patients, but also health professionals and health organisations.

Collaborative teams do not happen by chance. Within New Zealand, a number of factors have been shown to contribute to successful interdisciplinary teams including skillful leadership in each discipline, readiness for an interdisciplinary culture, commitment to change, interdisciplinary respect and opportunity for trust to develop between individuals and across the team.¹²¹

116 See footnote [105](#).

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

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

119 Orchard C, Curran V, Kabene S. Creating a culture for interdisciplinary collaborative professional practice. *Med Educ Online* 2009;10(11), 1–13.

120 Richards DA, Hill JJ, Gask L, Lovell K, Chew-Graham C, Bower P, et al. Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *BMJ* 2013;347:f4913.

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

Physical geography (including co-location or not of disciplines or services) also impacts on ability to work collaboratively. Effective building design positively influences team members' ability to talk frequently and informally and thus gain trust and confidence in each other.¹²² Organisational structures can support institutional change or lead to the formation of cross-disciplinary arrangements such as the Integrated Health Care Framework for Pharmacists and Doctors, which endorses doctors and pharmacists working together.¹²³ All these things result in positive "alterations to existing health professionals' values, socialisation patterns and workplace structures".¹²⁴

Disciplines now specifically define interdisciplinary competencies^{125,126,127,128} with increasing examples of these competencies being taught through interprofessional education programmes at pre-registration level in New Zealand.^{129,130,131,132}

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

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

123 https://www.nzdoctor.co.nz/media/6993749/integratedhealthcareframework_consultationdraft.pdf

124 See footnote 109.

125 <http://www.nursingcouncil.org.nz/content/download/263/1205/file/Nursing%20comp%20for%20RN.pdf>

126 <https://www.physioboard.org.nz/sites/default/files/PhysiotherapyPractice%20Thresholds3.5.16.pdf>

127 http://www.amc.org.au/files/d0ffcecd9608cf49c66c93a79a4ad549638bea0_original.pdf

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

129 Darlow B, Coleman K, McKinlay E, Donovan S, Beckingsale L, Gray B, et al. The positive impact of interprofessional education: a controlled trial to evaluate a programme for health professional students. *BMC Med Educ* 2015;15:98.

130 Pullon S, McKinlay E, Beckingsale L, Perry M, Darlow B, Gray B, et al. Interprofessional education for physiotherapy, medical and dietetics students: a pilot programme. *J PrimHealth Care* 2013;5:52–58.

131 Pullon S, Wilson C, Gallagher P, Skinner M, McKinlay E, Gray L, et al. Transition to practice: can rural interprofessional education make a difference? A cohort study. *BMC Med Educ* 2016;16:154.

132 McKinlay E, Pullon S. Back to back: having interprofessional education during the undergraduate years is essential for building teamwork skills in general practice: Yes. *J Prim Health Care* 2014;6:331–333.

Similarly, experienced doctors and other health professionals can achieve these competencies through intentionally learning about roles and skills of others and engaging in interdisciplinary programmes of postgraduate study.

Even though the evidence points to the benefits of collaborative approaches in health care delivery for patients with long-term and/or complex conditions, the application of these models is variable and far from being universally adopted. Champions are needed to support collaborative processes wherever these are appropriate for best patient care, regardless of tradition or discipline, and to actively work to overcome barriers to collaboration. Meeting in teams can be time and resource intensive with organisational and funding support being necessary. Practicalities need consideration: having a place or method to meet, time to build trust and a form of payment for members who are private businesses.¹³³ Professional regulation and legislation are also given as reasons to limit collaboration. Entrenched attitudes about scopes of practice, professional ‘turf’ and historical power structures can sabotage the essence of good teamwork.

Doctors have had a key role in supporting this change by fostering professional respect for and trust in other disciplines by initiating patient-centred, person-focused forms of clinical decision making in which various disciplines take the lead.¹³⁴

133 See footnote [90](#).

134 See footnotes [93](#) and [94](#).

Interdisciplinary collaboration in primary care

Great gains can be made in reducing inequalities in health care if professionals work collaboratively in primary care services. Collaborative service delivery models enable best use of other disciplines’

skill sets in a time when GPs are dealing with increasingly complex patients in the community. This means patients may not access GPs for all health presentations but can still receive excellent and appropriate care from nurses, community pharmacists or other health professionals working within primary care services.

Some factors may need to be changed when developing new collaborative teams or enhancing existing teams. As noted, limited geographical co-location of services, mixed capitation/fee for service funding and the owner-operated business model of many New Zealand primary care practices can make collaboration more difficult. Furthermore, barriers need to be overcome so professionals with the patient’s permission can access a common electronic platform with each other’s summary care records including prescribed medicines.¹³⁵ Thought also needs to be given to increase opportunities to meet physically or virtually together, develop processes for equal access to funding and ensure equality in decision making.¹³⁶

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

135 <http://www.health.govt.nz/our-work/ehealth/digital-health-2020>

136 Pullon S, McKinlay E, Dew K. Primary health care in New Zealand: the impact of organisational factors on teamwork. *Brit J of Gen Pract* 2009;59:191–197.

Measures to increase interdisciplinary collaboration

The management of people with long-term conditions is often shared between primary and secondary services and is an area where more attention to effective team work can reap dividends.¹³⁷ This means “sharing responsibilities for maintaining and improving health, and includes making and carrying out a collaborative plan to do so. Care can be shared by two or more agencies”¹³⁸ and the individuals within those agencies.

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

The MWOK programme was found to improve health literacy, decision making, self-management support, social issues and patient activation. It also resulted in more appropriate GP utilisation (an overall increase in GP visits in initial low and medium users and decreased visits in initial high users).

137 Smith S, Cousins G, Clyne B, Allwright S, O’Dowd T. Shared care across the interface between primary and specialty care in management of long-term conditions. *Cochrane Database Syst Rev*; 2017. Iss 2. Art. No.: CD004910. DOI: 10.1002/14651858.CD004910.pub3.

138 <http://www.networknorth.org.nz/file/Care-Connect/shared-care-for-mha-northern-region-workshop-summary.pdf>

A formal evaluation noted “the combination of the registered nurse and the kaiawhina role are central to this model ... The kaiawhina were particularly important for reaching highly disengaged or underserved patients, who were also Māori. Kaiawhina were seen as having a better understanding of the lived experience of the clients and were able to communicate more effectively than Pākehā health care professionals.”¹³⁹ This approach is required for those with the most complex needs.¹⁴⁰

Kaiawhina were seen as having a better understanding of the lived experience of the clients and were able to communicate more effectively than Pākehā health care professionals.

Tools and enablers for collaborative interdisciplinary care

Increasingly, electronic tools are being used to enhance collaborative interdisciplinary care. As in the example above, an approach that is gaining adoption is the use of a care plan developed either in primary care by the practice nurse and GP or in secondary services by clinical nurse specialists, oriented around the needs and goals of the patient and available electronically across sectors and agencies.¹⁴¹ This has proved especially beneficial during the discharge planning process.¹⁴² In collaboration with the patient, the care plan can be accessed and edited by the hospital specialists, specialist nurses, physiotherapist and then in primary care by the GP, nurse and community pharmacist.

139 Appleton-Dyer S, Boswell A, Goodwin D. Manawanui whai ora kaitiaki: implementation and initial outcomes. Auckland: Synergia; 2015.

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

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

142 Gonçalves-Bradley DC, Lannin NA, Clemson LM, Cameron ID, Shepperd S. Discharge planning from hospital. *Cochrane Database Syst Rev*; 2016, Iss 1. Art. No.: CD000313.DOI: 10.1002/14651858.CD000313.pub5.

There is facility for electronic messaging and tasking between all the professionals involved to facilitate necessary changes in care. Patients also access summary information (including medications and goals of care) through an electronic portal. It is likely that smartphones¹⁴³ and collaborative tools like e-scripts between doctors and pharmacists¹⁴⁴ will increase the capability for similar collaboration in the future.

Doctors and other health professionals can actively support patients to become more knowledgeable about their condition(s) by supporting them to access and use New Zealand evidence-based patient information and self-care resources (including effective mobile apps) from the Health Navigator New Zealand website (www.healthnavigator.org.nz). It has been shown that using localised evidence-based patient information helps patients participate in shared decisions about treatment.¹⁴⁵ Similarly, most health professionals can access localised interdisciplinary HealthPathways, which provide district health board tailored treatment pathways (www.healthpathwayscommunity.org).

Conclusion

In New Zealand, doctors work in collaborative interdisciplinary teams, particularly in the management of patients with long-term and complex conditions, and have an important role in supporting the further development of collaborative models of care. There are models of shared care between disciplines, across health sectors, including a range of health and professional groups as well as partnering with patients, family and whānau. Within teams, role clarification is necessary together with the building of professional trust in other disciplines' specialist skills.

143 Brown-Manhertz D. Using smartphones to improve interdisciplinary collaboration. *Nurs Pract* 2017;42:1–5.

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

145 See footnotes [102](#) and [103](#).

Current regulatory processes already enable shared decision making and shared leadership. However, institutional policies and funding mechanisms may not, and these need to be worked upon. In modern health care practice, collaborative care is not a ‘nice to have’. It is essential for the delivery of high-quality, safe and effective care that benefits patients, family, whānau, communities and health professionals.

The New Zealand Medical Association *Code of Ethics* (see [Chapter 2](#)) under recommendation 38 makes specific reference to a doctor’s responsibility when working in a team environment, and the Medical Council of New Zealand has a statement on unprofessional behaviour and the health care team and protecting patient safety.¹⁴⁶

¹⁴⁶ <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Unprofessional-behaviour-and-the-health-care-team.pdf>

CHAPTER 5

End-of-life issues

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Cite this as Davis A. End-of-life issues. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	101
Where people die	103
Cognitive impairment and mental capacity	103
Advance care planning	104
Advance directives	105
Ceilings of care and do not resuscitate orders	106
Age-related residential care (ARRC or RAC)	107
Enduring power of attorney	108
Withdrawing life-sustaining treatments	109
Euthanasia and physician-assisted suicide	110
Palliative care	112
Conclusions	112

Introduction

One of the major success stories of the twentieth century is the dramatic improvement in the health and longevity of our society. As we move further into the twenty-first century, this change is showing no signs of slowing. Coupled with the baby boom of the 1950s and 1960s, we are now experiencing a rapid growth in the size of the older population. As the population ages and medical interventions become more sophisticated, end-of-life issues are becoming more frequent and complex. Sudden unexpected death is much less common, with most people now dying after a period of decline from chronic disease, often with multiple co-morbidities and frailty. As a doctor, you play an important role in assisting patients, families and the community in dealing with the reality of death. In caring for patients at the end of life, you share with others the responsibility to take care that the patient dies with dignity, in comfort and with as little suffering as possible. You should take care to communicate effectively and sensitively with patients and their families so that they have a clear understanding of what can and cannot be achieved. You should offer advice on other treatment or palliative care options that may be available to them. You should ensure that support is provided to patients and their families, particularly when the outcome is likely to be distressing to them.

Although most people at the end of life have known life-limiting conditions, most have not had the opportunity to consider and communicate their preferences about end-of-life care to clinicians or family. In a survey conducted by the Royal Australasian College of Physicians (RACP), only 17 percent of responding physicians considered that doctors know the patient's preferences for end-of-life care. Far too often, when an end-of-life discussion does occur, it is during a health crisis and at a time when the patient can no longer participate.

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

An RACP position statement on end-of-life care¹⁴⁷ identified five essential elements for the provision of good patient and whānau-centred end-of-life care as:

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

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

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

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

Where people die

Most deaths occur in the older age group. Only 5 percent of deaths in our society occur before the age of 40. For those aged 65 years and over, 38 percent die in residential aged care (RAC), 34 percent in acute hospitals and only 28 percent in the community (home, workplaces, roads and so on). Some hospital deaths are of people who have been admitted from RAC, which means that nearly half of older people who die have an RAC facility as their final residence.¹⁴⁸ Doctors who support RAC facilities need to be skilled at managing end-of-life issues.

Cognitive impairment and mental capacity

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

Right 7.1 Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent...¹⁴⁹

This assumes that the patient has the mental capacity to make an informed choice. Mental competence (or capacity) is always presumed present until proven otherwise. Courts quite rightly take the stance that an individual's liberty is their most important possession and they should only be deprived of it for compelling reasons.

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

149 [http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-\(full\)](http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full))

However, there are times when the patient cannot participate in the discussions about treatment choices. Doctors should feel confident about assessing the capacity of their patients. Guidance about how to do this is covered elsewhere (see [Chapter 16 – Mental capacity](#)).

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

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

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

Advance care planning

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

It is never too early to have an ACP conversation. However, there are situations that should trigger the process. The diagnosis of a life-limiting condition or an admission to hospital with a chronic condition or a planned medical review would be appropriate times. There are also tools to assist in identifying which patients to consider. It is particularly important to initiate a conversation in those with early cognitive impairment or those likely to lose the ability to communicate. Once cognitive impairment has progressed, such conversations become more difficult.

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

ACP training is strongly recommended for health care professionals and can be accessed through the ACP website.¹⁵⁰ The ACP cooperative provides online resources and ACP training. This is recommended to all doctors.

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

Advance directives

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

¹⁵⁰ <http://www.advancecareplanning.org.nz/healthcare/>

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

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

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

Ceilings of care and do not resuscitate orders

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

Increasingly, DNR orders are being broadened to cover other urgent interventions such as ventilation, inotrope support, dialysis and so on. These are called ceilings of care. The goal of a ceiling of care order is to identify appropriate limitations to interventions that are likely to be futile, burdensome or contrary to the patient’s wishes.

It should encompass more than simply cardiopulmonary resuscitation and DC cardioversion. Unless the patient is unable to participate, the conversation about such an order should always follow a discussion with them. It should also include what treatments are appropriate.

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

Age-related residential care (ARRC or RAC)

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

A large proportion of residents of aged care facilities have significant cognitive impairment, and it may not be possible to establish their preferences for end-of-life care. Most residents have not completed an enduring power of attorney process, so there is no formal proxy decision maker in the situation where mental capacity has been lost. This makes it even more important to be able to assess mental competency and have discussions about advance care plans much earlier in the course of their illnesses. Unfortunately, the DNR advance directive in the resident file is often completed without substantial input from the affected individual. It frequently represents an agreement between the facility doctor and staff on one side and family representatives on the other. While this is considered to represent patient best interests, it is not an ideal way to determine patient preference.

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

Enduring power of attorney

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

Hence, when it comes to decisions about end-of-life treatments, the proxy's role is often as an adviser rather than decision maker.

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

Further information is available on the Office for Seniors website.¹⁵¹

A full discussion on this issue can be found in [Chapter 16 – Mental Capacity](#).

Withdrawing life-sustaining treatments

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

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

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

Good communication and documentation is vital at these times. Clear communication extends beyond doctor, patient and family, as other members of a health team may have differing opinions and people's own beliefs must be respected. All concerned must know the reasons for the change in plan, and a debrief after the patient's death is wise practice. The paper entitled 'Reducing the uncertainties of withdrawing or withholding treatment'¹⁵² is a useful resource for dealing with these complex situations.

Euthanasia and physician-assisted suicide

Strictly speaking, the term 'euthanasia' means a 'good death'. However, like many words in the English language, the meaning has changed with time. The word is also heavily emotionally charged.

- Euthanasia is the act of intentionally, knowingly and directly causing the death of a patient, at the request of the patient, with the intention of relieving intractable suffering. ...
- Assisted suicide is the act of intentionally, knowingly and directly providing the means of death to another person, at the request of the patient, with the intention of relieving intractable suffering, in order that that person can use the means to commit suicide.¹⁵³

Euthanasia does not include:

- a patient refusing to consent to or to continue life-sustaining or life-saving treatments
- the withdrawal of life-sustaining measures that are considered to be against the best interests of the patient
- failure to offer treatments that are considered futile

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

153 <http://www.anzspm.org.au/c/anzspm?a=sendfile&ft=p&fid=1491523669&sid>

- administering treatments with the express intention of relieving symptoms (for example, sedation or analgesia) even though a consequence may be a shortening of life expectancy.

The Australia and New Zealand Society of Palliative Medicine in its 2015 submission to the New Zealand Health Select Committee on Euthanasia made the following statements:

- We acknowledge that this subject is extremely challenging for all New Zealanders and appreciate the opportunity to address the Health Select Committee.
- As a Society we oppose any attempt to legalise assisted suicide and/or euthanasia in New Zealand under any conditions.
- Palliative Medicine exists to improve the quality of care of patients with life-limiting illnesses and their families. It encompasses not just the physical but emotional, social, spiritual and cultural needs of the individual and family unit.
- ANZSPM has a Position Statement opposed to euthanasia and doctor-assisted suicide in line with the New Zealand Medical Association and the World Medical Association.
- The withdrawal of treatment in any form is not euthanasia and results in the disease progressing on its natural course.
- It is our belief that most doctors in New Zealand are not deliberately ending the lives of their patients. Medication with the intent of symptom control is not euthanasia but rather good medical practice.¹⁵⁴

154 https://www.parliament.nz/resource/en-NZ/51SCHE_EVI_51DBHOH_PET63268_1_A454385/db81587eb70944cfe1fd18cd9b85d77dec9ff4f8

Under New Zealand law, both euthanasia and assisted suicide contravene the Crimes Act 1961 and are likely to lead to criminal charges. This has clearly been reinforced by recent cases. You must not participate in the intentional termination of lives of your patients.

Palliative care

New Zealand is fortunate to have well-developed palliative care services covering most of the country. These services generally (but not always) provide support to primary care, hospitals and the residential aged care sector to assist with managing patients at the end of their lives. Most provide care for all patients at the end of life and not just cancer patients. Any medical practitioner new to an area should ensure they are aware of what services are locally available.

Conclusions

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

CHAPTER 6

The purpose of medical records and notes

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

The contribution of **Robert Stevens** as author of the previous edition's chapter 'Medical records and patient access to information' is gratefully acknowledged.

Cite this as Lillis S. The purpose of medical records and notes. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

The purpose of the medical record and notes	114
Health Information Privacy Code (HIPC)	115
Other requested disclosures	120
Audit of your records	121
Transfer of patient records to another doctor	121

Dr D's documentation in relation to the consultation on 21 June was inadequate and, accordingly, he breached Right 4(2) of the Code. ([Health and Disability Commissioner's Decision 10HDC00753](#))

The purpose of the medical record and notes

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

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

Structures for recording information usually follow a pattern of (S) subjective, (O) objective, (A) assessment and (P) plan. It is also important that the notes can be ascribed to the appropriate patient (so the name, date of birth or other identifying details must be recorded accurately), at an identifiable time and by a recognisable author. A common error found in clinical notes is failure to record important negative findings. This particularly applies to vital signs. A record showing that there was no fever, a normal pulse, blood pressure and respiratory rate and a normal oxygen saturation is very useful information if the patient

subsequently deteriorates and the doctor is criticised for not taking a more proactive stance at the time of the consultation.

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

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

Health Information Privacy Code (HIPC)

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

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

155 [http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-\(full\)](http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full))

A brief outline of the 12 rules at the heart of the HIPC is given in this chapter, but in case of any doubt, doctors should refer to the words of the HIPC itself or obtain advice from someone else who is more familiar with the HIPC. The HIPC is published with accompanying commentary by the Privacy Commissioner. The commentary is not legally binding but contains a wealth of practical pointers and observations that will answer many a query.

Rule 1: Purpose of collection

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

Rule 2: Source of the information

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

Rule 3: Collection of health information

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

You should also ensure that the individual is told the name and address of the agency that will be keeping the information and that they have a right of access to it.

If it is practicable to do so, these steps should be taken before the health information is collected. Many health care agencies find it convenient to communicate these matters by the use of leaflets and by notices on the forms that the individual uses to give the information.

Rule 4: Means of collecting health information

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

Rule 5: Storage and security

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

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

Rule 6: Right of access

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

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

It sometimes happens that a doctor is given information about a patient by someone else, and the source of the information may ask that the patient is not to be told that the doctor has the information or who gave it. However, no matter what the doctor promises, the right of access under the Privacy Act still exists, so doctors should never give unqualified promises of confidentiality if they receive information about a patient from third parties.

Rule 7: Correction of health information

Every individual has the right to request correction of health information about them if they believe it to be wrong. The agency keeping this information may refuse to make the correction if the agency feels that it would not be appropriate to do

so, but in such a case, the agency must, if so requested, attach a note to the contested information showing the patient's assertion of the error. Quite apart from any request, if you become aware of an error in health information held, you should take steps to correct it. Any corrections made should be communicated, if practicable, to every other person or agency to which the erroneous information has been previously passed.

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

Rule 8: Check before use

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

Rule 9: Retention of medical records

This HIPC rule states that health information is not to be kept for longer than it is required for those purposes for which it may lawfully be used. Given that health information is normally kept for purposes that include future diagnoses and care, the rule itself will not often impose a limit on retention. Furthermore, there are specific regulations – the Health (Retention of Records) Regulations 1996 – requiring that health information relating to an identifiable individual must be retained for a minimum of 10 years from the day after the last treatment or care of that individual by the agency holding the information. Unless the accuracy of certain health information is being questioned, the most likely form of complaint in relation to retention is that it has not been retained for long enough. The Medical Council's guideline, and the advice of several colleges, is that records are retained for more than 10 years.

Rule 10: Limits on use

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

Rule 11: Limits on disclosure

Disclosures that were anticipated and intended when the information was obtained can proceed as planned. Other disclosures can be made with the authorisation of the individual. A further group of exceptions applies to allow other disclosures where it is not desirable or practicable to obtain the individual's authorisation and the situation fits into one of the limited exceptions set out in the full rule.

Examples of this group are where the disclosure is directly related to the purpose for which the information was obtained, where the disclosure is for a professionally recognised accreditation or quality assurance programme or where the disclosure is for statistical or approved research programmes (see below). The rule against disclosure applies to health information about individuals until 20 years after their death.

Rule 12: Unique identifiers

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

Other requested disclosures

There are a number of other provisions in legislation under which information can be requested from and supplied by a doctor. The bodies that make such requests should make it clear what statutory authority they are relying on. A doctor can and should ask the requesting body to clarify in writing exactly what information is sought, the reason for the request and the statutory provision that might permit or require the doctor to provide that information.

Audit of your records

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

Transfer of patient records to another doctor

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

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

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

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

CHAPTER 7

The management of clinical investigations

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

Cite this as Lillis S. The management of clinical investigations. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

The management of clinical investigations has been the subject of many complaints to the Health and Disability Commissioner. Below are a number of examples:

- 15HDC01387: Dr C, as the clinician who ordered the blood tests, had a responsibility to communicate to Mr A the diagnosis of CLL and its implications. Provision of this information would have enabled Mr A to be a partner in his own treatment.
- 14HDC01030: Dr A told Health and Disability Commissioner that he does not recall seeing Ms B's smear result in his inbox but thinks he must have viewed the result on its arrival and then probably he filed the result without actioning it.
- 15HDC00677: Dr A filed the elevated PSA result as "normal" and did not discuss the result with Mr B at his next consultation on 10 March 2012 or take any further follow-up action.
- 12HDC01133: At 3.24am on Day 5, the postoperative CXR was performed by radiology. It was not reviewed by any member of clinical staff until over 24 hours later.

- 13HDC00599: On 23 January 2010, Dr C referred Mrs A to an orthopaedic surgeon for a review of her left shoulder problems. The referral letter made no mention of the possibility of a bony metastasis being present, as stated in the imaging report, and referred to Mrs A's previous breast cancer only briefly.

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

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

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

BPAC^{NZ} produced an article ‘Taking responsibility for test results: A discussion’ in 2014¹⁵⁶ that also addressed the issue and noted that there is often a lack of agreement and consistency between clinicians, practices and health organisations as to what is reasonable and practical. In a paper in *New Zealand Doctor*, the previous Health and Disability Commissioner expressed his view about the key principles that should apply when managing clinical investigations.¹⁵⁷

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

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

157 <http://www.hdc.org.nz/media/147608/managing%20patient%20test%20results%205nov08.pdf>

The Medical Protection Society article ‘Handling test results’¹⁵⁸ looks at the issue of doctors’ responsibility for tests they did not order and notes the primary responsibility for following up abnormal results rests with the clinician who ordered the tests. However, the HDC has an expectation that an abnormal result will be followed up by a treating doctor regardless of who ordered the test to avoid patients falling through the cracks. This makes sense. If a general practitioner is in receipt of information that is of particular concern about a patient’s health (a markedly raised PSA, for example), there is the expectation that they would act on this test even if they were not the doctor who ordered it.

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

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

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

CHAPTER 8

Doctors in other roles

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Cite this as Morris KA. Doctors in other roles. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	127
Doctors as leaders and managers	129
Notifying poor performance	131
Disagreement about clinical decisions	132
Providing opinions about patients or other doctors	132
Working in a resource-constrained environment	133
Doctors in advisory roles	134
Expert witness	135
Acknowledgement	136

Introduction

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

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

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

The clinical role is well understood and the parameters of the role established through the apprenticeship that medical practitioners have served in their training years. The call to consider the health and wellbeing of the patient to be your first priority is well known as the first point in the New Zealand Medical Association *Code of Ethics* (see [Chapter 2](#)). However, when working in other roles, the last two points in the *Code of Ethics* are relevant:

- Accept a responsibility to advocate for adequate resourcing of medical services and assist in maximising equitable access to them across the community.
- Accept a responsibility for maintaining and improving standards of the profession.

159 <https://www.mcnz.org.nz/assets/Policies/Definitionmedicineandclinicalpractice.pdf>

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

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

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

This wider context was recognised when the NZMA, in 2011, developed with input from a wide range of practitioners, a consensus statement on the role of the doctor in New Zealand.¹⁶¹

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

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

161 www.nzma.org.nz/publications/role-of-the-doctor-consensus-statement

- Doctors work effectively as leaders. As members of health care teams, doctors recognise and respect skills and attributes of other practitioners.

The CanMEDS initiative began in the 1990s. The Royal College of Physicians and Surgeons of Canada developed the CanMEDS framework, which recognises seven roles for doctors of:¹⁶²

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

Doctors as leaders and managers

Doctors are increasingly involved in both leadership and management roles. The purpose of clinical leadership is to bring about movement and constructive change, while the role of medical management is to provide stability, consistency, order and efficiency.¹⁶³

‘Starting from isolated pockets of excellence and innovation, clinical leadership still has a long road to travel. But it is an essential road for both clinicians and their patients.’¹⁶⁴

162 www.royalcollege.ca/portal/page/portal/rc/canmeds

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

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

It is the clinical skills and knowledge inherent in medical training that separate clinical leaders from health service executives. In making day-to-day management decisions, the clinical leader is applying their medical knowledge to assess the impact, risk and clinical outcome of decisions. It is the role of the medical leader to apply clinical medicine to the development of policy, strategy, service design, behavioural change and effective clinical processes. The clinical leader is uniquely responsible for ensuring patient safety and monitoring both service and individual outcomes.

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

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

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

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

‘...administration or management utilising the medical and clinical knowledge, skill, and judgement of a registered medical practitioner, and capable of affecting the health and safety of the public or any person. This may include administering or managing a hospital or other health service, or developing health operational policy, or planning or purchasing health services. Medical administration does not involve diagnosing or treating patients.’¹⁶⁵

165 <https://www.mcnz.org.nz/get-registered/scopes-of-practice/vocational-registration/types-of-vocational-scope/medical-administration/>

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

The Medical Council provides guidance for doctors in management and governance roles in its statement on responsibilities of doctors in management and governance roles.¹⁶⁶

Notifying poor performance

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

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

The enquiry into clinical issues at the Bristol Royal Infirmary highlighted that the clinical leader has a responsibility to identify and report failing performance, even when that clinical leader is not in active clinical practice.¹⁶⁷

A medical practitioner has a mandatory requirement to report to the Registrar of the Medical Council another medical practitioner who they believe is not fit to practise medicine because of some mental or physical condition¹⁶⁸

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

166 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Responsibilities-of-doctors-management-and-governance.pdf>

167 [Bristol Royal Infirmary Inquiry. The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995: learning from Bristol. Stationery Office; 2001.](#)

168 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Responsibilities-of-doctors-management-and-governance.pdf>

Disagreement about clinical decisions

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

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

The clinical leader must put their concerns in writing and ensure they are addressed to the appropriate person. Where their concerns are not adequately addressed, they may raise the issue with the Director-General of Health, the Health and Disability Commissioner or the Medical Council.

It is strongly advised that they seek legal advice before raising the issue with an external party or the media. Be aware that the PDA does not apply to disclosures to some organisations such as the Medical Council. Further information can be obtained from the Office of the Ombudsman.¹⁶⁹

Providing opinions about patients or other doctors

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

169 www.ombudsman.parliament.nz/what-we-do/protecting-your-rights/protected-disclosures-whistle-blowing

170 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Non-treating-doctors.pdf>

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

If you become aware of another or new medical condition as the result of your assessment, you should inform the patient and refer them back to their usual doctor for further investigation. You should notify the patient's usual doctor in writing. You should not notify the third party unless your finding is relevant to their enquiries.

Working in a resource-constrained environment

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

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

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

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

171 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Safe-practice-in-an-environment-of-resource-limitation.pdf>

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

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

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

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

Doctors in advisory roles

Doctors are often engaged to serve on advisory committees to government agencies, DHBs or NGOs.

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

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

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

Expert witness

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

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

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

- clearly state their qualifications as an expert and indicate how the evidence they provide lies within their area of expertise.

172 [www.ssc.govt.nz/sites/all/files/CO_\(09\)5\[2\].pdf](http://www.ssc.govt.nz/sites/all/files/CO_(09)5[2].pdf)

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

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

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

The Royal Australian and New Zealand College of Psychiatrists has professional practice guidelines available from its website¹⁷⁴ that cover developing reports and conducting independent medical examinations in medico-legal settings and guidelines for psychiatrists in relationship to family court proceedings.

Acknowledgement

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

174 www.ranzcp.org/Publications/Guidelines-and-resources-for-practice.aspx

CHAPTER 9

Doctors' health

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The contribution of **Kate O'Connor** and **Joanna MacDonald** as authors of the previous edition's chapter 'Doctors' health' is gratefully acknowledged.

Cite this as Connolly A, Urquhart L. Doctors' health. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	138
Being a patient	139
Being a doctor's doctor	140
Maintaining good health	142
The law: fitness to practise	145
The Council's Health Committee	147
How the Health Committee deals with notifications	147
Infection with transmissible major viral infections (TMVIs)	151
Management of health information held about doctors	152
Conclusion	152

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

Introduction

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

These include working long hours, fatigue, sleep deprivation, consumer demands, secondary traumatic stress,¹⁷⁵ consequences of mistakes, debt, demands of external bodies (including the Council and colleges), fear of complaints and litigation, infectious diseases, radiation, noxious chemicals and so forth. In addition, we are

vulnerable to the same physical and psychological disorders as the rest of the community. The incidence of these disorders in doctors is comparable to that in the general population and in some cases considerably higher (for example, suicide, liver cirrhosis and accidents as well as cognitive decline as we age). The British Medical Association's working group on the misuse of alcohol and other drugs reported in 1998 that, in a lifetime, about one in 15 doctors in the UK may suffer from some form of dependence on alcohol or other drugs.¹⁷⁶

The Council has strengthened its standards about self-care, outlined in its statement on providing care to yourself and those close to you.¹⁷⁷ It is vital this statement is read and understood when considering your own health.

175 Huggard P. Secondary traumatic stress. *New Ethicals* 2003; Sept: 9–14.

176 British Medical Association. The misuse of alcohol and other drugs by doctors. A report of the working group on the misuse of alcohol and other drugs. London: BMA; 1998.

177 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-providing-care-to-yourself-and-those-close-to-you.pdf>

Being a patient

Doctors are often poor at seeking help and attending to their own health needs. A survey of the health practices of New Zealand general practitioners found that only 71 percent claimed to have their own family doctor, and only 10.9 percent said that they visited their doctor for regular checkups. Of women, 27.5 percent had not had recommended cervical screening.¹⁷⁸

Some factors that make it difficult for a doctor to become a patient are:

- a sense of being indispensable
- fear of moving from a position of power in the medical system to a position of powerlessness
- fear of breaches of confidentiality or of being recognised in the waiting room
- fear of having a serious condition
- shame or embarrassment particularly with respect to substance abuse or sexual issues
- a misperception that we lack time to see to our own health needs
- reluctance to impose on a busy colleague
- a belief we should be able to heal ourselves
- our ready access to a wide range of medication
- financial pressures to maintain high levels of income
- shame at having 'let ourselves down' and also our family and the profession at large
- a fear of disciplinary action and deregistration.

178 Richards JG. The health and health practices of doctors and their families. *New Zealand Medical Journal*. 1999;112:96–99.

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

- the 'there but for the grace of God go I' syndrome
- lack of knowledge of the notification process and the consequences of notification
- fear of the reaction, especially if the doctor is in a position of power
- anxiety about increasing our already overburdened workload, especially in shortage specialities and small practices
- misplaced loyalty – the 'he/she has always been a good bloke/woman' phenomenon
- judgemental attitudes
- denial that there is a problem.

Being a doctor's doctor

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

- fear of being seen as inadequate
- fear of offending a colleague
- role confusion
- hierarchy
- difficulties if you disagree with your doctor patient's self-diagnosis
- identifying with the doctor patient
- boundary issues
- difficulties saying 'no' to a colleague
- issues of privacy and confidentiality
- difficulties challenging a colleague, particularly with respect to lifestyle issues.

Dr Hilton Koppe, who works in the area of doctors' wellbeing, suggests a six-step consultation model when seeing a colleague as a patient.¹⁷⁹ The principles are those used in any consultation – the key issue being to retain these principles and your usual professionalism in this unusual encounter.

- **Connection:** As part of the process of agreeing to see a colleague, you should make a formal appointment in your rooms. You may need to discuss whether the doctor is comfortable to wait in the waiting room or elsewhere and whether an appointment at a quieter time of day would be easier. At the first appointment, issues of confidentiality, notes, payment and your expectations of each other (including how to address each other) should be clarified.
- **Information gathering:** You will need to walk the tightrope of acknowledging your colleague's knowledge while taking a thorough – and, if necessary, challenging – history as you would with any patient. It is important not to make assumptions, for example, that the doctor would tell you of symptoms without your needing to ask specifically. You will need to clarify what they think is the diagnosis then take the history and examine the patient to establish the diagnosis for yourself rather than accepting that diagnosis.
- **Exploring thoughts and feelings:** At this stage, you may need to reaffirm confidentiality and the difficulty of being a patient. You will need to explore the doctor's fears and look for any other issues. It is particularly important to be aware of the dangers of self-disclosure and identification or collusion. Keep the focus on the doctor who is here as a patient and avoid discussing mutual patients or experiences.

179 Koppe H. Self care strategies for doctors: making changes. *Australian Family Physician*. 2002 Jun;31(6):569–72

- **Education:** Again, you will need to walk a tightrope between assuming your colleague has specific knowledge and causing offence by imparting that knowledge. It can help to explain that hearing information about yourself is different from giving it to others, so you will explain it as you would to any patient. Acknowledge their fear if relevant, and admit the limits of your own knowledge. As with any patient, it will be important to negotiate the choice of treatment.
- **Safety net:** You should give clear instructions about follow-up and after-hours contact. Ask whether the doctor patient wishes to receive copies of test results and negotiate about minor procedures, for example, removal of sutures.
- **Closure:** This is just as important as starting the consultation. Check that everything has been dealt with and reinforce your commitment to them, and agree on how to book the next appointment.

Doctors are in the vanguard of illness prevention and health promotion and should lead by example.

Maintaining good health

Doctors are in the vanguard of illness prevention and health promotion and should lead by example. Sadly, this is not always the case with respect to our own health, and we often fall into unhealthy work patterns. This may begin during medical student years and then persist into vocational practice. A 2005 study found that the prevalence of depressive symptoms among medical students was 12.9 percent (significantly higher than the general population),¹⁸⁰ and an earlier

study showed that, at that stage of their careers, medical students were reluctant to seek help if stressed or distressed.¹⁸¹

180 Dahlin M, Joneborg N, Runeson B. Stress and depression among medical students: a cross-sectional study. *Medical Education*. 2005;39(6):594–604.

181 Chew-Graham CA. 'I wouldn't want it on my CV or their records': medical students' experiences of help-seeking for mental health problems. *Medical Education*. 2003;37:873–880.

The practice of medicine can place huge physical and emotional demands on doctors. In recent years, this has been increased further by administrative and reporting pressures as well as by the exponential rise in knowledge and literature in all medical fields. Increasing pressures, coupled with the subtly induced ethos of 'doctors must always cope', can be a very toxic mixture.

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

- Establish good health habits early.
- Set aside time each day to maintain your own fitness and health and to pursue other interests outside of medicine.
- Deal with your own reluctance to seek help and identify the barriers, both real and imaginary, that prevent help-seeking behaviour.
- Have your own general practitioner – someone who is comfortable treating doctors.
- Avoid corridor consultations about your own health.
- If you are feeling stressed, consider contacting support groups from your professional body, college or insurer.
- You should not prescribe for yourself as you lose the benefit of objective care, and insidious illness may ensue.
- When you visit your GP, leave your 'medical mantle' at the surgery door.

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

The future is perhaps a little rosier with a greater emphasis on promoting health, wellness and coping skills in the undergraduate programme, improvement in working conditions for those in training and a greater recognition and assistance for some groups with particular stresses – rural isolated doctors, women doctors and older doctors.

The law: fitness to practise

The Council states:

A doctor is not fit to practise if, because of a mental or physical condition, he or she is not able to perform the functions required for the practice of medicine. Those functions include:

- making safe judgements
- demonstrating the level of skill and knowledge required for safe practice
- not risking infecting patients with whom the doctor comes in contact
- behaving appropriately
- not acting in ways that impact adversely on patient safety.¹⁸²

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

Psychiatric disorders include:

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

182 <https://www.mcnz.org.nz/assets/News-and-Publications/Booklets/doctors-health.pdf>

Medical disorders include:

- head injury
- neurological diseases
- malignancy
- eyesight and hearing difficulties
- communicable diseases.

The Health Practitioners Competence Assurance Act 2003 provides for notification of any mental or physical condition affecting a doctor's fitness to practise medicine. Section 45 sets out the steps that must be taken when there is reason to believe a doctor is unable to perform the functions required for the practice of medicine because of some mental or physical condition. There is a mandatory requirement for registered health practitioners, their employers, medical officers of health and persons in charge of a hospital or other organisation that provides health services to notify the Council Registrar promptly in writing.

Persons in charge of health professional education programmes (for example, deans of medical schools) are similarly required to give written notice to the Registrar if students who are completing a course would be unable to perform such functions. People considering making a notification are entitled to seek medical advice to assist them in forming an opinion and must state whether such advice has been obtained when giving notice to the Registrar.

These provisions extend across and between all registered health practitioners and their professions.

Disruptive behaviours may indicate a health and/or competence problem, so it is important to make a notification rather than attributing the behaviour to 'personality'.¹⁸³ Any person making a notification is protected from civil or disciplinary proceedings unless the person acts in bad faith.

183 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Unprofessional-behaviour-and-the-health-care-team.pdf>

The Council's Health Committee

The Council's Health Committee is currently authorised by the Council to exercise the functions, duties and powers contained in sections 45–51 of the Act, except for those relating to registration.

The Health Committee is comprised of at least four members of the Council, including one public member. The Council's Health Manager is responsible for the administration functioning of the Health Committee's work between meetings and keeps close liaison with the committee chairperson.

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

How the Health Committee deals with notifications

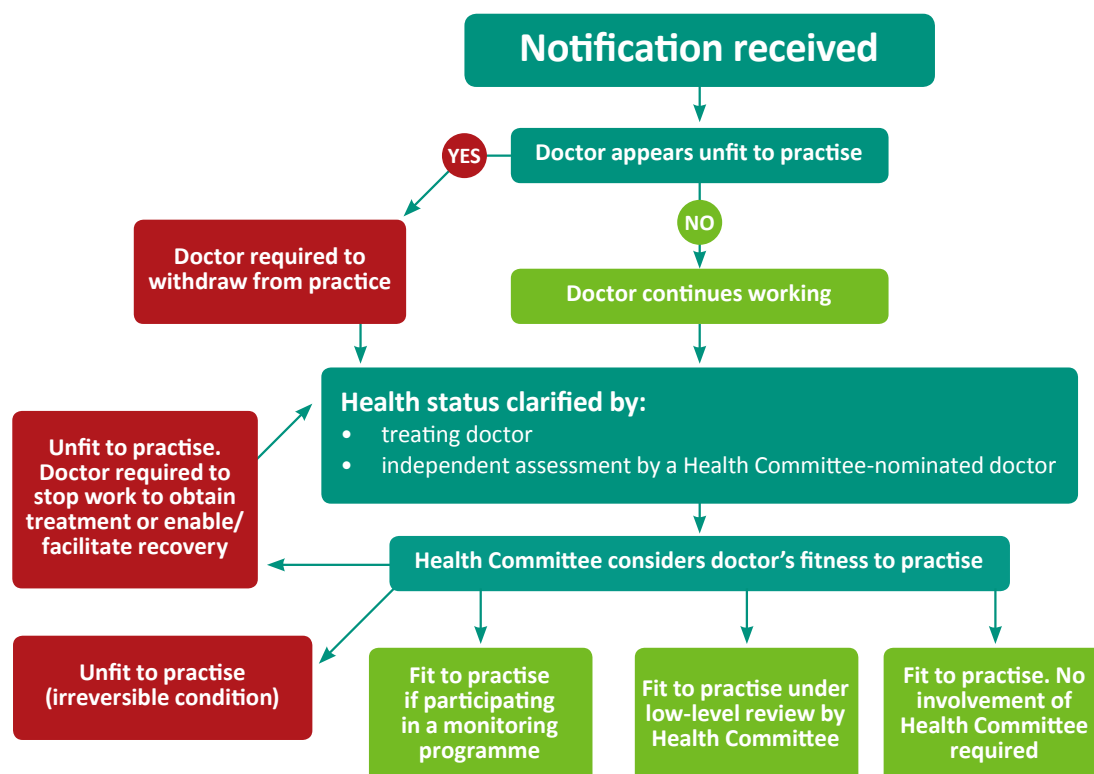
When the Council Registrar receives notification of the possible impairment of a doctor or graduate, the notice is passed to the Health Committee, which considers the notification and its potential implications. If necessary, and pending a full review, there is provision to suspend a doctor's practising certificate temporarily or alter a doctor's scope of practice in ways it considers appropriate. However, this course of action is rarely required. An important aim of the Health Committee is to keep the doctor working.

The doctor will be contacted by one of the Council's health case managers to discuss the concerns and how these might be impacting on the doctor's practice. If appropriate, a report might be requested from the doctor's general practitioner and other treating specialists. Sometimes, the doctor may be asked to make an agreement that limits their practice of medicine in relevant ways to ensure public safety while an expert examination is arranged.

The Act gives the Health Committee, acting under the Council's delegation, the power to order a doctor to attend a medical examination at the Council's expense. The examination is by a specialist relevant to the suspected (health) condition, and the Council would consult with the doctor about the specialist. The doctor receives a copy of the report. Failure to attend for such an examination may mean the Council suspends the doctor's registration. If the circumstances warrant, the Council can impose restrictions on a doctor's scope of practice. If an examination has been arranged and the examining doctor's report received, any initial limitations are reviewed in light of the report. If the examining doctor's report indicates that a mental or physical condition is affecting the doctor's ability to practise, the doctor will usually be invited to attend a meeting of the Health Committee to discuss the report and implications, with a support person if desired. The doctor is also entitled to make written submissions and to be represented.

See Figure 2 below.

Figure 2. Steps taken when a health notification is received.



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

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

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

A typical agreement may include the following:

- Limiting the doctor's practice to the place(s) of work, type(s) of work to be undertaken, workload and hours of work.
- Supervision of the doctor's practice if that is indicated.

- Treatment to be undertaken and the names of the treating doctors, therapists and agencies who may be involved in the doctor's treatment programme, with some indication as to the frequency of consultation. There may be provision for each to communicate with the Health Committee if problems arise, for example, non-compliance or relapse.
- Where relevant, provision for a key person in the doctor's workplace to be aware of the condition.
- Some monitoring by the Health Committee, for example, where the problem has involved abuse of drugs, random urinalysis or blood or hair testing will also form part of the agreement.
- Restricted access to prescription drugs and medicines.
- No self-prescribing, and in certain circumstances, this may extend to over-the-counter medications.
- Regular assessment of progress by a Health Committee-nominated doctor(s), which may include the treating doctor and any independent doctor tasked by the Council to provide a review.

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

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

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

Infection with transmissible major viral infections (TMVIs)

As with any illness that may pose a risk to patients, doctors who are or may be infected with one of the transmissible major viral infections (Hepatitis B, Hepatitis C or Human immunodeficiency virus) must take all necessary steps to minimise the possibility of transmission. Health Regulatory Authorities of New Zealand (HRANZ), with the Medical Council, has developed guidelines for all health care providers.¹⁸⁴ Key points are:

- learning and awareness must start early in students' training
- doctors should be tested if they may have been exposed to the viruses
- doctors should advise patients who may have been exposed to be tested
- doctors who perform exposure-prone procedures have a responsibility to know their viral status and notify the Council if they are infected
- being infected does not, by itself, justify either refusing registration of the doctor or limiting their practice – such decisions are always case by case
- doctors who know or think they may be infected with any of the viruses must seek advice and then act on it – a doctor should not continue practising based on their own assessment where there may be a risk to patients.

184 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/TMVI-HRANZ-guidelines.pdf>

Management of health information held about doctors

Health processes will usually run concurrently with any other processes under way or pending. The Health Committee holds very personal health information about doctors, and it has robust procedures in place in terms of its processes and who has access to that information to ensure that privacy is protected. However, information the Health Committee has is held on behalf of the Council. Where relevant, it can be used to inform other Council processes and decision making such as questions about a doctor's competence, conduct or compliance with set recertification programmes.

Conclusion

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

Resources

O'Hagan J, Richards J, editors. In sickness and in health: a handbook for medical practitioners, other health professionals, their partners and their families. Wellington: Doctors' Health Advisory Service; 1998.

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

CHAPTER 10

Maintaining competence

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Cite this as Lillis S. Maintaining competence. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	154
Evidence-based education	154
Does continuing professional development work?	155
What forms of ongoing professional development work?	155
› Audit	155
› Multisource feedback	156
› Education based on the practitioner's needs	156
› Outreach visits	157
› Observation of practice	157
› Multiple methods and multiple exposures	157
› Further information on feedback	158
How should educational evidence be used when planning your own CPD?	159
Regular practice review	159

Introduction

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

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

Evidence-based education

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

approved continuing professional development (CPD) activities in order to recertify,¹⁸⁵ but there is disquiet that the currently practised CPD, with its emphasis on continuing medical education, does not necessarily identify or improve underperformance and therefore cannot ensure doctors are competent.

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

185 <http://www.mcnz.org.nz/assets/News-and-Publications/Booklets/Continuing-Professional-Development.pdf>

CPD comes somewhat closer to the needs of doctors but is generally deficient in its ability to understand learning deficits at an individual level. Alongside these limitations is increasing awareness of the dangers inherent in self-assessment of learning need where inadvertent self-deception can colour objectivity.

Does continuing professional development work?

Using the criteria of making positive changes to what a doctor does and better patient outcomes as the criteria for success, it is clear that ongoing education does work. The most convincing evidence comes from a paper published in 2015 that combined eight systematic reviews, all published since 2003.¹⁸⁶ There are now 39 systematic reviews over all years in the medical education literature that present an overwhelming conclusion of ongoing education having a beneficial effect.

What forms of ongoing professional development work?

Audit

Audit is currently a required component of recertification. A Cochrane review was undertaken on 104 studies into effectiveness of audit on both physician performance as well as patient outcomes.¹⁸⁷ Modest gains were found overall, but better outcomes occurred when the baseline performance of the physician was poor.

186 Cervero RM, Gaines JK. The impact of CME on physician performance and patient health outcomes: an updated synthesis of systematic reviews. *J Contin Educ Health Prof.* 2015 Spring;35(2):131–8.

187 Ivers N, Jamtvedt G, Flottorp S, Young JM, Odgaard-Jensen J, French SD, O’Brien MA, Johansen M, Grimshaw J, Oxman AD. Audit and feedback: effects on professional practice and healthcare outcomes. *Cochrane Database Syst Rev.* 2012 Jun 13;(6):CD000259.

It appears that the supportive structures available to assist with reflection on audit results and instituting change in practice have significant impact on how successful audit is in assisting with improving practice.

Multisource feedback

Two systematic reviews on multisource feedback provide evidence of effectiveness. A review of 16 studies into workplace-based assessment concluded ‘...multisource feedback can lead to performance improvement, although individual factors, the context of the feedback, and the presence of facilitation have a profound effect on the response’.¹⁸⁸ A further review of 15 papers on the impact of feedback on workplace-based assessment also found that well-implemented feedback was influential in increasing effectiveness of this modality.¹⁸⁹

Education based on the practitioner’s needs

As would be expected, education that focuses on providing solutions to problems that exist at a practitioner level is associated with positive change. The most effective teaching reflects practice needs. A study of 23 research papers into teaching evidence-based medicine found that learning on real-world problems resulted in a greater depth of education.¹⁹⁰ Teaching that is relevant to real-world practice has the capability to improve skills, knowledge, attitudes and behaviours, whereas stand-alone teaching that is not based on practice improves knowledge only.

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

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

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

Outreach visits

Academic outreach visits (trained facilitators visiting the workplace of the doctor) have historically been utilised mainly as a method of improving prescribing practice. A Cochrane review of 69 studies revealed that such visits are effective in changing physician performance with modest results.¹⁹¹ Prescribing changes would appear to reliably improve, but other facets of practice have more variable results. Physician peers rather than non-physician peers are advantageous.

Observation of practice

This modality of improving practice has been used in undergraduate and vocational training for many years and is the cornerstone of workplace-based assessment. It has a track record for being able to distinguish between differing levels of performance of trainees.¹⁹² Again, the nature and form of feedback given after the use of rating scales is critical to the educational value of rating tools such as mini-CEX.¹⁹³

Multiple methods and multiple exposures

A review of 105 papers for evidence of both short-term (<30 days) and long-term (>30 days) gains in physician practice performance indicated that strong evidence exists for using multiple exposures, multiple instructional techniques and multimedia delivery.¹⁹⁴ They also found convincing evidence that single print media is ineffective.

191 O'Brien MA, Rogers S, Jamtvedt G, Oxman AD, Odgaard-Jensen J, Kristoffersen DT, Forsetlund L, Bainbridge D, Freemantle N, Davis DA, Haynes RB, Harvey EL. Educational outreach visits: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev*. 2007 Oct 17;(4):CD000409.

192 Fromme HB, Karani R, Downing SM. Direct observation in medical education: a review of the literature and evidence for validity. *Mt Sinai J Med*. 2009 Aug;76(4):365–71

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

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

Further information on feedback

Feedback, defined as any clinical summary of clinical performance over a specified period of time, features as a variable that predicts the effectiveness of many learning modalities. A review of factors that increase effectiveness was reported in a systematic review of 41 studies.¹⁹⁵ Over 70 percent of the studies showed beneficial effect of feedback on performance. The source and the duration of feedback are both important. Feedback from professional groups or administrative groups had greater effect than from academic groups. The duration was also positively associated with effectiveness. Contrary to commonly held belief, involvement in the design of the feedback process was not associated with better effectiveness. Comparison with local statistical norms or guidelines did not have a significant effect. A scoping review of 650 research papers on feedback added different insights.¹⁹⁶ The review found that praise improved knowledge and skills but criticism did not, yet feedback needs to clearly describe deficiencies too for it to be effective. Similar to other studies, feedback that is both immediate and longitudinal is more effective, and individual rather than group feedback increases effectiveness.

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

196 Bing-You R, Hayes V, Varaklis K, Trowbridge R, Kemp H, McKelvy D. Feedback for learners in medical education: What is known? A Scoping Review. *Acad Med*. 2017 Feb 7. [Epub ahead of print] PubMed PMID:

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

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

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

Regular practice review

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

CHAPTER 11

Credentialling

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Cite this as Clark K. Credentialling. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Definition of credentialling	161
The interface with medical regulation	161
Consumer input	162
Benefits of credentialling	163
Fairness and transparency	163
Standards of credentialling	164

Definition of credentialling

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

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

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

The interface with medical regulation

The Medical Council of New Zealand is the medical regulator and is responsible for ensuring that doctors maintain high standards of practice. Doctors working in New Zealand are respected for the high standard of care they provide. However, the public's expectations have increased, and patients are more questioning of the medical advice they receive. The profession and the Council need to take the lead in providing assurance to the public and patients that their trust and confidence in doctors is warranted.

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

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

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

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

Consumer input

Credentialling aims to improve outcomes for patients. Effective credentialling processes can provide assurance to the public of the quality of care they can expect from their doctor. Consumers play an important role in credentialling processes primarily as members of the credentialling committee of a health provider. A consumer representative is also often involved in credentialling during the process of appointment of doctors.

Benefits of credentialling

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

Effective credentialling systems for the medical profession:

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

Fairness and transparency

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

There is a public interest in the outcome of credentialling processes. Policies need to identify what information is made available to patients.

The credentialled status of a doctor should be made available to the public. However, the information generated during the credentialling process may be confidential.

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

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

Standards of credentialling

There is a need for consistent processes to be followed to ensure effective credentialling across all health service providers. *The Credentialling Framework for New Zealand Health Professionals*¹⁹⁷ lays out general principles with a purpose of promoting a nationally consistent credentialling system. Within medicine, credentialling is reasonably well established in hospital settings, both public and private, but in contrast is yet to be introduced to a significant extent in primary care settings.

This is a key challenge for the profession and one that the Council and the national Chief Medical Officers Group is keen to see taken up. Even where credentialling is routinely practised in New Zealand, the overall standard needs to be raised in order to truly aid in the assurance of high-quality care and patient safety. Exploration of a set of national standards for credentialling, ideally monitored by an external accreditation system, would be likely to result in further improvement in the current high standards of practice of doctors in New Zealand.

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

CHAPTER 12

Doctors who use complementary and alternative medicine

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Cite this as Holt S. Doctors who use complementary and alternative medicine. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

What is complementary and alternative medicine (CAM)?	166
How CAM can harm	169
› Direct harm	169
› Indirect harm	169
› Bad advice	170
› Psychological harm	170
› Financial harm	170
Evidence-based CAM	171
› Placebo effect	171
› Natural history	171
› Additional measures	172
Medicolegal guidance	173
Resources	176

What is complementary and alternative medicine (CAM)?

Treatments that are not commonly accepted in mainstream medical practice have been given a number of names over the years, from quackery to unproven to unorthodox to unconventional. The most widely used current description is complementary and alternative therapies and medicines,

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

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

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

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

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

CAM use is increasing, and there are now more visits to CAM practitioners than there are to primary care or family doctors in many developed countries. An interesting aspect of CAM use is that it is almost totally patient-driven. Proponents and consumers of CAM will often say that they are worried about the safety of conventional medicines and medical procedures, that the patient-doctor relationship is unsatisfactory for them in terms of the perceived power disparity and that traditional Western medicine treats them as a disease to be cured rather than a person to be healed.

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

The vast majority of New Zealanders take dietary supplements or use CAM.^{198,199} Despite this, health professionals receive little if any training on this subject, and often the patient may know more than the health professional they are consulting with. Studies investigating the knowledge of health care professionals show that they mostly rate their knowledge in this area as inadequate and are not confident in answering patient enquiries, but they do want to learn more.²⁰⁰

198 Holt S, Holt A, Erasmus P, et al. A survey of use and knowledge of vitamins and supplements in the Bay of Plenty, New Zealand. NZMJ. 2010 Jan 29;123:114–6.

199 Nicholson T. Complementary and alternative medicines (including traditional Maori treatments) used by presenters to an emergency department in New Zealand: a survey of prevalence and toxicity. NZMJ. 2006 May 5;119(1233).

200 Holt S, Gilbey A. A survey of New Zealand general practitioners' understanding of CAM therapies and recommendations they make. Focus on Alternative and Complementary Therapies. 2011 Jun 1;16(2):189–90.

How CAM can harm

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

Direct harm

Adverse events from CAM can range from a trivial stomach upset from a herbal preparation to serious injury, disfigurement or even death. Many of the drugs that are used in everyday medical practice are extracts from plants themselves, and many more are closely related to plant extracts – in other words, natural products can be every bit as powerful (and harmful) as prescription medications. CAM proponents argue that severe side effects are rare, and to a large degree, they are correct. However, it is also likely that side effects are more common than is claimed, because unlike for conventional medicines, there are no good systems in place to monitor side effects from CAM therapies.

Indirect harm

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

Bad advice

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

Psychological harm

People with cancer and other serious diseases are often emotionally and psychologically very vulnerable. Extravagant claims for unproven therapies can give a patient false hope. Denial is one of the stages in the grief process that occurs with a diagnosis of a serious disease, and bad advice

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

Financial harm

It has been estimated that around US\$1 billion per year is wasted on CAM therapies for cancer that do not work, around the same amount that is spent each year on cancer research. Any money spent on a CAM therapy that does not work is wasted, and there are many sad reports of people who, not wanting to leave any stone unturned, have spent all their savings or even lost their family home trying a variety of expensive and ineffective treatments.

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

Evidence-based CAM

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

Placebo effect

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

Natural history

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

Additional measures

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

Controlled clinical trials factor in these and other sources of error, because although they will still be present to some degree, they will be present to around the same level in both the active and control groups and therefore the difference between the two groups will be due to the treatment under investigation. This of course applies equally to the investigation of orthodox medical treatments as well as CAM.

The New England Journal of Medicine summarised the requirement for CAM therapies to be supported by robust research as follows:²⁰¹

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

201 Angell M, Kassirer JP. Alternative medicine – the risks of untested and unregulated remedies. *N Eng J Med*. 1998 Sep 17;339:839–41.

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

Medicolegal guidance

The Medical Council of New Zealand issued an updated statement on CAM in November 2017,²⁰² and it is strongly recommended that doctors who recommend or practise CAM therapies are familiar with the contents. The statement was written to inform doctors of the standards of practice that are expected of them by the Medical Council of New Zealand should they choose to practise CAM or if they have patients who use CAM. It may be used by the Health Practitioners Disciplinary Tribunal, the Council and the Health and Disability Commissioner as a standard by which a doctor's conduct is measured.

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

‘...will be found guilty of a disciplinary offence under the Health Practitioners Competence Assurance Act 2003 merely because that person has adopted and practised any theory of medicine or healing if, in doing so, the person has acted honestly and in good faith.’²⁰³

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

Previous decisions by the Medical Practitioners Disciplinary Tribunal also

202 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Complementary-and-alternative-medicine.pdf>

203 See footnote [202](#).

provide important guidance as to what is expected of doctors in this regard. For example, decision 02/89D²⁰⁴ stated:

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

The Tribunal also stated, among other things:²⁰⁵

‘Where a registered medical practitioner practises ‘alternative or complementary’ medicine, there is an onus on that practitioner to inform the patient not only of the nature of the alternative treatment offered but also the extent to which that is consistent with conventional theories of medicine and has, or does not have, the support of the majority of practitioners. The Tribunal recognises that persons who suffer from chronic complaints or conditions for which no simple cure is available are often willing to undergo any treatment which is proffered as a cure. As such, they are more readily exploited. The faith which such persons place in practitioners offering alternative remedies largely depends on the credibility with which such practitioners present themselves. Where such remedies are offered by a registered medical practitioner, it is difficult to escape the conclusion that the patient derives considerable assurance from the fact that the practitioner is so registered. It follows, therefore, that a registered medical practitioner cannot discharge his or her obligation to treat the patient to the acceptable and recognised standard simply by claiming the particular treatment was ‘alternative or complementary’ medicine.’

204 <http://www.mpdn.org.nz/decisionsorders/precis/0289d.asp>

205 See footnote [204](#).

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

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

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

Resources

Web

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

Books

- Ernst E, et al. Oxford handbook of complementary medicine. OUP Oxford. 2008. ISBN-10: 0199206775
- Hoffman R, Fox B. Alternative cures that really work. Rodale Press. 2008. ISBN-10: 1594864535
- Holt S. Complementary therapies for cancer. Pottton & Burton. 2010. ISBN: 9781877517211

Journals

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

New Zealand training course

- 8-hour RNZCGP CME-approved DVD course
www.cammasterclass.weebly.com

CHAPTER 13

eHealth

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Cite this as Garrett J. eHealth. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	178
The New Zealand Health Strategy and Digital Health 2020	178
The educated patient	180
Continuing professional development	181
Communicating with or about patients	183
Assessment and treatment	186
Prescribing	191
Bringing it all together – virtual health care	194
Acknowledgement	195

Introduction

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

Collected under the umbrella term eHealth are all the digital processes and communications supporting the practice of health care, including prevention, diagnosis, treatment and monitoring. There is of course in almost every example of eHealth an overlap with the analogue world – a world in which traditionally some patients have had inequitable or inefficient access to health care. eHealth affords us an opportunity to address these inequalities and inefficiencies while at the same time opening up a selection of traps, pitfalls and temptations.

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

The New Zealand Health Strategy and Digital Health 2020

The New Zealand Health Strategy²⁰⁶ published in April 2016 sets out clear goals for creating a more sustainable and equitable health system. Digital Health 2020²⁰⁷ is the plan for strategic investment in digital technologies to help achieve these goals. The five core components are a single electronic health record (EHR), a health and wellness dataset, digital hospitals, a preventive health IT capability and regional IT foundations. The single EHR in particular is an ambitious goal, as shown by the many countries who have tried without success to create one. It is, however, an entirely logical undertaking in a country the size of New Zealand.

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

207 <http://www.health.govt.nz/our-work/ehealth/digital-health-2020>

As well as providing direction, the Ministry of Health has provided a number of tools to support the growth of eHealth. These include a secure network over which health information can be shared, a set of standards to guide digital processes²⁰⁸ and identity management systems such as the National Health Index for patients and the Health Provider Index for health practitioners, organisations and facilities. Prior to the release of the 2016 Health Strategy, it had been actively promoting patient portals, electronic prescribing and administration of medications in hospitals, common clinical information repositories and telehealth. Much of this work will carry on through Digital Health 2020.

District health boards (DHBs) are actively pursuing smarter more-efficient systems to provide patient care, and more of this work is being done regionally. For example, the South Island DHBs now have a common clinical information system, have begun the rollout of a common patient administration system²⁰⁹ and have a system for providing a common view of patient information from a variety of sources such as hospital, community pharmacies and general practice.²¹⁰ Most of this information is also accessible remotely, with the only requirement being access to a web browser and the internet. This provides clinicians with the not always welcome opportunity to work from anywhere at any time.

In 2016, all the DHBs were benchmarked on their use of digital systems against the EMR Adoption Model (EMRAM) developed by the Healthcare Information and Management Systems Society. The model generates a score between 0 and 7, with 7 representing a fully digital hospital. Three DHBs achieved a score of just over 5, while the rest scored between 2 and 3. Lifting these scores will take an enormous amount of effort.

208 <http://www.health.govt.nz/about-ministry/leadership-ministry/expert-groups/health-information-standards-organisation>

209 <https://www.sialliance.health.nz/our-priorities/information-services/si-pics/>

210 www.healthone.org.nz

As this happens, clinicians need to keep their focus on doing what is best for patients and what supports their workflow.

Many smart systems are available at the primary and community care level. For example, most of New Zealand's telephone help lines were amalgamated in 2016 into the National Telehealth Service, which provides a simple contact point for the public to access a wide range of health services and advice, integrated across a consistent platform. Triage of patients calling for acute advice is done by a range of clinicians, supported by clinical decision software.

The educated patient

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

The challenge for patients is to find the true and relevant information that is bobbing about in a sea of conjecture, opinion and marketing and then apply it to their own health. Doctors are in a privileged position, especially if they understand the internet themselves, to guide patients. The National Library of Medicine in the United States has produced a resource to help patients evaluate health information.²¹¹ In New Zealand, an excellent resource for patients and clinicians is the Health Navigator website (www.healthnavigator.org.nz).

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

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

Continuing professional development

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

Many sites are not peer reviewed and are not subject to the publishing and review rules that we expect of evidence-based medical information. To determine the value of information you find on the internet, it’s important to check each article for the basics of quality evidence-based medicine:

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

The Health on the Net Foundation (www.hon.ch) has developed a Code of Conduct and has developed databases of health information resources that have been assessed as meeting the requirements of their code. Practitioners intending to publish information on the internet should follow the HON code of conduct when writing and publishing.

As with any form of medical literature review, when searching the internet, it is best to stick to mainstream, peer-reviewed, evidence-based information resources. The availability of electronic copies of a number of the mainstream medical journals makes internet literature review easier, and abstracts of some of the lead articles in these journals can be obtained free of charge from their websites.

Another key information resource is Pubmed. This database contains all articles and letters published in over 5,600 peer-reviewed medical journals from around the world. Abstract data can be obtained free from Pubmed, and you can purchase copies of complete articles from the website. Alternatively, you can use Pubmed to identify the key references and then search them out at your local medical school library. Taking up an academic or honorary clinical lecturer position will often come with online access to the medical library subscriptions.

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

Communicating with or about patients

When you communicate with or about a patient in person, it is possible to do so in a secure and private way – no one else can intercept the communication and no one else can observe the communication at its source or destination. When you use an electronic method of communication, it becomes harder to give this guarantee, but the same rules, as set out in the Privacy Act and its associated codes and regulations and the *Code of Health and Disability Services Consumers' Rights*, still apply.

The other thing to consider is how communicating by email affects the flow of communication with patients and how this can at times lead to a misunderstanding or miscommunication.

The use of email as a means of communicating with patients significantly increases the problems of confidentiality, privacy and data security.

- How do you determine that the person asking the question is actually the patient named on the email and not some other member of the household who has access to the family computer?
- What can you do to be assured that any results sent by email will be read by the patient only?
- Is this information so sensitive that it is inappropriate to send it by email?
- Can you be sure that the patient has received the information?
- Is there someone monitoring your email address if you are away?

The other thing to consider is how communicating by email affects the flow of communication with patients and how this can at times lead to a misunderstanding or miscommunication. All of the above apply in greater measure to communicating with patients by text message, although this is a common communication channel, as messages can often be generated through the patient management system.

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

The use of patient portals can solve some of the problems mentioned above. Patients can more easily exercise their right to access their information, and most portals support the secure transfer of messages between doctor and patient, with the ability to confirm that the message has been received and read. Nearly 300,000 New Zealanders now use a patient portal, and the rate of uptake is steadily increasing.

Using any form of social media in relation to specific patients is very difficult to justify, and you should do so with great caution. You may feel that you are not identifying a patient to others, but if they or their family are able to identify themselves, they may find this distressing. Even when you are not using social media in relation to your work, your patients may be able to see what you post, and this may determine, rightly or wrongly, how they view you as a professional. The Medical Council has detailed their view on the use of social media in their statement on the use of the internet and electronic communication.²¹²

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

212 <https://www.mcnz.org.nz/assets/News-and-Publications/Statement-on-use-of-the-internet-and-electronic-communication-v2.pdf>

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

None of these systems have been particularly good at managing the sharing of patient images, and this doesn't always occur in the context of a formal referral. It may be that one doctor is seeking advice from another, for example, a rural hospital medicine specialist is working with a plastic surgeon to determine whether a patient needs to be transferred to a burns unit. The lack of appropriate tools has meant that this is usually done with the use of a personal mobile device to capture the image, which is then sent by text or email. The New Zealand Medical Association has recently provided some guidance on how to do this properly,²¹³ and secure image capture and transfer applications are starting to become available.

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

Outside of the health intranet, however, the internet is essentially an unsecured network, and unless you take adequate precautions, the data on your computers and computer terminals themselves can be captured (hacked) and read by anyone outside of your medical practice.

213 http://www.nzma.org.nz/_data/assets/pdf_file/0003/50988/Clinical-images-guide-ONLINE.pdf

Before you begin any process that involves you or your practice sending or receiving information about patients over the internet, especially if you intend to operate outside of the health intranet, you should consider whether the system you are using is secure and able to maintain patient confidentiality and privacy. The website of the Privacy Commissioner (www.privacy.org.nz) sets out the Commissioner's requirements for data security. Health Information Standards Organisation (HISO) has developed a Health Information Security Framework,²¹⁴ and if you want to go deep into the topic, try the New Zealand Information Security Manual.²¹⁵ A much easier guide to get you started is the checklist put together by Patients First,²¹⁶ and if this raises any doubts in your mind about the security of your system or network, you should seek professional advice.

Assessment and treatment

It is possible to argue that an in-person assessment is not always required in order to make treatment decisions with a patient. On many occasions, particularly for follow-up visits, no physical examination is necessary (although we may do one to complete the experience), and this provides us with an opportunity to work in a different way. More broadly, this is the concept of telehealth – the use of information and communication technologies to deliver health care when patients and care providers are not in the same physical location.

Under this umbrella term sit four modalities:

- **Video consultation** – videoconferencing used for real-time consultation where usually there is direct patient involvement but also episodes where the patient is not directly involved yet remains the focus of the consultation, for example, multi-disciplinary meetings and case conferences.

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

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

216 <http://www.patientsfirst.org.nz/downloads/gp-security-checklist.pdf>

- **Store and forward** – collecting clinical information and sending it electronically to another site for evaluation by a clinician at their convenience. Transmitted information typically includes demographic data, medical history, documents such as laboratory reports and image, video and/or sound files.
- **Telemonitoring** – refers to remotely collecting and sending patient data so that it can be interpreted and then contribute to the patient's ongoing management. It allows the patient to stay in their home or usual place of residence and maintain contact with the team providing their care. Most commonly, the data collected is a physiological variable like blood pressure, but it can also be self-reported symptoms or activity levels. In addition, alarm systems, fall detection, treatment adherence and environmental monitoring are also forms of telemonitoring. Collecting and sending the data in real time is referred to as telemetry.
- **mHealth** – the use of mobile communications technologies in medical and public health practice, including the delivery of health information, health services and healthy lifestyle support programmes. Mobile communications devices include mobile phones (these days generally smartphones such as iPhones or Android-based phones), tablet computers, mobile sensors and other devices that use cellular networks (3G or 4G), WiFi or Bluetooth. Specific functionality that mobile communications technology enables include text messaging (SMS), smartphone/tablet apps, mobile web browsing, video calling, MMS/pxt and allowing the mobile use of technologies such as QR code scanning and GPS locating.

The New Zealand Telehealth Resource Centre (www.nztrc.org.nz) is a valuable source of further information, particularly if you are contemplating setting up a telehealth service.

Video consulting (VC) is now quite widely practised. It has evolved from occurring primarily between secondary care sites to now involving links between primary and secondary care and, in some cases, directly into a patient's home. In addition, complex VC systems are used within clinical networks, usually oncology, to allow multiple specialists to discuss

individual patients, while simultaneously viewing radiology, histology and pathology images and results.

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

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

There are advantages for the health system too. Video consulting helps to enable equitable and efficient access to care, and that may apply particularly to rural, Māori and Pasifika patients. It may actually improve the quality of care. Because it is efficient, it may support the sustainability of the New Zealand health care system, reduce the cost of care and make better use of the contemporary specialist workforce.

The Medical Council has provided a statement on telehealth²¹⁷ showing clear support for doctors who work in this way, as long as the same standard of care is able to be provided.

217 <https://www.mcnz.org.nz/assets/News-and-Publications/Statement-on-telehealthv3.pdf>

This means that, if a physical examination is required to make the right treatment decision, one must occur before you proceed. They also provide specific guidance on prescribing, discussed in the next section.

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

The use of store and forward technology is very common – consider radiology where all images are now captured digitally. Most are read within the organisation that acquires them, and many are read at a distance by radiologists based overseas. The Medical Council since 2010 has provided a teleradiology special-purpose scope of practice,²¹⁸ which limits access to radiologists whose qualifications and registration are recognised by the Council and who are employed by a fully credentialled health care provider in New Zealand. Dermatology is another speciality that lends itself to store and forward.²¹⁹ The efficiency of these systems is key given that access to an in-person dermatologist is very limited in most of our public hospitals.

Mobile health is plagued with the same difficulties as the internet in that a small number of safe, secure, accurate and effective apps are buried under a landslide of games and apps designed to acquire personal data and track spending habits and movements. The NHS has had a previous failed attempt to create an app library but has just relaunched this service.²²⁰ We have a local app library available through the Health Navigator website.²²¹ Remember that if you promote an app to a patient as a form of treatment, just as with prescribing a medication, it is important to check understanding, compliance and effectiveness.

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

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

220 <https://apps.beta.nhs.uk/>

221 <https://www.healthnavigator.org.nz/app-library/>

At an organisational level, approaches to mobile device management are being developed so that staff can use apps at work, often on their own device, without compromising the security of patient data or the organisation's network.

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

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

Internationally, medical licensing authorities such as the Medical Council and the Federation of State Medical Boards of America and regulatory authorities such as Medsafe have indicated that they are prepared to prosecute doctors involved in online medical practice who provide inadequate care, and the authorities have done so on multiple occasions.

Medsafe has already successfully prosecuted a pharmacy that was supplying prescription medicines to consumers in the United States and has investigated several cases where doctors are signing or countersigning prescriptions for patients overseas to allow medicines to be dispensed from New Zealand pharmacies. This activity is contrary to best medical and pharmacy practice, and the Medical Council's statement on telehealth and the Pharmacy Council's statement on the promotion and supply of medicines over the internet²²² are examples of how the professions are no longer prepared to tolerate these activities.

Before considering any scheme to prescribe over the internet, you should take legal advice on your potential liabilities in both New Zealand law and in the law of the countries where your patients reside. You should also check that the terms of your medical practice (malpractice) insurance would cover you for care of patients in other countries.

Prescribing

The issuing of prescriptions is legally restricted:

- Under clause 39 of the Medicines Regulations 1984, no doctor is permitted to prescribe medication to an individual unless it is for the treatment of a patient under their care.

222 <http://www.pharmacycouncil.org.nz/Portals/12/Documents/standardsguidelines/Promotion%20and%20Supply%20of%20Medicines%20over%20the%20Internet%20-%20November%202015.pdf?ver=2017-02-20-104757-057>

- Prescriptions must be legibly and indelibly printed and personally signed by the prescriber with their usual signature (not a facsimile or other stamp). Therefore, those issued only by email or other electronic means do not meet New Zealand legislative standards under clauses 40–41 of the Medicines Regulations.²²³ The Medical Council’s statement on telehealth provides some clarity around how these legal requirements apply in the context of telehealth. You should also review the statement on good prescribing practice.²²⁴

The Council’s statement advises that you may issue a prescription, including repeat prescriptions, only when you:

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

The Council also expects that, before any prescription is issued, you should have had at least one in-person consultation with the patient or have discussed the patient’s treatment with another New Zealand registered health practitioner who can verify the patient’s physical data and identity.

Some exemptions to the requirement apply where a video consultation may suffice, with examples including the urgency of the situation or the unavailability of a doctor. You should though be very cautious issuing a prescription by means of telehealth outside of this broad expectation. If you are not the patient’s usual doctor, you also need to seek the patient’s permission and share information about your prescribing with the patient’s principal health provider who will usually be their general practitioner (see [Chapter 1 – Good medical practice](#), paragraphs 46–49).

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

224 <https://www.mcnz.org.nz/assets/News-and-Publications/Statement-on-good-prescribing-practice.pdf>

If you are asked to prescribe by email for one of your own patients, a telephone script to a pharmacy followed by faxing and sending a written prescription to that pharmacy is required.

It is illegal for a patient to be in possession of a prescription medicine other than that obtained by filling a prescription written by a registered doctor. Prescription medicines purchased over the internet are therefore likely to be stopped at the border and the patient asked for proof that they have a prescription. If you are asked to write a prescription to allow your patient to obtain a medicine they have bought over the internet, you should consider a number of ethical and practical questions:

- Many medicines purchased on the internet are counterfeit products. Are you prepared to facilitate patient access to such medicines?
- Is the medicine available in New Zealand?
- Does the patient actually need the medicine?
- Are you satisfied that the medicine being imported meets the necessary standards of safety, quality and efficacy of locally available medicines or in fact even that the product actually contains the stated active ingredient? There may be legal liabilities if harm is caused by the use of medicine purchased on the internet.²²⁵

225 <http://www.medsafe.govt.nz/profs/PUarticles/counterfeit.htm>

Bringing it all together – virtual health care

The logical evolution of eHealth is to bring all the various components mentioned above together in a specific and planned way to create a virtual version of health care. The opportunity this provides is not simply to replicate what we do at the moment but to change the focus and rearrange the workflow. Analogue health care is location based, and usually the patient comes to the doctor. Digital health care can bring together the patient and doctor, as well as the wider health care team, regardless of location. This is already happening in New Zealand, with Waikato claiming the title of Virtual DHB and offering a service they have termed SmartHealth.²²⁶

Other organisations and individuals, both public and private, will be sure to follow. The only thing that is certain is that, if we as doctors aren't involved in shaping these changes, we won't have any valid reason to complain about them. When involved, we must also seek a balance between profit and professionalism, between altruism and entrepreneurialism, and must, as always, consider what we are doing in terms of beneficence, non-maleficence, autonomy and distributive justice.

Joe White makes an online follow-up hypertension appointment and tells the doctor his home recordings. He looks healthy and happy. Routine enquiry elicits no problems. It is time to recheck his bloods, so the doctor sends him a form electronically as well as his prescription and instructions that next time will be his annual in-person check.

226 <https://www.waikatodhb.health.nz/for-patients-and-visitors/smarthealth/>

Brian Pink comes online and tells the doctor he has a mole that has changed colour and moves so that the lesion on his shoulder is in front of the camera. The doctor is not reassured by its appearance – actually, she rarely is and certainly never online – and asks him to come in for a closer look. The treatment room will be ready for possible excision biopsy.

Jack Black manoeuvres his red hot swollen first MTPJ in front of his laptop camera. It is his third attack of gout in 5 years, triggered by a dietary indiscretion on a familial hyperuricemia. The doctor introduces the idea of allopurinol, and they discuss the pros and cons, but he opts for the short sharp course of naproxen that has promptly settled it in the past, understanding it may not be his last.

None of these have phoned for an appointment, taken a taxi to the surgery, taken 2 hours off work, negotiated their way past a protective receptionist, sat inadvertently in a small puddle of vomit or picked up influenza in the waiting room. There is nothing second rate or unsafe about the care they receive. It is also cheap green care – the doctor does not need a high-rent well-equipped consulting room for these meetings, so their room at the practice is, for the time, free for another doctor to do face-to-face work.

Acknowledgement

I would like to acknowledge Drs Stewart Jessamine and Ian St George for their contribution to earlier versions of this chapter, previously titled 'Medicine and the internet. A significant amount of their work has been retained.

CHAPTER 14

Choosing Wisely – more isn’t always better

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Cite this as Sherwood D, Read D, Ineson S. Choosing Wisely – more isn’t always better. In: Morris KA, editor. Cole’s Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	197
What is low-value care?	197
Why does low-value care happen?	199
Is there care in New Zealand that does not add value?	200
Choosing Wisely principles	201
How to be involved in Choosing Wisely	202
Putting Choosing Wisely into practice	203
Engagement with patients and the public	204
Conclusion	205
Choosing Wisely resources	207

Introduction

Choosing Wisely is a global initiative that has been implemented in a number of countries, including USA, Canada, UK, Australia, some of Europe and a few counties in Asia.²²⁷ The campaign aims to promote a culture where low-value care and inappropriate clinical interventions are avoided and patients and health professionals have well-informed conversations around their treatment options, leading to better decisions and improved outcomes.

In New Zealand, Choosing Wisely involves a number of professions including doctors, nurses, midwives and allied health professionals. It also has strong consumer involvement and works closely with the Health Quality & Safety Commission and Consumer NZ.

Choosing Wisely NZ has the support of over 30 health sector groups.

Choosing Wisely involves a number of professions including doctors, nurses, midwives and allied health professionals. It also has strong consumer involvement.

What is low-value care?

This is care that gives little or no benefit to patients, care where the risk of harm exceeds likely benefits and care where the costs do not provide proportional benefit. As Dr Roy Moynihan noted 'medicine's much hailed ability to help the sick is fast being challenged by its propensity to harm the healthy'.²²⁸

227 Australia, Austria, Brazil, Canada, Denmark, England, France, Germany, India, Israel, Italy, Japan, Netherlands, South Korea, Switzerland, United States and Wales are currently all involved in this campaign.

228 Moynihan R, Doust J, Henry, D. Preventing over diagnosis: how to stop harming the healthy. BMJ. 2012;344:e3502.

Supporters of Choosing Wisely accept that, of the complexity of tests, treatments and procedures available to modern medicine, many do not add value. Some are rendered redundant as others take their place, but they continue to be used in practice. Interventions that are not supported by evidence do not lead to high-quality care and may even cause harm.

Professor Wendy Levinson, Professor of Medicine at Toronto University and Chair of Choosing Wisely International, has commented that:

'...overuse, waste and harm in the healthcare delivery sector is a far larger and far more common problem than most realise. Publicity around healthcare delivery gives the impression that under-performance and under-delivery are the core issues in health these days. But actually, in America, Canada and most other health systems up to 30 percent of health care delivered adds no further value.'²²⁹

These comments have recently been confirmed by the report *Unnecessary care in Canada* by the Canadian Institute for Health Information, which examined selected Choosing Wisely recommendations²³⁰ promoted in Canada and found that up to 30 percent of tests, treatments and procedures associated with the eight selected Choosing Wisely recommendations were potentially unnecessary.²³¹

229 Presentation from Professor Wendy Levinson of Toronto University at the first symposium for New Zealand Choosing Wisely held in Wellington on 30 March 2017.

230 Health professional colleges, societies and associations and service delivery groups are encouraged to develop lists of recommendations about appropriate tests, treatments or procedures that are commonly used in their speciality but are not supported by evidence and/or could expose patients to unnecessary harm and contribute to stress and avoidable cost for patients and/or create an increased strain on our health care system.

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

Why does low-value care happen?

Reasons for unnecessary interventions include lack of time for shared decision making,²³² fear of missing a diagnosis, financial incentives, the way doctors are taught, patient expectations and avoiding the challenging conversation of telling patients they do not need specific tests, procedures or treatments.²³³ An understanding of what lies behind unnecessary care is required to inform ways of reducing the use of these interventions.²³⁴

Doctors in New Zealand work in a sector where there are resource limitations so they have a responsibility to ensure the allocation of health resources is based on need and evidence.²³⁵ In a system where resources are constrained, it is unethical as well as inefficient to provide interventions that have no clinical value.

Doctors are also concerned about complaints if they do not undertake a test, procedure or treatment. Professor Wendy Levinson was recently asked about the risk of complaints to the Health and Disability Commissioner or practitioners' professional bodies if, for example, a patient is advised not to have a particular test or procedure done but later feels their health has suffered as a result? Dr Levinson's response was:

‘...the campaign is not about forcing people to do things a particular way. It's about engaging in a conversation. Patients who feel informed and involved are less likely to sue, in our experience. A fundamental component of Choosing Wisely is shared decision-making and information. So far in Canada there has not been a single case where Choosing Wisely has come up in a case.’²³⁶

232 Zikmund-Fisher BJ, Kullgren JT, Fagerlin A, et al. Perceived barriers to implementing individual Choosing Wisely recommendations in two national surveys of primary care providers. *J Gen Int Med*. 2016 Sep 6. [Epub ahead of print] doi: 10.1007/s11606-016-3853-5.

233 Levinson W, Kallewaard M, Bhatia RS, et al. 'Choosing Wisely': a growing international campaign. *BMJ Qual Saf*. 2014;0:1–9. doi: 10.1136/bmjqs-2014-003821

234 Colla CH, Kinsella EA, Morden NE, et al. Physician perceptions of Choosing Wisely and drivers of overuse. *Am J Manag Care*. 2016; 22:337–343.

235 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Safe-practice-in-an-environment-of-resource-limitation.pdf>

236 Levinson W. Reducing harm and creating a sustainable health system: Choosing Wisely. *The Specialist*. 2017 July; 111:18–19.

In a similar vein, at a recent presentation at the Australian Choosing Wisely 2017 symposium, Associate Professor Nola M Ries noted that a doctor's duty is to exercise reasonable care and skill, and one of the arbiters of this is the peer opinion of competent practitioners.²³⁷ Choosing Wisely recommendations are based on evidence and developed with the support of peers.

Is there care in New Zealand that does not add value?

In December 2016, the Council of Medical Colleges (CMC)²³⁸ surveyed doctors in New Zealand with the assistance of the New Zealand Medical Association (NZMA) and Association of Salaried Medical Specialists (ASMS).²³⁹ The survey was answered by 1,024 people. A total of 46.4 percent of ASMS respondents considered that the provision of unnecessary tests, procedures or treatments was either a 'serious' or 'very serious' issue in their current area of practice. This compared with 56.6 percent of NZMA respondents. The survey found that two-thirds of doctors (61.6 percent) think that unnecessary testing, procedures and treatments is a serious or very serious issue in the New Zealand health sector.

The survey results appear to confirm that it is quality of care rather than cost reduction that is the predominant factor in New Zealand doctors' decision making as to whether a test, process or treatment is appropriate.

237 Ries N. Choosing Wisely: Law's contribution as a cause of and a cure for unwise healthcare choices. Forthcoming in the Journal of Law and Medicine. 2017 May 1.

238 The Council of Medical Colleges is facilitating this initiative in New Zealand as part of its commitment to improving the quality of care for all patients.

239 The ASMS survey covered senior medical officers across a range of specialities working in hospitals. Most of the respondents from NZMA (71.3%) worked in general practice – a further 2.2% were in the General Practitioner Education Programme (GPEP), while 20.5% were resident medical officers. For the full survey, see <http://choosingwisely.org.nz/wp-content/uploads/2016/12/Survey-of-doctors%E2%80%99-practice-regarding-unnecessary-tests-treatments-and-procedures-in-New-Zealand-.pdf>

While doctors are conscious of cost, time and resources, this is a secondary factor in their considerations.

Doctors in the CMC survey also noted that the decision whether or not to provide a potentially unnecessary test, procedure or treatment is not a clear-cut issue. Rather, it depends on the broader context and situation. Respondents highlighted a number of factors that need to be considered, including the cost of the tests, procedures and treatments, the extent to which they might be harmful, whether the patient was paying for them, the nature of the doctor-patient relationship and the level of patient anxiety associated with not having the test, procedure or treatment.

A number of respondents considered that the survey answer options did not reflect the complex and nuanced reality faced by practitioners. Many highlighted that there was a process of shared decision making and negotiation between doctor and patient. As noted above, fear of being subject to a complaint was also mentioned.

Choosing Wisely principles

The concepts behind the Choosing Wisely campaign are not necessarily new. What links proponents of the Choosing Wisely campaign across the world is acceptance of the five Choosing Wisely principles:

- **Health professional-led:** The campaign must be health professional-led (as opposed to payer/government-led). This is important to building and sustaining the trust of health professionals and patients. The campaign is focused on quality of care and harm reduction rather than cost reduction.
- **Patient and consumer-focused:** The campaign must be patient-focused and involve efforts to engage patients in the development and implementation process. In New Zealand, CMC has been working with consumer groups and Consumer NZ to implement this principle. Communication between health professionals and patients is central to Choosing Wisely.

- **Multi-professional:** Where possible, the campaign should include doctors, nurses, pharmacists and other health care professionals. In New Zealand, CMC has the support of the Health Quality & Safety Commission, NZMA, Medical Council of New Zealand, ASMS, Cochrane New Zealand, New Zealand College of Midwives, the Pharmaceutical Society of New Zealand and allied health groups.
- **Evidence-based:** The recommendations issued by the campaign must be evidence-based and must be reviewed on an ongoing basis to ensure credibility.
- **Transparent:** Processes used to create the recommendations must be public, and any conflicts of interest must be declared.

How to be involved in Choosing Wisely

Health professional groups are asked to develop a list of tests, treatments or procedures that health professionals and patients should question. These are tests, treatments or procedures that are frequently used and may expose patients to harm or unnecessary stress. While professional groups are free to determine the process for creating their lists, each item on the list should be within the group's scope of practice. There should be generally accepted evidence to support each recommendation.

In 2017, over 20 groups had developed lists of over 100 recommendations they are promoting to their membership. Recommendations have also been developed by the New Zealand Medical Student Association, which has adopted a WISE acronym to help promote Choosing Wisely and help students remember the key concepts:

- **Why?** What will this test, treatment or procedure change?
- **Is there an alternative?** Less invasive, less resource intensive?
- **Seek clarification.** Clarify why the doctor ordered this test.

- Explore/explain. Be the patient's advocate. Explore concerns, take time to explain why a test, treatment or procedure is or isn't necessary.

Just developing recommendations is insufficient. Effective Choosing Wisely programmes are clinician-led.^{240, 241} Health professionals need to start to challenge themselves and their colleagues on the way they think about health care, questioning the notion 'more is always better'. They need to start a conversation with their colleagues about what care is truly needed, identifying which practices are helpful and which are not.

Putting Choosing Wisely into practice

Several services in New Zealand are now implementing Choosing Wisely recommendations and, where possible, measuring changes. Implementation is best carried out at a local level from the bottom up.²⁴² This may involve an individual department or service selecting relevant recommendations that have already been developed, modifying these recommendations to suit local circumstances or deriving their own recommendations.

Examples of Choosing Wisely interventions being undertaken in New Zealand include reduction in unnecessary blood tests and reduction of insertion of unnecessary intravenous cannulas at Waikato Hospital's Emergency Department. At Capital & Coast DHB, measures have been undertaken to improve inclusion of relevant clinical details on phlebotomy forms.

240 Hurley R. Can doctors reduce harmful medical overuse worldwide? *BMJ*. 2014;349:g4289. doi: 10.1136/bmj.g 4289.

241 Stinnett-Donnelly JM, Stevens PG, Hood VL. Developing a high value care programme from the bottom up: a programme of faculty-resident improvement projects targeting harmful or unnecessary care. *BMJ Qual Saf*. 2016;25:901–8. doi: 10.1136/bmjqs-2015-004546.

242 See footnote [241](#).

In other countries, Choosing Wisely interventions have included avoidance of transfusion of red blood cells for arbitrary haemoglobin or haematocrit thresholds in the absence of symptoms and reducing unnecessary bladder catheterisation.

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

Engagement with patients and the public

A core element of Choosing Wisely is to promote shared decision making between health professionals and patients and to develop accessible, plain-language materials for the public about the recommendations. In New Zealand, over 35 Choosing Wisely resources have been developed for patients, which are promoted on the Choosing Wisely and Consumer NZ websites. CMC is now working with Health Navigator NZ²⁴³ to extend this work.

Choosing Wisely encourages the patient to ask these four questions:

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

CMC has worked with Consumer NZ to survey health consumers about their views as to whether or not their doctors prescribed tests or treatments that were unnecessary.

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

The results of the survey are intended to provide a baseline against which the campaign can be measured in the future. The survey, completed in late 2016, was of a nationally representative sample of 1,318 people. A total of 49 percent of respondents agreed some tests or treatments that are done do not benefit the patient in any meaningful way. Just under 30 percent disagreed. Nearly one in five respondents felt their doctor had recommended a test or treatment that was unnecessary. When they visited a doctor, 56 percent of respondents generally expected the doctor to provide a prescription or send them for a test, 31 percent did not and 13 percent were unsure.

As the Medical Council of New Zealand *Statement on information, choice of treatment and informed consent* states with clarity:

‘Trust is a vital element in the patient-doctor relationship and for trust to exist, patients and doctors must believe that the other party is honest and willing to provide all necessary information that may influence the treatment or advice. The doctor needs to inform the patient about the potential risks and benefits of the options available and support the patient to make an informed choice.’²⁴⁴

Conclusion

Since the formal launch of the Choosing Wisely campaign in New Zealand in late 2016, a total of 20 Australasian and New Zealand colleges, specialist societies and associations have endorsed over 100 recommendations that health care professionals, patients and consumers should question.²⁴⁵ Each recommendation is based on the best available evidence.

244 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Information-choice-of-treatment-and-informed-consent.pdf>

245 <http://choosingwisely.org.nz/health-professionals/>

Don't do something because it can be done; do it if it is necessary for your patient.

The key message accompanying the Choosing Wisely recommendations is that they are not prescriptive but intended as a guideline to start a conversation about what is appropriate and necessary. The campaign highlights that each situation is unique, and health care professionals and patients should use the recommendations to collaboratively formulate their own appropriate health care plan together.

It is clear from CMC doctor survey results that many New Zealand doctors are already taking a nuanced approach to determine whether certain tests, treatments and procedures are appropriate for their patients. Moreover, they are typically doing so using a process of discussion, negotiation or shared decision-making. One of the key themes emerging from survey comments is that smart choices are not just an issue for the doctor-patient relationship but one that also needs to be addressed across the whole health care team. This is consistent with the multi-professional principle endorsed by Choosing Wisely.

While Choosing Wisely has faced criticisms that it is about saving money, one of the core principles of the campaign is that it must be health professional-led and be about rationalising, not rationing. This emphasises that campaigns are focused on quality of care and harm reduction rather than cost reduction.

Don't do something because it can be done; do it if it is necessary for your patient.

Choosing Wisely resources

New Zealand

Developed by CMC in 2016 and 2017 from Choosing Wisely resources in Canada and the USA.

- **Starter kit for your Choosing Wisely campaign**
This is an introduction to the Choosing Wisely concepts. This guide is aimed at assisting colleges, societies and other organisations to develop a list of recommendations for the Choosing Wisely campaign.
- **Developing recommendations to implement Choosing Wisely in New Zealand**
This guide is aimed at colleges, specialist societies, associations, health professional groups and service organisations wanting to develop recommendations to implement Choosing Wisely.
- **Implementing choosing wisely principles in a service**
This guide is aimed at those working within services in New Zealand (DHBs and PHOs) to give guidance on how to implement Choosing Wisely in a service and identifies factors for success. Updated June 2017.
- **Measuring the impact of Choosing Wisely interventions**
This guide is to help those implementing Choosing Wisely work in services to assess any resulting changes and measure the impact of the work.
- **A synopsis of Choosing Wisely literature arranged by year and alphabetically by author**

These and many other resources are on the Choosing Wisely NZ website www.choosingwisely.org.nz

Overseas

www.choosingwisely.org.au in Australia

www.choosingwiselycanada.org in Canada

www.choosingwisely.org in the USA

www.choosingwisely.co.uk in the UK

CHAPTER 15

Informed consent

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Cite this as Coates J, Deans C, Connolly A. Informed consent. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	209
Code of Health and Disability Services Consumers' Rights 1996	210
Key elements of legally valid informed consent	211
› Competence	211
› Information	213
› Voluntary	216
Obtaining informed consent	216
Form of consent	217
Giving informed consent on behalf of another person	218
Children and informed consent	219
Unexpected events	220
When informed consent is not necessary	220
Teaching and research	222
Consequences of treating without consent	223
Acknowledgement	224

Introduction

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

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

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

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

A patient's right to give informed consent is entrenched in the New Zealand Bill of Rights Act, the common law and the Code of Health and Disability Services Consumers' Rights 1996. Informed consent is more than getting a patient to sign a consent form. It is also more than a one-off action. It is a process that continues throughout all stages of the treatment or procedure. The Medical Council of New Zealand has a *Statement on information, choice of treatment and informed consent*.²⁴⁶

Code of Health and Disability Services Consumers' Rights 1996

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

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

246 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Information-choice-of-treatment-and-informed-consent.pdf>

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

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

Key elements of legally valid informed consent

There are three key elements for informed consent:

- **Competence:** the person must have the necessary capacity to consent to the intervention or refuse the treatment.²⁴⁷
- **Information:** the person must be appropriately informed in order to make an informed choice about the proposed treatment.
- **Voluntariness:** the person’s consent must be given voluntarily and without pressure from any other person.

Competence

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

Every patient is presumed competent unless there are reasonable grounds for believing that the patient is not competent. This presumption is set out in Right 7 of the Code of Rights. A patient may be wholly or partially competent, and competency can vary throughout a course of treatment.

²⁴⁷ Practitioners should be aware that ‘capacity’ is sometimes used interchangeably with ‘competence’. Insofar as the principle of informed consent is concerned, capacity and competence have the same meaning.

Capacity may fluctuate, for example, from anaesthesia or as a result of a head injury. It is the responsibility of the practitioner who will be providing the treatment to consider whether at any given point in time the patient has sufficient competence to consent to the specific treatment decision in question. Sometimes, the responsible doctor may need to obtain the assistance of another medical doctor who specialises in making this type of assessment.

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

Assessing competence is a matter of clinical judgement. A person will have capacity to make a particular decision if they can:²⁴⁸

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

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

248 *Re C (Adult: Refusal of medical treatment)* [1994] 1 All ER 819, 824.

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

A higher level of competence may be required for interventions that are particularly invasive or carry material risk than is required for treatment for a minor health matter. A child, for example, may be able to consent to a knee being bandaged but may not have competence to make complex decisions about cancer treatment. Where it is unclear whether a patient has the level of competence required for the particular decision, the health practitioner responsible for the patient's care should seek a second opinion by a senior doctor. Where the decision in question has potentially serious consequences, it may be necessary to obtain the opinion of a psychiatrist or another health professional with particular expertise in assessing competence.

Information

A competent patient or a person legally entitled to consent on behalf of an incompetent patient must be given sufficient information to enable them to make an informed choice and give or refuse informed consent. The practitioner providing the treatment is responsible for ensuring the patient has sufficient information. The bottom line is that a patient must receive all information that a reasonable patient in the circumstances would expect or that is needed to make an informed choice or give informed consent.²⁴⁹

249 Right 6(1) and (2) of the Code of Rights

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

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

If at any time prior to the treatment a doctor is privy to information that is relevant to the treatment, the doctor must pass that information on to the patient.

In one case, abnormal liver function blood tests were not noticed by the surgeon until after the patient was anaesthetised. The patient died during the surgery from complications associated with the abnormal liver function. The HDC found that the surgeon should have woken the patient from anaesthesia and discussed the significantly increased risks associated with the abnormal results and only proceeded after fresh consent was obtained from the patient.²⁵⁰

250 Health and Disability Commissioner Case: 07HDC11318.

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

Sometimes, a competent patient wants treatment, but does not want to be told all the details of the treatment. If a patient refuses to hear the ‘gory details’, it is unlikely that they will fully understand what is involved in the procedure. This raises serious questions as to whether they can give informed consent. In relation to a patient’s right not to hear the details necessary to understand the proposed surgery, the High Court has said that:²⁵¹

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

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

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

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

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

Voluntary

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

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

Obtaining informed consent

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

Form of consent

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

Only in a few situations does the Code of Rights mandate that written consent must be obtained, which are that:²⁵²

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

Regardless of the legal requirements, obtaining consent in writing and/or recording the options and risks discussed with the patient in their clinical notes is a 'simple and obvious precaution' available to doctors.²⁵³

There may be situations where obtaining written consent is impracticable, but ensuring there is written record, completed as contemporaneously as possible from when consent was obtained, is the best protection for doctors where there is any later complaint or concern as to the validity of the consent. However, the more invasive the procedure or the more risks it involves, the more prudent it is to have the patient sign a consent form.

252 Right 7(6) of the Code of Rights.

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

Giving informed consent on behalf of another person

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

- a welfare guardian appointed under the Protection of Personal and Property Rights Act
- a parent of an incompetent child or a guardian appointed under the Care of Children Act 2004
- an attorney holding an enduring power of attorney (EPOA) for personal care and welfare.

A spouse or next of kin cannot consent to or refuse medical treatment on behalf of an incompetent adult unless they hold an EPOA or are their welfare guardian. While both welfare guardians and an EPOA can

consent to treatment on behalf of the person they represent (unless such power has been specifically excluded), they cannot refuse to grant consent to the administration of 'standard medical treatment' or procedures intended to save a patient's life or to prevent serious damage to that person's health.²⁵⁴

The extent of a welfare guardian and EPOA's authority to consent will be set out in the specific court order or document appointing the person. It will likely be necessary to review the relevant document before relying on the consent of the welfare guardian or EPOA.

A spouse or next of kin cannot consent to or refuse medical treatment on behalf of an incompetent adult unless they hold an EPOA or are their welfare guardian.

254 Protection of Personal and Property Rights Act 1988, s 18(1)(c).

Children and informed consent

There is no age of consent for treatment, and the right to give informed consent applies equally to all patients regardless of age. The relevant question is whether the level of understanding of the child enables them to consent to a particular treatment. This position confirms the common law view that minors may provide legally effective consent for medical treatment if they are mature enough to understand what is proposed and are capable of expressing their own wishes.²⁵⁵

It is helpful to think of consent for children and young persons in three age groups:

- **Persons aged 18 years and over:** Presumption of competence. The law treats persons 18 years and over as an adult for purposes of consent and refusing consent. Legal guardianship of parents and any other court-appointed guardian ends at 18 years of age.
- **Young person aged 16–17 years:** Presumption of competence. In New Zealand, young persons 16 and 17 years of age have the statutory right to consent and refuse consent as if the child were of full age. Guardians continue to have a guardianship role until a child is 18 years old and are able to consent or refuse consent for an incompetent 16 or 17-year-old in most situations. A refusal of consent can only be overridden by the courts.
- **Child aged less than 16 years:** Presumption of competence, but this will readily be rebutted where the child is of a very young age. Children can consent to treatment for which they have been judged competent, and a guardian's consent will not be required. Guardians can also consent and refuse consent for a child under 16 years. Where there is doubt about who can make the decision or there is a conflict between the child and a guardian, advice should be sought.

255 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112.

Unexpected events

Unexpected events may occur during the provision of treatment – for example, surgery – which mean the patient might benefit from an additional procedure that goes beyond what was consented. The doctor should only proceed with the additional procedure without consent if it is in the patient's best interests and any delay would endanger the patient's life or cause serious damage to health. Otherwise, the doctor will need to obtain consent from the patient before proceeding with further treatment. In some cases, an operation will need to be stopped and the patient woken up in order to get consent to proceed. An additional procedure should not be performed just because it is convenient and cost-effective to do so.

When informed consent is not necessary

There are rare occasions when it is not necessary to get informed consent.

In an emergency situation, a doctor can (and in most cases must) treat a patient who is not competent to consent to treatment where the treatment is necessary to preserve the patient's life, health or wellbeing and where the treatment is in the patient's best interests. The key features of an emergency are extreme urgency or serious adverse consequences of failure or delay in acting. However, even in an emergency, a competent patient has the right to consent to or refuse medical interventions. Only those treatments that are necessary to preserve life or health should be done at this time.

In an emergency situation, a doctor can (and in most cases must) treat a patient who is not competent to consent to treatment where the treatment is necessary to preserve the patient's life, health or wellbeing.

Any procedure that can reasonably be delayed should be delayed until an opportunity can be given for the patient to consent. Moreover, if a patient has a valid advance directive refusing treatment in an emergency, unless there is any reason to doubt the validity of the directive, treatment should not be provided.

The principle of necessity is a common law principle that overrides the requirement for informed consent. It allows treatment to proceed where a patient is not competent to give consent and treatment is necessary to save the patient's life or prevent a serious risk to health. The action taken must accord with good medical practice – it must be one that a reasonable practitioner would take in the circumstances acting in the patient's best interests. The most common application of this principle will be in an emergency situation. A doctor cannot justify treatment on the basis of necessity when it is contrary to a valid advance directive or the known wishes of the patient.

Right 7(4) of the Code of Rights provides that, if a patient is incompetent and if there is no other person legally entitled to consent on behalf of the patient, treatment can be provided if the following criteria are met:

- a. It is in the best interests of the consumer; and
- b. Reasonable steps have been taken to ascertain the views of the consumer; and
- c. Either, –
 - i. If the consumer's views have been ascertained, and having regard to those views, the provider believes, on reasonable grounds, that the provision of the services is consistent with the informed choice the consumer would make if he or she were competent; or
 - ii. If the consumer's views have not been ascertained, the provider takes into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

A number of statutory exceptions also exist that override the requirement to obtain informed consent, for example:

- a person can be detained and treated without consent under the Health Act 1956 to prevent the spread of infectious disease
- compulsory treatment for a person's mental disorder can be provided where a person is subject to a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992
- under Right 7(10), body parts or bodily substances may be removed from a living person as part of a health care procedure and stored, preserved or used without consent if done for a professionally recognised quality assurance programme, an external audit or evaluation of services or for research that has been approved by an ethics committee.

Teaching and research

The Code of Rights provides that patients have a right to be informed of any proposed participation in any research or teaching, including whether the research requires and has received ethical approval, and the right to be informed of any results of the research (Right 6(1)(d) and 6(3)(d)). If the research or procedure is experimental, consent must be in writing.

Where medical trainees are involved in the treatment or care of a patient, the patient should be informed about the extent of the involvement of the trainee and the trainee's experience. Consent should be obtained from the patient if the care or treatment is part of the trainee's education. This is a requirement even if the trainee is simply observing. The patient has a right to refuse to participate in teaching or have an observer present.

Consequences of treating without consent

The consequences to a doctor of treating a patient without consent may be serious. As a general rule, it is unlawful to treat a competent person without their consent or to treat an incompetent person without the consent of a person who is legally able to consent for that person (unless there is other legal authority to treat without consent). This is even if the doctor carries out the treatment in good faith and in the patient's best interests. There are various forms of liability that may be incurred:

- **Code liability:** A failure to obtain informed consent may amount to a breach of the Code of Rights. The HDC may investigate an alleged breach of the Code of Rights, and if the allegations are proven, a practitioner and/or health provider may be the subject of an adverse opinion from the HDC.
- **Disciplinary liability:** A doctor may face disciplinary action from the Medical Council for a failure to obtain consent. A finding of professional misconduct against the practitioner may result in the Health Practitioners Disciplinary Tribunal imposing a penalty on the practitioner, such as a fine, conditions on their practice and/or, in severe cases, suspension or cancellation of registration.
- **Criminal or civil liability:** Touching a patient without valid consent or other legal authority could amount to battery or assault. In most cases, any injury sustained as a result of the tort will come within the scope of the ACC regime, and a doctor will not be liable for compensatory damages. However, criminal liability for assault or battery remains a possibility.
- **Public law damages:** Although there have been no cases to date, public law compensation could be awarded to a patient for a breach of section 11 of the New Zealand Bill of Rights Act.

Acknowledgement

This chapter is based on the previous chapter ‘Informed consent’ in this publication. The authors acknowledge the previous authors of this chapter – Judith Fyfe and Dr Barnett Bond.

CHAPTER 16

Mental capacity

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Cite this as Douglass A. Mental capacity. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	226
Key concepts of capacity	229
Supported decision-making in practice	231
Tikanga Māori and cultural diversity	232
The legal framework	233
› Code of Health and Disability Services Consumers' Rights (Code of Rights)	233
› Right 7(4) of the Code of Rights: justifying treatment decisions without consent	234
› Protection of Personal and Property Rights Act (PPPR Act)	235
Assessing capacity	236
› Medical conditions affecting capacity	237
› The core legal test	238
› A checklist for assessing capacity	239
Practice points	241
› Who should carry out the assessment?	241
› Form of assessment	242
› Refusal to undergo a capacity assessment	242
› Capacity is not the same as best interests	243
› Undue influence	244
Summary	245
Further resources	245

Introduction

This chapter provides an introduction to mental capacity law and clinical practice. It covers the key concepts, the legal framework and a checklist for assessing capacity. It is based on a clinical and legal guide for health practitioners when assessing an adult's capacity to make decisions.²⁵⁶

New Zealand law in this area is out of date and in need of review.²⁵⁷

The toolkit was developed with input from doctors, lawyers and ethicists. It aims to provide a nationally consistent and systematic approach to assessing capacity specific to the New Zealand health care setting.

Mental capacity (or simply capacity) refers to an individual's ability to make particular decisions or take actions. A capacity assessment focuses on whether the person retains that ability and, if not, who should decide on their behalf and on what basis. These decisions can range from a simple everyday decision about what to have for breakfast to far-reaching decisions about medical treatment or financial investments. A person's inability to make decisions may have legal consequences for them or others. For example, how do we decide whether a patient who has suffered a stroke can give informed consent or make informed choices about their treatment and care? How does a young adult with learning disabilities negotiate choices about their living arrangements? How do we support an older adult experiencing onset of dementia to decide their next steps? In some instances, where a person is in a coma on life support, for example, the extent of a person's incapacity means they are unable to participate in the decisions made about them.

256 Douglass A, Young G, McMillan J. A toolkit for assessing capacity. In: Douglass A, editor. Mental capacity: updating New Zealand's law and practice. Appendix D. Report for the New Zealand Law Foundation; 2016. www.alisondouglass.co.nz

257 Douglass A, editor. Mental capacity: updating New Zealand's law and practice. Report for the New Zealand Law Foundation; 2016. www.lawfoundation.org.nz

Assessing capacity is an essential skill for doctors.²⁵⁸ Any doctor seeking consent for investigation or treatment needs to be able to assess the patient's capacity to give or refuse consent. Doctors may also be asked to assess a patient's capacity to decide about their care and living arrangements, to make a will, to make or activate an enduring power of attorney or to make financial decisions. Although assessing any particular capacity does not require detailed legal knowledge, a doctor must understand in broad terms the relevant legal tests or thresholds for capacity.

Any doctor seeking consent for investigation or treatment needs to be able to assess the patient's capacity to give or refuse consent.

The increasing prevalence of dementia and Alzheimer's disease means there are now more people with impaired capacity in the community, and there is a greater need to support them within the health system. A review of 58 international studies of capacity reported that 45 percent of patients in psychiatric settings and 34 percent of patients in general medical settings lacked decision-making capacity.²⁵⁹ Dementia is the leading cause of incapacity and is expected to affect over 78,000 New Zealanders by 2026.²⁶⁰ In view of the growing prevalence of dementia along with many other brain conditions that affect capacity, it is likely that doctors will need to assess capacity more frequently in the future.

258 See footnote [257](#), para 7.31.

259 Lepping P, Stanley T, Turner J. Systematic review on the prevalence of lack of capacity in medical and psychiatric settings. Clin Med (Lond). 2015 Aug;15(4):337–43.

260 <http://www.health.govt.nz/publication/new-zealand-framework-dementia-care>

The focus in this chapter is on providing a basic introduction to key capacity concepts and on how to carry out a capacity assessment. There are other aspects of mental capacity law and practice with which a doctor should be familiar:

- **Advance directives:** An instruction (written or oral) made by an adult person, while still capable, to refuse specified medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment (see [Chapter 5 – End-of-life issues](#)).
- **End-of-life decision making:** Many decisions in end-of-life care depend on whether the patient has capacity for decision-making (see [Chapter 5 – End-of-life issues](#)).
- **Children and capacity:** The rights and interests of children under the age of 18 to make decisions for themselves or when parents withhold consent to medical treatment (see [Chapter 15 – Informed consent](#)).
- **Mental health law:** Mental health law is specifically for the compulsory assessment and treatment of a patient's mental illness (see [Chapter 25 – The psychiatric patient and the law](#)).
- **Research:** Clinical trials may involve a therapeutic intervention on a patient who lacks capacity to consent or to refuse participation.²⁶¹

In some situations, such as where there is treatment refusal or family conflict about the patient's interests, capacity can be difficult to assess and may not be clear cut. Where the decision involves significant risk or where there is conflict about the decision, it is a good idea to seek the advice of colleagues and members of the multi-disciplinary team. In more borderline or complex cases, a referral to a consultant psychiatrist or geriatrician may be necessary to undertake the assessment and/or provide a second opinion.

²⁶¹ See footnote [257](#), Chapter 6.

Key concepts of capacity

Deciding whether a person has capacity is a legal decision informed by medical and other evidence. A capacity assessment is used to establish whether a person lacks capacity for making certain decisions.

The outcome of the assessment may have significant implications for a patient's autonomy and the legal decisions and processes that may follow. A capacity assessment may be used, for example, to decide whether a patient has the right to refuse medical treatment or to support an application to the court appointing someone else, a welfare guardian, to make decisions for them.

Both the terms 'capacity' and 'competence' can be used. In a clinical context, competence often refers to the process of decision making and capacity to the legal term that is used.

In every assessment of capacity the following key concepts need to be considered:

- There is a presumption that all adults have the capacity to make decisions on their own behalf. The starting point when assessing capacity is always to presume that the person has capacity to make the decision. However, the assessment will be taking place because a reason exists to question the presumption of capacity.
- A presumption of capacity does not diminish the duty of care owed to patients in the delivery of health care. There remains a duty to assess the person so that decisions can be made about the appropriate provision of health care.

Deciding whether a person has capacity is a legal decision informed by medical and other evidence.

- Capacity is decision and time-specific. Someone who cannot make a complex decision may be able to make a simple one. A person whose capacity fluctuates may not be able to make a decision at one point in time, but they might be able to make that decision at a later time. The assessment must relate to the decision that needs to be made at the specific time that it needs to be made.
- A person cannot be deemed to lack capacity solely because they make an unwise decision. A capacity assessment is concerned with a person's decision-making ability, not the decision itself. There may be triggers for questioning a person's capacity, for example, where a person is at significant risk of harm or exploitation or the decision is obviously irrational or out of character for that person.
- A diagnosis is not the same as an assessment of capacity. As with many countries, New Zealand follows a functional approach to capacity not a status approach. A diagnosis or the fact that someone may have dementia, for example, does not necessarily mean that they lack capacity.
- Supported decision making is a human rights concept under the United Nations Convention on the Rights of Persons with Disabilities (CRPD). It emphasises that not only is it important that good judgements are made about whether or not a person has decision-making capacity, but it is equally important to provide ways in which a person can be supported so as to make their own decisions.²⁶² New Zealand law also reinforces that people with impaired capacity should participate as much as possible in decisions about them.

262 United Nations Convention on the Rights of Persons with Disabilities, Article 12, ratified by the New Zealand Government in 2008. <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-12-equal-recognition-before-the-law.html>

Supported decision-making in practice

Supported decision making involves doing everything possible to maximise the opportunity of a person to make a decision for themselves.

A capacity assessment can give guidance about the extent and nature of what a support person requires. For example, a patient may need more time to consider the information about the risks and benefits of the operation for which their consent is sought.

The doctor has a role in ensuring that the person to be assessed has already been given the best chance of making the decision, for example, by the existing health care team or service and/or with the assistance of the person's family. All reasonable attempts that have been made to support the person making a decision should be documented, including what these attempts have entailed. In practice, supported decision making may include:

- treating a medical condition that may be affecting the person's capacity (for example, delirium)
- using an alternative means of communication (for example, providing written material) or providing information in a more accessible form (for example, drawings)
- ensuring that discussions with the person about the decision have been conducted in an appropriate environment (for example, respecting the person's privacy and minimising distractions on a busy hospital ward or visiting the person in their own home)
- giving the person extra time to understand and reflect upon the decision.

Where necessary, arrange to have the assistance of a professional interpreter with appropriate accreditation and experience in health interpreting. It is not advisable to use a family member because of the potential for bias or a vested interest. Even with an interpreter available, a fully bilingual clinician, if available, may be a preferable option for undertaking the assessment (see [Chapter 21 – Working with interpreters](#)).

Consider the time and place for the interview. Ensure that enough time is available for the interview to be conducted at an easy pace and that the place chosen for the interview is comfortable and private. It is important to avoid interviewing later in the day for older persons when they may be suffering from fatigue or ‘sundowning’.

Hearing, visual and communication aids, where used, should be brought to the interview.

Tikanga Māori and cultural diversity

There is a need to recognise cultural diversity, and in particular the rights of Māori as tangata whenua, in all aspects of clinical practice in New Zealand (see [Chapter 18 – Māori and health](#)). This remains true when assessing capacity. Culture, language and religion are integral factors in how a person makes decisions and what decisions they make. For Māori, whakawhanaungatanga, the process of establishing connections through family and other social connections, can greatly enhance the assessment process and provides a platform for supported decision-making.²⁶³

In practice, carrying out capacity assessments requires clinicians to be culturally competent, especially if the person being assessed is from a different culture. This involves knowing when and how to enlist the support or assistance from whānau and others to support the person through the assessment process.

263 J Baxter, Associate Dean of Māori, University of Otago, in the Toolkit for Assessing Capacity – see footnote [257](#).

The legal framework

There is a wide range of legislation (statutes) and common law (case law) that is relevant to people who may lack capacity for decision making. In New Zealand, the adult guardianship law, the Protection of Personal and Property Rights Act 1988 and the right to informed consent under the Code of Health and Disability Services Consumers' Rights are the main legislation that applies to adults with impaired capacity.

Code of Health and Disability Services Consumers' Rights (Code of Rights)

Informed consent is the cornerstone of the Code of Health and Disability Services Consumers' Rights. Under Right 5 (communication), Right 6 (information) and Right 7 (right to informed consent and choice), the essential components of the right to give or refuse consent to health care are:

- adequate information
- capacity to decide
- voluntariness.

Capacity is therefore an essential component to validating consent or refusal to consent to health care. However, there is no specific legal test for capacity set out in the Code of Rights itself. The person must be able to understand the nature, effects and purpose of the proposed treatment, the likelihood of success and other options including doing nothing.

The possible consequence to the person of receiving or not receiving the proposed treatment should be explained. Even where there is an appointed decision maker, such as a welfare guardian or an attorney, every effort should be made to help the person participate as much as possible in the decision to be made.

Right 7(4) of the Code of Rights: justifying treatment decisions without consent

Doctors may find themselves in situations where they need to provide treatment without the patient's consent. In emergency or life-threatening situations, treatment can proceed without the patient's consent. Where the situation is not urgent and there is no authorised decision maker, Right 7(4) of the Code of Rights provides a basis to treat if it is considered to be in the patient's best interests.

Doctors may find themselves in situations where they need to provide treatment without the patient's consent. In emergency or life-threatening situations, treatment can proceed without the patient's consent.

In making a decision to provide treatment under Right 7(4) (for example, carrying out a medical procedure), the following steps should be followed:

- Decide whether or not the patient has the capacity to make that particular decision.
- If not, check no one who is legally authorised to consent is available.
- Assess whether the decision to provide treatment or care is in the patient's best interests, taking into account the views of the patient or, where these are not possible to ascertain, the views of other suitable people interested in the welfare of the patient.

The third step may include consulting with the family as well as other health practitioners or social workers who know some background and are able to tell the doctor about the patient's preferences where the patient cannot speak for themselves. Family or next of kin are not legally authorised to make decisions for the patient unless they have been appointed into this role.

The use of Right 7(4) is most appropriate where decisions need to be made in the short term and should not be relied upon for ongoing decision making regarding longer-term health care and placements into residential care. In these circumstances, those involved in such decisions should consider making an application to the court for orders under the Protection of Personal and Property Rights Act 1988. A number of DHBs have policies for clinical staff that outline the circumstances where formal applications need to be made to the court and the role doctors have in assisting the court.

Protection of Personal and Property Rights Act (PPPR Act)

The Protection of Personal and Property Rights Act 1988 (PPPR Act) is the adult guardianship law that applies to people who lack capacity and who are aged 18 or older. The PPPR Act authorises the appointment of a substitute decision maker by the Family Court (welfare guardians and property managers) or one-off orders for care and treatment decisions (personal orders). It also sets out the procedures for making and activating enduring powers of attorney (EPOAs) when a person lacks capacity for decision making.

An EPOA is a legal document where the donor gives someone else (the attorney) the power to act for the donor if they become mentally incapable and lose the ability to make significant decisions for themselves.

Under the PPPR Act, a substitute decision maker can include the following:

- An attorney appointed by the person for property and care and welfare decisions under an EPOA. Doctors may be asked to provide a medical certificate to activate the EPOA, confirming that the person lacks capacity for a significant health care decision.

- A welfare guardian or property manager appointed by the court. There is a medical report form that is usually completed by a doctor or other relevant health practitioner that is part of the evidence given to the court when deciding whether a substitute decision maker should be appointed to make decisions on behalf of the person who lacks capacity. The reasons why a person is assessed as lacking capacity (or not) should be made clear in the report.

Where there is an application to the court, a lawyer will be appointed to represent the subject person and to report to the court. The lawyer may interview the doctor about the assessment. However, capacity assessments are rarely contested in court. The lawyer will report on whether the court has the authority to make an order because of the person's incapacity and, if so, what intervention, such as a court order, may be necessary.

There are limitations placed on the appointed decision maker's powers so, for example, the decision maker cannot refuse life-saving treatment for the person or consent to medical experimentation on their behalf.

Assessing capacity

Although capacity involves a legal decision, the assessment of capacity is clinical. The purpose of assessing capacity is to determine by clinical interview whether the person is unable to make a legally effective decision. The clinical assessment aims to determine the extent, cause and possible reversibility of the patient's incapacity. In general, the outcomes of the assessment include that the patient has capacity to decide, they need support to make the decision, they are unable to make a particular decision or they are unable to make any decision.

A variety of methods of capacity assessment have been published internationally, but these mainly relate to other countries. The McArthur Competence Assessment Tool for Treatment (MacCAT-T), for example, is a clinical tool now widely used to assess capacity but requires some training and familiarity. There is growing recognition in New Zealand of the need to have a consistent approach for assessing capacity.²⁶⁴

It is important to be aware that brief tests of cognitive function, such as the Montreal Cognitive Assessment (MOCA) or the Mini Mental State Examination (MMSE), do not provide a measure of capacity. A functional test is used.

Medical conditions affecting capacity

A range of conditions and disabilities can impair capacity. The most common of these, in the context of community care of older people, is dementia. It is difficult to predict from the stage of dementia whether a person retains or has lost the capacity to make a particular decision. Measures of dementia severity correspond only approximately with capacity. It is important to recognise that different types of dementia may impair capacity in different ways. The most common form of dementia, Alzheimer's disease, affects memory in the first instance, whilst dementia secondary to vascular disease of the brain tends to impact on frontal and subcortical systems, causing problems with higher cognitive functions.

Delirium is a disorder that is seen more commonly in residential care and hospital settings and is characterised by a relatively sudden decline in cognitive function or fluctuations in such function and impaired condition.

264 Astell H, Lee JH, Sankaran S. Review of capacity assessments and recommendations for examining capacity. *The New Zealand Medical Journal* (Online). 2013;126(1383).

It occurs in the context of physical illness or toxic states and may present the first time a capacity assessment is required. Head injury (or acquired brain injury) and intellectual disability (also referred to as learning disability) are usually chronic, stable states where it is more likely the person's abilities will be understood and the focus should be on optimising the person's capacity.

Mental incapacity is not the same as mental disability. Mental disability, including mental illnesses such as depression, anxiety and psychosis, can impair capacity in a number of ways, including being forgetful or reducing the person's ability to think through complex issues, through inattention or by causing a bias in reasoning to the point of impairing capacity. In psychiatry, there are approaches for making self-binding directives (the Ulysses contract) by which patients with bipolar affective disorder commit themselves to treatment during episodes of mania, even if unwilling. For certain individuals, this can seem the most rational way to deal with their fluctuating condition.²⁶⁵

The core legal test

When assessing capacity, it is necessary to identify the decision required to be made and the relevant test (legal threshold for capacity). The PPPR Act has four different tests for capacity depending on the kind of appointment or decision to be made. In general terms, a person is assessed as lacking capacity if they cannot understand the nature and foresee the consequences of decisions or are unable to communicate them.²⁶⁶

265 Owen G, Gergel T. Fluctuating capacity in advanced decision-making in bipolar affected disorder – self-binding directives and self determination. *Int J Law Psychiatry*. 2015 May-Jun;40:92–101.

266 Protection of Personal and Property Rights Act 1988, s 6.

The core legal test can be used to give a structure for the assessment interview.²⁶⁷ A person lacks capacity if they are unable to:

- **understand** the nature and purpose of a particular decision and appreciate its significance for them
- **retain** the relevant essential information for the time required to make the decision
- **use or weigh** the relevant information as part of the reasoning process of making the decision and to consider the consequences of the possible options (including the option of not making the decision)
- **communicate** their decision, either verbally, in writing or by some other means.

Only one of these elements need be present to establish that the person lacks capacity for the specific decision.

A checklist for assessing capacity

A Toolkit for Assessing Capacity sets out a three-stage procedure for assessing capacity based on a semi-structured interview. Consider these questions when assessing capacity.

Stage 1: Preparing for the assessment

- **Triggers:** Why is this person's capacity being questioned now?
- **Decision:** What is the capacity decision to be assessed?
- **Legal test:** What is the legal test against which capacity is to be assessed under the PPPR Act or other laws?

²⁶⁷ Mental Capacity Act 2005 (England and Wales), s 3. See also the capacity criterion for compulsory treatment under the Substance Addiction (Compulsory Assessment and Treatment) Act 2017, s 9.

- **Gathering information:** Do you have all the relevant information about the decision, including the circumstances and details of the choices available?
- **Medical history:** Does the person have a medical condition that impairs their capacity, and does this need treatment before the assessment can be done?
- **Support measures:** What can be done to assist the person to make the decision?
- **Cultural considerations:** Is cultural support needed?
- **Where and when:** What is the best time and place for the assessment?

Stage 2: The assessment Interview

- **Engagement:** Have you explained who you are and the purpose of the assessment?
- **General health and cognition:** What is the person's mental state? Is there a medical condition that is currently active and is impairing the person's cognitive function? If so, can you measure its severity using a cognitive screening test?
- **Legal test:** Have you asked questions to determine whether the person is able to understand, retain, use or weigh the information or communicate the decisions by any means?

Stage 3: After the interview

- **Decide:** Do you have enough information to decide if the person has capacity or not? Is a second interview necessary?
- **Communicate:** Have you told the person, and where appropriate their family, the outcome of the assessment?
- **Document:** Have you recorded your reasons in the person's clinical records that the person has or lacks capacity for a particular decision? Is a medical certificate or report required?

Practice points

There are some additional practice points for the assessing clinician to consider.

Who should carry out the assessment?

If the assessment is about a medical decision, the clinician who is providing the treatment should assess the person's capacity to consent to that treatment, though they may consult others for assistance.

Where the decision is about other matters such as personal welfare, living arrangements or property matters, it is usually best for a clinician who is well known to the person, for example, the family GP, to do the assessment. Where this is not the case, particular attention will need to be given to the process of engagement and, in the case of Māori, whakawhanaungatanga.

In cases of doubt or in relation to complex major decisions, it may be advisable to collaborate with other health practitioners with experience in relation to the needs of the person, such as a nurse, occupational therapist, psychologist or speech-language therapist.

Final responsibility for obtaining effective consent for treatment rests with the person intending to carry out the proposed medical procedure, not with other health practitioners advising about capacity.

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Form of assessment

It is important to apply a sense of proportionality to what might be involved with a capacity assessment and to allow for the best use of time within the time pressures inherent in clinical practice.

Informal assessments occur all the time in medical practice. These capacity assessments are often conducted intuitively by clinicians without recourse to courts or formal legal processes, but may be documented in the medical notes. For example, if a residential care patient with dementia implicitly agrees to having a wound from a fall treated, an assessment is not necessary. However, if the same patient is refusing treatment and a decision needs to be made in their best interests, a capacity assessment will be necessary.

Formal assessments are assessments that are required to provide an opinion (often with a medical certificate) under the adult guardianship law (PPPR Act) or for other legal proceedings or for some other legal purpose, such as a will. These capacity assessments are used to support, for example, the activation of an EPOA or an application to the Family Court to appoint a welfare guardian.

Refusal to undergo a capacity assessment

In circumstances where a person refuses to undergo a capacity assessment, it may be possible to persuade them to agree to an assessment if the consequences of refusal are carefully explained, for example, the implications of a medical procedure. However, in the face of an outright refusal (and in the absence of a court order), no one can be forced to undergo a capacity assessment. Refusal to cooperate with an assessment together with other available information may be relevant in the legal decision about the person's capacity.

Where there are serious concerns about the person's mental health, the Mental Health (Compulsory Assessment and Treatment) Act 1992 may be used only for the purpose of assessment or treatment of the mental disorder itself. It does not apply to physical treatments. A decision to admit a person to hospital and take them out of their home setting is a significant decision where that person is clearly expressing a refusal. Such decisions should not be made by a doctor without reference to the multi-disciplinary team.

Capacity is not the same as best interests

Where someone lacks capacity to make a particular decision, 'best interests' is the legal standard by which any action is taken or decision made on that person's behalf, that is, someone else (a substitute decision maker) will make the decision. Examples where a decision maker needs to decide what is in the person's best interests include:

- an attorney appointed under an EPOA making a decision once the EPOA is activated
- a welfare guardian or property manager appointed by the court
- a doctor or other health practitioner justifying a decision to proceed with treatment under Right 7(4) of the Code of Rights.

Where someone lacks capacity to make a particular decision, 'best interests' is the legal standard by which any action is taken or decision made on that person's behalf.

New Zealand legislation does not define how best interests should be applied or assessed as a standard for decision making. Instead, there are the principles of applying the least-restrictive intervention and maximising a person's participation in the decision(s) that need to be made.²⁶⁸

²⁶⁸ Protection of Personal and Property Rights Act 1988, ss 8 (a) and (b). See also Right 7(3) of the Code of Health and Disability Services Consumers' Rights.

English law, which is influential in New Zealand, has codified an approach to the assessment of a person's best interests, including taking into account the person's past and present wishes and feelings and their beliefs and values.²⁶⁹ In reaching a best interests decision, the law has substantially developed from the paternalistic notion of what the doctors think best to an approach that takes into account the person's preferences – the patient's point of view.²⁷⁰ This approach is more in keeping with the human rights concept of supported decision making and seeks to prevent professionals involved with a patient's care from being overly protective.

A doctor's opinion of what is the best or the most appropriate form of treatment may conflict with what the patient wants. There is a risk that professionals, including lawyers and judges, may conflate a capacity assessment with a best interests analysis.²⁷¹ It is tempting, but ethically and legally wrong, for the doctor to underestimate the capacity of a patient in order to achieve what they believe to be in that person's best interests.²⁷²

Undue influence

Undue influence is a legal term most often used when considering whether a person had the capacity to make or change a will and who may have been vulnerable to improper pressure from others. There are also situations of elder abuse (psychological and financial), for example, where there is pressure or coercion being placed on the person by family members or others. Social workers from agencies such as Age Concern may provide useful independent background information about a patient's family and their living circumstances.

269 Mental Capacity Act 2005 (England and Wales), s 4.

270 *Aintree University Hospital NHS Foundation Trust v James* [2013] UKSC 67, Lady Hale at [45].

271 *CC v KK and STC* [2012] EWHC 2136 (COP), Baker J.

272 Ruck Keene A, editor. *Assessment of mental capacity: a practical guide for doctors and lawyers* (4th edition). British Medical Association and Law Society: 2015, at 207.

A doctor's capacity assessment can provide information about the susceptibility of the person to undue influence and whether the person is freely making their decisions. The overpowering will of a third party is relevant to the 'use or weigh' aspect of the capacity test, especially where a person with borderline capacity may be less able to resist pressure from others.

Summary

Assessing a patient's capacity for decision making requires both legal and clinical knowledge, including knowing the key concepts and how to apply the elements of the core legal test: the person is unable to understand, retain, use or weigh, or communicate information relevant to a specific decision. A capacity assessment may have significant implications on a patient exercising their personal autonomy, even if others consider their decisions unwise. Doctors have an important responsibility in this regard to ensure that the capacity assessment process is transparent and that all necessary support has been provided to a patient to enable them where possible to make decisions for themselves.

Further resources

Online course – Mental capacity assessment in primary care (2017)

www.goodfellowunit.org/courses/mental-capacity-assessment-primary-care

A toolkit for assessing capacity

www.alisondouglass.co.nz

CHAPTER 17

Cultural competence, cultural safety and health equity in medical practice in Aotearoa/New Zealand

Curtis Walker was elected to the Medical Council in 2015 and is a Māori doctor of Te Whakatōhea and Ngāti Porou descent.

The contribution of **Jean Hera** as author of the previous edition's chapter 'Cultural competence and patient-centred care' is gratefully acknowledged.

Cite this as Walker C. Cultural competence, cultural safety and health equity in medical practice in Aotearoa/New Zealand. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Historical context in Aotearoa/New Zealand	247
The challenge of Māori health equity	248
Definitions of culture, cultural competence and cultural safety	250
A consumer perspective	255

Historical context in Aotearoa/New Zealand

He ao, he aotea, he aotearoa.

It is a cloud, it is a white cloud, it is a long white cloud.

(Kuramārōtini, circa 950CE)

These are the words said to have been spoken in 950CE by Kuramārōtini, wife of the Polynesian navigator Kupe, on first sighting the landmass that would come to be known as Aotearoa/New Zealand. Subsequent waves of Polynesian migration from the Cook and Society Islands over the next few centuries established Māori as the indigenous people or tangata whenua (people of the land) in Aotearoa by the fifteenth century.²⁷³

Dutch explorer Abel Tasman was the first European to discover Aotearoa in 1642. Englishman James Cook's visit aboard Endeavour in 1779 was followed by the arrival of sealers, whalers, traders and missionaries.

In 1840, the Treaty of Waitangi was signed between the British Crown and Māori chiefs, which resulted in hundreds of thousands of mainly British migrants colonising Aotearoa/New Zealand from 1840 onwards.

Colonisation had a despoiling and devastating effect on the Māori population, and the results of this are still manifested today in a multitude of poorer socioeconomic outcomes experienced by the Māori population compared with non-Māori.²⁷⁴ These disparities include health and health care provision.^{275,276}

273 Anderson A, Binney J, Harris A. Tangata whenua: an illustrated history. Bridget Williams Books; 2014.

274 Bhopal R. Racism, socioeconomic deprivation, and health in New Zealand. *The Lancet*. 2006 Jun;367(9527):1958–9.

275 Robson B, Harris R. Hauora: Māori standards of health IV. A study of the years 2000–2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare; 2007.

276 Penney L, Barnes HM, McCreanor T. The blame game: Constructions of Māori medical compliance. *AlterNative: An International Journal of Indigenous Peoples*. 2011;7(2).

In recent decades, there has been a prolonged and concerted effort across society and from within Māori society to address the effects of colonisation and reduce socioeconomic disparities. One important aspect of this is reforming Aotearoa/New Zealand's health system to be more responsive to the needs of the Māori population. Part of this effort is ensuring that doctors working in Aotearoa/New Zealand are culturally competent and practising safely in a cultural context.

In addition to the predominantly bicultural origins of early Aotearoa/New Zealand, over the course of the twentieth century and to the present day, many other cultural and ethnic groups from Asia, Africa, Europe, the Middle East and the Pacific have continued to migrate to Aotearoa/New Zealand, resulting in an ever more culturally diverse environment in which doctors are required to practise confidently, compassionately and competently.

The challenge of Māori health equity

Health inequities are avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically. The Medical Council sees all health inequities, including those that exist for Māori, as unacceptable, and therefore professional obligations arise to address health inequities where they exist.

The Council acknowledges the negative impacts of colonisation for Māori in Aotearoa/New Zealand and acknowledges the specific rights of Māori as the indigenous people of Aotearoa/New Zealand.

The Medical Council sees all health inequities, including those that exist for Māori, as unacceptable, and therefore professional obligations arise to address health inequities where they exist.

In 2015, the Council released a document on cultural competence, partnership and health equity and professional obligations towards Māori health improvement.²⁷⁷ While the Council recognises that many of the causes of health inequity for Māori (such as colonisation, land and resource loss and environmental degradation) are outside the scope of the health system and the Council's ability to influence them, it is nevertheless vital that the causes of health inequity that can be influenced are. Through the statement on health equity, the Council is signalling its desire to see improvements in the quality and equity of health care delivery to Māori.

The statement encourages partnership between health institutions and Māori organisations, supports protection of Māori health as a taonga (treasure) and calls on health institutions such as medical schools, specialist colleges and health care providers to engage Māori health consumers and practitioners in all aspects of their organisations, including governance.

In 2016, the number of Māori doctors graduating from Otago Medical School (45) reflected the demographic proportion of Māori in the population (15.7 percent), although overall, Māori are still only around 3 percent of the medical workforce. Given the diversity of doctors practising in Aotearoa/New Zealand, including the increasing numbers of Māori doctors, the Council is encouraging training institutions and health care providers to carefully examine their organisations to ensure they are culturally safe places for doctors to work and learn.

It is recognised that, although cultural competence is necessary to realise the potential of the health system to respond to our diverse society and intersects with improving Māori health, cultural competence is not synonymous with Māori health, which is a broad and varied discipline in and of itself.

277 <https://www.mcnz.org.nz/assets/News-and-Publications/Competence-Partnership-Equity.docx.pdf>

Similarly, providing expert knowledge and training in cultural competence is not solely the responsibility of Māori health experts and providers but is a responsibility shared by the entire health system and every practitioner.

Definitions of culture, cultural competence and cultural safety

The Medical Council defines a person's culture as extending beyond their ethnicity. It is recognised that patients may identify with multiple cultural groupings. A person's culture includes but is not limited to gender, spiritual and other belief systems, sexual orientation, disability, lifestyle, age and socioeconomic status.

The Medical Council defines a person's culture as extending beyond their ethnicity.

The diversity and plurality of cultures in Aotearoa/New Zealand society as a whole is reflected in the diversity of doctors practising in Aotearoa/New Zealand, with over 42 percent of registered doctors having trained overseas.²⁷⁸ As a result, cross-cultural interactions are an everyday reality in the doctor-patient relationship, and it is the doctor's responsibility to ensure that cultural differences are acknowledged and managed to allow effective clinical care.

The Council's statement on cultural competence²⁷⁹ defines cultural competence as requiring of a practitioner an awareness of cultural diversity and the ability to function effectively and respectfully when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this.

278 <https://www.mcnz.org.nz/assets/News-and-Publications/Workforce-Surveys/2013-2014.pdf>

279 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-cultural-competence.pdf>

A culturally competent doctor will acknowledge that:

- Aotearoa/New Zealand has a culturally diverse population
- a doctor's culture and belief systems influence their interactions with patients and accepts this may impact on the doctor-patient relationship
- a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding.

Of these, it can be argued that attitude is the most important aspect of cultural competence for it allows the necessary skills and knowledge to be gained and applied in practice with sensitivity and awareness. Cultural competence involves working effectively with interpreters to enable and improve communication and developing networks with individuals and organisations who can provide expertise to assist in better understandings of patients' cultural needs.

Understanding how one's own biases and those of the health care system itself affect patient care is vital to avoid 'othering', where the practitioner sees themselves and the culture of health care delivery as normal and those being treated as outsiders required to fit into the system rather than ensuring the system fits the patient.

This idea leads on to cultural safety or *kawa whakaruruhau* (cultural safety in a Māori context), which embodies related concepts to cultural competency. However, it may also be viewed as a distinct paradigm. The concept of cultural safety originated in Aotearoa/New Zealand in the 1980s through the pioneering work of Irihapeti Ramsden, a Māori nurse educationalist.²⁸⁰

280 Papps E, Ramsden I. Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care*. 1996;8(5):491–497.

Cultural safety was adopted by the Nursing Council of New Zealand in 1992 and has been in the nursing profession's training curriculum since that time. The Nursing Council defines cultural safety as:

‘The effective nursing practice of a person or family from another culture, and is determined by that person or family ... The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual.’²⁸¹

Whilst cultural competency and cultural safety both concern the relationship between the helper (the health professional) and the person being helped (the patient), cultural competence is frequently described as being more centred on the health professional's experience, while cultural safety centres on the experiences of the patient.²⁸² It can be argued that cultural safety fits better with a patient and whānau-centred approach to health care. In essence, the patient can and should determine what is culturally important to their needs, not the doctor.

It is argued that, through this, health consumers are then able to become full partners in health care interactions, are active in their treatment and are assisted to feel safe, respected and empowered. The development of culturally safe practice requires health practitioners to establish, maintain and develop cultural competency. It can be argued then that these terms are intertwined. Competency requires safety, and safety requires competency.

281 <http://www.nursingcouncil.org.nz/index.php/content/download/721/2871/file/Guidelines%20for%20cultural%20safety.%20the%20Treaty%20of%20Waitangi.%20and%20Maori%20health%20in%20nursing%20education%20and%20practice.pdf>

282 Paul D, Hill S, Ewen S. Revealing the (in) competency of ‘cultural competency’ in medical education. *AlterNative: An International Journal of Indigenous Peoples*. 2012;8(3):318–328.

Concepts of cultural competence and cultural safety both recognise the importance of culturally appropriate and respectful professional relationships with colleagues and staff and the responsibility health professionals have in challenging cultural bias in health care systems where this brings negative impacts for patients.

Cultural competence and clinical competence in practice

As a health practitioner, cultural competence is an essential and indivisible component of clinical competence and is therefore required in order to deliver effective, quality health care. There is ample evidence that a lack of cultural awareness and knowledge contributes to poorer health outcomes,^{283,284} although it is more difficult to ascertain that simply teaching cultural competence results in improved health outcomes.²⁸⁵ Recognising health inequities and the harm that can be done by culturally unsafe practice, the Health Practitioners Competency Assurance Act 2003 (HPCAA) requires that health practitioner regulatory authorities, including the Medical Council, establish standards of cultural competence for practitioners.²⁸⁶

The Council sets the overarching standards and expectations of medical practice through *Cole's Medical Practice in New Zealand* and via its other resources and statements. An important theme throughout these resources is that of working in partnership with patients and families/whānau in the practice of patient-centred care. Practising in a culturally competent fashion is a key element of patient-centred care.

283 Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Racism and health: the relationship between experience of racial discrimination and health in New Zealand. *Social Science & Medicine*. 2006;63(6):1428–1441.

284 van Ryn M, Burgess DJ, Dovidio JF, Phelan SM, Saha S, Malat J, et al. The impact of racism on clinician cognition, behaviour and clinical decision making. *Du Bois Rev*. 2011 Apr 1;8(1):199–218.

285 See footnote [282](#).

286 Health Practitioners Competence Assurance Act 2003, s 118(i).

The Council released a general statement on cultural competence²⁸⁷ in 2006 alongside a *Statement on best practices when providing care to Māori patients and their whānau*.²⁸⁸ A resource booklet prepared for the Council by Māuri Ora Associates on practice implications when treating Māori patients and their whānau was also released at this time.²⁸⁹ In 2010, the Council published a resource booklet to assist doctors when providing services to Pasifika patients and their families.²⁹⁰ At the time of writing, the Council is updating and expanding these resources to include other ethnicities and cultural groups. These statements provide guidance in developing the cultural competence of individual practitioners and also guide organisations such as medical schools, specialist colleges and other health care providers.

In addition to setting professional standards for individual doctors, the Medical Council accredits medical training providers. Accordingly, accreditation standards for medical schools, district health boards (DHBs) and specialist medical colleges all require that cultural competence teaching and assessments be integrated into training programmes and continuing professional development activities.^{291,292}

Assessing cultural competence and practising it proficiently are not without significant challenges. Culture is complex, and ascertaining competency is complex. It is argued that cultural competency is not something that can be easily assessed or measured and signed off, but is rather a career-long journey of constant reflection, infinite learning and continuous expansion.²⁹³

287 See footnote 279.

288 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-best-practices-when-providing-care-to-Maori-patients-and-their-whanau.pdf>

289 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Maori.pdf>

290 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Pacific-Peoples.pdf>

291 <http://www.stats.govt.nz/~media/Statistics/browse-categories/snapshots-of-nz/nz-in-profile/2015/nzip-2015.pdf>

292 http://www.amc.org.au/files/d0ffcecd9608cf49c66c93a79a4ad549638bea0_original.pdf

293 See footnote 282.

A consumer perspective

Ms Jean Hera, the author of the chapter on cultural competence in the 12th edition of *Cole's Medical Practice in New Zealand*, provides an invaluable consumer perspective on the importance of cultural competence.²⁹⁴

‘As a patient I feel vulnerable and I find it hard to feel empowered even as a knowledgeable and assertive person. Although I was born in this country, have always lived here, and I am from the ‘dominant’ culture, the health environment often still feels strange and alienating to me even though I know a lot about it, including my rights as a health consumer and how to follow up on any concerns that I may have. I feel nervous about what I don’t know and also what I do know from my own past experiences and the stories I have heard from others. I have also personally experienced and heard about many excellent health experiences but somehow the not so good ones are often more prominent in my mind. I am aware that it can be far more difficult for patients with less education, whose culture is far removed from the context they are in, for those who feel judged because of how they look, act or because of their lifestyle, for those who don’t have English as a first language or who barely speak English at all, and for many of those who can no longer speak or act for themselves.

294 Hera J. Cultural competence and patient-centred care. In: St George IM, editor. *Cole's Medical Practice in New Zealand*. 12th ed. Wellington: Medical Council of New Zealand; 2013.

We patients need you, our doctors, to develop a general and interconnected set of attitudes, behaviours, knowledge and skills that enable you, to be non-judgemental and show us respect and understanding, to be approachable, and to communicate well. We want you to behave in ways that make us feel safe, assist us to ask questions and give feedback about any concerns we have, and we want to be listened to. If our requests cannot be accommodated, we want you to be honest with us about why this is. It is helpful when you are friendly, and pronounce our name correctly or at least talk with us so that you can learn how to do this. We appreciate it when you show humility and assist us to tell you if there is any cultural need we may have that you are not aware of. If it is possible, help us to ensure that any important cultural requirements we have are accommodated. As a general rule, we want to be active partners in our health care decision-making however in some cultural contexts, we may not want this and we may not find it easy to communicate this to you. If we do not understand you, we may find it hard to tell you this and in some cultural contexts even nod as if we do understand. We hope that you do not label us as non-compliant or difficult, but work to find ways to understand our reality and adapt to this.

We also need doctors to engage well and in a culturally competent way with our family and other support people when this is appropriate. We hope that our doctors are culturally sensitive in all aspects of their work with us, not just to our face, and when we are conscious. Cultural competence also needs to extend beyond the patient to apply to interactions with colleagues and others encountered in the health environment to help ensure safe, collaborative and supportive health systems are in place around us. Cultural competence involves the heart as well as the intellect. We can teach you a lot if you are open to this.

General cultural competencies must be recognised as significantly more important than developing a range of cross-cultural knowledge about specific ethnicities and cultures. If you manage to achieve this as well it could be very helpful unless you embarrass and undermine us by knowing more about our culture than we do – but then this would not be our lived culture. If you are not able or are too busy to meet absolutely all these needs, we hope you will help to develop and support health systems that can. Is this too much to ask?’

CHAPTER 18

Māori and health

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Cite this as Jansen P, Jansen D. Māori and health. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	259
Māori history and the Treaty	260
The Treaty and health	263
Māori health and inequalities	264
Differential approaches to treatment	265
The impact of culture on health	267
Culture of the doctor	267
Māori concepts and Māori health values	268
› Tapu and noa	268
› Whanaungatanga	269
› Tangihanga	269
› Manaakitanga	270
Rongoā and traditional healers	270
Māori language	271
› Ngā whakahua/pronunciation guide	272
› Glossary	273

Introduction

Māori are indigenous to Aotearoa/New Zealand and a significant proportion of our society, comprising some 668,000 people of Māori descent at Census 2013²⁹⁵ and growing at a faster rate than the overall population. Māori comprise approximately one in seven people usually living in Aotearoa/New Zealand. Māori peoples are essentially a tribal society constructed from small family-based units (whānau) organised into subtribes (hapū), which contribute to larger tribal entities (iwi).

Providing culturally competent care for Māori increases the likelihood of Māori engaging with health professionals and health services, improves adherence to treatment plans and ultimately improves overall Māori health status.

Providing culturally competent care for Māori increases the likelihood of Māori engaging with health professionals and health services, improves adherence to treatment plans and ultimately improves overall Māori health status. This chapter recognises that culturally competent practice should include consideration of Māori needs, values and preferences across all domains of practice. Readers should familiarise themselves with the relevant Medical Council statements on best practice when providing care to Māori patients and their whānau,²⁹⁶ best health outcomes for Māori: Practice implications²⁹⁷ and cultural competence²⁹⁸ and resources to support culturally competent care. Chapters on other ethnic groups and on the principles of culturally competent care are also included in this book.

295 <http://stats.govt.nz/Census/2013-census/profile-and-summary-reports/qstats-about-maori-english-mr.aspx>

296 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-best-practices-when-providing-care-to-Maori-patients-and-their-whanau.pdf>

297 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/best-health-maoricomplete.pdf>

298 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Statement-on-cultural-competence.pdf>

Māori history and the Treaty

Traditional and modern scientific knowledge concur that Māori arrived in Aotearoa/New Zealand from Hawaiki, the east Polynesian homeland, at least 500 years before contact with European explorers. After the late eighteenth century, an increasing number of traders, whalers, sealers and settlers came to Aotearoa/New Zealand. The British Government appointed James Busby as British Resident in 1833 to protect British trading interests and counter the increasing lawlessness amongst traders and settlers. By 1839, there were an estimated 2,000 Pākehā and 150,000 Māori living in Aotearoa/New Zealand.

A Declaration of Independence was signed in 1835 by 52 Māori chiefs at the instigation of Busby and later tabled in the British Parliament. As a result, the British Crown could make no claim on Aotearoa/New Zealand without Māori agreement. In 1840, the British Government sent out Captain William Hobson to sign a treaty with the Māori chiefs. Hobson carried instructions from Lord Normanby of the Colonial Office to secure sovereignty over the independent state of Aotearoa/New Zealand.

Consequently, in 1840, a treaty was drawn up and translated into Māori by Henry Williams, an English missionary, prior to being debated at Waitangi. After a single day of debate, the Treaty was signed on 6 February 1840 at Waitangi in the Bay of Islands by 43 Northland chiefs. Over the next 8 months, the Treaty was signed at more than 40 other locations by more than 400 Māori chiefs including some women. However, many important chiefs refused to sign the Treaty.

Both the English and Māori versions of the Treaty contain three articles, but the Māori translation differs significantly from the English version, resulting in two documents with different meanings and interpretation.

The first article covers sovereignty. The English version states that Māori give up 'sovereignty' to the British Crown, describing it as a complete transference of power to the Crown.

By contrast, the Māori version implies a sharing of power and uses the word ‘kāwanatanga’, an improvised word that did not mean a transfer of authority from Māori to British hands but implied the setting up of a government by the British. The nearest Māori equivalent to the English term would have been ‘mana’ or ‘rangatiratanga’.

The second article, mainly about the protection of property rights, also concerns tino rangatiratanga or chieftainship. The English version specifically gives Māori control over lands, forests, fisheries and other properties, but the Māori version implies possession and protection of cultural and social items such as language and villages and promises much broader rights for Māori in regard to possession of existing properties.

Explanations given at the Treaty signings support the conclusion that Māori expected that rangatiratanga would be enhanced, not eroded, with the Queen or her representative having the power of governorship alongside their sovereignty as chiefs.

The third article promises Māori the same citizenship rights as British subjects.

Both versions of the Treaty of Waitangi are legitimate as both versions are signed. However, despite the promises and protection offered in the Treaty of Waitangi, the document was ignored in spirit and disregarded materially for many years. Many of the rights guaranteed to Māori were violated, and Māori lost most of their land through the nineteenth and twentieth centuries. The manner in which the land was lost was often questionable and led to considerable protest from Māori. These protests largely fell on deaf ears until the establishment of the Waitangi Tribunal in 1975.

In 1896, the Māori population reached its lowest point, estimated at 42,000, while migration of non-Māori accelerated.²⁹⁹

299 Pool I. *Te iwi Māori: A New Zealand population past, present, and projected*. Auckland: Auckland University Press, 1991.

The cultural and political structure of Aotearoa/New Zealand in 1840 was still essentially Polynesian, and all European residents absorbed Māori values to some extent. During this period, Māori commercial enterprise prospered. For instance, in 1857, Te Arawa and Tūwharetoa Māori (connected tribes descended from the Te Arawa canoe and covering the Bay of Plenty, Taupō and Rotorua areas), consisting of approximately 8,000 people, had an estimated 3,000 acres of land in wheat, 300 acres in potatoes, nearly 2,000 acres in maize and 1,000 acres of kumara. In addition, they owned some 100 horses, 200 cattle, 5,000 pigs, four water-powered mills, 96 ploughs and 43 coastal vessels averaging nearly 20 tonnes each.

Māori were actively and purposefully organising successful commercial ventures and exporting from their tribal estates to the growing settler communities in Aotearoa/New Zealand and New South Wales. Māori demonstrated a clear determination to gain the literacy skills of the Europeans. Māori tribes actively sought missionaries to settle in their areas to acquire these skills.

During the twentieth century, the Māori population had recovered and, at over 500,000, is now larger than ever before. However, social and economic disparities continue to exist.

The Waitangi Tribunal was established in 1975 to rectify past breaches of the Treaty by the Crown. Claims cannot be made against private organisations or individuals. The Tribunal considers both English and Māori versions of the Treaty when making decisions and is also instructed to have regard for the principles of the Treaty rather than the precise words. In this way, some of the difficulties of conflicting texts (English and Māori) can be avoided.

Since its establishment, the Waitangi Tribunal has ruled on many claims brought by Māori, and many others have been settled through direct negotiation between the Crown and claimant tribes. In many cases, compensation has been granted, often including return of land and financial recompense, which is vested in the tribal authorities for economic development.

The Treaty and health

The government has identified three principles derived from the Treaty and relevant to Māori health in key statements and policies.³⁰⁰

- **Partnership** – working with Māori communities at all levels to develop strategies for the community's health care.
- **Participation** – involving Māori at all levels of the planning and delivery of health care services.
- **Protection** – working to ensure that Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.³⁰¹

The Treaty ensures that taonga, or precious possessions, would be protected and retained. In this context, health is sometimes considered a taonga.

The Treaty of Waitangi can be seen to apply to Māori health in numerous ways. Most importantly, the Treaty should have ensured that Māori retained their land, forests and fisheries. In addressing land rights, loss of language and social disruption, compensation can help to address some of the social determinants of health. Further, in the Māori version, the Treaty ensures that taonga, or precious possessions, would be protected and retained. In this context, health is sometimes considered a taonga. In addition, the New Zealand Public Health and Disability Act 2000 recognises the Treaty of Waitangi by requiring district health boards to improve the health outcomes of Māori and other population groups.

300 These include the New Zealand Health Strategy, New Zealand Disability Strategy, Māori Health Strategy and Royal Commission on Social Policy.

301 Tapsell R. Māori health in 2004. In: St George IM, editor. Cole's Medical Practice in New Zealand. 6th ed. Wellington: Medical Council of New Zealand; 2004.

Māori health and inequalities

Māori have the poorest health of any Aotearoa/New Zealand group with a higher mortality rate than non-Māori^{302,303} as well as higher rates of illness.^{304,305} Māori infants die more frequently from SIDS and have lower birth weight than non-Māori children.³⁰⁶

Avoidable death rates are almost double for Māori than for other New Zealanders, and Māori die, on average, 8–10 years earlier.^{307,308}

Aotearoa/New Zealand has a higher rate of death from cancer than Australia, with Māori accounting for two-thirds of the excess male cancer deaths and one-quarter of the excess female cancer deaths.³⁰⁹ Māori women have rates of breast, cervical and lung cancer that are several times those of non-Māori women.³¹⁰

There is a higher incidence of obesity in the Māori community (27 percent versus 16 percent), which contributes to the higher incidence of diabetes (8 percent versus 3 percent) and the younger age at diagnosis (43 years versus 55 years).

This is compounded by lower rates of diagnosis and lesser access to effective treatment.³¹¹

302 Ajwani S, Blakely T, Robson B, Tobias M, Bonne M. Decades of disparity: ethnic mortality trends in New Zealand 1980–1999. Wellington: Ministry of Health and University of Otago. 2003.

303 Blakely T, Fawcett J, Atkinson, J, Tobias M, Cheung J. Decades of disparity II: socioeconomic mortality trends in New Zealand 1981–1999. Public Health Intelligence Occasional Bulletin #25. Wellington: Ministry of Health. 2005.

304 <https://www.acc.co.nz/assets/provider/acc1625-maori-cultural-competency.pdf>

305 See footnote [302](#).

306 Ministry of Health. Our health, our future. Hauora pakari, koiora roa. The health of New Zealanders 1999. Wellington: Ministry of Health, 1999.

307 Ring I, Brown N. The health status of indigenous peoples and others. BMJ. 2003;327:404–5.

308 McPherson K, Harwood M, McNaughton HK. Ethnicity, equity, and quality: lessons from New Zealand. BMJ. 2003;327:443–4.

309 Skegg DCG, McCredie MRE. Comparison of cancer mortality and incidence in New Zealand and Australia. NZMJ. 2002 May 10;115(1153):205–8.

310 See footnote [306](#).

311 Crengle S, Lay-Yee R, Davis P, Pearson JA. A comparison of Māori and non-Māori patient visits to doctors: The national primary medical care survey (NatMedCa): 2001/02. Report 6. Wellington: Ministry of Health. 2005.

In summary, Māori are sicker for longer periods but have less access to care and die earlier than Pākehā. These disparities in overall Māori health persist even when factors such as poverty, education and location are accounted for, demonstrating that culture is an independent determinant of health status.^{312,313} These lower standards of health lead to suboptimal outcomes for individual Māori and influence the Māori community's negative perceptions of the health system as a whole.^{314,315} These negative experiences can also reinforce stereotypes within the practitioner community if a provider does not understand a Māori patient's dissatisfaction and thus cannot prevent similar experiences with other patients.³¹⁶

Differential approaches to treatment

Studies have consistently demonstrated that some doctors treat Māori differently from non-Māori. Examples of this include the findings of the 2001/02 National Primary Medical Care Survey (NatMedCa) where it was observed that doctors spent 17 percent less time (2 minutes out of a 12-minute consultation) interviewing Māori patients than non-Māori patients.

Once age is taken into account, Māori turn up for GP appointments at the same rate as non-Māori but obtain fewer diagnostic tests, less-effective treatment plans and are referred for secondary or tertiary procedures at lower rates than non-Māori patients.³¹⁷

312 Marwick JC, Scott KM, Crampton PR. Utilisation of general practitioner services in New Zealand and its relationship with income, ethnicity, and government subsidy. Presented at RNZCGP Annual Conference. 2000.

313 Smedley BD, Stith AY, Nelson AR. Unequal treatment: confronting racial and ethnic disparities in health care. Washington DC: Institute of Medicine, 2003.

314 Durie M. Māori attitudes to sickness, doctors, and hospitals. NZMJ. 1977;86:483.

315 Laveist TA, Nuru-Jeter A. Is doctor-patient race concordance associated with greater satisfaction with care? J Health Soc Behav. 2002;43:296–306.

316 Jansen P, Sorenson D. Culturally competent health care. NZFP. 2002 Oct;29(5):306-18.

317 Gribben B. Ethnicity and resource use in general practice in West Auckland. Experience in Practice 1999;1.

Analysis of the National Minimum Database over the period 1990–1999³¹⁸ suggests bias against Māori receiving cardiac revascularisation procedures even though the clinical need is much greater. Similar evidence of bias is available for outcomes following stroke,³¹⁹ obstetric intervention,³²⁰ heart failure³²¹ and asthma.³²² These studies point to unconscious bias by providers rather than frank racism in health service delivery.

However, the impact is that Māori patients are less likely to receive adequate care or adequate and understandable health information. This will in turn compromise the ability of Māori patients to adhere to treatment recommendations and the effectiveness of any treatments offered.

There is evidence too of the impact of racism on Māori health status. Harris et al.³²³ reviewed the New Zealand Health survey data and made adjustments for sociodemographic factors and deprivation and identified that the remaining differences in self-perceived health status between Māori and non-Māori could be accounted for in terms of self-perceived experiences of racism. These effects appeared to be dose-related, that is, the greater the number of experiences of racial discrimination, the lesser was self-perceived health status.

318 Tukuitonga CF, Bindman AB. Ethnic and gender differences in the use of coronary artery revascularisation procedures in New Zealand. *NZMJ*. 2002 Apr 26;115(1152):179–82.

319 McNaughton HK, Weatherall M, McPherson KM, Taylor WJ, Harwood, M. The comparability of resource utilisation for Europeans and non-Europeans following stroke in New Zealand. *NZMJ*. 2002 Mar 8;115(1149):101–3.

320 Sadler L, McCowan L, Stone P. Associations between ethnicity and obstetric intervention in New Zealand. *NZMJ*. 2002 Feb 8;115(1147):36–9.

321 Carr J, Robson BH, Reid P, Purdie GL, Workman P. Heart failure: ethnic disparities in morbidity and mortality in New Zealand. *NZMJ*. 2002 Jan 25;115(1146):15–7.

322 Ellison-Loschmann L, King R, Pearce N. Time trends and seasonal patterns of asthma deaths and hospitalisations among Māori and non-Māori. *NZMJ*. 2002 Jan 25;115(1146):6–9.

323 Harris R, Cormack D, Tobias M, et al. Self-reported experience of racial discrimination and health care use in New Zealand: results from the 2006/07 New Zealand Health Survey. *Am J Public Health*. 2012;102(5):1012–1019.

The impact of culture on health

Culture plays an important role in health because culture influences behaviours through customs, traditions, beliefs and values. In the Māori world view, there is a fundamental belief that understanding and being connected to the past are important for both the present and the future. This is demonstrated by the importance placed on tūpuna (ancestors) and whakapapa (genealogical connections over many generations). In addition, the importance of a healthy environment, which impacts both community and individuals, is incorporated into the world view of many Māori.

Culture of the doctor

Like other cultures, Māori value highly effective communications with health professionals.³²⁴

However cultural misunderstandings, unconscious bias and unfounded beliefs about Māori by practitioners contribute to problems in communication between non-Māori doctors and Māori patients. All these problems have been demonstrated in studies of general practitioners³²⁵ and psychiatrists in Aotearoa/New Zealand.³²⁶

Cultural misunderstandings, unconscious bias and unfounded beliefs about Māori by practitioners contribute to problems in communication between non-Māori doctors and Māori patients.

324 Jansen P, Bacal K, Crengle S. He ritenga whakaaro: Māori experiences of health services. Auckland: Mauri Ora Associates. 2009.

325 McCreanor T, Nairn R. Tauīwi general practitioners' talk about Māori health: interpretative repertoires. NZMJ. 2002;115(1167).

326 Johnstone K, Read J. Psychiatrists' recommendations for improving bicultural training and Māori mental health services: A New Zealand survey. Australian and New Zealand Journal of Psychiatry. 2000 Feb;34(1):135–145.

It is expected that improved integration of cultural and clinical competence should lead to better outcomes through improvements in communication, acceptability of treatment and adherence to treatment plans^{327,328,329} and through measurements of doctor performance in delivery of services to Māori .

Māori concepts and Māori health values

Māori beliefs, customs and values are often expressed as tikanga. Tikanga Māori describe a guide for living, support Māori social systems and reflect Māori knowledge and traditions.

Doctors may have opportunity to recognise or come into contact with many Māori values, including tapu and noa (a pervasive static dichotomy of restricted and ordinary or normal), mana (reflecting authority, status and control), wairua (reflecting spiritual elements and power), whanaungatanga (relationships interpersonal and familial) and manaakitanga (the duty and obligations of care).

Tapu and noa

Although tapu is often described as a state of sacredness, it also has the more general meaning of being special or restricted. Noa is the absence of tapu and denotes the state of being normal, ordinary or safe. All things to do with death or the body are tapu, while anything related to cooked food is noa.

327 Crengle S. The development of Māori primary care services. *Pac Health Dialog*. 2000;7:48–53.

328 Baxter J. Barriers to health care for Māori with known diabetes. *A literature review and summary of issues*. Dunedin: Te Rōpū Rangahau Hauora a Ngāi Tahu; 2002.

329 Krupat E, Bell RA, Kravitz RL, Thom DH, Azari R. When physicians and patients think alike: patient-centered beliefs and their impact on satisfaction and trust. *J Fam Pract*. 2001 Dec;50(12):1057–62.

Many Māori feel that keeping tapu items separate from noa items is very important and find it distressing when this division is not observed. For example, in the case of a patient's death, the whānau will likely wish to spend time in the room with their loved one. The presence of the dead body (tūpāpaku) makes the room tapu and therefore food cannot be brought in. There will of course be wide variation in how strictly such controls are practised and how observance of the traditional practice might be amended for practical reasons.

Whanaungatanga

Māori culture emphasises familial and community connections to the past and to the present. The extended family or whānau is the basic unit of Māori social organisation. Familial relationships and responsibilities are central to Māori identity and are often expressed in the Māori term whanaungatanga. Māori patients will often bring family members to medical visits and may consult with them before considering or accepting treatment. Māori usually prefer face-to-face interactions with their practitioners and, until relationships are established, may prefer formality.

Tangihanga

The rituals and customary practices that surround death are regarded as very important within Māori communities. The familial and community obligations to the deceased and the bereaved family are extensive. The tangihanga is a coordinated set of formal procedures that recognise the relationships of the deceased with the ancestors and with the living relatives. Many Māori recognise very strong imperatives to attend tangihanga of anyone in their extended family and friends and will often travel great distances to fulfil their obligations in this regard. A person may be grieved over for 3 or more days at their home or at a marae and often returned to their traditional tribal home for burial. Death itself, however, may not be feared so much as the manner and circumstances of dying, with many Māori preferring to die at home with the attention and support of their family.

Manaakitanga

The obligations and responsibilities to demonstrate care for your family and for visitors is expressed in the Māori term of manaakitanga. This customary value will involve the process of welcoming and caring for visitors to one's home or marae, as well as the provision of food and accommodation. Food (kai) has a central importance in these practices. A guest (manuhiri) has a complementary obligation to accept and receive this hospitality.

There are many useful texts that can provide deeper insight into Māori customary practices,³³⁰ and Māori patients are generally happy to educate a provider who seeks guidance about their preferences.

Rongoā and traditional healers

Māori patients may seek assistance from traditional healers like people from other cultural backgrounds. For Māori, this may include consulting people with special skills (tohunga) in herbal preparations (rongoā rākau), massage therapies (mirimiri), prayers and incantations (karakia).³³¹

There are few absolute contraindications to the use of traditional healing techniques alongside Western therapies. However, knowing about all the non-prescribed therapy a patient is using will assist the doctor and patient to monitor and adjust medications or to make appropriate choices. The key then is to maintain open and non-judgemental communication with the patient, allowing or encouraging them to share information with you.

330 Mead HM. *Tikanga Māori: Living by Māori values*. Wellington: Huia Publishers; 2003.

331 bpac^{nz}. Demystifying rongoā Māori: traditional Māori healing. *Best Practice Journal*. 2008;13:32–36.

Māori language

There are several general introductory Māori language courses and a small number of dedicated Māori language phrasebooks for the health sector.³³²

Welcome everybody.	Kia ora tātou.
I would like to acknowledge the family.	Ka mihi atu ki te whānau.
Greetings all.	Tēnā koutou.
Let's introduce ourselves and get to know each other.	Tēnā, me whakamōhio atu ko wai rā tātou.
How can I help you?	Ka pēhea taku āwhina i a koe?
How can I help your family?	Ka pēhea taku āwhina i tō whānau?
Do you have pain anywhere?	He wāhi anō kei tō tinana e mamae ana?
How long have you had that pain?	Kua pēhea te roa e mamae ana?
Where did the pain start?	I tīmata mai tēnā mamae ki hea?
What were you doing when the pain started?	I te aha koe i te wā i tīmata ai te mamae?
What makes it worse?	Ka nui atu te mamae i te aha?
What makes it better?	Ka whakaeaeatia te mamae ki te aha?
Have you been vomiting.	I te ruaki koe?
Do you have diarrhoea?	I te torohī koe?
My name is Richard. I am a doctor.	Ko Richard ahau, he rata ahau.
My job is to listen to your concerns and support you.	Ko tāku, he whakarongo ki ō āwangawanga, he tautoko hoki i a koe.
What are the main issues for you?	He aha ngā tino take ki ōu whakaaro?
How would you like me to help?	Me pēhea taku āwhina atu?

332 Jansen D. He pukapuka reo hauora Māori. Whaingaroa: Ahuru Press. 2005.

Ngā whakahua/pronunciation guide

Vowel sounds

- a** as in car, far
- e** as in bed
- i** as in eel
- o** as in awe, saw
- u** as in chew, moo

Consonants

- wh** pronounced much like 'f' (whā pronounced far)
- ng** pronounced like the 'ng' in singer

Macrons

The vowels may take a short or long form. This is indicated by the macron over the vowel – ā, ē, ī, ō, ū. This is the method preferred by the Taura Whiri i to Reo Māori – Māori Language Commission, although others occasionally use a double vowel to indicate the long form – aa, ee, ii, oo, uu.

The long vowel is pronounced in the same way as the short vowel but the length is extended and has a significant effect on the sound and meaning of a word. Knowing the length of each vowel is important in establishing correct pronunciation.

Ōtāhuhu	Ō - tā - hu - hu
Waitematā	Wai - te - ma - tā

Glossary

hauora	health
hinengaro	psychic dimension
hongi	press noses, share breath
karakia	prayer, incantation, invocation
koha	gift, donation
mana	power, authority, prestige
manuhiri	visitor, guest
mihi	greet, greetings
mihimihi	introductions
noa	normal, profane
oranga	wellbeing, health
pōwhiri	formal welcome
reo	language
tāngata whenua	people of the land
tapu	restricted, reserved, sacred
tinana	physical body
waiata	song, to sing
wairua	spirit, spiritual dimension
whānau	family
whanaunga	relations
whanaungatanga	relationships
whare	house

CHAPTER 19

Pacific people in New Zealand

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*The contribution of **Colin Tukuitonga** as author of the previous edition's chapter 'Pacific people in New Zealand' is gratefully acknowledged.*

Cite this as Fonua-Faeamani TL. Pacific people in New Zealand. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	275
Background	275
Health and socioeconomic inequalities	277
Morbidity and mortality	279
Access to and quality of health care	281
Community-controlled primary health care	283
Ethnic-specific considerations	283
› The assumptions of being Pacific	283
› Family structure	284
› Holistic concept of health	284
› Respect and religion	285
› Traditional medicine	285
› Care of the older and disabled	286
› Kava	287
› Non-residents	287
› Tropical disease	288
Getting assistance	288

Introduction

This chapter describes Pacific people in New Zealand, their health status, health service usage and ethnic-specific factors that may affect the interactions between health professionals and their patients. This chapter will allow some insight into working with Pacific people, their families and communities to assist in providing high-quality health care, which will lead to improved health outcomes and reduced inequalities for Pacific people in New Zealand.

Background

The 2013 Census revealed that 7.4 percent (295,941) of the New Zealand population identify themselves as being of Pacific ethnicity. This is the fourth largest ethnic group behind European, Māori and Asian populations.³³³

Initially, this population grew rapidly in the 1950s to 1970s due to work-related migration. These days, this rapidly growing population is due to births within New Zealand and is growing faster than the European population. Almost two-thirds of the current Pacific population were born in New Zealand. The Pacific population is projected to make up approximately 10 percent of the New Zealand population in 2026.³³⁴

The Pacific population is very young, with 46 percent being younger than 20 years of age compared to 27 percent of the total population. In fact, 54 percent of the Pacific population are less than 25 years of age. In 2013, the median age of people who identified with one Pacific ethnicity was 22.1 years (compared to 41 years for European).³³⁵

333 <http://www.mpp.govt.nz/pacific-people-in-nz>

334 See footnote 333.

335 <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/infographic-culture-identity.aspx>

The term “Pacific” or “Pasifika” usually refers to people who identify as having heritage from one of the Pacific islands.

The term ‘Pacific’ or ‘Pasifika’ usually refers to people who identify as having heritage from one of the Pacific islands. This includes a large number of ethnicities (Samoan, Cook Island Māori, Rarotongan, Tongan, Niuean, Tokelauan, Fijian, Hawaiian, Kiribati, Nauruan, Papua New Guinean, Pitcairn Islander, Rotuman, Tahitian, Solomon Islander, Tuvaluan and Ni Vanuatu).³³⁶ Being called Pacific gives a false impression that this diverse group have a uniform culture. Inter-marriage amongst these ethnicities is adding to the mixing of the cultures as well as

the influence of having been born and raised in New Zealand amongst Māori and European (Pākehā/palangi) cultures. It is important to be aware that each individual has a unique culture based on their background, and assumptions based on their ‘Pacific’ background can be misleading.

The Samoan people make up 48 percent of the total Pacific population with Cook Island Māori at 20 percent, Tongan 20 percent and Niuean 8.1 percent.

The majority of the Pacific population (92 percent) live on the North Island with two thirds living in the Auckland region.³³⁷

Although less than 5 percent of the Pacific population are over 65 years of age, the cultural importance of the elderly in most Pacific societies often means that the needs of the elderly take precedence over the needs of younger people. Respect and care for the elderly is an important aspect of all Pacific societies in New Zealand, and this fact has a major influence on how Pacific families live.³³⁸

336 <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/ethnic-profiles>

337 See footnote 336.

338 Tukuitonga C. Pacific people in New Zealand. In: St George IM, editor. *Cole’s Medical Practice in New Zealand*. 12th ed. Wellington: Medical Council of New Zealand; 2013.

Health and socioeconomic inequalities

Pacific people have some of the worst health and social indicators in New Zealand, and there are considerable unmet health needs in these communities.³³⁹

Examples of worse health outcomes for Pacific peoples compared to the general population in New Zealand include the following:

- **Lower life expectancy:** Based on death rates in New Zealand in 2012–14, life expectancy was 78.7 years for Pacific females and 74.5 years for Pacific males, compared with 83.2 years for females and 79.5 years for males in the total New Zealand population.³⁴⁰
- **Higher rates of chronic disease:** Three times more likely to have diabetes, approximately 90 percent of the adult Pacific population are overweight or obese compared with 60 percent of the total New Zealand population.³⁴¹
- **Higher hospitalisation rates:** Twice the rates of other New Zealanders in general, five times more likely to have a hospital admission with cellulitis in children, 2.5 times more likely to have a hospital admission with respiratory disease in children compared to the general population.³⁴²
- **Premature disability:** More severe disabilities in children and young adults compared to the general population.
- **Higher incidence of mental disease:** Higher rates than the general population but much lower access of mental health services.³⁴³

339 See footnote 338.

340 http://www.stats.govt.nz/browse_for_stats/health/life_expectancy/NZLifeTables_HOTP12-14.aspx

341 See footnote 338.

342 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Pacific-Peoples.pdf>

343 See footnote 342.

Pacific people are disproportionately represented in lower socioeconomic brackets.³⁴⁴ Socioeconomic disadvantage is closely correlated with poor health and poor access to health services.

Studies have shown that nine out of 10 Pacific people live in low-decile areas with significant social and economic disadvantage.³⁴⁵

Despite being 7 percent of the general population of New Zealand, 27 percent of this population live in severe hardship, 15 percent in significant hardship and only 1 percent have very good living standards.

They are more likely to be living in overcrowded homes that are cold and damp, and rates of home ownership are much lower than the general population. Pacific people have twice the unemployment rates of the New Zealand population.³⁴⁶

Health literacy is very poor amongst this population. This is apparent when statistics show that, despite Pacific people accessing the health system (high GP attendance, high PHO enrolment), they do not achieve the same benefits of preventive and primary care services as other population groups.

For example, Pacific women have much lower rates of cervical and breast screening, and Pacific people have disproportionately lower rates of referrals to specialists.

Current disease patterns amongst this population largely reflect the socioeconomic conditions under which they live, and poverty is a major contributor of ill health among Pacific families. Although socioeconomic factors are the main underlying factors contributing to poor health in Pacific people, there may be an effect of Pacific cultures and practices on the overall result, mainly due to delay in seeking health care.

344 See footnote [342](#).

345 See footnote [338](#).

346 See footnote [342](#).

This, however, may be a direct result of low health literacy.

These health and social inequalities affect the individual, their family and the community as a whole in view of the family/community-oriented nature of Pacific cultures.

It is important to build rapport with these patients in order to understand their needs and address issues in a way that will help to reduce these health disparities.

Unfortunately, several reports show little improvement in the socioeconomic circumstances of Pacific people and little change in their overall health status.³⁴⁷

It is important to build rapport with these patients in order to understand their needs and address issues in a way that will help to reduce these health disparities.

Morbidity and mortality

Pacific people experience significant premature mortality and preventable morbidity mainly due to chronic non-communicable diseases such as diabetes and heart disease. Cardiovascular diseases are the leading cause of death and disability in the adult population. Although coronary artery disease mortality rates are declining, the rate of decline is less rapid in this population compared to the total New Zealand population

Stroke incidence and mortality has not declined in line with other New Zealanders, and stroke tends to affect younger adults in their most productive years in Pacific people. Ethnic differences in CVD mortality and morbidity are attributable to differences in risk factor prevalence and access to health care services.^{348,349,350}

347 See footnote [338](#).

348 See footnote [338](#).

349 <https://www.mentalhealth.org.nz/assets/ResourceFinder/tupu-ola-moui-pacific-health-chart-book-1.pdf>

350 http://www.stats.govt.nz/browse_for_stats/people_and_communities/pacific_peoples/pacific-progress-health.aspx

The prevalence of smoking has declined in the Pacific population but still remains higher than the smoking rate in other New Zealanders especially amongst youth, with Pacific girls smoking at much higher rates than their peers. Smoking remains one of the most important and preventable causes of morbidity and premature mortality among Pacific people in New Zealand.

Type 2 diabetes is more prevalent among Pacific people in New Zealand due in part to the higher prevalence of overweight and obesity among them. High prevalence of obesity in Pacific people is attributable to the obesogenic environment (consumption of highly processed food and reduced physical activity) that exists in urban areas in New Zealand.

Studies have shown that Pacific people are more likely to consume diets high in fats, sugar and salt, more likely to have takeaway meals and less likely to cook at home. Young Pacific boys consume sugar-sweetened soft drinks more often than their peers. Preventing and managing obesity in Pacific people is the most urgent priority for the New Zealand health system. Demand for services such as renal dialysis as a result of renal failure due to diabetes is already reaching a point where health services are struggling to meet demand.³⁵¹

Pacific children experience significant preventable morbidity. Several studies have shown that respiratory disorders and skin infections are very common and hospital admissions are higher than other New Zealand children.³⁵² Acute rheumatic fever and rheumatic heart disease are three times more common among Pacific children and young people compared with other New Zealand children and young people. Unless effective action is taken to address poverty, interventions directed at specific diseases are unlikely to be sustainable.

351 See footnote [338](#).

352 See footnote [342](#).

The 2006 New Zealand Mental Health Survey (Te Rau Hinengaro) showed that the prevalence of mental disorders among Pacific people in New Zealand is similar to Māori and other New Zealand populations, except psychotic disorders where the prevalence of schizophrenia is higher among young Pacific men.³⁵³ Survey findings showed that only one-quarter of Pacific people with severe mental disorders were receiving recommended care.³⁵⁴

Access to and quality of health care

Pacific people are known to have low uptake of preventive and primary health care services, for example, low uptake of cervical and breast cancer screening and low immunisation coverage rates. These observations are supported by high rates of ambulatory sensitive hospitalisation (ASH) among Pacific people.³⁵⁵ ASH admission rates are generally accepted as a reasonable indicator of the quality and effectiveness of primary health care services. A recent review of the primary health care for Pacific people in New Zealand³⁵⁶ showed a potential disconnect between primary health care providers and Pacific patients. General practitioners (GPs) were less likely to record high levels of rapport with Pacific patients, and Pacific patients had low uptake of subsidised care, high use of accident and medical (A&M) clinics and lower levels of satisfaction with their experiences of primary health care. The report also concluded that the top three barriers to primary health care for Pacific people were cost, transport and language.

353 <http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey>

354 See footnote 338.

355 See footnote 349.

356 Southwick M, Kenealy T, Ryan D. Primary care for Pacific people: a Pacific and health systems approach. Wellington: Pacific Perspectives; 2012.

Reforms of the health sector and changes to the funding and delivery of primary health care in New Zealand as part of the New Zealand Primary Health Care Strategy and the Pacific Health Strategy has resulted in some improvements for Pacific people. Information from primary health organisations (PHOs) has shown high enrolment rates for Pacific people. Furthermore, the New Zealand Health Surveys have shown that the per capita GP consultation rates for Pacific people is comparable to other New Zealanders, although the level of consultation may not be appropriate for the level of health needs in these communities.³⁵⁷ Immunisation coverage rates among Pacific children are now among the best in the country.

Despite these improvements, it is clear that Pacific people continue to receive variable quality of health care. Studies of almost all health conditions have shown that Pacific people continue to receive lower levels of care, especially at the primary health care level. Health practitioners who work in health settings in communities need to ensure that best practice is normal practice at all times. Additional support, education and information for patients and their families will assist in improving the consistency and impact of primary health care for Pacific people. Improvements in the quality of primary health care will reduce attendance rates at emergency departments and avoidable hospital admissions among Pacific people. It is also worth noting that ‘free’ health care in hospitals will continue to be a factor influencing Pacific people’s decisions about where to seek health care services.

Improvements in the quality of primary health care will reduce attendance rates at emergency departments and avoidable hospital admissions among Pacific people.

³⁵⁷ See footnote [353](#).

Community-controlled primary health care

The emergence of Pacific-owned community health services in New Zealand has contributed to the overall improvements in access to and quality of health care provided to Pacific patients and their families. However, it is estimated that 90 percent of Pacific patients continue to receive health care from mainstream providers, and this situation is likely to continue. Many Pacific patients and their families also receive care from Māori service providers, especially in Auckland in view of the similarities in service delivery ethos of Māori providers to Pacific providers. Most Pacific community-owned services are located in areas with high Pacific populations in urban centres. Informal feedback confirms that Pacific patients report positive interactions with Pacific-owned providers although there has been no independent evaluation of these services. In general, Pacific-owned clinics have distinct advantages over conventional care models, such as lower fees, clinical staff who speak a Pacific language and good community support for patients and their families.

Ethnic-specific considerations

The assumptions of being Pacific

A generalised grouping of Pacific people and cultures can be misleading to a health practitioner treating them. This population has differing cultures with similar but unique cultural beliefs. However, this population is changing as a result of being born and raised in the multicultural environment of New Zealand, intermarriage and mixing of cultures and increasing education. It is important for health practitioners to be aware that generalisation can be misleading. Treat patients as individuals, and verify any assumptions you may have based on their ethnic background. It is also important to be aware that a patient's sense of identity and self-knowledge may change over time.

Family structure

Family rather than individuals are the basic unit of organisation in Pacific society. Family more often than not refers to nuclear and extended family, which can affect the interaction that one has with a patient. It is common for a patient to be seen with family during consultations, they may defer to family for decisions and consent can often involve a group rather than an individual decision-making process.

Holistic concept of health

Pacific society has a holistic concept of health where a combination of physical, mental, social and spiritual wellbeing contributes to an individual's wellbeing. Being able to contribute fully to one's family and community is paramount.

Older Pacific people who were born in the islands have a socioecological approach to health with strong spiritual dimensions to their beliefs about illness, healing, death and dying. Death, disease and disability are often attributed to the will of God and/or a superior being. Mental disorders in particular are often regarded as possession by evil spirits or deceased relatives as retribution for wrongdoing by the affected individual or members of their family. As a result, health care practitioners often have difficulty understanding the apparent fatalism that can be seen in some Pacific patients. These beliefs can lead to much 'shopping around' with different health care practitioners, including traditional healers.

Attitudes to health and illness among younger members of the Pacific communities are less clear. It is likely that young people are less likely to hold traditional attitudes and views about health and illness.³⁵⁸

³⁵⁸ See footnote [338](#).

Respect and religion

Respect is very important in the Pacific culture especially of elderly and those with authority, for example, church ministers, politicians and health care professionals. It is not unusual for a patient to defer to their health care provider or elders in the family or church for important decisions about their health.

Spirituality, especially the Christian faith, is very important in most Pacific cultures, and this may influence their decisions on their health. Many patients will defer to their God being in charge and accept whatever their God has planned for them. It is important not to see this as a fatalistic attitude, and all options for treatment or management should be fully discussed as many will see the doctor as an extension of God's healing hands to help them.

While most Pacific adults are regular church attendees, an increasing proportion of young people are less religious in their outlook compared with their parents. For most Pacific people, the church remains a significant influence on their lives, attitudes to health, illness, death and dying.³⁵⁹

Traditional medicine

Traditional medicine is still commonly used by the Pacific population. These treatments are based on individual need, and there is no prescriptive treatment for conditions – individuals with the same or similar conditions may be treated differently according to the healer's perception of the patient's need.

³⁵⁹ See footnote [338](#).

Treatment can involve massage, plant-based balms or applications, herbal concoctions or baths. It is important to be open about the possibility that traditional treatment may be used and accept that individuals may have made a choice to seek this treatment. Patients are more likely to discuss it if their health care provider is receptive and accepting of this treatment modality.

It is acceptable to respectfully challenge a treatment (by explaining your concerns) if you see that it is dangerous or interferes with successful treatment of a condition. However, if you accept that a traditional treatment is not going to cause any harm, it is useful to acknowledge that you are aware and accept their use of traditional treatment but encourage them to ensure that the Western medicine you are advising be used in conjunction. Compliance with Western medicine is likely to be better if the patient is given the permission to use both rather than one over another. Work with the patient/family on the best way to help them use both if they prefer.

Care of the older and disabled

Pacific people generally prefer to provide care for the older and disabled patients themselves. This is seen as the right thing to do and often keeps problems within the family as part of respecting the elderly. This can cause significant carer stress, which may not be discussed openly due to respect of the person being cared for. It is important to discuss and offer assistance if available, as often knowledge is the issue and families may take up varying options of assistance according to their needs and acceptance amongst their family.

Kava

Drinking kava is still a common practice amongst certain Pacific communities in New Zealand. It is estimated that more than 20,000 people drink kava on a Friday and Saturday night.³⁶⁰ This is largely a male activity, but in some cultures (such as Fijian), women also consume kava. This traditional root drink acts as a sedative and anaesthetic, slowing reactions and causing euphoria. Kava is not addictive and does not cause dependency. Kava is not picked up by alcohol breathalysers, and it is not unusual for people to drive after consuming kava. Significant consumption over prolonged periods can cause an ichthyosis of the skin. There is some anecdotal evidence that kava causes some hepatotoxicity, but there is no clear evidence. It is important to discuss this as a possible cause of abnormal liver function tests, particularly in Pacific males.

Non-residents

Due to close proximity to the Pacific Islands, there are a large number of this population who are not eligible for publicly funded treatment due to immigration status (visitors, overstayers and those with short-term work visas). Family will often bring family members from the islands to New Zealand to seek medical treatment for conditions unable to be diagnosed or treated in their home island. This can cause issues for the health professional providing care to these individuals as they are dependent on the individual and family to fund any treatment required. It is best to provide all treatment options including recommended gold standard treatment options with these patients in order to fully inform them of their treatment options. Assumptions on what the family is willing and able to afford can often be misleading.

360 <https://www.tvnz.co.nz/one-news/new-zealand/thousands-drinking-kava-in-nz-but-cure-killer>

If these individuals need urgent/acute care, an admission to hospital for stabilisation should be arranged before non-acute/ongoing care options can be discussed. It is important to advise family that payment will be required following discharge.

Tropical disease

Due to frequent travel to and from the Pacific Islands, the risk of tropical disease remains high, and one needs to be aware and open to this when seeing patients with unusual symptoms. Ask about travel to the Pacific and any knowledge of any local illnesses that may have been present while they were there. Dengue fever, malaria, chikungunya and typhoid outbreaks are examples of tropical diseases that have occurred amongst this population in New Zealand as a result of this frequently travelling population.

Getting assistance

The Ministry of Health has a well-developed strategy for improving the health of Pacific people and funds service delivery by selected district health boards (DHBs) that serve large numbers of Pacific people. The key Ministry strategy is the *Ala Moui Pathways to Pacific Health and Wellbeing 2010–2014*,³⁶¹ which outlines government priorities, programmes and major contributors to health. Much of the actual service delivery and support for health care providers is funded and coordinated by selected DHBs, mainly in urban centres. Pacific teams in DHBs are well placed to provide an overview of service delivery in their districts and advise on how best to support health care professionals. In addition, there are several Pacific-owned health care providers in most urban centres throughout New Zealand. These providers have well-developed networks that can assist with advice and support.

361 <http://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018>

The Pasifika Medical Association (PMA) (www.pacifichealth.org) is the leading Pacific organisation dedicated to improving the health status of Pacific people, both in New Zealand and the Pacific region. The PMA has close ties with individual medical associations of the Pacific countries. Membership includes doctors, nurses, other health workers and community leaders. PMA provides professional support to its members, delivers health workforce development in schools and advocates for better policies and services for Pacific people. Most of the senior and experienced clinicians of Pacific descent in New Zealand are members of PMA. Most Pacific nations also have associations and community groups with an interest in health such as the Tongan and Samoan Nurses Associations and the Cook Islands Health Network Association.

The Medical Council has produced an excellent resource for clinicians working with Pacific patients with an emphasis on supporting the best outcomes for patients. The resource includes information on key concepts in Pacific societies that impact on health and health care provision and specific advice on how best to manage Pacific patients.³⁶²

Pacific Heartbeat at the National Heart Foundation has been providing information and training for health and community workers for several years. Their focus is on improving nutrition and physical activity as well as a smoking prevention and cessation information service. The New Zealand Stroke Foundation has recently established the Pacific Stroke Prevention Project dedicated to preventing stroke in Pacific communities.

The Medical Council has produced an excellent resource for clinicians working with Pacific patients with an emphasis on supporting the best outcomes for patients. The resource includes information on key concepts in Pacific societies

362 See footnote [342](#).

CHAPTER 20

Asian people in New Zealand

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Cite this as Wong GH, Hong C. Asian people in New Zealand. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	291
Specific health needs of Asian patients	292
› Refugee health	294
Ways to engage Asian migrant patients	295
› Appreciate health beliefs	295
› Understand health practices	296
› Realise Asian people's use of medication	297
› Be aware of patients' expectations	297
› Have effective communication	298
› Know your patients' names and dates of birth	299
› Work with guardians/support persons	299
› Deal with sensitive issues	299
› Work with individuals from a refugee background	300
Working with interpreters	300
› Introductions/briefing	301
› Agreement on type of interpreting	301
› Seating arrangements	302
Conclusions	302
Acknowledgement	302

Introduction

Asian people were the third largest ethnic groups in New Zealand, making up 11.8 percent of the New Zealand population (471,708) in 2013, compare to 9.2 percent (354,552) in 2006.³⁶³ The Asian population is projected to grow faster than the New Zealand population as a whole, increasing to 0.81–0.92 million in 2025 and to 1.06–1.26 million in 2038.³⁶⁴ The increasingly diverse immigration to New Zealand built momentum following the changes to legislation in 1987 and 1991, which removed a bias in favour of British and West Europeans who were considered ‘preferred sources’ of migrant population.

According to the 2013 Census, Chinese made up the largest ethnic group with 36.3 percent of the total Asian population, followed by Indian (32.9 percent). Other major ethnic groups included Filipino, Korean, Japanese, Sri Lankan, Cambodian and Vietnamese. The Indian ethnic group grew faster than the Chinese between 2006 and 2013. The Filipino ethnic group in New Zealand had more than tripled in size between 2001 and 2013, with the Vietnamese ethnic group increasing by 92.4 percent during the same period. Of the people living in New Zealand and born in Asia, less than half (47.4 percent) had been living in New Zealand for 10 years or more by 2013. Some do not speak English.

This rapidity and diversity of Asian ethnic growth in New Zealand will impact on the host population health delivery system due to possible language and cultural barriers between clients, health workers and health services. For discussion on the use of the term ‘Asian’, please refer to the work by Rasanathan, Craig and Perkins.³⁶⁵

363 <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity.aspx>

364 http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalEthnicPopulationProjections_HOTP2013-38.aspx

365 Rasanathan K, Craig D, Perkins R. The novel use of ‘Asian’ as an ethnic category in the New Zealand health sector. *Ethnicity and Health*. 2006;11(3):211–27.

Specific health needs of Asian patients

Asian people in New Zealand are very diverse in religion, culture, language, education and socioeconomic experiences. It is therefore difficult to generalise the health needs of the Asian people in New Zealand as a whole, although there is a selection of published reports on the health needs of Asian people in New Zealand.^{366,367,368,369}

Whilst the Asian people in New Zealand are relatively healthy overall, much of this result is due to the so-called the healthy immigrant effect. Most migrants need to be in good health to be allowed to immigrate to a new host country, and many have high socioeconomic status in their countries of origin. These migrant groups also have high levels of education, which are associated with better health status. However, this positive effect on health gradually disappears with increasing length of residency in the new host countries. Many high-priority health issues and unmet health care needs were identified:^{370,371,372}

- Asian ethnic groups, compared to the European/other category, had higher age-standardised prevalence of diabetes, were less likely to be physically active and had lower proportions of people eating the recommended daily number of servings of fruits and vegetables.
- Asian women's cervical screening rates were less than half of women in the European/other category.

366 Scragg, R. Asian health in Aotearoa in 2011–2013: trends since 2002–2003 and 2006–2007. Auckland: Northern Regional Alliance Ltd; 2016.

367 Walker R. Auckland Region DHBs Asian & MELAA: 2013 Census demographic and health profile. Auckland: Northern Regional Alliance (NRA); 2014.

368 Mehta S. Health needs assessment of Asian people living in the Auckland region. Auckland: Northern DHB Support Agency; 2012.

369 Rasanathan K, Ameratunga S, Chen J, Robinson E, Young W, Wong G, Garrett N, Watson PD. A health profile of young Asian New Zealanders who attend secondary school: findings from Youth2000. Auckland: The University of Auckland; 2006.

370 See footnote [366](#).

371 See footnote [368](#).

372 Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Racism and health: The relationship between experience of racial discrimination and health in New Zealand. *Social Science and Medicine*. 2006;63(6):1428–1441.

- Asian ethnic groups had lower and delayed access to disability services due to stigma and lack of awareness of available service options.
- Asian people were more likely to think constantly about their ethnicity, to have ever been a victim of an ethnically motivated verbal attack and to have experience of being treated unfairly because of their ethnicity.

Mental health issues including depression and psychosomatic illness are frequently encountered among Asian people, and they often have a complex interplay among social isolation (from migration), language barrier, underemployment or unemployment.³⁷³ Stigmatisation and taboo of psychiatric illness compound the problem further, resulting in a reluctance by Asian people and their families to seek early intervention or treatment. Other mental health issues identified in New Zealand include problem gambling and alcohol abuse. Furthermore, the New Zealand Mental Health Commission's report on Asian mental health mentioned several specific concerns:³⁷⁴

- The high mental health needs of women and refugees from smaller ethnic communities.
- Mental health needs of older people.
- Refugees adapting to a new culture because of pre-migration traumas and post-migration stressors.

373 Asian Public Health Project Team. Asian public health project report. Auckland; 2003.

374 Ho E, Au S, Bedford C, Cooper J. Mental health issues for Asians in New Zealand: a literature review. Wellington: Mental Health Commission; 2002.

Primary health organisations (PHOs) are playing a pivotal role in the New Zealand health care system. Every Asian must be advised to register themselves and their families with these organisations through individual general practices. However, PHO enrolment rate and health service utilisation in primary care were low among Asian people.^{375,376}

There are many known barriers to explain the lower health service utilisation among Asian people:^{377,378}

- Language barriers during encounters with health professionals and brochures and health service facility signs written in English for people who are unable to read English.
- Lack of awareness and knowledge of the New Zealand health system, confusion of the referral system by primary care practitioners for hospital assessment and treatment and frustration at perceived long referral waiting times and a tendency for ‘doctor shopping’.
- Stigma and perceived lack of confidentiality, especially for disability and mental health issues.
- Lack of cultural competency among health professionals.

Refugee health

Refugees enter New Zealand under three categories – refugee quota, family reunification members and asylum seekers. All of the above categories are health screened for immigration purposes.

375 See footnote [368](#).

376 See footnote [369](#).

377 See footnote [368](#).

378 Anderson A. Understanding migrants’ primary healthcare utilisation in New Zealand through an ethnographic approach. *Diversity in Health and Social Care*. 2008;5(4):291–301.

Primary health care plays a significant role as individuals with a refugee background have had very limited health care in their respective countries before arriving in New Zealand. Conditions prevalent in their respective geographical zones include sickle cell anaemia, malaria, hepatitis B carrier state and gastrointestinal infections.³⁷⁹ With regard to services for refugee mental health, a mobile health team employed by Refugees As Survivors (RAS) is already functioning in Auckland and is of great help to individuals and families from a refugee background.

Ways to engage Asian migrant patients

In order to provide practical suggestions to engage Asian migrant patients, the following material will be useful as examples for those working with Korean and Chinese patients.³⁸⁰

Appreciate health beliefs

Chinese patients in general are very health conscious even though they appear to be less knowledgeable in human anatomy or the scientific basis behind Western medicine. The fundamental belief of good health among Chinese people is the ability to maintain a peaceful state of mind and to be in harmony with the surroundings. It stems from the philosophy that everything in this universe is interrelated and is forever changing with the life force/energy (known as qi) flowing through all matter continuously.

Chinese patients in general are very health conscious even though they appear to be less knowledgeable in human anatomy or the scientific basis behind Western medicine.

379 Ministry of Health. Refugee health care: a handbook for health professionals. Wellington: Ministry of Health; 2012.

380 Tse S, Lloyd C, McKenna K. When clients are from diverse linguistic and cultural backgrounds. In: McKenna K, Tooth L, editors. Client education: A practical guide for clinical therapists. Sydney: UNSW Press; 2006.

Qi is the fundamental substance, and its movements produce everything that constitutes the universe. The concept of yin and yang describes the dynamic and oscillating relationship of the flow of qi between these two extreme states. Yin represents cold, dark, inactive, negative and female-like energy, whereas yang represents hot, bright, active and male-like energy. Everything in the universe has an element of both yin and yang. On an individual level, good health is about having a balanced flow of qi between the yin and yang.³⁸¹

An example of misunderstanding resulting from differences in health beliefs is the Chinese patient who says, “I have too much heat in my body.” From a Western medicine perspective, most doctors would tend to think that the patient is implying that they have a fever. However, it is often not the case, as the patient is trying to say they have too much yang in their body.

Understand health practices

Chinese patients often use folk medicine or tonics in the early stages of illness. In addition, self-medicating with Chinese medicine and consultation with a traditional Chinese medicine (TCM) practitioner and concomitant use of both Chinese and Western medicine is not unusual. It is also very common for Chinese and Koreans to be taking vitamins, propolis, calcium supplements, green-lipped mussels and royal jelly as a regular daily supplement. Therefore, it is important to seek a full drug and medication history, especially enquiring about the use of TCM or alternative health supplements. Chinese and Korean patients will often request injections, as they perceive it as a more direct and potent route of drug delivery with a more rapid onset of action than the oral route.

381 Yu ECL. Essential traditional Chinese medicine: Western scientific medicine perspective. Hong Kong Practitioner. 2001;23:20–27.

A perceived imbalance of the yin and yang forces can be influenced by many factors including dietary intake. It is therefore common for a Chinese patient to ask the health practitioner about food avoidance in times of illness. For those health practitioners who are not familiar with the yin and yang concept, it would be best to advise the Chinese patient to seek dietary advice from a TCM practitioner or suggest the patient to eat whatever they feel comfortable with or accustomed to.

Realise Asian people's use of medication

Non-compliance to medication is an issue with any group of patients, including Asian patients. Until recently, many Koreans have been used to easy access to most medications from their local pharmacy in Korea. Medicines like antihypertensive drugs and oral antibiotics were freely available, leading to resistance and misuse problems. Doctors in New Zealand need to reinforce the correct use of medication and check for compliance at each visit. It is helpful to use medication cards with the name of the medicine, times to be taken and treatment duration clearly stated on them.

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Be aware of patients' expectations

The family doctor is a rather foreign concept as it is not common practice in many Asian countries for a patient to have a family doctor. When Asian people are unwell in their country of origin, they tend to present to the first available doctor or whoever is the most reputable in treating the condition. Walk-ins and self-referral to specialists are the norm. Medical consultations in many Asian countries are relatively short in duration and often conducted in a doctor-centred manner. Some Chinese patients are used to doctors who give quick and authoritative diagnosis, whereas many are used to asking for medical tests and medicines that they want.

In addition, some patients expect to be told what to do and expect the doctor to prescribe concrete tests or treatment, for instance, writing out a prescription.

Many Chinese and Koreans are familiar with total body checks, which are screening tests and investigations performed in many hospitals across Asia. They will often ask for the same in New Zealand. Many are used to being investigated extensively with a whole batch of routine and screening tests, including blood tests, X-rays, ultrasounds, CT and endoscopy of the gastrointestinal tracts. Medical practitioners may need to explain that, in New Zealand, we only request blood tests or investigations that we feel are necessary or pertinent to the problem involved. Many patients become anxious at the perceived long waiting lists for specialist appointments or investigations in New Zealand so they often travel to their country of origin for specialist appointments or investigations. They often return with abnormal test results, which they expect their doctor in New Zealand to follow up. This is a common practice, so advising them to bring back medical certificates or clinical summaries in English will assist with their ongoing medical care.

Despite all the patients' various expectations, it is important to remember that, as a medical practitioner in New Zealand, the patient-centred care model is crucial in the provision of good medical services. In short, it is important to seek patients' ideas, concerns and treatment expectations of their illness regardless of their ethnicity.

Have effective communication

Even simple tasks such as making an appointment with a general practitioner can be a huge obstacle for some Asian patients with limited English proficiency. For example, when answering phone calls from Asian patients, it helps to speak clearly and in short simple English. Offer appointment times that are easy to understand for example, "two o'clock" not "twenty to four".

Asian patients with limited English proficiency will often make appointments through friends or family members, so make sure you have the right person's details.

Know your patients' names and dates of birth

Getting this right is tricky. When Asian people come to New Zealand, they often take on an English name, so they end up with more than one name. For women, it is further complicated by adopting the Western culture of taking on the husband's surname. This results in a possibility of three names for the one person. It is recommended that medical practices use the name on the patient's passport.

Dates of birth are also tricky because Koreans and some elderly Chinese people use two birthdays – one according to the solar calendar and the other according to the lunar calendar. Therefore, it is important to clarify the correct date of birth information.

Work with guardians/support persons

Many Asian patients are used to having a guardian or support person with them in consultations, similar to the whānau in Māori culture. It is appropriate to allow at least one person to accompany the patient into the consultation room, especially if they need help with interpreting. Beware of the fact that the guardian or support person often speaks on behalf of the patient, so do try to encourage the patient to speak for themselves.

Deal with sensitive issues

It has been suggested that Confucian teaching, which discourages open displays of emotions in order to maintain social and family harmony, is contributing to the high rate of psychosomatic illness among Chinese patients. Regardless of the reason, sensitivity and tact are important when dealing with the psychosocial aspect and sensitive issues like suspected abuse. Marital status is another sensitive topic.

Some Asian patients may feel uncomfortable answering questions on marital status if they are divorced. A useful question may be “Who lives at home with you?” rather than “Are you married?”. A polite and respectful manner will be appreciated.

Work with individuals from a refugee background

This subgroup of Asian patients may have been inadequately treated and need a complex follow-up plan. Some tend to use the emergency services as their first and last resort because they have limited understanding of the New Zealand health system or they can't afford to visit their family doctor. The lack of interpreters to help the health care team may lead to wrong diagnoses, unnecessary investigations and referrals to tertiary care. The mental health of refugees needs special care in view of possible history of torture. Torture history and the consequence of their sufferings have to be carefully understood for any treatment plan to be successfully pursued. Building a good rapport with refugee patients is a useful strategy in addressing their health needs.

Working with interpreters

For Asian people with limited English proficiency, this can be a highly anxiety-provoking experience. They are faced with putting their trust in a doctor or health professional with a different language and culture to their own. Thus, it is vital to employ a trained interpreter. In reality, the use of trained interpreters is often not possible due to lack of access and cost.^{382,383} Hence, friends and family members are frequently used as default interpreters.

382 Chan I, Lloyd T, Tong K. The use of interpreters by South Auckland GPs. *New Zealand Family Physician*. 1999;26:52–56.

383 Gray B, Hilder J, Stubbe M. How to use interpreters in general practice: the development of a New Zealand toolkit. *J Prim Health Care*. 2012 Mar 1;4(1):52–61, A1–8. PubMed PMID: 22377550.

Some doctors are more experienced than others at adjusting their consultations in the presence of an interpreter. Some may feel uncomfortable when facing patients with little or no command of English. Many may feel culturally incompetent in understanding the patient's health beliefs.

No doctor is expected to be fully competent in the many Asian cultures that exist in New Zealand. The key is to approach the Asian patients with genuine concern and interest. Non-verbal messages and reassurance like smiles and good eye contact along with a clear, kind tone of voice go a long way. Sentences should be short, in simple English and not spoken too quickly. Do allow more time than the standard consultation when using an interpreter.

Some basic ground rules should be set and agreed on before the consultation begins.

No doctor is expected to be fully competent in the many Asian cultures that exist in New Zealand. The key is to approach the Asian patients with genuine concern and interest.

Introductions/briefing

It is important if the interpreter can be briefed as to the problem or the context of the consultation. This will enhance the quality of the interpretation. In an ideal situation, the doctor might like to find out some do's and don'ts of the particular Asian culture before the consultation. For example, the colour red is good luck in China and bad luck in Korea. Number 4 is symbolic of death in both cultures.

Agreement on type of interpreting

In the medical setting, it is recommended that the doctor speaks in one or two sentences followed by interpretation. Interpreting long sentences is less conducive to the flow and understanding of the consultation.

Seating arrangements

Where possible, the doctor, patient and interpreter should be seated in a triangle formation with the doctor and the patient sitting in direct and full view of each other. The interpreter should be seated in between the doctor and the patient, slightly out of view from both. The doctor should look and talk directly to the patient instead of talking through the interpreter.

Interpreter services are being made available at PHO level to Asian migrants from non-English speaking backgrounds. Further enquires can be made at the local practices.

Conclusions

Asian people in New Zealand are very diverse in religion, culture, language, education and socioeconomic experiences. Whilst Asian people in New Zealand are relatively healthy overall, there are many important health issues and unmet health care needs. Mental health is a challenging area because of the degree of stigma attached to such illness in many Asian cultures, resulting in treatment delay and possible worsening of prognosis. The cultural beliefs of Asian people's countries of origin still prevail in their initial settlement period. Efforts must be made to get Asian people integrated into the New Zealand health system, and this will require ongoing education for both patients and doctors. Careful use of interpreters is important to communicate effectively with Asian people with limited English proficiency.

Acknowledgement

We would like to acknowledge the contribution of past authors to this chapter – Professor Samson Tse, Dr Kenneth Tong and Dr Nagalingam Rasalingam.

CHAPTER 21

Working with interpreters

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Cite this as Gray B. Working with interpreters. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	304
Right to communication	304
Is any interpreter satisfactory?	305
Using a professional interpreter	306
Telephone versus face to face	307
Organisational systems required to care for LEP patients	308
Skills required	309
Assessing English fluency	309
Working with an interpreter	310
Working with a family member interpreter	310
Communicating with deaf people	311
Funding for interpreters	311
Availability of professional interpreters	312
Uptake of professional interpreters is poor	312
Summary	313
Acknowledgement	314

Introduction

Increasing numbers of New Zealand residents are born overseas – since 1996, the percentage has increased from 17 percent to 25 percent. The Asian ethnic group has doubled in size since 2001, and net migration will become an increasingly significant contributor to population growth.³⁸⁴ The proportion of people from non-English-speaking backgrounds is also increasing. People of Chinese origin are the second-most common group of migrants after those of English origin, and Hindi and Samoan are the most widely spoken languages in New Zealand after English and Māori.³⁸⁵ New Zealand's immigrant population is disproportionately concentrated in the Auckland region, with 64 percent of all the Asian population living in Auckland.³⁸⁶ New Zealand has three official languages – New Zealand Sign Language (for which there are 20,000 users),³⁸⁷ English and Māori.

Right to communication

Right 5 of the Health and Disability Commission's Code of Patient Rights (effective communication) includes a right to a competent interpreter.³⁸⁸ Without an interpreter, many of the other patient rights are not available to a person with limited English proficiency (LEP).

Right 5 of the Health and Disability Commission's Code of Patient Rights (effective communication) includes a right to a competent interpreter

384 <http://www.statisticsnz.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-national-highlights/cultural-diversity.aspx>

385 See footnote 384.

386 http://www.statisticsnz.govt.nz/browse_for_stats/population/estimates_and_projections/SubnationalEthnicPopulationProjections_HOTP2013base/Commentary.aspx#asian

387 See footnote 384.

388 [http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-\(full\)](http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full))

Is any interpreter satisfactory?

Accurate complete interpreting is a difficult professional job that requires significant training. In addition, good interpreting is founded on trust. The patient must trust the interpreter to hold any information confidential and trust them to accurately interpret their communication, and the doctor has to trust the interpreter to be accurate and to signal if there are any doubt as to how a phrase should be translated. The further apart culturally two languages are, the more likely that concepts do not translate. For example, there is no equivalent term to schizophrenia in Somali. It requires significant practice to be able to recall all that is said in English and then accurately translate it into another language.

It is common practice for clinicians to use ad hoc interpreters – family members, friends or bilingual colleagues – to aid communication with LEP patients. Table 2 lists the important linguistic and ethical problems with this approach. It is very hard for the clinician to judge the adequacy of interpretation.

Table 2. Problems using ad hoc interpreters.

Linguistic problems	Ethical problems
<ul style="list-style-type: none">• Accuracy of interpreting• Degree of English fluency• Unfamiliarity with medical terms• Incomplete interpretation• Adding in advice or opinion of interpreter	<ul style="list-style-type: none">• Confidentiality• Difficulty with talking about sensitive matters• Role conflict (for example, abusing husband interpreting for abused wife)• Disrupting family dynamics, in particular, the use of young children as interpreters for their parents is unacceptable

It is useful to think of there being a continuum in degree of need to use a professional interpreter.

Looking at clinical complexity at one end, it is essential – for example, explaining a new diagnosis of cancer or gaining informed consent for a major procedure. At the other end, a family member may be satisfactory – for example, doing a repeat prescription for hay fever medication.

In judging the likelihood that a professional interpreter is needed, the following issues should be considered:

- Complexity of anticipated clinical content.
- Language ability of the patient.
- Language ability of available ad hoc interpreter.
- Degree of ethical risk, for example, is the patient vulnerable with mental health issues? Is the available ad hoc interpreter a child? Does the available ad hoc interpreter have a position of power over the patient?
- Sensitivity of clinical content, for example, gynaecology, family discord.
- Legal need for informed consent.
- Urgency of presentation – in an emergency, use the best available option.
- Wishes of the patient.
- Ability to pay for an interpreter.

Using a professional interpreter

Every doctor must have the ability to employ a professional interpreter if caring for an LEP patient.

If a patient has LEP, then there will be times when care cannot be provided without a professional interpreter.

Telephone versus face to face

Many organisations preferentially use telephone interpreting (rarely video interpreting in New Zealand), predominantly because of cost issues.

Table 3 contrasts the risks and benefits of telephone and face-to-face interpreting.

Table 3. Comparing telephone and face-to-face interpreting.

	Telephone interpreter	Face-to-face interpreter
Benefits	<ul style="list-style-type: none">• Anonymity of interpreter• Availability (for smaller language groups or at short notice)• Cheaper	<ul style="list-style-type: none">• Relative ease of communication including non-verbal• Easier if needing to consult with a family group
Disadvantages/risks	<ul style="list-style-type: none">• Distancing effect of the phone• Possible background noise• Difficulty in gauging quality of interpreter• Lack of continuity (more likely)	<ul style="list-style-type: none">• Possible issues with confidentiality/comfort if the patient and interpreter are socially acquainted or part of a small ethnic community• More costly

Computerised translation applications

These have the advantage of ready availability and no cost. Accuracy is better if the language pair are closely related (for example, French and English) but much worse if they are unrelated. In a recent study of translating medical phrases, only 58 percent overall were correct.³⁸⁹ The field is developing quickly, and for some language pairs, there is significant improvement.³⁹⁰ Clearly, use of a computer application is better than nothing, but it is difficult to assess accuracy, and even slight discrepancies in translation can lead to important misunderstandings. Importantly, even the most accurate automated translation system can at best render only literal meanings – this technology cannot take account of meanings that could otherwise be inferred from aspects of the context or interaction or from knowledge of intercultural differences. Issues of confidentiality are not transparent, and of course using such applications requires typing or speaking language into a computer. The patient may not be literate in their own language, and this will be more challenging for languages that use a different script (such as Arabic or Mandarin).

Organisational systems required to care for LEP patients

Doctors work in organisations, and there are many things at a systems level that will facilitate communication with LEP patients:

- Routine collection of ethnicity, preferred language and need for interpreter data on registration.
- Organisational policy on use of interpreters.
- Provision of a budget for employing interpreters.

389 Patil S, Davies P. Use of Google Translate in medical communication: evaluation of accuracy. *BMJ*. 2014;349:g7392.

390 <https://www.technologyreview.com/s/602480/googles-new-service-translates-languages-almost-as-well-as-humans-can/>

- Register kept of available interpreters.
- Speaker phones available (telephone interpreters are commonly used and most available).
- Staff training on managing LEP patients including reception and administration staff.
- Look at all communications from the organisation to patients through the eyes of an LEP patient: do any of them need translating?
- Patient safety incident management system flagging when language barrier may have been a factor.

Skills required

Any clinician new to working with interpreters would benefit from basic training in the skills required for this. An online e-module 'Working with interpreters' is available at www.otago.ac.nz/working-with-interpreters.

Assessing English fluency

If the patient speaks no English, it is easy to work out that you need an interpreter. It is rarely helpful to ask someone if they speak English. It is better to ask open-ended questions or ask the patient to repeat back in their own words what they have understood you to have said. Even if someone has sufficient English for conversation at work, they may still have insufficient English for discussing or fully understanding complex health issues.

Even if someone has sufficient English for conversation at work, they may still have insufficient English for discussing or fully understanding complex health issues.

Working with an interpreter

Organisations providing interpreter services all offer brief advice or training on how to work with an interpreter. Some basic points:

- Speak as if you are talking to the patient (“How do you feel?” not “How does she feel?”).
- Sit in an equilateral triangle so the patient, doctor and interpreter can easily see each other.
- Speak in small chunks. The longer you speak without a break for interpreting, the harder it is to interpret accurately.
- Use illustrations where possible.
- Try to explain medical concepts in simple language, and avoid the use of jargon.
- Avoid colloquialisms. Jokes are often hard to explain and risk being misunderstood.

Working with a family member interpreter

There will be times when clinicians choose to work with a family member as an interpreter rather than a professional interpreter.³⁹¹ This requires a number of additional skills to those needed for professional interpreters:

- You may need to coach the family member by explicitly asking them to interpret everything the patient says. This is more likely to happen if you speak in very short chunks.
- Simplifying the language is even more important, and you will need to continually assess whether the family member understands what you are saying in English.

391 Hilder J, Gray B, Dowell A, Macdonald L, Tester R, Stubbe M. ‘It depends on the consultation’: revisiting use of family members as interpreters for general practice consultations – when and why? *Australian Journal of Primary Health*. 2016.

- When working with a professional interpreter, the normal practice would be to face the patient as you speak (rather than the interpreter). This may require some adjustment when working with a family member.

Communicating with deaf people

Past prohibition of the use of sign language in schools means that there are significant numbers of deaf people with low levels of literacy. Written communication in English (or another spoken language) is not a suitable or reliable substitute for communicating with many deaf people. If you have deaf people in your practice, there is a detailed guide on managing this at www.odi.govt.nz/new-zealand-sign-language-nzsl/nzsl-tools-and-resources/publications.

Written communication in English (or another spoken language) is not a suitable or reliable substitute for communicating with many deaf people.

Funding for interpreters

All public hospitals in New Zealand have policies and a budget for the use of interpreters, although anecdotally, the budgets are constrained.

Any public sector organisation can join Language Line (see below), which provides subsidised telephone interpreting. This includes PHOs.

The three Auckland DHBs have a fully funded primary care interpreting service.

Many PHOs provide some funding through Services to Improve Access funding.

Availability of professional interpreters

Language Line is a partially subsidised telephone interpreting service that is provided from the Office of Ethnic Affairs. It provides interpreters in 43 languages and is available Monday to Friday 9am–6pm and Saturday 9am–2pm.

www.ethnicaffairs.govt.nz/oeawebsite.nsf/wpg_url/language-line-Index

Auckland has its Primary Health Interpreting Service available to primary health services in Auckland, Waitemata and Counties Manukau DHBs.

www.watis.org.nz/info/Primaryservice.php

Decypher provides interpreters in over 50 languages in Waikato.

www.hmstrust.org.nz/decypher-interpreting-and-translation

The New Zealand Society of Interpreters and Translators keep a database of interpreters.

www.nzsti.org

Interpreting New Zealand provides interpreters in 70 languages from Wellington and Christchurch face to face and by telephone to other regions.

www.interpret.org.nz

Uptake of professional interpreters is poor

Two New Zealand studies document that the use of interpreters is inadequate and that clinical harm is likely to be happening as a result of impaired communication.^{392,393}

392 Gray B, Hilder J, Donaldson H. Why do we not use trained interpreters for all patients with limited English proficiency? Is there a place for using family members? *Australian Journal of Primary Health*. 2011;17(3):240–9.

393 Gray B, Stanley J, Stubbe M, Hilder J. Communication difficulties with limited English proficiency patients: clinician perceptions of clinical risk and patterns of use of interpreters. *The New Zealand Medical Journal*. 2011;124(1342):23.

Cost can be a significant barrier to using professional interpreters. Doctors working for organisations who care for LEP patients where there is no budget for interpreters have a responsibility to lobby for funding to be found.

However, even if the service is free, there can be a low uptake. This has particularly been noted in Australia where, despite the availability of a comprehensive free interpreting service, uptake is significantly lower than anticipated.³⁹⁴

The main identified barriers to uptake identified were training of clinical staff and particularly training and attitudes of reception staff.³⁹⁵ A toolkit has been developed for use in primary care in New Zealand to address this need.³⁹⁶

Summary

New Zealand has an increasingly diverse population with significant numbers of people who are not proficient in English, particularly in the Auckland region. It is not possible to provide good care for an LEP patient without an interpreter, and there are some situations where a professional interpreter is essential. Current use of interpreters in New Zealand is such that it is very likely that LEP patients are being exposed to increased clinical risk. Attention to the systems within which doctors work as well as the skills and knowledge of clinicians is needed to improve this problem.

394 Phillips CB, Travaglia J. Low levels of uptake of free interpreters by Australian doctors in private practice: secondary analysis of national data. *Australian Health Review*. 2011;35(4):475–9.

395 Huang Y-T, Phillips C. Telephone interpreters in general practice – bridging the barriers to their use. *Australian Family Physician*. 2009;38(6):443–6.

396 Gray B, Hilder J, Stubbe M. How to use interpreters in general practice: the development of a New Zealand toolkit. *J Prim Health Care*. 2012 Mar 1;4(1):52–61, A1–8. PubMed PMID: 22377550.

Acknowledgement

Much of the research on which this chapter is based was conducted with Jo Hilder, Maria Stubbe Tony Dowell , Lindsay Macdonald and Rachel Tester under the auspices of the Applied Research in Communication and Health team at University of Otago Wellington www.otago.ac.nz/wellington/research/arch/publications. Jo Hilder and Maria Stubbe provided input to the written chapter.

CHAPTER 22

How medical practice standards are set and maintained: the Health Practitioners Competence Assurance Act 2003

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Cite this as Dunbar D. How medical practice standards are set and maintained: the Health Practitioners Competence Assurance Act 2003. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	316
Registration	317
Practising certificates	318
Scopes of practice	319
› General scope of practice and provisional general scope of practice	319
› Vocational scopes of practice and provisional vocational scopes of practice	319
› Special-purpose scopes of practice	320
› Recertification	321
Professional standards	321
› Competence and performance	321
› Conduct	322
› Interim suspension or imposition of conditions	324
› Health Practitioners Disciplinary Tribunal	325

Introduction

The regulation of health practitioners in New Zealand is governed by the Health Practitioners Competence Assurance Act 2003. The principal purpose of the Act is to protect the health and safety of the public by establishing mechanisms to ensure that health practitioners are competent and fit to practise medicine. This provides the framework for the policies, procedures and standards applied by the Medical Council of New Zealand to the regulation of doctors.

The principal purpose of the Act is to protect the health and safety of the public by establishing mechanisms to ensure that health practitioners are competent and fit to practise medicine.

The intention of the Act is to ensure consistency, transparency and efficiency in the regulation of health practitioners. In establishing policy to give effect to the mechanisms in the Act, the Council ensures that the principles of natural justice are applied, with the Council striving to balance the need for standards-based regulation and accountability of health professionals with the desire to maintain professional autonomy.

The Act details a number of important functions that the Council is required to perform, including:

- determining scopes of practice and qualifications required for registration
- registering doctors in a scope of practice
- requiring doctors to demonstrate competence at registration and maintenance of competence when applying for practising certificates
- conducting competence reviews (performance assessments) and requiring programmes for upskilling or retraining of doctors who are not practising at the required standard

- receiving notifications of any mental or physical conditions affecting the fitness of a doctor to practise medicine (see [Chapter 9 – Doctors’ health](#))
- setting standards of cultural and clinical competence and ethical conduct
- accrediting vocational and educational advisory bodies,³⁹⁷ medical schools and clinical attachments (see [Chapter 29 – Medical Council of New Zealand](#)).

Registration

Under the Act, health practitioners must apply for registration in one or more scopes of practice defined by the relevant regulatory authority. Thus, the Council is required to define what falls within the practice of medicine in New Zealand in terms of one or more scopes of practice. These scopes of practice, determined by the Council, define aspects of the practice of medicine and the health services that a doctor may provide within the scopes. In addition and for each scope of practice, the Council must prescribe³⁹⁸ the qualification required to be held by a doctor wishing to be registered in that scope of practice. These prescribed qualifications will vary between the different scopes of practice. In many cases, a prescribed qualification will be an identified medical degree or fellowship of a medical college, but in some cases, the Council will require a combination of a medical degree and additional training or approved experience. In such cases, a doctor seeking registration will be required to satisfy all the required elements before they will be recognised as holding the prescribed qualification.

397 The vocational and educational advisory body (VEAB) is an accredited Council agent, drawn from a relevant medical college that provides a training programme and the New Zealand-approved postgraduate qualification.

398 Section 12(2) of the Act lists the aspects that may form part of a prescribed qualification, which include training, educational qualification and experience.

In summary, to qualify for registration, a doctor must:

- have a relevant prescribed qualification for the scope of practice in which they seek to be registered
- be competent to practise in that scope of practice
- satisfy a number of requirements relating to their fitness for registration.

In assessing an application, the Council may consider placing one or more conditions on a person's scope of practice. In the context of registration, such conditions are not a response to an identified competence, conduct or health concern. Rather, they are used to facilitate registration by allowing the Council to modify the scope of practice in that individual case and enable a doctor to be registered in a practice context that best corresponds to the areas that the doctor has previously worked in or been formally assessed in. Conditions may also record a requirement for a period of supervision in a specified position or identify an examination that must be passed to enable the removal of any limitations on the doctor's registration.

Once a doctor is registered, their authorised scope of practice is entered on the publicly available medical register, along with any conditions.

Practising certificates

A doctor must hold a practising certificate to work in New Zealand. The practising certificate is valid for a period of time up to 1 year and is issued in cycles. The certificate records the doctor's registered scope(s) of practice and any conditions (if applicable). The certificate will specify the period for which it has been issued and may also, on occasion, record the place of work and any supervision requirements.

A doctor must hold a practising certificate to work in New Zealand.

Scopes of practice

General scope of practice and provisional general scope of practice

New Zealand and Australian medical graduates who have completed their internships in New Zealand or Australia are eligible for registration in the general scope of practice.

International medical graduates who apply for registration within New Zealand in the general scope of practice must first obtain registration in the provisional general scope of practice and practise for a minimum period. This allows the Council to determine whether a doctor is able to work at the required standard in the New Zealand health system.

In particular, doctors registered in the provisional general scope of practice are required to work satisfactorily under supervision in an approved position or positions for 6–12 consecutive months to qualify for registration in the general scope of practice. Once the doctor has satisfied the Council that all conditions have been met under their provisional general scope of practice, they can then apply for registration within the general scope of practice.

Vocational scopes of practice and provisional vocational scopes of practice

The vocational scopes of practice are the scopes for specialised medical practice. There are currently 35 different scopes of practice in the vocational pathway. Each scope has an associated accredited postgraduate training programme and postgraduate qualification.³⁹⁹

³⁹⁹ The Council has a system of accrediting and reaccrediting the postgraduate training and recertification programmes associated with each vocational scope.

International medical graduates who hold a postgraduate qualification and wish to apply for registration within a vocational scope of practice must first be eligible or become registered within a provisional vocational scope of practice.⁴⁰⁰ The Council seeks advice from the branch advisory bodies when determining whether the doctor has training, qualifications and experience equivalent to or as satisfactory as that of a New Zealand trainee, and the Council considers this advice in making its final decision.

Special-purpose scopes of practice

The Council provides special-purpose scopes of practice for short-term registration. All of these pathways are limited in duration and are for defined purposes. They provide registration options for doctors wishing to teach, train, conduct research, work as a locum specialist, assist in an emergency or pandemic scenario in New Zealand or provide teleradiology in New Zealand.

Doctors may work as a postgraduate trainee registered in a special-purpose scope of practice for a maximum of 2 years. This pathway to registration is specifically designed to allow international medical graduates to work in New Zealand and gain skills and experience that they can take back to their country of origin. Therefore, time registered in a special-purpose scope of practice as a postgraduate trainee will not be counted towards gaining registration in any other scope of practice.

400 See footnote [399](#).

Recertification

While practising in New Zealand, all doctors must meet ongoing recertification requirements. These requirements broadly fall into two sets of requirements. For the general scope of practice, there are a range of requirements that include maintaining a collegial relationship, participation in clinical audit, peer review and continuing medical education. Within a vocational scope of practice, doctors must participate in an approved recertification programme.

While practising in New Zealand, all doctors must meet ongoing recertification requirements.

Professional standards

Competence and performance

The Act permits the Council to review the competence of a doctor to practise medicine at any time, whether or not there is a reason to believe the doctor's practice may be deficient. Commonly, however, such reviews follow formal notification to the Council of potential competence concerns. The Act refers to the "required standard of competence" as the standard reasonably to be expected of a doctor practising within the doctor's scope of practice. The assumed ability to practise well is not enough. The assessment also needs to show whether the doctor is actually practising well. A competence review (also known as a performance assessment) is a broad-based assessment of how the doctor is practising and is, as a minimum, intended to be educative.

If, following the assessment, the Council has reason to believe that the doctor does not meet the required standard of competence, the Council must make one or more of the following orders:

- That the doctor undertakes a competence programme.
- That conditions be placed on the doctor's scope of practice.
- That the doctor sits an examination or assessment.
- That the doctor is counselled or assisted by a named person.

Conduct

The Act enables the Council to appoint a professional conduct committee (PCC) to investigate a complaint or investigate the circumstances of offences committed by doctors. There are three sources for referrals to a PCC:

- If a doctor is convicted of an offence punishable by imprisonment for a term of 3 months or more, the Council will be notified and is required under the Act to refer the matter to the PCC for an investigation (regardless of the actual sentence ordered by the court).
- If the Health and Disability Commissioner⁴⁰¹ formally refers a complaint to the Council, the Council must promptly assess the complaint and may decide to refer the complaint to a PCC.

401 The Office of the Health and Disability Commissioner was created under the Health and Disability Commissioner Act 1994 to promote the rights of the health and disability services consumers and facilitate the fair, simple, speedy and efficient resolution of complaints.

- The Council has residual power to refer the matter to a PCC if the Council considers that information in its possession raises one or more questions about the appropriateness of the conduct of the safety of the doctor's practice. This can include breaches of standards of cultural and clinical competence and ethical conduct set by the Council. These standards may be used by the Health Practitioners Disciplinary Tribunal, the Council and the Health and Disability Commissioner as standards against which a doctor's conduct is measured.

Importantly, any complaint⁴⁰² the Council receives directly must first be promptly forwarded to the Health and Disability Commissioner. The Council is not able to consider referral of the matter to a PCC until the Commissioner informs the Council that:

- the matter is not being investigated by the Commissioner
- the matter has been resolved by the Commissioner or
- the Director of Proceedings⁴⁰³ will not be considering or proceeding with the matter.

After considering a case, the PCC may make a number of recommendations to the Council, including recommending that the Council review a doctor's competence or fitness to practise or scope of practice (including placing conditions on their scope of practice) and in some cases referral to the Police. The PCC may, alternatively, make its own determinations, independent of the Council. These include laying a charge before the Health Practitioners Disciplinary Tribunal.

402 That is "a complaint alleging that the practice of conduct of a [doctor] has affected a health consumer".

403 The Director of Proceedings (DP) is a lawyer appointed under the Health and Disability Commissioner Act. When the Commissioner has found a breach of consumer rights, they may refer the provider to the DP. The DP reviews the case and makes an independent decision on whether or not to take any further action.

Interim suspension or imposition of conditions

In association with a review of a doctor's competence or conduct, the Council has power, in more serious cases, to suspend a doctor's right to practise or impose conditions on a doctor's scope of practice for an interim period. The processes differ depending on whether the core concern relates to matters of competence or conduct.

Competence

Where a doctor's competence is being or has been reviewed and the Council considers it has reasonable grounds for believing the doctor poses a risk of serious harm to the public by practising below the required standard of competence, the Council may impose conditions or suspension. The conditions or suspension will remain in effect until the performance assessment is completed or the doctor has passed an examination or assessment required by the Council.

Conduct

Where a matter has been referred to a PCC, the Council may also impose conditions or suspension where the Council believes on reasonable grounds that the alleged conduct casts doubt on the appropriateness of the doctor's conduct in their professional capacity. This power is not limited to matters referred to a PCC. The power also applies where the alleged conduct is being investigated by the Commissioner or is relevant to a criminal proceeding pending against the doctor.

However, in either situation, the Council adheres to natural justice principles and the specific provisions in the Act. The Council will first propose its decision and give the doctor the opportunity to provide submissions and be heard by the Council before finalising any proposed interim suspension or conditions.

Health Practitioners Disciplinary Tribunal

The Tribunal hears and determines charges brought by a PCC or by the Director of Proceedings. The main purpose of the Tribunal is to protect the health and safety of the public by ensuring that doctors conform to standards reasonably expected from them.

A doctor can be found guilty of professional misconduct or have a range of other findings made against them. Professional misconduct can be found to have arisen from an act or omission that the Tribunal considers amounts to malpractice or negligence in relation to the doctor's registered scope of practice or that the Tribunal concludes has brought or was likely to bring discredit to the medical profession.

The Tribunal might also find that the doctor:

- has been convicted of an offence that reflects adversely on their fitness to practise
- has practised their profession while not holding a current practising certificate
- has performed a health service that forms part of a scope of practice of the profession in respect of which they are or were registered without being permitted to perform that service by their scope of practice
- has failed to observe any conditions included in the practitioner's scope of practice
- has breached an order of the Tribunal under section 101 of the Act.

Should the doctor be found guilty, the gravity of the doctor's offence is reflected in the nature of the penalty imposed by the Tribunal.

Penalties could include cancellation of a doctor's registration, suspension for a period of up to 3 years, imposition of conditions and a fine not exceeding \$30,000.

Decisions of the Tribunal may be appealed to the High Court. The High Court decision is final and can only be appealed to the Court of Appeal on points of law.

CHAPTER 23

How medical practice standards are set and maintained: other legislation

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The contribution of **Michael Thorn** as one of the authors of this chapter in the previous edition of *Cole's* is gratefully acknowledged.

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Cite this as Ooi K, Morris KA. How medical practice standards are set by and maintained: other legislation. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	328
Prescribing medicines	328
› Good prescribing practice	329
› Medication with a risk of addiction or misuse	331
› Standing orders	332
Crimes Act 1961	333
› Withdrawal of care and euthanasia	334
Protecting vulnerable patients	335
› Protecting vulnerable children	335
Public health	338
Cervical screening	338
Contraception, sterilisation and abortion	339
Assisted human reproduction	339
Advance directives and enduring powers of attorney	340
Fitness to drive motor vehicles	341
Deaths and medical certificates of causes of death	342

Introduction

Medicine is a risky business, and where there is risk, governments tend to enact laws. Many of these laws have a direct impact on the way you practise medicine. Some grant you protections and powers, and others place limits on what you can do. It is important that you have a basic understanding of these laws and their impact on your practice.

If you are unsure about something, ask a colleague or an adviser from your indemnity insurer.

Other chapters in this book deal with specific areas of medical law in detail. The Council also provides a variety of statements that discuss how aspects of the law apply in particular situations.⁴⁰⁴ This chapter aims to provide a brief overview of aspects of the law not discussed elsewhere in this book and discuss how they apply to your practice. Much of the law is complex, and this chapter is unlikely to answer all of your questions. If you are unsure about something, ask a colleague or an adviser from your indemnity insurer.

The Acts and Regulations mentioned below can all be read online at www.legislation.govt.nz.

Prescribing medicines

The Medicines Act 1981, the Misuse of Drugs Act 1975 and the Medicines Regulations 1984 provide controls over the manufacture, storage, prescribing, dispensing and advertising of medicines. Medicines Control, a regulatory team within the Ministry of Health, is responsible for monitoring and administration of medicines and controlled drugs, and staff can provide you with advice on the legislation and your responsibilities.⁴⁰⁵

⁴⁰⁴ Refer to [Chapter 1 – Good medical practice and Council Statements](#)

⁴⁰⁵ Licensing enquiries – (04) 816 2579 or (04) 816 2444. Drug abuse containment enquiries – 0800 163 060 or (04) 496 2437.

The Council has also issued a portfolio of statements on good prescribing practice, which outlines its expectations within the context of these laws.^{406,407}

Good prescribing practice

The issuing of prescriptions for prescription medicines is legally restricted. In particular, you should be aware that, while a doctor can generally prescribe from the full range of approved medicines,⁴⁰⁸ under regulation 39 of the Medicines Regulations 1984, they are only permitted to prescribe for a patient “under his or her care” and “within and in accordance with all conditions (if any) stated in, [his or her] scope of practice...”.⁴⁰⁹

Regulation 41 of the Medicines Regulations 1984 require that your prescriptions be “legibly and indelibly printed” and include:

- your signature (not a facsimile or stamp)
- the date
- your full name and your address
- the name and address of the person for whom the prescription is given (and date of birth if they are a child under 13 years)
- the name and strength of the medicine
- the total amount to be dispensed
- dose and frequency (and method of delivery in some cases)
- the number of occasions on which it may be supplied

406 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Good-prescribing-practice.pdf>

407 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Doctors-and-performance-enhancing-medicines-in-sport.pdf>

408 See [406](#).

409 For a discussion on how “under the doctor’s care” should be interpreted, see footnote [406](#).

- the interval between each date of supply
- the period of treatment.
- Misuse of Drugs Regulations 1977. Regulation 29.
- You should also include your contact phone number and medical registration number. Regulation 29 of the Misuse of Drugs Regulations 1977 requires that prescriptions for some controlled drugs must be written on a prescribed form and require additional information.

You should also ensure that your prescriptions include all the information needed for appropriate dispensing and compliance with subsidy requirements.⁴¹⁰ It is wise to avoid using any abbreviations that could be misunderstood. Mistakes, missing information or illegibility can have serious consequences. It is not permissible to issue prescriptions by email or other electronic means.⁴¹¹ Faxed or telephone prescriptions are permitted but only in cases where a medicine is needed urgently. In such cases, regulation 40 of the Medicines Regulations 1984 requires that the original prescription must be forwarded to the pharmacist within 7 days. Be aware that the Medicines Act and Regulations are currently under review, and the requirements may well change in the following months. The Council will advise you of any relevant changes, and will update the statement on good prescribing practice to incorporate any legislative amendments.

Approved medicines and their uses are outlined in MIMS New Ethicals,⁴¹² and you should keep a copy on hand.

410 See footnote [406](#).

411 Unless special dispensation has been obtained. Contact the Ministry of Health for information on how to obtain such dispensation.

412 Subscription details are available from www.mims.co.nz or 0508 464 676.

If you prescribe an unapproved medicine (or a medicine for a purpose for which it has not been approved), you should advise the patient of the unapproved status of the medicine and be frank about the standard of support for the use of the medicine and any safety concerns. You are also required to pass certain details relating to the supply of that medicine to the Director-General of Health.⁴¹³

Medication with a risk of addiction or misuse⁴¹⁴

The Misuse of Drugs Act classifies some medicines as controlled drugs and further classifies these according to the risk of harm they pose. Class A controlled drugs are very high risk (for example, cocaine, heroin and methamphetamine), and these can only be prescribed in rare circumstances. Class B controlled drugs (high risk) include methadone, morphine and pethidine, while Class C controlled drugs (moderate risk) include codeine, diazepam and temazepam.

Inappropriate prescribing of medication with a risk of addiction or misuse is unacceptable, both clinically and ethically. It is usually also against the law. In particular, you should be aware that, under section 25 of the Misuse of Drugs Act 1975, it is illegal to prescribe controlled drugs to any person deemed a “restricted person” by a medical officer of health. If you prescribe medication that has the potential for addiction or misuse, you should make sure you are aware of any restricted persons living in your area. Lists of restricted persons are maintained through prescriber updates and peer-review processes. If you have any doubts about the appropriateness of a request for medication, especially controlled drugs, it is wise to discuss your concerns with an adviser from Medicines Control (0800 163 060).

413 Refer to Rights 6 and 7 of the Code of Health and Disability Services Consumers’ Rights and to the advice provided by Medsafe at www.medsafe.govt.nz/profs/RISS/unapp.asp.

See also footnote 406 – ‘Prescribing unapproved medicines’.

414 See footnote 406 – ‘Prescribing medication with a risk of addiction or misuse’.

Section 48 of the Medicines Act 1981, section 23 of the Misuse of Drugs Act 1975 and the Health Practitioners Competence Assurance Act 2003 empower the Medical Council to inquire into the prescribing of any doctor to consider and determine whether they are prescribing inappropriately.⁴¹⁵ If the Council has concerns, it can recommend to the Minister of Health that a doctor be prohibited from prescribing all or specific classes of prescription medicines.

Under section 24 of the Misuse of Drugs Act, it is an offence to prescribe, administer or supply a controlled drug to a person you believe is reliant on that drug for the purpose of treating dependency, unless you are an authorised person (or working for an authorised facility).

If you hold or dispense controlled drugs, you are required to keep a controlled drugs register. Under regulation 28 and Schedule 1 of the Misuse of Drugs Regulations 1977, you are also required to keep Class A and Class B controlled drugs and your controlled drug prescription pad in a secure cupboard or compartment, which must be of metal or concrete construction or both.

Standing orders

The requirements for initiating and using standing orders are set out in the Medicines (Standing Order) Regulations 2002. These only allow medicines to be administered or supplied to patients by way of a standing order if certain conditions are met. If you delegate the administration or supply of medicines to a non-doctor colleague by means of a standing order, you need to make yourself familiar with these conditions⁴¹⁶ and with the Ministry of Health's Standing Orders Guidelines.⁴¹⁷

415 "Inappropriate prescribing" can include indiscriminate, excessive or reckless prescribing – see footnote [406](#).

416 Refer to the Medicines (Standing Order) Regulations 2002. Regulation 5.

417 www.health.govt.nz/publication/standing-order-guidelines

If you sign a standing order, the responsibility for the effects of the medicines administered or supplied under that standing order rests with you (see [Chapter 1 – Good medical practice](#), paragraph 32), and under regulation 8 of the Medicines (Standing Order) Regulations 2002, you must also countersign the charted treatment or record and put in place a process to monitor and review the correct operation of the standing order.

Crimes Act 1961

The Crimes Act 1961 section 155 imposes a legal duty on those who “undertake ... to administer surgical or medical treatment” to have and to use reasonable knowledge, skill and care. An omission or failure to discharge this duty without lawful excuse will leave you criminally responsible for the consequences. However, the law also provides you with a degree of protection from prosecution in circumstances where you do administer treatment in accordance with this duty.

Under section 61, if you perform a surgical operation with reasonable care and skill upon any person for that person’s benefit, the Act provides you with protection from criminal responsibility. This section applies if the performance of the operation was reasonable, having regard to the patient’s state at the time and to all the circumstances of the case. Under section 61A, you are also protected if you perform a surgical operation with reasonable care and skill when you have the patient’s consent and the operation is for a lawful purpose.

So long as you comply with either of these sections, you cannot be charged with a crime such as manslaughter if something goes wrong. The common law also contains ‘Good Samaritan’ principles, which may protect you from legal action if you perform a procedure in an emergency.

The Crimes Act 1961 section 155 imposes a legal duty on those who “undertake ... to administer surgical or medical treatment” to have and to use reasonable knowledge, skill and care.

Withdrawal of care and euthanasia

Section 151 of the Crimes Act places legal duties on any person “who has actual care or charge of a person who is a vulnerable adult⁴¹⁸ to provide himself or herself with necessities”. Under this section, you are required to supply a sick person in your charge with the necessities and to take reasonable steps to protect that person from injury. Although not defined, ‘necessaries’ could include medical and hospital treatment. However, the law also recognises a distinction between active killing and merely allowing someone to die by the withdrawal of life support. The New Zealand Court of Appeal has upheld the withdrawal of treatment in circumstances where the Court was satisfied that treatment was futile and merely prolonging death.

Under the New Zealand Bill of Rights Act 1990, withdrawal of care necessary to keep someone alive is also permitted if the patient refuses the care or treatment – under section 11, patients have the right to refuse medical treatment. In one incident, a severely physically disabled patient refused to accept nourishment needed to keep her alive. In this case, her carers made sure that they offered her treatment every day, ensured that she was well informed about the consequences of her decision and documented these discussions.

Euthanasia, the provision of treatment when the primary aim is to assist a patient to die, is illegal.

Euthanasia, the provision of treatment when the primary aim is to assist a patient to die, is illegal.⁴¹⁹

418 A “vulnerable adult” is defined in the Act as a “person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person”.

419 Clause 28 of the NZMA Code of Ethics advises you to bear in mind always the obligation of preserving life wherever possible and justifiable, while allowing death to occur with dignity and comfort when it appears to be inevitable. In such treatment situations, treatment applied with the primary aim of relieving patient distress is ethically acceptable, even when it may have the secondary effect of shortening life.

When a medical or surgical treatment is not for the patient's benefit or where it is not reasonable, a patient death may result in a conviction for murder (if deliberate) or manslaughter. In 2001, a doctor was convicted of manslaughter of his mother who was nearing the end of her life. He injected her with a cocktail of drugs in significant quantities that she might die and he also strangled her.

Protecting vulnerable patients

You have a responsibility to report suspected child abuse or abuse of a vulnerable adult patient as part of your responsibility to patients and the community. A change to the Crimes Act 1961 in March 2012 made this ethical obligation a legal one. Section 195A states that a staff member of a hospital, institution or residence where a child or vulnerable adult resides commits an offence if they know that the person is at risk of death, grievous bodily harm or sexual assault and fail to take reasonable steps to protect that person.

Section 15 of the Children, Young Persons, and their Families Act 1989 allows you to report ill treatment or neglect of children and young persons to the Police or a social worker. You do not need to seek authorisation from a child or parent before making this disclosure, and section 16 provides you with protection from civil, criminal or disciplinary proceedings for doing so (although this protection does not apply if the disclosure is made in bad faith).

Protecting vulnerable children

The Vulnerable Children Act 2014 is aimed at improving the protection of children at risk of abuse or neglect. It also introduces stronger vetting requirements on those who work with children for government and community agencies and bans those with serious convictions from working closely with children.

Part 3 of the Vulnerable Children Act sets out the requirements for all government-funded employers to conduct background checking (safety checks) on all new and existing employees and contractors who have regular and unsupervised contact with children (children's workers). The need for a safety check also applies to those who do unpaid work with children as part of an educational or vocational training course (for example, student doctors). The safety checks include identity verification, Police vetting, reference checks, checks with professional registration bodies or licensing authorities and a risk assessment that considers specific child safety-related risks. The aim of the safety check is to prevent those who are a risk to children from working with them as staff members or volunteers.

It is the employer's responsibility to determine whether a particular role is a children's worker role. Where it is, those making decisions about the children's worker should be satisfied that they do not pose any undue risk to the safety of children if employed or engaged. It is also important that the employer has in place policies on child protection and safe recruitment practices.

Key timeframes have been set for completing the safety checks for all new and existing children's workers.⁴²⁰ In addition, Part 2 of the Vulnerable Children (Requirement of Safety Checks of Children's Workers) Regulations 2015 states that periodic safety checks have to be conducted every 3 years.

420 <http://www.health.govt.nz/our-work/health-workforce/childrens-action-plan-childrens-worker-safety-checking-and-child-protection-policies>

The Vulnerable Children Act applies to a wide range of government and community agencies that work with children to provide a regulated service (section 24 defines “specified organisation”). Regulated health services include:⁴²¹

- services provided at a public hospital
- services provided at a publicly funded medical practice or facility, including blood and cancer centres, treatment centres, outreach clinics and mental health services
- services provided through medical practices belonging to primary health organisations (PHOs)
- services provided by health practitioners
- Well Child/Tamariki Ora services (for example, Plunket)
- home-based disability support services
- residential disability support services
- ambulance services
- maternity services, including lead maternity carers and midwives.

If you work with children in a regulated health service, you should be familiar with the requirements of this legislation including the need to undergo periodic safety checks.

If you work with children in a regulated health service, you should be familiar with the requirements of this legislation including the need to undergo periodic safety checks.

421 For more information on regulated health services and the Vulnerable Children Act 2014, see <http://www.health.govt.nz/our-work/health-workforce/childrens-action-plan-childrens-worker-safety-checking-and-child-protection-policies>

Public health

The Health Act 1956 is intended to improve, promote and protect public health. It covers a range of issues such as ensuring the safety of drinking water and giving certain officials the power to quarantine ships or aircraft. It also outlines the statutory duties and responsibilities of medical officers of health and sets out when and how doctors must notify infectious and notifiable diseases.

Section 74 states that, if a doctor has a reason to believe that a patient is suffering from a notifiable disease, they must advise their local medical officer of health. The local authority must also be informed in some cases. If the notifiable disease is infectious, the doctor must also “inform the occupier of the premises and every person nursing or in immediate attendance on the patient of the infectious nature of the disease and the precautions to be taken”.

The list of diseases and infectious diseases that must be notified are set out in Schedule 1 and Schedule 2 of the Act.

Cervical screening

The Health (National Cervical Screening Programme) Amendment Act 2004 established a national cervical screening programme intended to reduce the incidence and mortality of cervical cancer. Under sections 112L and 112M, you must tell a woman about the screening programme whenever you take a specimen from her for the purpose of a screening test or perform a colposcopic procedure. If this is the woman’s first screening test or you are performing a colposcopic procedure, you must also tell her about the importance of having regular screening tests, the objectives of the screening programme, who has access to information on the programme’s register and how that information might be used. For colposcopic procedures, you must also tell the woman that she will be automatically enrolled on the programme but may withdraw at any time.

Section 112ZB of the Act also states that you must make health information and specimens available to a screening programme evaluator, but the evaluator is bound by strict confidentiality rules to ensure that the patient's privacy is protected.

Contraception, sterilisation and abortion

The Contraception, Sterilisation and Abortion Act 1977 and section 174 of the Health Practitioners Competence Assurance Act 2003 outline the duties of doctors in respect of reproductive health services. If you are likely to be approached for contraception, sterilisation or abortion services, you should be familiar with the requirements of these complex pieces of law.

Assisted human reproduction

The Human Assisted Reproductive Technology Act 2004 regulates assisted reproductive procedures, prohibits some unacceptable procedures (such as sex selection of human embryos) and prohibits commercial transactions relating to human reproduction. Under section 16, organisations that wish to perform assisted reproductive procedures or conduct research into reproduction are required to first obtain the written approval of a specially designated ethics committee.

Part 3 of the Act also establishes an information-keeping regime to allow people born from donated embryos or donated cells to find out about their genetic origins.

The Human Assisted Reproductive Technology Act 2004 regulates assisted reproductive procedures, prohibits some unacceptable procedures (such as sex selection of human embryos) and prohibits commercial transactions relating to human reproduction.

Advance directives and enduring powers of attorney

Advance directives and enduring powers of attorney are methods that patients can use to ensure that their treatment wishes are met, even after they are no longer able to communicate those wishes to you.

An advance directive is also sometimes referred to as a living will. Right 7(5) of the Code of Health and Disability Services Consumers' Rights says that "every consumer may use an advance directive in accordance with the common law". Clause 4 of the Code of Rights goes on to define an advance directive as:

...a written or oral directive –

- (a) By which a consumer makes a choice about a future healthcare procedure; and
- (b) That is intended to be effective only when he or she is not competent.

This means that a person can make an advance choice about receiving or refusing services. In some countries, there is specific legislation setting out requirements that need to be followed and met before such a directive is legally valid. There is no equivalent legislation in New Zealand, and the validity of an advance directive under common law is currently unclear.

Although the law is not clear, there are some steps that it would be prudent for you to take before acting in accordance with a patient's advance directive or living will. You should ensure that the advance directive was made without undue influence and that the patient was competent and fully informed about the consequences of their decisions.

You should also be satisfied that the patient intended the advance directive to apply to the current situation and that they reviewed the advance directive recently.

The Protection of Personal and Property Rights Act 1988 allows a patient formally to nominate someone else to make personal care and welfare decisions on their behalf should they become mentally incapable. If a patient has appointed someone to act as an enduring power of attorney with respect to their personal care and welfare and has been assessed as lacking capacity, you should generally treat the attorney as the patient for most information and consent purposes. However, section 18(1)(c) of the Act specifically forbids the attorney from refusing consent “to the administering ... of any standard medical treatment or procedure intended to save [the patient’s] life or to prevent serious damage to that person’s health.”

In making decisions about the patient’s personal care and welfare, the attorney must consult, as much as possible, with the patient and with other people named and must have regard for any advance directive expressed by the patient. If you are concerned that an attorney has made a decision that is not in the patient’s best interests, section 103 empowers you to ask a court to review that decision.

Fitness to drive motor vehicles

The Land Transport Act 1998 requires you to report to the Chief Medical Adviser of the New Zealand Transport Agency when:

- in your judgement, a patient is not medically fit to drive
- you have advised the patient not to drive
- you believe or know that the patient is continuing to drive despite this advice.

Some drivers (for example, drivers over the age of 75 and bus drivers) are required to regularly obtain a medical certificate to state that they are medically fit to drive a motor vehicle.

When assessing such a driver and completing a certificate, under Part 7 and Part 13 of the Land Transport (Driver Licensing) Rule 1999, you are required to consider the information contained in the booklet entitled *Medical Aspects of Fitness to Drive*.⁴²²

At some point, you might be called upon to take a blood specimen for evidential purposes from a person who is suspected of an offence relating to alcohol or drug-involved driving. Sections 72 and 73 of the Land Transport Act 1998 allows you to take a blood sample without a person's consent if they present as a result of a motor vehicle accident or when an enforcement officer asks you to. When taking a blood sample, you must be satisfied that doing so would not be prejudicial to the person's proper care or treatment and must tell them (unless they are unconscious) that the blood specimen is being taken for evidential purposes.

Deaths and medical certificates of causes of death

The requirements for the issuing of a medical certificate of causes of death are outlined in the Burial and Cremation Act 1964. Section 46B(2) of the Act states that a doctor attending a patient who dies as a result of an illness must sign such a certificate "immediately after the doctor learns of the death". Urgency is often important in such situations, because the body cannot be released for burial or cremation until you have issued the certificate.

422 <https://www.nzta.govt.nz/assets/resources/medical-aspects/Medical-aspects-2014.pdf>

Under section 46B(3), if you were not the last doctor to attend the patient during the illness, you may only complete the certificate if you are satisfied that the death was a result of the illness and:

- the doctor who last attended the person during the illness is unavailable or
- less than 24 hours have passed since the death, and the doctor who last attended the person during the illness is unlikely to be able to complete a certificate within 24 hours after the death or
- 24 hours or a longer period has passed since the death and the doctor who last attended the person during the illness has not completed a certificate.

In such situations, you are required under section 46B(8) to consider the patient's medical records and the circumstances of their death and to examine the body before completing a certificate.

You should be as precise and specific as possible when completing a certificate of causes of death. The information you provide not only appears on the official death certificate issued by the Births, Deaths, and Marriages Office but is also used in the national cause of death statistics that are reported to the World Health Organization.

You should pay particular attention when specifying the underlying cause of death. Often, it can be a combination of a number of serious conditions that leads to the death of the person. In such cases, you should record the condition that you believe is most likely to have initiated the train of morbid events leading to the death. There are a range of specific provisions that apply to issuing death certificates in different circumstances (for example, still-births or where an elderly patient dies as a result of an accident).

For further information, you should refer to the booklet A guide to certifying causes of death.⁴²³

There are some circumstances when you should not issue a certificate and must instead report a death to the Police. These circumstances are outlined in section 13 of the Coroners Act 2006 and include when:

- death appears to be without known cause or is a suicide, unnatural or violent
- death occurs during or apparently as a result of some medical, surgical, dental or similar operation or procedure
- death occurs while a person was affected by an anaesthetic or the result of the administration of the anaesthetic
- death occurs while the woman was giving birth or that appears to have been the result of the pregnancy or giving birth
- death occurs in certain types of institutions or custody, including Police or prison custody, or treatment facilities for mental illness or alcohol or drug addiction.

Once you have notified the Police, they will usually make some enquiries and then notify a coroner. The coroner might then contact you and, in some situations, might require you under section 40 of the Coroners Act 2006 to complete a written report. If you are uncertain about your obligations in these circumstances or how to go about completing a report, you can contact a coroner directly. A 24-hour phone service has been set up to facilitate this – (04) 910 4482.

423 www.health.govt.nz/publication/guide-certifying-causes-death

CHAPTER 24

The complaints and disciplinary process

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***Cite this as Hall A. The complaints and disciplinary process.
In: Morris KA, editor. Cole's Medical Practice in New Zealand,
13th ed. Wellington: Medical Council of New Zealand; 2017.***

Introduction	346
› Competence	348
› Conduct	349
Professional conduct committees	350
› Membership	350
› Process	351
› Recommendations and determinations	352
Health Practitioners Disciplinary Tribunal	353
› Function	353
› Membership	354
› Charges	354
› Interim suspension	354
› Public hearings	355
› Procedures	356
› Findings	357
› Who sets the standard?	358
› Penalties	359
› Appeals	361
Acknowledgement	361

Introduction

Part 4 of the Health Practitioners Competence Assurance Act 2003 (Act) sets out the complaints procedures that apply to doctors and establishes the Health Practitioners Disciplinary Tribunal, which hears and determines disciplinary charges brought against doctors and other health practitioners.

The principal purpose of the complaints and disciplinary process is public protection – to protect the public and the profession from health practitioners who are unfit to practise.

The principal purpose of the complaints and disciplinary process is public protection – to protect the public and the profession from health practitioners who are unfit to practise. Another purpose is to enable the profession to ensure the conduct of its members conforms to the standards generally expected of them.

Complaints about doctors may be made to the Medical Council and/or the Health and Disability Commissioner). If the Council receives a complaint alleging that the practice or conduct of a doctor has affected a health consumer, it must refer the complaint to the Commissioner.

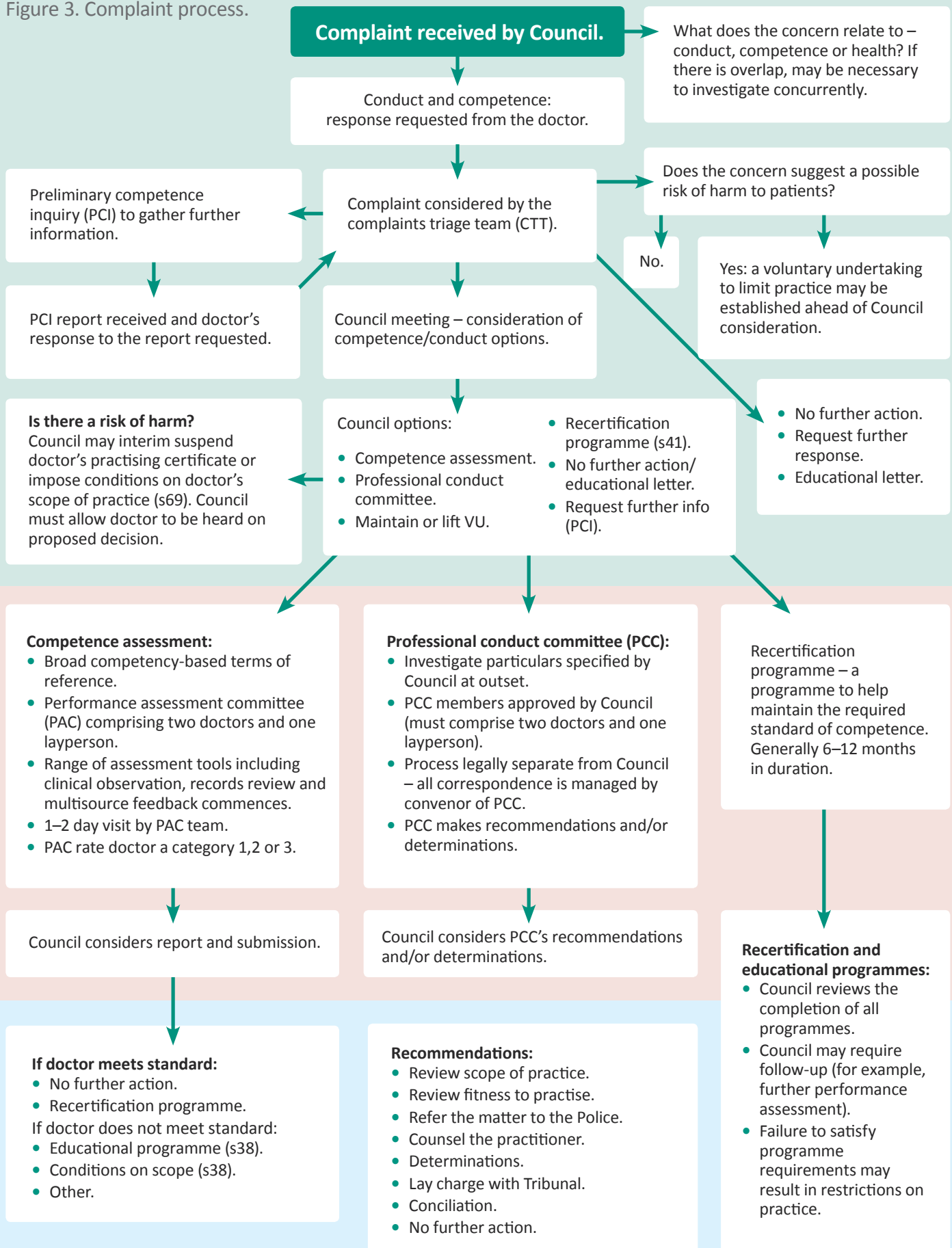
The Commissioner has the option to refer a complaint back to the Medical Council. If a complaint is referred back, the Medical Council must promptly assess the complaint and consider what action is necessary in response. The process is set out in Figure 3 on the next page.

Figure 3. Complaint process.

Initial consideration and risk management

Assessment and investigation

Outcomes



The Medical Council has a complaints triage team (CTT) to manage referrals made to the Council by the Commissioner, the public or another medical practitioner. The CTT in the first instance will check to see that there is sufficient information and detail to allow careful consideration of the complaint and more specifically whether the complaint concerns an issue of competence, conduct or health of the doctor complained about. It is possible that a complaint raises concerns that relate to more than just the one area, and if so, it may be necessary to investigate concurrently issues of competence, conduct and/or health.

It is usual for most complaints that the doctor is asked to provide a response to the complaint for CTT to consider whether the complaint will be treated as a competence, conduct or health matter or a combination of these matters.

CTT may then consider that there is still not sufficient information to make a decision on the next steps and can ask that a preliminary competence inquiry (PCI) be undertaken.

CTT will also consider whether the complaint raises a possible ongoing risk of harm to patients and seek a voluntary undertaking to limit practice pending full consideration by the Council.

CTT may decide that that no further action is needed, may request further information, may write an educational letter to the doctor or may refer the complaint for consideration by the full Council at the next Council meeting.

Competence

If the complaint raises concern about the doctor's competence, the Medical Council may request a performance assessment to be done by a performance assessment committee (PAC). The PAC is made up of two doctors and one layperson who use a range of assessment tools including clinical observation, records review, multisource feedback and interviews over a 1–2-day visit with the doctor.

The PAC will provide a report to the Council that will provide a supported conclusion as to whether the doctor meets, meets in part or does not meet the expected standard of competence.

If a doctor meets the standard, the options for the Council can be no further action, an educational letter or a recertification programme.

If a doctor does not meet the standard, options for the Council can be an educational programme, conditions on the doctor's scope of practice or other steps including removal from the register.

Conduct

If the complaint raises concerns about the doctor's conduct, the Medical Council may decide to refer the matter to a professional conduct committee (PCC) for investigation.

The Commissioner must notify the Medical Council of any investigation under the Health and Disability Commissioner Act 1994 that directly involves a doctor (see [Chapter 28 – The role of the Health and Disability Commissioner and the Code of Rights](#)). If the complaint relates to conduct concerns, the Medical Council must not take any action while the matter is under investigation by the Commissioner. However, if the concerns relate to competence, it is possible for both the Commissioner and Medical Council to undertake dual processes.

If the complaint raises concern about the doctor's competence, the Medical Council may request a performance assessment to be done by a performance assessment committee

Professional conduct committees

A professional conduct committee (PCC) is established to investigate complaints from:

- the Commissioner
- the public
- convictions in court. If the conviction carries a term of imprisonment of 3 months or more, it must be referred to a PCC.

In addition, if the Medical Council considers information in its possession raises questions about the conduct or safety of a doctor's practice, it may refer those questions to a PCC. Further, if, while a matter is under consideration by a PCC, the Medical Council thinks a further matter concerning that doctor should form part of the PCC's consideration, it may refer the further matter to the PCC.

A charge brought by the Director of Proceedings goes directly to the Tribunal and bypasses the PCC process.

Membership

PCCs comprise three members appointed by the Medical Council. Two are doctors and one is a layperson. One member coordinates the investigation process and presides at PCC meetings. This member is known as the convenor. Both the doctor and the complainant are advised of the intended composition of a PCC and have an opportunity to request changes in membership.

Usually, where possible, one of the doctors on the PCC practises in the same vocational scope of medicine or a similar vocational scope as that in which the doctor being investigated practises. The other doctor is usually selected from a more general area (for example, general practice). This ensures there is an appropriate mix of general medical knowledge and specialised knowledge on the PCC.

If there are multiple complaints involving one doctor, the same PCC generally deals with all the complaints.

Process

The PCC may investigate however it sees fit.

The PCC must ensure the parties are informed about the progress of the investigation and that the investigation is carried out fairly and in accordance with natural justice principles.

The PCC has wide powers to receive evidence and may receive any statement, document, information or matter that, in its opinion, may assist it to deal effectively with its investigation (even if the evidence would not be admissible in a court of law). The PCC has the power to call for information or documents from any person, and in the event of refusal or failure without reasonable excuse to comply with a request for information (or knowingly or recklessly providing false or misleading information), that person is liable to a fine not exceeding \$10,000.

The PCC must give the doctor who is under investigation and the complainant a reasonable opportunity to be heard and to provide written submissions on each matter that is the subject of the PCC's investigation.

Complainants may bring a support person (patient advocate, family or whānau member, friend or counsellor) to a PCC meeting.

The PCC appoints a legal adviser to advise it on matters of law, procedure and evidence. It is also entitled to appoint an investigator to collect information and to investigate complaints. However, neither the legal adviser nor the investigator may be present during the PCC's deliberations.

The PCC must give the doctor who is under investigation and the complainant a reasonable opportunity to be heard and to provide written submissions on each matter that is the subject of the PCC's investigation

Recommendations and determinations

Once the PCC has gathered all information relevant to its investigation, the PCC must recommend and/or determine an appropriate course of action. The PCC may make one or more of the following recommendations to the Medical Council:

- Assess the doctor's performance.
- Review the doctor's fitness to practise medicine.
- Review the doctor's scope of practice.
- Refer the subject matter of the investigation to the Police.
- Counsel the doctor.

The PCC may also make one of the following determinations, in accordance with section 80 of the Act:

- That no further steps be taken in relation to the complaint or conviction.
- That a disciplinary charge should be brought against the doctor before the Tribunal.
- That the complaint should be submitted to conciliation.

The PCC must make its recommendation(s) and/or determination within 14 days after the completion of its investigation. Written notice of any recommendation(s) and/or determination, and the reasons on which they are based, must be given to the Registrar of the Medical Council and to the doctor concerned (and in the case of a complaint, to the complainant). The Medical Council must promptly consider any recommendations.

It is not the responsibility of the PCC to reach a view on the guilt of the practitioner if the matter is considered to be a disciplinary matter. If the PCC determines to lay a disciplinary charge, the Tribunal will determine the outcome and whether or not the established conduct amounts to professional misconduct.

If the PCC decides the complaint or conviction should be considered by the Tribunal, it must frame an appropriate charge and lay it before the Tribunal in writing. Where a charge is laid against a doctor before the Tribunal, the chairperson of the Tribunal is required to convene a hearing of the Tribunal to consider the charge as soon as reasonably practicable.

If the PCC determines the complaint should be the subject of conciliation, it must appoint an independent conciliator to help those concerned resolve the complaint by agreement. If the complaint has not been successfully resolved by agreement, the PCC must promptly decide whether it should lay a charge against the doctor before the Tribunal, whether to make any recommendations to the Medical Council about the doctor or whether no further steps should be taken in relation to the complaint.

Health Practitioners Disciplinary Tribunal

Function

The Tribunal's principal function is to hear and determine charges brought against doctors (and other health professionals) by the Director of Proceedings or by a PCC. The Tribunal controls its own procedures in accordance with the Act and has wide powers to summon witnesses and records. Refusing to attend or cooperate or acting in contempt are offences punishable by a fine.

Membership

The Tribunal has a legal chairperson, one or more legal deputies and a panel of health practitioners and laypersons. The panel is maintained by the Minister of Health. For each hearing, the Tribunal must comprise a legal chair and four other persons selected by the chair or deputy from the panel, three of whom must be professional peers. One member must be a layperson.

Charges

The Tribunal must notify the doctor in writing of the charge and ensure that the charge contains sufficient particulars to inform the doctor clearly of the substance of the allegations against them. A provisional hearing date is set between 20 and 60 working days from the date of the notice of the charge. In most cases, the hearing dates are rescheduled once the availability of the parties and their counsel has been ascertained at a directions conference. On occasion, hearings are adjourned.

Once a doctor has been notified of a charge, they must advise the Tribunal within 10 working days whether or not they wish to be heard by the Tribunal. Doctors can be heard personally, or they may be (and usually are) represented by a lawyer.

Interim suspension

The Tribunal has the power, pending the hearing of a charge, to suspend the doctor or impose conditions on their practice if the Tribunal is satisfied that is necessary or desirable in order to protect the health or safety of the public. The Tribunal does not have to give notice to the doctor that it intends to make such an order, but it must advise the doctor of the order once it has been made, the reasons for it and the doctor's right to apply for variation or revocation of the order. The Tribunal must also serve a copy of the order on the doctor's employer and on the Medical Council. Any application for revocation has to be heard within 10 working days after it is received by the Tribunal.

Public hearings

Although the Tribunal has the power to restrict publication and hold hearings in private, the emphasis is on public hearings. The Tribunal can make various orders restricting the public nature of the hearing, including ordering that the whole or part of the hearing be heard in private and suppressing publication of the name or particulars of any person, including the doctor.

Applications for private hearings are rarely granted. Applications for name suppression are usually supported by affidavit evidence of the reasons why an order is sought, and the Tribunal is required to balance the respective interests of the doctor, the complainant and the public interest before exercising its discretion.

Witnesses are given special protection if their evidence relates to a sexual matter or relates to another matter that may require the witness to give intimate or distressing evidence. Only certain people may be present during evidence of this nature, including a news media reporter, any person the witness chooses and any person the doctor chooses. The witness may object to the presence of a person of the doctor's choice.

The Tribunal has the power to order that a witness be permitted to give their evidence from behind a screen, if necessary.⁴²⁴

In sexual cases, no person may publish the name of the complainant or any particulars likely to lead to the complainant's identification, unless the complainant is 16 years or older and the Tribunal makes an order permitting the publication. However, if the complainant is 16 years or older and applies to the Tribunal for such an order and the Tribunal is satisfied the complainant understands the nature and effect of the application, the Tribunal must make the order.

424 7/Med04/03P.

The Tribunal may restrict publication of any evidence relating to the sexual acts. If the Tribunal makes a privacy order, any person can apply for it to be revoked, including representatives of the media.

Procedures

The Tribunal can regulate its own procedures. However, the procedures must accord with the rules of natural justice. Each party must be given a fair opportunity to put their evidence and call relevant witnesses. The Tribunal may receive as evidence any statement, document, information or matter that may help it deal effectively with the matters before it, whether or not it would be admissible as evidence in a court of law.

Witnesses usually read out their evidence from a written statement. They are then cross-examined by opposing legal counsel and questioned by members of the Tribunal. The evidence is recorded by a stenographer. The hearings are most often heard in the closest major centre to where the events that were the subject of the PCC's investigation occurred.

The prosecution has the burden of proving the charge. The Tribunal has to be satisfied to the civil standard of proof (on the balance of probabilities rather than beyond reasonable doubt) that a doctor is guilty of the charge. The civil standard of proof is applied flexibly depending on the seriousness of the allegations.⁴²⁵

425 *Z v Dental CAC* ([2008] NZSC 55).

Findings

The Tribunal may find that the doctor has:

- been guilty of professional misconduct because of an act or omission that amounted to malpractice or negligence in relation to the doctor's registered scope of practice when the conduct occurred
- been guilty of professional misconduct because of an act or omission that has brought or was likely to bring discredit to the medical profession
- been convicted of an offence that reflects adversely on the doctor's fitness to practise (convictions for offences against relevant health Acts, including the Contraception, Sterilisation and Abortion Act, Coroners Act, Medicines Act, Injury Prevention, Rehabilitation, and Compensation Act and Misuse of Drugs Act or for an offence punishable by a term of 3 months' imprisonment or longer)
- practised their profession while not holding a current practising certificate
- performed a health service without being permitted to perform that service by their scope of practice
- failed to observe any conditions included in their scope of practice
- breached a penalty order of the Tribunal.

Professional misconduct

The charge of professional misconduct has been part of New Zealand's medical disciplinary regime for many years.

A two-step process is involved in testing what constitutes professional misconduct under the Act.

The first step involves an objective assessment of whether the doctor's acts or omissions in relation to their practice can reasonably be regarded as constituting malpractice or negligence or otherwise meet the standard of having brought or been likely to bring discredit to the profession. The second step, often referred to as the threshold test, involves the Tribunal being satisfied that the doctor's acts or omissions require a disciplinary sanction for the purposes of protecting the public or maintaining professional standards (that is, that the conduct was sufficiently serious to justify the imposition of a sanction).

Malpractice involves immoral, illegal or unethical conduct or neglect of professional duty (improper professional conduct). Negligence generally involves breach of a doctor's duty in their professional setting. Bringing discredit to the profession involves bringing harm to the reputation of the profession and requires an objective assessment of whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good standing of the profession was lowered by the behaviour of the doctor concerned.

The threshold test recognises that not all acts or omissions that constitute a failure to adhere to the standards expected of a medical practitioner will constitute professional misconduct.

Who sets the standard?

In *Tizard v Medical Council of New Zealand* (Full Court, Auckland, M 2390/91, 10 December 1992) the Full Court stated:

“Professional misconduct” is behaviour in a professional capacity which would reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct. It ... is an objective test judged by the standards of the profession: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR, 369, 374. (p 16)

However, when assessing a doctor's conduct, the Tribunal cannot lose sight of the fact that the Tribunal's role is partly one of setting standards (including the expectation that professional standards should not be permitted to lag) and that, in some cases, patient interests and community expectations may require the Tribunal to be critical of the usual standards of the profession.⁴²⁶ The Tribunal's deliberations now rely on both public as well as professional opinion, and it is that mix of opinion that sets the standard.

The Tribunal usually issues a fully reasoned written decision once it has determined the charge. The Tribunal posts its decisions on its website (www.hpdt.org.nz).

Penalties

When fixing a reasonable and proportionate penalty, the Tribunal balances the aggravating and mitigating factors in the case. To ensure there is consistency in the penalties imposed, the Tribunal also considers previous relevant cases.

The penalties available to the Tribunal if a doctor is found guilty are cancellation of the doctor's registration, suspension of the doctor for up to 3 years, the imposition of conditions on practice for up to 3 years, censure and a fine of up to \$30,000.

The Tribunal cannot impose a fine when it is dealing with an offence for which the doctor has been convicted by a court. In all other cases, the full range of penalties (including cancellation of registration) is available. Before determining to cancel a doctor's registration, the Tribunal must consider the lesser alternatives available to it.

426 *B v The Medical Council of New Zealand* (Unreported, High Court, 11/96, Elias J).

If the Tribunal decides to order that the doctor's registration be cancelled, it must explain why any lesser options have not been adopted in the circumstances of the case.⁴²⁷

After cancelling the doctor's registration, the Tribunal may impose one or more conditions that the doctor must satisfy before applying for registration again. The conditions may include any or all of the following:

- To undertake a specified course of education or training.
- To undergo a medical examination and treatment or a psychological or psychiatric examination, counselling or therapy.
- To attend a course of treatment or therapy for alcohol or drug abuse (the doctor must consent to those).
- Any other condition designed to address the matter that gave rise to the cancellation of the doctor's registration.

The Tribunal also has the power to order that the doctor pay a percentage of the reasonable costs and expenses incurred by the prosecution (either the Director of Proceedings or the PCC for the investigation and prosecution) and by the Tribunal (hearing costs).

There is no power to order costs to be paid to a doctor acquitted of a charge.

The Tribunal has no power to award compensation or costs to a complainant.

427 *Patel v PCC* (High Court, Auckland, CIV 2007—404—1818 Lang J, 13 August 2007).

Appeals

Appeals must be filed within 20 working days from the date of the Tribunal's decision. Unless a court orders otherwise, the penalties imposed by the Tribunal stay in force pending the outcome of an appeal. Appeals against decisions of the Tribunal are to the High Court, whose decision is final on all matters except points of law, which may be appealed to the Court of Appeal. Instead of determining an appeal, the High Court may direct the Tribunal to reconsider the whole or any part of its decision or order. When reconsidering, the Tribunal must take the Court's reasons into account and give effect to the Court's directions.

Appeals are generally conducted by way of a rehearing on the record of the Tribunal, following the approach outlined in *Austin, Nicholls & Co Inc v Stichting Lodestar* [2007] NZSC 103.⁴²⁸ The High Court must form its own assessment of the merits of the case, having regard to the expertise of the Tribunal members who heard the charge but not approaching that expertise with undue deference. If the High Court is of a different view of the merits from the Tribunal and is, therefore, of the opinion that the Tribunal's decision is wrong, the High Court must act on its own view. The appellant bears the onus of satisfying the appeal court that its decision should differ from the decision under appeal.

Acknowledgement

I would like to acknowledge Jo Hughson for her contribution to earlier versions of this chapter, previously titled 'The disciplinary process: the Professional Conduct Committee and the Health Practitioners Disciplinary Tribunal'. A significant amount of her work has been retained.

⁴²⁸ See, for example, *Harman v Director of Proceedings* (High Court, Auckland, CIV 2007—404—3732) and *Dr G v Director of Proceedings* (High Court, Auckland CIV 2009— 404—000951, 13 October 2009, Duffy J).

CHAPTER 25

The psychiatric patient and the law

Anthony Duncan is a forensic psychiatrist. He was formally Deputy Director of Mental Health and is currently the National Advisor in the ID CCR Act.

Cite this as Duncan A. The psychiatric patient and the law.

In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	363
Mental Health (Compulsory Assessment and Treatment) Act 1992	365
› Why have a Mental Health Act?	365
› How is 'mental disorder' defined?	366
› How is the process of committal under the Mental Health (Compulsory Assessment and Treatment) Act managed?	368
› Issues in civil commitment	371
Criminal Procedure (Mentally Impaired Persons) Act 2003	372
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003	373
Substance Addiction (Compulsory Assessment and Treatment) Act 2017	374
Protection of Personal and Property Rights Act 1988	375
Acknowledgement	378

Introduction

In a typical day, a practitioner working in general practice and indeed in most areas of medicine can expect to assess and potentially manage several people presenting with psychological symptoms or distress. They may present with a clear psychological issue, for example, “I am depressed doctor...” or with other symptoms, which include psychological concerns, for example, “I haven’t been able to sleep properly for ages...” or “I’ve got this pain in my guts and it’s really getting to me.” In most cases, their psychological issues can be assessed and treated in primary care, but some will require assessment and treatment from secondary (psychiatric) services.

Most of these referrals will be made with the agreement and consent of the patient and are made to their local district health board (DHB) community mental health service. A DHB’s mental health service is funded to provide assessment and treatment to 3 percent of the population experiencing the most serious mental distress at the time. These services are free to all New Zealanders and are mainly delivered through community mental health teams. Some people will elect to be seen in private by counsellors, clinical psychologists or psychiatrists. Private practice is less common in New Zealand than in some other countries. New Zealand private health insurance policies have very low rebates for mental health consultation and provide very low or absent cover for inpatient mental health care.

The standards of care required of providers seeing people in primary and secondary mental health services are the same as those required for all consumers of health and disability services. As such, they are afforded all the rights contained in the Code of Health and Disability Services Consumers’ Rights.⁴²⁹

429 [http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-\(full\)](http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-(full))

Right 7(7) states: “Every consumer has the right to refuse services and to withdraw consent to services.” However, Right 7(1) states: “Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.”

As is the case in other countries, a number of these enactments relate to the provision of compulsory mental health care. This chapter briefly reviews New Zealand’s legislative provisions under which individuals with mental health problems can, in specific circumstances, be compulsorily detained and/or treated:

- The Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH CAT Act).
- The Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP MIP Act). This Act provides the legislative framework whereby the cases of individuals appearing before courts charged with criminal offending and who are considered likely to be mentally impaired are progressed.
- The Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID CCR Act). This Act provides for the compulsory care and rehabilitation of certain individuals with a statutorily defined intellectual disability who have either been found unfit to stand trial or convicted of imprisonable offences.
- The Substance Addiction (Compulsory Assessment and Treatment) Act 2017 (SA CAT Act). This Act provides for the short-term compulsory assessment and treatment of certain individuals with serious substance addiction.
- The Protection of Personal and Property Rights Act 1988 (PPPR Act). This Act provides the protective legislative framework available for individuals who have either lost or never had sufficient mental capacity to make competent informed decisions about their health and welfare and/or financial matters.

Mental Health (Compulsory Assessment and Treatment) Act 1992

Why have a Mental Health Act?

Our society stresses individual rights and responsibility. People are, on the whole, assumed to be competent to make their own decisions and to be accountable for the consequences of their actions. This framework extends to people's right to accept or reject offers of medical help when they are ill. However, a state of severe mental disturbance can rob a person of their competence to make the type of decisions they would normally make. It can also mean they can't competently assess their psychological state or the treatment options available. Mental health legislation therefore exists to provide a robust legal framework for the compulsory assessment and treatment of people suffering an episode of serious mental disturbance associated with a risk of serious harm to themselves or others. This is happening within a system with sufficient checks and balances to ensure the provisions of the legislation are not over or under used and the rights of the individual are maintained to the maximum extent possible consistent with their safety.

New Zealand's current iteration of compulsory mental health legislation is the MH CAT Act, which:

- defines mental disorder for the purposes of the Act
- specifies the rights of and protections available for patients subject to the Act
- provides a framework of accountability for their care.

A process of assessment and treatment under this Act is initiated by a person making an application to the local Director of Area Mental Health Services for someone with a seriously disturbed mental state to be compulsorily assessed by the local mental health service.

In 2017 and into 2018, the application is required to be supported by a medical certificate from a registered medical practitioner stating the person is likely to have a statutorily defined mental disorder for a process of compulsory assessment to begin. However, after the 2016 MH CAT Amendment Act comes into force in 2018, such certificates can also be provided by certain other health professionals.

For the sake of brevity, this section will refer to the MH CAT Act as it applied in 2017. It first considers the term ‘mental disorder’ as it applies in the MH CAT Act before briefly addressing some of the practical aspects of using the Act. It uses the term ‘patient’ as defined in section 2 of the Act to mean:

...a person who is —

- (a) required to undergo assessment under section 11 or section 13 [of this Act]; or
- (b) subject to a compulsory treatment order made under Part 2 [of this Act]; or
- (c) a special patient

How is ‘mental disorder’ defined?

The Act eschews the term ‘mental illness’. Instead, ‘mental disorder’ is defined by the presence of one or more specified mental phenomena and associated risk. It is defined in section 2 of the Act as:

...in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it —

- (a) poses a serious risk of danger to the health or safety of that person or of others; or

(b) seriously diminishes the capacity of that person to take care of himself or herself —

and **mentally disordered**, in relation to any such person, has a corresponding meaning.

The two parts of the definition, the requisite phenomena and associated risk, are often described as the first and second limb of the definition. A person is mentally disordered if their presentation meets/fulfils both the first and the second limbs of the definition.

The term ‘mental disorder’ is subject to section 4 ‘General rules relating to liability to assessment or treatment’, which states that the process of assessment and treatment under the MH CAT Act:

...shall not be invoked in respect of any person by reason only of —

- (a) that person’s political, religious, or cultural beliefs; or
- (b) that person’s sexual preferences; or
- (c) that person’s criminal or delinquent behaviour; or
- (d) substance abuse; or
- (e) intellectual disability.

However, if a person has the requisite phenomena and risk, they can still be mentally disordered even if they also meet one or more of these exclusory criteria.

In the definition of mental disorder, ‘abnormal state of mind’ refers to a qualitatively abnormal mental state, one that is distinct from that of other people of similar cultural or religious backgrounds.

‘Continuous or intermittent’ acknowledges that many mental disorders follow a fluctuating course, meaning treatment may need to continue without the requisite phenomena and/or risk being apparent at interview.

The threshold criteria mean that people can only become subject to the MH CAT Act if the possible consequences of their abnormal mental state are so severe that it seriously endangers them and/or others or seriously impairs their ability for self-care. Information of how the courts have interpreted this definition is contained in the Ministry of Health's Guidelines to the MH CAT Act.⁴³⁰

How is the process of committal under the Mental Health (Compulsory Assessment and Treatment) Act managed?

A compulsory assessment is initiated by someone concerned about the mental health of another person through contacting the Crisis Assessment and Treatment Team (CATT) or equivalent service at their local DHB. These teams have a statutory official, the duly authorised officer (DAO), available at all times to respond to such calls. They report to another statutory official, the Director of Area Mental Health Services (DAMHS). The DAMHS oversees the operation of the MH CAT Act in the area covered by the DHB.

A compulsory assessment is initiated by someone concerned about the mental health of another person through contacting the Crisis Assessment and Treatment Team (CATT) or equivalent service at their local DHB.

If the DAO considers that the concerns expressed are genuine and has reasonable grounds for believing the person may be mentally disordered, they then organise the process of initial assessment. The first step is ensuring a formal application for assessment is made to the DAMHS pursuant to section 8 of the MH CAT Act. This consists of two certificates — an 8A and an 8B.

430 <http://www.health.govt.nz/publication/guidelines-mental-health-compulsory-assessment-and-treatment-act-1992>

The section 8A certificate can be provided by anyone over the age of 18 who has seen the person in the past 3 days and “who believes that the person may be suffering from a mental disorder”. The applicant “states the grounds on which the applicant believes the person to be suffering from a mental disorder”. An initial application for assessment is completed when a medical practitioner who has assessed the person issues an 8B medical certificate stating they have “reasonable grounds for believing that the person may be suffering from a mental disorder”. The practitioner is required to also document the assessment and provide the reasons why they believe the person may be suffering from a mental disorder.

The section 8B certificate can be provided by any medical practitioner, who can also provide the section 8A certificate if they see a person they think may be mentally disordered and there is no one willing or able to do something. This sometimes happens in general practice or hospital emergency rooms.

If a DAO receives only a section 8A certificate and they have reasonable grounds for believing the person the certificate concerns may be mentally disordered, they are then empowered to organise for the initiating medical assessment to be undertaken. This is often done by a psychiatric registrar with the DHB, and the DAO can request Police assistance to effect this assessment interview.

Once the DAO has both a section 8A and 8B certificate, they arrange, pursuant to section 9, for a further assessment to be undertaken. This section 10 assessment is undertaken by a psychiatrist or by another approved practitioner who must determine whether or not “there are reasonable grounds for believing that the proposed patient is mentally disordered and that it is desirable that the proposed patient be required to undergo further assessment and treatment”. You will note that, while the initiating section 8B certificate requires the practitioner to have reasonable grounds for believing the person **may** have a mental disorder, the section 10 certificate can only be issued if the psychiatrist has reasonable grounds for believing the person is mentally disordered.

If the section 10 certificate is issued, a period of 5 days' compulsory assessment begins pursuant to section 11 of the MH CAT Act. This almost always happens in a mental health inpatient unit but can be undertaken in a community setting in some instances. During this first assessment period, the patient can be compulsorily treated, and their treatment is the responsibility of a responsible clinician (RC), usually a psychiatrist.

The patient can be released before the end of the 5-day assessment if the RC concludes the patient is not mentally disordered. If, on the other hand, they reassess and certify, pursuant to section 12, that "there remain reasonable grounds for believing that the patient is mentally disordered and that it is desirable that the patient be required to undergo further assessment and treatment", a further 14-day period of assessment is commenced (section 13). Before the end of this period, the patient must be released or an application made for a compulsory treatment order (CTO). This application is heard by a Family or District Court Judge within the following 14 days. At the hearing, the Judge examines the patient and hears evidence from the patient, the RC and at least one other health professional involved in the case as well as any other evidence the Judge considers relevant. The Court acts in an inquisitorial not an adversarial fashion, but the patient usually has a state-funded lawyer who can address the Judge on the patient's behalf and can question the RC and any other witness.

If the Judge determines the person is mentally disordered and a CTO is necessary, they first consider whether this can be a community CTO, and then only if this is not a safe option, an inpatient order is made. The initial CTO is for 6 months. If at any time during the order the RC concludes the patient is no longer mentally disordered, they are released, and the RC can also send the patient on leave from the hospital or convert the inpatient order to a compulsory community treatment order. Orders can be extended by the Family Court for another 6 months.

Then, if there is a 12-month extension hearing and the Judge concludes the patient remains mentally disordered, the order is extended “indefinitely”. Thereafter, throughout the currency of the order, 6-monthly statutory reviews are conducted by the RC. A copy of the review certificate is provided to the DAMHS, the patient and specified others interested in the care of the patient. If at any time during the tenure of the order, including at the statutory reviews, the RC concludes the patient is no longer mentally disordered, they must be released from this status under the MH CAT Act.

During the assessment phase and for the first month of a CTO, a patient is required to accept treatment as directed by the RC. Thereafter, the patient can still be required to accept treatment if it is considered to be in their interests by another psychiatrist appointed by the Mental Health Review Tribunal (MHRT) to review such matters. The primary role of the MHRT is to review patients who have applied to the MHRT to have their detention under the Act reviewed.

Issues in civil commitment

Part 6 of the MH CAT Act specifies the rights of the patients while undergoing compulsory treatment. These are to be read in conjunction with the Code of Health and Disability Services Consumers’ Rights, which also apply. District inspectors (DIs) are lawyers appointed by the Minister of Health and are tasked with informing patients of their rights and monitoring the care of patients against the rights specified in the MH CAT Act. They can conduct inquiries into the care of any patient either in response to complaints by or on behalf of the patient on their own recognisance and also at the direction of the Ministry of Health’s Director of Mental Health. Another of their roles is ensuring that patients are aware of the circumstances in which they can appeal their compulsory detention (to the High Court under section 16 of the Act and to the MHRT) and assist them with the information they need to make such appeals.

The viewpoint of the family and other carers is important, and the Act mandates consultation with the patient's family or whānau in section 7A. This must be undertaken unless the RC has good clinical reasons not to do so or it is not practicable to do so.⁴³¹

Criminal Procedure (Mentally Impaired Persons) Act 2003

The CP MIP Act was introduced in 2003 and provided the legislation framework under which the cases of individuals appearing before the criminal courts who are suspected of having significant mental impairment are progressed. It replaced Part 7 of the Criminal Justice Act 1985 (CJA) and was developed in tandem with the ID CCR Act.

One of the drivers for developing these Acts was the difficulties courts had faced in dealing with defendants with an intellectual disability (ID) after the introduction of the MH CAT Act. Individuals with an ID alone appearing before the court could no longer be easily directed to hospital care as they were no longer considered to be mentally disordered. Another was the fact that, under the CJA, an individual could be found unfit to stand trial and potentially then be detained in hospital without an inquiry into whether they had actually offended as had been alleged. The CP MIP Act provides for a process to establish the involvement of the defendant in the charge on which they might be found unfit. The CP MIP Act also provides the court with the option of sentencing an offender to a term of imprisonment while contemporaneously ordering they be held in a hospital or secure facility subject to an order under the MH CAT Act or the ID CCR Act.

431 For further reading, see Dawson J, Gledhill K, editors. *New Zealand's Mental Health Act in practice*. Victoria University Press; 2013.

The CP MIP Act provides, pursuant to section 38, for the preparation of psychiatric or psychological assessment of defendants suspected of being mentally impaired to assist the court in deciding whether the defendant is unfit to stand trial or was insane within the meaning of section 23 of the Crimes Act at the time the offence was committed. Then when a defendant has been found unfit to stand trial or insane or convicted of imprisonable offences, the Act mandates further

assessments pursuant to sections 23 and 35 respectively to assist the court in making the most appropriate disposition. These can include orders under the MH CAT Act or the ID CCR Act. The terms ‘special patient’ and ‘special care recipients’ refer to those individuals who remain subject to the criminal justice system while subject to the MH CAT Act or ID CCR Act.

In most cases, these assessment reports are requested from forensic practitioners contracted to or working for the Regional Forensic Services or the National Intellectual Disability Care Agency and will not be further addressed in this chapter.

Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003

This Act provides for the compulsory care and rehabilitation within a health and disability framework of certain individuals with a statutorily defined ID who have been either found unfit to stand trial on or convicted of imprisonable offences and ordered into care under this Act. There is no other mechanism in New Zealand law for an individual with an ID alone to be detained purely on the basis of risk they pose to others.

This Act provides for the compulsory care and rehabilitation within a health and disability framework of certain individuals with a statutorily defined ID who have been either found unfit to stand trial on or convicted of imprisonable offences and ordered into care under this Act.

Most compulsory care orders are made by a criminal court as a disposition under the CP MIP Act. An initial order of up to 3 years' duration is made in a criminal court, and this can be extended by the Family Court depending on the risk the individual still poses. In addition, the ID CCR Act provides for the transfer into its regime of appropriately sentenced prisoners with an ID or certain individuals with an ID detained in a psychiatric facility under the MH CAT Act who would be more appropriately cared for within an ID service environment.

The structure and content of the ID CCR Act closely mirrors the MH CAT Act. Individuals detained under this Act are defined as 'care recipients' instead of patients. Their care and rehabilitation is the responsibility of a care manager. Their role is broadly analogous to the RC's role, and they are employed by the service detaining the care recipient. The care manager's work is overseen by a care coordinator who is employed by the National Intellectual Disability Care Agency and has a role broadly analogous to that of the DAMHS.

Substance Addiction (Compulsory Assessment and Treatment) Act 2017

The SA CAT Act provides for the compulsory assessment and treatment of individuals who have a severe substance addiction and do not have the capacity to consent to treatment for their addiction.

The SA CAT Act comes into effect on February 2018 and replaces the Alcoholism and Drug Addiction Act 1966 (ADA Act). The ADA Act had no longer reflected modern treatment delivery, nor did it specify the residual rights of individuals who became subjected to compulsory assessment and treatment. The use of committal procedures under the ADA Act had been declining steadily since the 1970s.

The SA CAT Act is focused on the small number of people with severe substance addiction and severely impaired capacity, both of which are defined in the legislation. Its aim is to enable people with a severe substance addiction and with severely impaired decision-making capacity to receive compulsory treatment for their addiction. This is undertaken with the aim of protecting them from harm, stabilising their health, protecting and enhancing their mana and dignity and restoring their capacity to make informed decisions about further treatment and substance use.

In most cases, compulsory treatment under the SA CAT Act will be limited to less than 56 days. This reflects the importance of ensuring people with severe substance addiction are supported to engage with treatment on a voluntary basis wherever possible. In the case of individuals subject to the SA CAT Act who also have a substance-related brain injury impacting on their recovery, the compulsory treatment order can be extended by the court for a further 56 days. In some cases, this will be followed by arrangements being made for their ongoing care in a more specialised environment such as dementia-specific residential care.

The SA CAT Act also contains provisions to protect the rights of people subject to compulsory assessment and treatment and provides for the investigation of alleged breaches of their rights.

Protection of Personal and Property Rights Act 1988

This Act provides for the protection and promotion of the personal and property rights of adults who are not fully able to manage their own affairs. The PPPR Act is predicated on a presumption of a person having the competence to manage themselves and their assets until and unless the contrary is proven.

It states in section 5 of Part 1, which deals with personal rights:

For the purposes of this Part, every person shall be presumed, until the contrary is proved, to have the capacity—

- (a) to understand the nature, and to foresee the consequences, of decisions in respect of matters relating to his or her personal care and welfare; and
- (b) to communicate decisions in respect of those matters.

And in section 24 of Part 4, which deals with property rights:

For the purposes of this Part, every person shall be presumed, until the contrary is proved, to be competent to manage his or her own affairs in relation to his or her property.

When the contrary is proved in the Family Court, PPPR Act provides processes to establish alternative decision making for individuals who it has found to have significant impairment in their capacity to make decisions about their health, welfare and property. These orders can be because of lifelong impairment of capacity – mainly individuals with significant intellectual disability and when a person has developed impaired capacity due to brain injury, mental disorder or some other condition affecting brain function such as dementia.

The court can make one or more nuanced personal orders pursuant to section 10. These can include regulating where a person resides or what medical or other care they are to receive. These orders can only be made when the court considers the individual has either wholly or partially lost their capacity to make best-interests decisions in particular or all aspects of their personal care and welfare.

There is also a power for the court to appoint a welfare guardian pursuant to section 12 to make ongoing welfare decisions in the areas where the court has determined the individual has wholly lost their decision-making capacity. In most cases, welfare guardianship is only sought where the individual has wholly lost their capacity to make decisions for all or virtually all aspects of their personal care and welfare. However, in New Zealand, there is no statutory body able to act as a welfare guardian, and in most cases, welfare guardianship is established by a concerned family member or close friend. In cases where there is no identified individual prepared to take on this role, the court may need to make a number of personal orders to perform a similar function.

These powers are provided to a nominated attorney while the individual is still competent to make another person their enduring attorney. The attorney has no power to act on a person's behalf until that person has been certified to have lost the requisite capacities.

There is also a power to appoint a property manager pursuant to Part 3 of the Act. This can be a trustee corporation.

The PPPR Act prescribes a regime that, on the face of it, provides only for substitute decision making. However the PPPR Act requires that anyone exercising a power under this Act always acts to assist and encourage the subject person to exercise whatever decision-making capacity they retain.

The PPPR Act also provides the framework within which enduring powers of attorney for personal care and welfare and for property matters can be established. These powers are provided to a nominated attorney while the individual is still competent to make another person their enduring attorney.

The attorney has no power to act on a person's behalf until that person has been certified to have lost the requisite capacities. The certificates are provided by a health practitioner, often a medical practitioner whose scope of practice includes the assessment of a person's capacity.

With the increasing percentage of elderly in the population, medical practitioners in a variety of areas of practice are finding they are being increasingly asked to provide certificates in relation to the PPPR Act. These can be to support applications for appointment of a welfare guardian and/or a property manager or in support of applications for personal orders. In addition, they may also be asked whether a person still has the capacity to establish enduring powers of attorney or whether somebody has lost their capacity and the enduring attorney now needs to act for them. These certificates must be provided on specified templates.⁴³²

Acknowledgement

In closing, I wish to acknowledge my debt to the previous author of this chapter, Dr David Chaplow, whose work I have updated.

432 These templates and general information about the PPPR Act can be downloaded from <https://www.justice.govt.nz/family/powers-to-make-decisions/>

CHAPTER 26

The organisation of medical services in New Zealand

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Cite this as Adams J. The organisation of medical services in New Zealand. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	380
Health service structure	380
Ministry of Health	382
Changing models of care	382
Registration of medical professionals	383
The Medical Council of New Zealand	384
Workforce	385
Education and postgraduate training	385
Medical liability	386
Drug purchase and prescribing	386
Medical research	387
Doctors' associations	387
Organisation of medical services in hospital practice	387
Organisation of medical services in general practice	388

Introduction

New Zealand has a proud history of social reform and innovation, including health service provision. New Zealand-trained doctors have contributed significantly on the international stage over decades, in spite of the country's small size, highlighting the high standard of medical training and practice. There are strong structures in place to protect patient rights and ensure that people receive the highest level of medical care possible within the available resources.

Health service structure

Medical services in New Zealand are primarily delivered through publicly funded services. Public funding accounts for about 82 percent of service provision. Twenty district health boards (DHBs) are largely responsible for dispersing the public funds and purchasing required medical and disability services from public hospitals, general practitioners and non-government organisations. Care in public hospitals is free,⁴³³ and general practice visits and pharmaceuticals are subsidised.

The governance of the DHBs lies with a board for each region that is partially elected at local body elections and partly appointed by the Minister of Health. DHBs are responsible to the Minister of Health through the Ministry of Health by contract. Each DHB has a CEO who is responsible for operations and management. Many have held the view that there are too many DHB areas for a country of New Zealand's size, and active collaboration and combination between DHBs is occurring.

433 Care is free only if you meet the eligibility criteria set out in the Ministry of Health website – <http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services>

Medical practitioners who work in public hospitals are employed by DHBs, mostly under the terms of national industry employment agreements covering senior doctors (SMOs) and resident medical officers (RMOs) separately.

Many senior doctors also work in private settings, charging patients the full fee for their services. Private hospital services are also full charge to the patient. Several companies provide private health insurance with differing reimbursement plans.

General practitioners predominantly own their practices, although employment models are becoming more common, including some DHB primary care services in hard-to-staff areas and doctor-owned practices that employ other doctors. Urban areas may also be serviced by accident and medical clinics owned by conglomerates who employ doctors to staff the centres.

General practice services are organised into primary health organisations (PHOs), governed by DHBs. Through the DHBs, PHOs receive capitated government funding, most of which is passed to general practices, and provide varying levels of subsidy for patient visits. Some PHOs provide services directly to patients as well as through their general practice members. All patients need to be registered with a practice. Most GPs charge most patients directly a co-payment for services.

New Zealand has a no-fault accident compensation scheme that pays for a portion of treatment for accidents in primary care and some private specialist services, particularly surgery. The Accident Compensation Corporation (ACC) also pays public hospitals bulk amounts for their treatment of accident victims.

The no-fault scheme includes injury caused by medical treatment. Because of this, there is only a right to sue in New Zealand for recompense of injuries that fall outside the scheme or in cases of severe negligence where exemplary damages can be sought. Doctors are therefore seldom sued.

Ministry of Health

The Minister of Health has overall responsibility for the health system, and the Ministry of Health is principal adviser to the government on health and disability policy and is responsible for leading and supporting the sector.

The Ministry is led by the Director-General of Health and structured into business units covering the main functions of the Ministry in policy, regulation, strategy, leadership, purchasing of services, and DHB funding and monitoring of performance. Business units also include those responsible for advice and policy on Māori health and clinical advice and leadership from the Chief Nursing Officer and Chief Medical Officer.

General practice is the cornerstone of medical care in New Zealand. Practices are becoming more multi-disciplinary.

Changing models of care

General practice is the cornerstone of medical care in New Zealand. Practices are becoming more multi-disciplinary, with practice nurses particularly providing more frontline services. There are a small number of nurse practitioners providing general practice services, particularly in areas hard to staff with doctors. Nurse practitioners are also providing some specialist services in secondary and tertiary care. Physician assistants as new work roles in New Zealand have also been trialled successfully in both primary and secondary care.

Although there is variation between DHBs, there are initiatives in place to develop greater integration

between primary and secondary care, ranging from DHBs providing their own primary care services (predominantly in provincial areas) to establishing patient flow pathways and guidelines as collaborations between primary and secondary care to greater sharing of combined electronic records, particularly in relation to results of investigations.

An overall strategy is to move more care away from hospitals and into the community, with an accompanying expectation that primary care will provide a greater range of services. Some general practitioners are establishing special areas of interest. There are some issues with the funding of general practice, with many feeling that the current

system of differential capitation based on practice demographics results in inequity across the country as far as co-payments for general practice visits are concerned. Cost to the patient for general practice visits is seen as a significant barrier to access in some situations.

Regionalisation, and in some cases nationalisation, of tertiary and quaternary services continues in New Zealand. Patients are transported around the country to centres where more specialised care and facilities are available.

An overall strategy is to move more care away from hospitals and into the community.

Registration of medical professionals

Registration and regulation of medical practitioners is legislated by the Health Practitioners Competence Assurance Act, which sets up regulatory authorities for each health profession and prescribes processes for assuring standards of competence, conduct and fitness to practise.

Regulatory authorities set scopes of practice for each registrant. Medical vocational or specialist registration is recognised after the attainment of appropriate Australasian or New Zealand specialist college qualifications or qualifications and training that are deemed to be equivalent to or as satisfactory as the Australasian training. Doctors can practise independently with general registration but require a collegial relationship to support them to maintain their competence in the chosen area through appropriate continuing professional development (CPD).

International medical graduates can apply for registration under several pathways according to their planned work arrangements in New Zealand. Both provisional general and vocational registration require a period of supervision. The Medical Council of New Zealand (see below) engages with vocational educational and advisory bodies (VEABs) to assess whether doctors from overseas applying for vocational registration have equivalent or as satisfactory training as New Zealand-trained specialists. Details of registration for international graduates are available on the Council website (www.mcnz.org.nz).

The Medical Council of New Zealand

The Medical Council of New Zealand is the statutory regulatory authority for medical practitioners. Its statutory role is to protect the health and safety of the public in New Zealand by ensuring that doctors are competent and fit to practise. The Council registers doctors and issues practising certificates, deals with issues of competence when they arise, institutes remedial competence programmes, refers conduct issues for further assessment if required and assesses and monitors the health of sick doctors.

It is not a disciplinary body, although it manages some complaints to do with professional conduct. All patient complaints in New Zealand are channelled initially through the Health and Disability Commissioner's Office (see [Chapter 23 – How medical practice standards are set by legislation: other legislation](#)).

The Medical Council of New Zealand is the statutory regulatory authority for medical practitioners. Its statutory role is to protect the health and safety of the public in New Zealand by ensuring that doctors are competent and fit to practise.

The Council is also responsible for accrediting educational programmes for doctors including medical schools, specialist college training programmes and the intern (PGY1) year. In practice, much of the accreditation of medical schools and Australasian colleges is done in collaboration with the Australian Medical Council (AMC).

Workforce

Health workforce strategy and planning is the responsibility of Health Workforce New Zealand (HWNZ), a ministerial committee situated in the Ministry of Health and responsible to the Minister of Health. The role of HWNZ is to provide advice to both the Minister of Health and the Director General of Health and to purchase education and training within the health and disability sector.

Education and postgraduate training

There are two medical schools in New Zealand at the University of Auckland and the University of Otago, which has major campuses for medical training in Dunedin, Christchurch and Wellington. There are placements for undergraduate students in all major hospitals and increasingly in provincial and rural hospitals. General practices throughout the country are also involved in undergraduate experience and teaching. Both medical schools have established rural programmes.

Training in the PGY1 or probationary registration year is managed by the hospitals who are accredited by the Medical Council to provide an adequate supervision and training experience. Recent changes in expectations and processes in the provisional registration year from the Medical Council have resulted in the PGY1 and PGY2 years having a stronger educational focus. Vocational training is the responsibility of the colleges in association with the employers and the universities.

The training programmes are set and supervised by the specialist colleges and purchased from the health providers through Health Workforce New Zealand. Specialist qualifications in New Zealand are fellowships of the specialist colleges, gained after meeting their training and examination requirements.

All doctors in New Zealand must participate in ongoing education in order to gain their practising certificate. A mandatory CPD programme for general registrants was recently instituted by the Medical Council and includes practice visits and multisource feedback. The Medical Council sets requirements for and accredits the CPD programmes of the vocational colleges and audits compliance by doctors.

Medical liability

Whilst doctors are rarely sued in New Zealand, there are numerous ways in which their conduct and competence can be investigated, including by employers, the Health and Disability Commissioner, coroners' inquiries and the Medical Council. Indemnity cover is recommended and required by most employers. It is usual for employers to reimburse fees. Indemnity organisations provide legal advice to individual doctors.

Drug purchase and prescribing

Medicines are purchased in New Zealand on behalf of the government by a central purchasing agency called PHARMAC. PHARMAC establishes a schedule of subsidised medicines that details the various restrictions and availability of medicines. Some drugs are only available for prescription by specialists, and others require a special authority to be subsidised.

Medical research

New Zealand has an international reputation for the quality of its medical research. Increasingly, research is also performed outside the universities in DHBs and primary care. Funding for medical research is tight but available from many sources for good projects. The predominant purchaser of medical research in New Zealand is the Health Research Council, which distributes more than \$80 million annually of public funds.

Doctors' associations

The major professional association in New Zealand is the New Zealand Medical Association (NZMA), which has Specialist, General Practitioner and Doctors-in-Training Councils. The NZMA publishes the New Zealand Medical Journal, deals with medico-political issues and generates the *Code of Ethics*.

Smaller special-interest associations such as Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA) and the Pasifika Medical Association cater for the needs of specific groups of doctors. Industrial organisations for senior doctors (Association of Salaried Medical Specialists) and interns and registrars (New Zealand Resident Doctors' Association) are responsible for negotiating with health providers for salaried doctors' terms and conditions.

Organisation of medical services in hospital practice

The 6th year of medical school in New Zealand is known as the trainee intern year, where students participate in medical teams in a junior capacity whilst maintaining their student status. After graduation, the first intern or PGY1 year is a probationary registration year with requirements from the Medical Council having to be met before full general registration is approved. Most young doctors complete a second intern year before entering formal training programmes in their chosen speciality.

Once in a training programme, registrars (residents), although employed by the DHB, come under the auspices of the relevant college for their training and are supervised by college-accredited supervisors. After fulfilling the required training experience and exams, registrars become fellows of the appropriate college, gain vocational registration with the Medical Council and are employed as senior medical officers (SMOs) with the DHB. Many SMOs also work part-time in private practice. The medical structure of health delivery teams on a DHB service usually consists of a SMO, registrar, house surgeon and possibly trainee intern.

Medical clinical leadership in DHB services is provided through the chief medical officers (CMOs). Typically, CMOs will have medical directors of individual services or clinical leaders reporting to them.

Private hospitals in New Zealand provide around 50 percent of elective surgery. Individual specialists are accredited to work in specific private hospital services.

Organisation of medical services in general practice

General practitioners in New Zealand are both vocationally registered and generally registered. General registrants practise within a collegial relationship with a doctor vocationally registered in general practice. Trainee interns also contribute in general practices, where they are under the supervision of the general practitioner. Changed requirements for the provisional registration year will mean PGY1 and PGY2 doctors gaining experience in community placements including general practice. General practice registrars are employed by general practitioners to provide services as a part of training.

CHAPTER 27

Overview of the New Zealand public health and disability system

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Cite this as Simpson A. Overview of the New Zealand public health and disability system. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	391
Vote Health	393
The Minister of Health	394
The Ministry of Health	396
› Purpose and role	396
› Leadership	397
› Advising the government	397
› Buying health and disability services	398
› Information and payments	398
Priority areas	398
Organisational structure	400
› Client Insights and Analytics	400

› Strategy and Policy	400
› Service Commissioning	400
› Protection, Regulation and Assurance	401
› Technology and Digital Services	401
› Finance and Performance	401
› People and Transformation	401
› Office of the Director-General	402
› Māori Leadership	402
› Chief Nursing Officer	402
› Chief Medical Officer	402
› Critical Projects	403
Statutory positions	403
› Director-General of Health	403
› Director of Mental Health	403
› Director of Public Health	404
› Chief Financial Officer	404
Clinical leadership within the Ministry	404
District health boards	405
› DHB appointments	407
› Funding and services	408
› Accountability	409
› Government expectations	409
› Planning documents	409
› Accountability documents	410
› Performance	412
› Financial performance	412
› Non-financial performance	412
New Zealand Health Strategy	413

Introduction

The Minister of Health, with Cabinet and the government, develops policy for the health and disability sector and provides leadership. The Minister is principally supported and advised by the Ministry of Health.

Most of the day-to-day business of the system and nearly three-quarters of the funding is administered by district health boards (DHBs). DHBs plan, manage, provide and purchase health services for the population of their district, implement government health and disability policy and ensure services are arranged effectively and efficiently for all of New Zealand. This includes funding for primary care, hospital services, public health services, aged care services and services provided by other non-government health providers, including Māori and Pacific providers. There are currently 20 DHBs across New Zealand.

The Ministry has a range of roles in the system in addition to being the principal adviser and support to the Minister. It funds an array of national services (including disability support and public health services), provides clinical and sector leadership and has a number of monitoring, regulatory and protection functions.

The entire system extends beyond the Ministry and DHBs to ministerial advisory committees, other health Crown entities, primary health organisations, public health units, private providers (including Māori and Pacific providers) and independent GPs. It includes professional and regulatory bodies for all health professionals, including medical and surgical specialities, nurses and allied health groups. There are also many non-government organisations (NGOs) and consumer bodies that provide services and advocate for the interests of various groups (see Figure 4 on the next page).

Overview of the New Zealand health and disability system



Vote Health

The health system's funding comes mainly from Vote Health, which is administered by the Ministry. For 2016/17, this totalled \$16.142 billion.

Other significant funding sources include other government agencies (most notably the Accident Compensation Corporation – ACC), local government and private sources such as insurance and out-of-pocket payments.

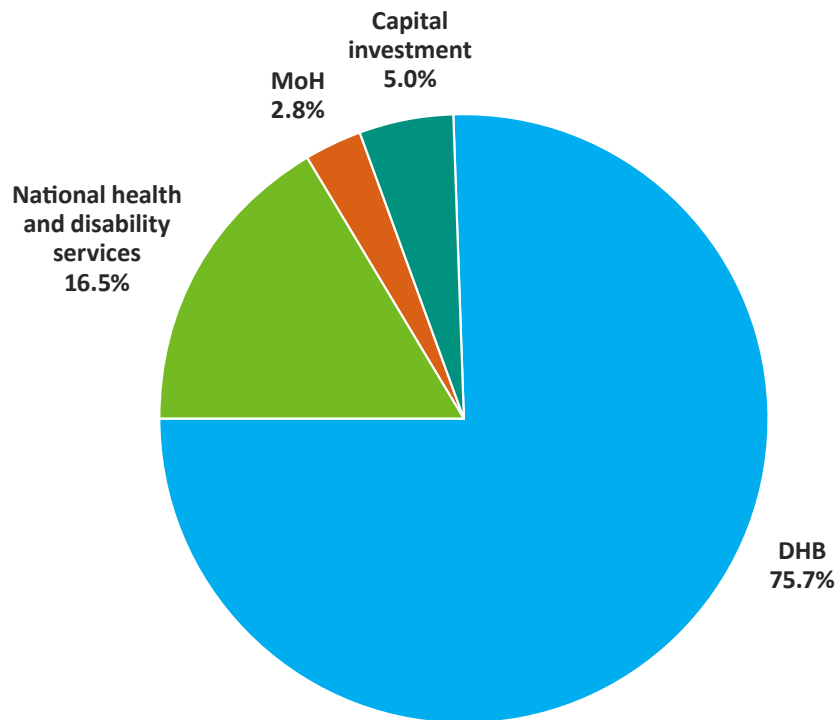
The majority of public funds managed through Vote Health are allocated to DHBs: \$12.220 billion in 2016/17 or 75.7 percent of Vote Health. DHBs use this funding to plan, purchase and provide health services for the population of their district so as to ensure effective and efficient services for all of New Zealand. DHBs oversee – but exercise varying control over – all levels of care, including hospital services, aged care services and primary care, such as GPs, nurses and pharmacists.

The Ministry will spend \$2.659 billion in 2016/17 (16.5 percent of Vote Health) to directly purchase a range of services, such as disability support services, public health services, specific screening programmes, elective services, Well Child and primary maternity services, Māori health services and postgraduate clinical education and training as well as Māori and Pacific provider development.

Capital funding comprises \$803 million in 2016/17 (5 percent of Vote Health). This includes provision of debt or equity for DHBs (and other health Crown entities and/or Public Finance Act Schedule 4A companies) to cover new investments or other purposes agreed by the Crown.

The final \$459 million in 2016/17 (2.8 percent of Vote Health) funds the Ministry's operating costs, health workforce training and development, national health information systems and other expenses (see Figure 5).

Figure 5. Allocation of \$16.142 billion Vote Health funding in 2016/17.



The Minister of Health

The Minister has overall responsibility for the health and disability system and for setting the sector's strategic direction. The Minister's functions, duties, responsibilities and powers are provided for in the New Zealand Public Health and Disability Act 2000, the Crown Entities Act 2004 and in other legislation. Some responsibilities may be delegated to one or more Associate Ministers of Health.

There are various ways the Minister, or the Ministry on the Minister's behalf, can direct activity in the sector. Because it is a semi-devolved system, many day-to-day functions and detailed decisions happen at a local level. Due to the system's complex set of governance, ownership, business and accountability models, the levers available to the Minister are varied and exert differing levels of control.

The Minister is responsible for strategies that provide a framework for the health and disability system such as the New Zealand Health Strategy, the New Zealand Disability Strategy and He Korowai Oranga: Māori Health Strategy.

The Minister is also responsible for the strategic direction of the Ministry through the statement of intent, 4-year plan, budgets and output plan.

Beyond setting the system's strategic direction, the Minister has an array of performance levers available. Given the Minister's legislative and financial responsibilities, specific levers are largely focused around ensuring strong performance from DHBs and other health Crown entities.

These levers can be broadly grouped into three categories:

- Setting entities' strategic direction and annual performance requirements (for example, through letters of expectation, statements of intent/statements of performance expectations, setting funding parameters and giving directions).
- Monitoring strategic direction and results (for example, through a monitoring agent, discussing results with entities, requesting information).
- Board appointments, remuneration and removals (for example, appointing chairs and members, setting terms and conditions of appointment, ensuring quality induction and review processes).

Other key roles of the Minister under legislation include the power to declare health emergencies and responsibility for decisions about extended leave from hospital and eventual change of legal status of special and restricted mental health patients.

Beyond setting the system's strategic direction, the Minister has an array of performance levers available. Given the Minister's legislative and financial responsibilities, specific levers are largely focused around ensuring strong performance from DHBs.

The Ministry of Health

The Ministry of Health is the government's principal agent in the New Zealand health and disability system and has overall responsibility for the stewardship of that system. The Ministry acts as the Minister's principal adviser on health policy, thereby playing an important role in supporting effective decision making. At the same time, the Ministry has a role within the health sector as a funder, monitor, purchaser and regulator of health and disability services.

In this way, the Ministry provides leadership across the system and is the government's primary agent for implementing the government's health priorities and policies within the system. The Ministry also has a wider role in coordinating action with other government agencies to deliver on the government's agenda across the spectrum of social sector services.

As well as its key relationships with the government and the health and disability system, the Ministry aspires to be a trusted and respected source of reliable and useful information about health and disability matters for all New Zealanders and the wider international community.

Purpose and role

The Ministry seeks to improve, promote and protect the health and wellbeing of New Zealanders through:

- its leadership of New Zealand's health and disability system
- advising the Minister and the government on health issues
- directly purchasing a range of national health and disability support services
- providing health sector information and payment services for the benefit of all New Zealanders.

The Ministry works in partnership with other public sector agencies and by engaging with people and their communities in carrying out these roles.

Leadership

The Ministry leads the health and disability system and has overall responsibility for the management and development of that system. It steers improvements that help New Zealanders live longer, healthier and more independent lives.

The Ministry ensures that the health system is delivering on the government's priorities and that health sector organisations are well governed and soundly managed from a financial perspective. To do this, the Ministry:

- funds, monitors and drives the performance improvements of DHBs and other health Crown entities
- supports the planning and accountability functions of DHBs and other health Crown entities
- regulates the sector and ensures legislative requirements are being met.

Advising the government

Health and disability policy choices are complex and challenging, and the Ministry has a responsibility to provide clear and practical advice to the Minister and Associate Ministers, supported by strong, evidence-informed analysis.

The Ministry provides expert clinical and technical advice to Ministers, organisations and individuals within the health and disability sector. Some Ministry functions (such as those that rest with the Director of Public Health) include clinical decision making or statutory responsibilities.

Buying health and disability services

The Ministry is a funder, purchaser and regulator of national health and disability services on behalf of the Crown. These services include:

- public health interventions (for example, immunisation)
- disability support services
- elective services
- screening services (for example, cervical screening)
- mental health services
- maternity services
- ambulance services.

Information and payments

The Ministry provides key infrastructure support to the health and disability system, especially through:

- the provision of national information systems
- a payments service to the health and disability sector (totalling \$8.7 billion of services funded by the Ministry and DHBs in 2015/16 from processing 108 million transactions).

Priority areas

The improved wellbeing and health of New Zealanders will be achieved by the delivery of services that are accessible, safe, individual and family-centred, clinically effective and cost-effective. The Ministry has a multi-faceted strategy, as is appropriate for a complex sector. As set out in the Ministry's Statement of Intent 2015–2019 (published June 2015).⁴³⁴

434 <http://www.health.govt.nz/system/files/documents/publications/ministry-of-health-soi-2015-to-2019-aug15-v2.pdf>

The Ministry will:

1. contribute to the Government's strategic priorities by:
 - delivering Better Public Services in a challenging fiscal environment
 - responsibly managing the Government's finances
 - supporting the Christchurch rebuild
 - building a more competitive and productive economy
2. deliver on the Government's cross sector priorities in the health and social sector arena:
 - supporting vulnerable children, including reducing rheumatic fever cases and assaults on children
 - social sector trials
 - the Prime Minister's Youth Mental Health project
 - health targets
 - Whānau Ora
 - National Drug Policy
3. implement the Minister's objectives for the sector:
 - make services more accessible, including shifting services
 - maintain wellness for longer by improving prevention
 - reduce obesity – childhood obesity plan
 - implement a diabetes plan
 - improve the quality and safety of health services
 - support the health of older people
 - implement Rising to the Challenge
 - Smokefree 2025
 - therapeutic products regulatory regime
 - make the best use of information technology and ensure the security of patients' records
 - strengthen the health and disability workforce
 - support regional and national collaboration.

Organisational structure

The Ministry is made up of 12 business units, each with its own functions and areas of responsibility.

Client Insights and Analytics

The Client Insights and Analytics business unit is responsible for ensuring that all of the Ministry's clients, especially the people of New Zealand, are front of mind in all that the Ministry does. The business unit manages national data collections and provides evidence-based insights and analytics relating to the health and wellbeing of New Zealanders. The business unit works closely with the Strategy and Policy and the Technology and Digital Services business units on information management and on the evidence base for service design.

Strategy and Policy

The Strategy and Policy business unit is responsible for the Ministry's advice on the health and disability system. It develops and enables implementation of strategy and policy, including advice on Māori health, technology and regulation.

Service Commissioning

The Service Commissioning business unit manages the relationships between the Ministry and health and disability service providers including DHBs. This includes funding, purchasing, performance management, commercial advice and contractual arrangements. The business unit works closely with the Strategy and Policy and the Finance and Performance business units to design, plan and fund health and disability initiatives.

Protection, Regulation and Assurance

The Protection, Regulation and Assurance business unit ensures the quality and safety of health and disability services, protects and promotes the health of New Zealanders and provides assurance and enforcement for both regulatory and contract compliance. The business unit works closely with the Service Commissioning business unit and DHBs to ensure service quality is a high standard.

Technology and Digital Services

The Technology and Digital Services business unit delivers technology and digital services to the Ministry and the health and disability sector. It also plays an important role in assessing the potential impact of existing and emerging health technology. The business unit works closely with the Strategy and Policy business unit, the Chief Medical Officer and the Chief Nursing Officer to develop and implement the technology and digital strategy for the health and disability sector.

Finance and Performance

The Finance and Performance business unit is the authority on the health and disability system's finance, financial and non-financial performance and risk. It is also responsible for managing and delivering the Ministry's finance functions, payments to the health and disability sector and an enterprise portfolio management office. The Finance and Performance business unit works closely with the Service Commissioning business unit supporting and advising the commissioning of services.

People and Transformation

The People and Transformation business unit is responsible for the sector workforce through Health Workforce New Zealand and managing and delivering the Ministry's human resources and internal organisational strategy. The unit is also the business owner for the Ministry's in-house information technology strategy and leads the Ministry's change programme and operating model.

Office of the Director-General

The Office of the Director-General of Health is responsible for government and ministerial services, internal and external communications, assurance and risk management as well as support to the Director-General of Health, Ministers and the Executive Leadership Team. The office also supports the Chief Science Officer.

Māori Leadership

Māori Leadership is a strategic role that leads the Ministry and sector in reducing Māori health inequalities. It is the pou tokomanawa (backbone) for the Ministry and health and disability sector in their efforts to promote, protect and partner with Māori. Māori Leadership has strong relationships within the health and disability sector, government agencies and with iwi Māori. Ministry business units support Māori Leadership and are jointly responsible for improving Māori health outcomes and reducing inequalities.

Chief Nursing Officer

The Chief Nursing Officer is the point of contact for clinical leadership and advice to the Ministry, Ministers and health and disability sector. The role supports professional development within the Ministry and the nursing workforce. The Chief Nursing Officer works in partnership with the Chief Medical Officer, DHBs and clinicians.

Chief Medical Officer

The Chief Medical Officer supports clinical leadership across the health and disability system and provides clinical advice to inform health policy and delivery. The role leads engagement with the medical profession and maintains links between New Zealand and the international medical community for the purpose of benchmarking New Zealand practice against international standards and ensuring that New Zealand medical practice is abreast of international developments. The Chief Medical Officer works in partnership with the Chief Nursing Officer, DHBs and clinicians.

Critical Projects

Critical Projects oversees and manages critical priority projects on behalf of the Director-General of Health. Critical Projects has been established for a fixed-term of 2 years

Statutory positions

Director-General of Health

The Director-General of Health is the Chief Executive of the Ministry and, like most public service chief executives, is appointed on a fixed-term contract by the State Services Commissioner under the State Sector Act 1988. In addition to responsibilities in the State Sector Act, the Director-General has a number of other statutory powers and responsibilities under various pieces of health legislation. These include:

- powers relating to the appointment and direction of statutory public health officers, oversight of the public health functions of local government and authorising the use of special powers for infectious disease control under the Health Act 1956
- certifying providers under the Health and Disability Services (Safety) Act 2001
- issuing guidelines under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 and other Acts.

Director of Mental Health

The positions of Director and Deputy Director of Mental Health are both provided for in the Mental Health (Compulsory Assessment and Treatment) Act 1992. The Director of Mental Health is responsible for the general administration of the Act under the direction of the Minister and Director-General. The Director is also the Chief Advisor of Mental Health and is responsible for advising the Minister on mental health issues.

The Director's functions and powers under the Act allow the Ministry to provide guidance to mental health services, supporting the strategic direction provided in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*⁴³⁵ and a recovery-based approach to mental health.

Director of Public Health

The Director of Public Health position is provided for in the Health Act 1956. The Director of Public Health has the authority to independently advise the Director-General and Minister on any matter relating to public health. The Director also provides national public health professional leadership and professional support and oversight for district medical officers of health.

Chief Financial Officer

The Public Finance Act 1989 requires all departments to have a chief financial officer responsible for the quality and completeness of the department's statement of intent and annual accounts. The Chief Financial Officer ensures that internal controls are effective and efficient and heads the Finance and Performance business unit.

Clinical leadership within the Ministry

The Ministry employs health practitioners from a variety of backgrounds in a range of clinical leadership roles. These staff provide clinical expertise and sector leadership and engagement and manage clinical areas of the Ministry's work programme. The Ministry's clinical leadership is jointly led by the Chief Medical Officer and the Chief Nursing Officer.

435 <https://www.mentalhealth.org.nz/assets/ResourceFinder/rising-to-the-challenge-mental-health-addiction-service-development-plan.pdf>

This clinical leadership:

- provides strategic, clinical leadership across the health and disability system
- leads engagement with the medical profession and organisations
- provides clinical advice and input across the Ministry to help inform policy, programme development and legislative administration and to plan, fund and monitor health service delivery
- maintain links between New Zealand and the international medical community for the purpose of benchmarking New Zealand practice against international standards and ensuring that New Zealand medical practice is abreast of international developments.

District health boards

There are currently 20 district health boards (DHBs) in New Zealand. DHBs are responsible for implementing the health policies of the government and for providing or funding the provision of health services in their districts. DHBs fund primary health organisations to provide essential primary health care services to their populations. Public hospitals are owned and funded by DHBs.

The New Zealand Public Health and Disability Act 2000 created DHBs and sets out their objectives, which include:

- improving, promoting and protecting the health of people and communities
- promoting the integration of health services, especially primary and secondary care services

DHBs are responsible for implementing the health policies of the government and for providing or funding the provision of health services in their districts. DHBs fund primary health organisations to provide essential primary health care services to their populations.

- seeking the optimum arrangement for the most effective and efficient delivery of health services in order to meet local, regional and national needs
- promoting effective care or support of those in need of personal health services or disability support.

Other DHB objectives include:

- promoting the inclusion and participation in society and the independence of people with disabilities
- reducing – with a view to eliminating – health disparities by improving health outcomes for Māori and other population groups.

DHBs are required to plan and deliver services regionally as well as in their own individual districts. To do this, DHBs are generally grouped into four regions. The DHBs of each region work together in order to find new and better ways of organising, funding, delivering and continuously improving health services to the people in their wider community. Agreed regional actions are approved by the Minister as part of a regional services plan.

The four regions are:

- Northern – Northland, Waitemata, Auckland and Counties Manukau DHBs
- Midland – Waikato, Lakes, Bay of Plenty, Tairāwhiti and Taranaki DHBs
- Central – Hawke's Bay, Whanganui, MidCentral, Hutt Valley, Capital & Coast and Wairarapa DHBs
- South Island – Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs.

DHB appointments

For each of the 20 DHB boards, seven members are elected by the community every 3 years (concurrently with local elections), and up to four members are appointed by the Minister. The Minister also appoints each board's chair and deputy chair from among the elected and appointed members. Should a vacancy arise, regardless of whether it is an elected or appointed position, the Minister can fill that vacancy at any time.

Members typically hold office for a 3-year term. All appointed members can be reappointed to the DHB at the end of their term, up to a maximum of 9 consecutive years. Elected members can be re-elected indefinitely.

At present, a number of DHB board positions are held jointly. Such cross-appointments are made to foster greater collaboration between DHBs. For example, there is a consistent chair across Auckland, Waitemata and Counties Manukau DHBs and also across Hutt Valley and Capital & Coast DHBs.

The Minister may appoint a Crown monitor or monitors to sit on a DHB's board if the Minister considers it desirable to do so to improve that DHB's performance. The Minister may also dismiss a DHB board and replace it with a commissioner if the Minister is seriously dissatisfied with that board's performance.

Funding and services

DHBs exist within a funding environment where:

- there is a mix of funding models (capitation, fee-for-service, pay-for-performance and individualised funding) and a range of financial and non-financial incentives – the Ministry also contracts directly with providers of some services, such as disability support and some maternity services
- a population-based funding formula determines the share of funding to be allocated to each DHB, based on the population living in the district – the formula includes adjustors for population age, sex, relative measures of deprivation status and ethnicity
- DHBs are responsible for making decisions on the mix, level and quality of health and disability services within the parameters of national strategies and nationwide minimum service coverage and safety standards
- the Ministry, as the Minister's agent, defines nationwide service coverage, safety standards and the operating environment – the Minister enters into funding agreements with DHBs and may exercise reserve powers in the case of repeated performance failure (such as appointing a Crown monitor to the DHB board or dismissing the DHB board).

DHBs may provide services directly or contract with third parties. A DHB may also purchase certain specified services for their population from another DHB using a system known as 'inter-district flows'. Where these services are provided by another DHB, a national agreed price is generally used or DHBs may agree on local arrangements between themselves. DHBs pay an additional lump sum to the tertiary hospitals to compensate them for the higher costs of maintaining specialist tertiary capability and access.

Accountability

As Crown agents, DHBs are accountable to the government through the Minister. The accountability documents that guide DHBs' planning and performance can be broadly split into three groups: government expectations, planning documents and accountability documents.

Government expectations

The following documents set out the policies of the government of the day and the role DHBs are expected to play in implementing these policies.

- **Annual letter of expectations:** The Minister provides a letter of expectations to all DHBs and their subsidiaries annually. This letter sets out the strategic priorities of the government for the health and disability system. DHBs use this as a focus when they produce their annual plan, regional services plan, statement of intent and statement of performance expectations.
- **Enduring letter of expectations:** The Minister of Finance and the Minister of State Services issue an enduring letter of expectations periodically to all Crown entities (including DHBs). This letter sets out more general expectations, including the need to achieve value for money and for strong entity performance.

Planning documents

The following documents set out the short-term course DHBs intend to follow to best meet the health needs of their populations.

- **Annual plan:** Each DHB agrees with the Minister on an annual plan. This plan sets out the best way of delivering health services locally, regionally and nationally and how this can be provided in a financially responsible manner and in line with the DHB's role and functions.

- **Regional services plan:** The regional services plan identifies a set of goals for a particular region and sets out how these goals will be achieved. Collaborating regionally has the potential to increase efficiency and provide a better standard of care across a greater area than if each DHB were to act alone. The Minister approves the regional services plan, and regions regularly report on their plan.
- **Māori health plan:** Māori health plans provide a summary of the health needs of a DHB's Māori population and set out the DHB's plan to meet these needs in order to reduce the health disparities between Māori and non-Māori. The plan is finalised by agreement between the DHB and the Ministry.

Accountability documents

The following documents allow Parliament and the public to measure the performance of DHBs and to hold them accountable.

- **Statement of intent:** Each DHB is required to publish a statement of intent (SOI) once every 3 years setting out the high-level objectives and strategic focus for the next 4 financial years (for example, an SOI published in the 2014/15 financial year will also cover 2015/16, 2016/17 and 2017/18). The DHB board prepares the SOI, with comment from the Minister. Once the board signs it off, the Minister tables the SOI in Parliament.
- **Statement of performance expectations:** DHBs include, as a component of the annual plan, a statement of performance expectations (SPE) containing the forecast financial statements for the current year. This document also sets out non-financial performance measures against which the DHB's performance can be assessed. The DHB board prepares the SPE, with comment from the Minister. Once the board signs it off, the Minister tables the SPE in Parliament.

- **Crown funding agreements:** Crown funding agreements (CFAs) are made between DHBs and the Minister. These set out the public funding the DHB will receive in return for providing services to its resident population. These agreements can also set out accountability requirements. CFA variations recognise changes in funding responsibilities for services or reporting requirements. The CFA variation process has four ‘omnibus’ rounds in the financial year. The execution date is the date on which the variation has been signed by both parties (the DHB’s chief executive and the Director-General of Health).
- **Operational policy framework:** The operational policy framework is a set of business rules, policies and guideline principles that outline the operating functions of DHBs. The operational policy framework is incorporated as part of the CFA.
- **Annual report:** DHBs are required to report on their performance for the year against the measures set out in their SPE and their current SOI. Other information must be included in an annual report, such as:
 - › a statement of service performance
 - › an annual financial statement for the DHB
 - › any direction given to the DHB by the Minister
 - › the amount of remuneration paid to DHB board members and employees in the year
 - › an audit report produced on behalf of the Auditor-General.

Annual reports must be signed off by two board members and provided to the Minister within 15 working days of the DHB receiving the audit report.

- **Quality accounts:** Quality accounts are a means by which health care providers account for the quality of the services they deliver, just as financial accounts show how an organisation uses its money. Quality accounts are produced annually by DHBs with guidance from the Health Quality & Safety Commission.

Performance

In addition to performance reported on in accountability documents, DHBs' progress towards achieving financial and non-financial performance targets is reported throughout the year.

The Ministry uses a monitoring and intervention framework that allows it to influence DHB performance through increasingly intensive levels of monitoring and, where necessary, intervention to ensure that issues relating to poor performance are addressed.

Financial performance

DHBs provide financial data from financial templates after the end of each month. The information is analysed, and net results by DHB against plan are reported to the Minister. Following this, a further report presents an overview of the DHB sector as a whole (highlighting where the sector or an individual DHB reports a significant variance against plan or against comparable performance within the sector). Interpretation of the data provided by DHBs enables areas of financial pressure and risks as well as best practice within the DHB sector.

Non-financial performance

Health targets

Health targets are a set of national performance measures designed to improve the performance of health services that reflect significant public and government priorities.

There are currently six health targets: three focus on patient access (shorter stays in emergency departments, improved access to elective surgery and shorter waits for cancer treatment), and three focus on prevention (increased immunisation, better help for smokers to quit and raising healthy kids). The health targets are reviewed annually to ensure they align with current health priorities, and performance is publicly reported on a quarterly basis.⁴³⁶

Patient experience survey

DHBs are expected to survey adult inpatients (aged 15 and older) on the experience of the care they received at least quarterly. The patient experience survey enables patients to provide feedback that can be used to monitor and improve the quality and safety of health services. Capturing, understanding and acting on patient experiences in a timely manner provides a vital contribution to improving health service delivery and to prioritising attention and resources.⁴³⁷

New Zealand Health Strategy

In April 2016, the Minister of Health, Hon Dr Jonathan Coleman, released a refreshed New Zealand Health Strategy.⁴³⁸

The strategy sets the framework for the health system to address the pressures and significant demands on its services and on the health budget. As the first refresh of this country's health strategy since 2000, it sets the direction New Zealand's health and disability system needs to take into the future.

436 The current health targets and DHBs' results are on the Ministry's website – www.health.govt.nz/new-zealand-health-system/health-targets

437 Information about patient experience and current survey results are on the Health Quality & Safety Commission's website – <http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/health-quality-and-safety-indicators/patient-experience/>

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

Central to the strategy is the idea of all New Zealanders living well, staying well and getting well. This highlights the need for:

- a shift from treatment to prevention, improving people's lives and supporting greater financial sustainability
- overcoming the inequities in the health system so that it works for every New Zealander
- a deep understanding of what it's like to use the health system – so that services are customer-friendly and barriers to equity can be removed
- the Ministry, health providers, other government agencies, NGOs and communities working better together in recognition that a range of factors affect a person's health and wellbeing.

The health strategy has five strategic themes that summarise the overall thinking (see Figure 6 on the next page):

- **People-powered** – providing services in different ways that reflect the varying needs of our diverse communities and providing information that helps people take control of their health and wellbeing.
- **Closer to home** – making it easier for people to access health services and working with local communities to provide tailored support on the ground.
- **Value and high performance** – making better use of data to understand all the factors that affect health outcomes and putting resources in the places they will make the most difference.
- **One team** – government agencies, health care providers, NGOs, experts, analysts and communities working together, designing and delivering services and support in a coordinated way.
- **Smart system** – using technology to improve services and make it easier to share information across the health system.

Figure 6. Five strategic themes of the New Zealand Health Strategy.



CHAPTER 28

The role of the Health and Disability Commissioner and the Code of Rights

Anthony Hill has been New Zealand's Health and Disability Commissioner since July 2010.

Cite this as Hill A. The role of the Health and Disability Commissioner and the Code of Rights. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	417
The Code of Rights	419
Complaints resolution	421
› No further action	422
› Provider resolution	425
› Mediation	426
› Investigations	428
Relationships with other organisations	429
› Nationwide Health and Disability Advocacy Service	430
Options where there is a breach of the Code of Rights	431
› Proceedings	437
› The Human Rights Review Tribunal	438
Conclusion	439

Introduction

The role of the Health and Disability Commissioner is to:

- promote and protect the rights of consumers who use health and disability services
- facilitate the fair, simple, speedy and efficient resolution of complaints relating to infringement of those rights.

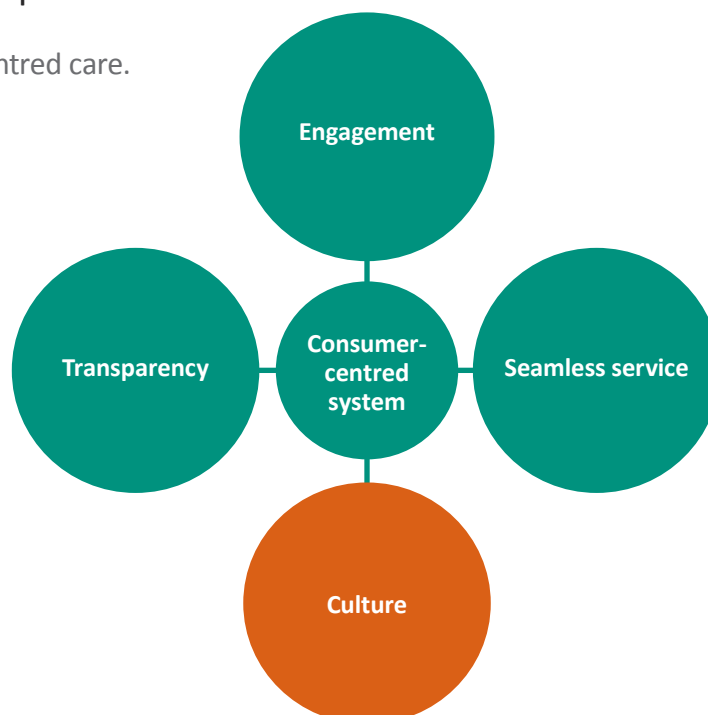
The Commissioner also has responsibility for monitoring mental health and addiction services and advocating for improvements to those services. This function is delegated to the Mental Health Commissioner.

HDC supports the provision of consumer-centred health and disability services. Consumer-centred care (see Figure 7) involves:

- sharing information and understanding
- engagement between provider and consumer
- quality and continuity of care
- an open environment.

This is underpinned by respect for the consumer and the consumer's culture, values and preferences.

Figure 7. Consumer-centred care.



Culture – ‘the way we do things around here’ – is critical and should involve the whole team caring for the consumer. Staff may have concerns about a consumer’s presentation, but if the organisational culture does not encourage and support junior staff raising concerns, the consumer’s management may not be questioned and concerns about the care being provided may not be escalated to senior staff. DHBs and senior practitioners need to encourage a culture where it is acceptable and even commonplace for questions to be asked to and from any point in the hierarchy at any time.

This issue arose in a case (14HDC01187) where DHB staff inappropriately discharged a 2-year-old child home on her second visit to the emergency department without first taking sufficient steps to consider her history and investigate the cause of her presenting symptoms. The house officer and a nurse were concerned about the child but felt unable to successfully advocate on her behalf. It was found that the DHB failed to encourage an organisational culture where staff felt comfortable questioning or challenging decisions, and it lacked a multi-disciplinary approach to the girl’s care.

The Commissioner aims to achieve resolution of complaints as well as safety and quality improvement through targeted recommendations leading to systems changes both within organisations and the wider health and disability sectors. A key aspect of successful resolution involves ensuring that the provider, the organisation and the system identify what went wrong and successfully learn from the case and that the system is strengthened as a result.

The Code of Rights

The Code of Health and Disability Services Consumers' Rights confers legal rights on those who use health and disability services in New Zealand (consumers) and places corresponding responsibilities on providers of those services.

The Code of Rights became law on 1 July 1996 as a regulation under the Health and Disability Commissioner Act 1994 (HDC Act).

Application of the Code of Rights is very wide and includes public and private services, paid and unpaid services, hospitals and individuals. The Code of Rights covers all registered health professionals, such as doctors, nurses and dentists, and also unregulated providers such as naturopaths and caregivers. The Commissioner can consider systems issues as well as individual actions.

The Code of Rights does not override duties or obligations established in other legislation. For example, confidentiality of information about a consumer is affirmed in separate privacy legislation (see [Chapter 6 – The purpose of medical records and notes](#)).

Further, the Code of Rights does not extend to funding decisions or confer entitlement to any particular service, nor are the rights absolute. It is a defence for a provider to show that they took 'reasonable actions in the circumstances to give effect to the rights, and comply with the duties in [the] Code'. The circumstances are defined to include the consumer's clinical circumstances, the provider's resource constraints and any other relevant circumstances.

The Code of Health and Disability Services Consumers' Rights confers legal rights on those who use health and disability services in New Zealand (consumers) and places corresponding responsibilities on providers of those services.

In summary, there are 10 rights:

1. Consumers should always be treated with respect.
2. Consumers have the right to be free from discrimination, coercion, harassment and exploitation.
3. Consumers have the right to dignity and independence.
4. Consumers should be provided with services of an appropriate standard.
5. Consumers have a right to effective communication in a form, language and manner that they can understand. The environment should enable open, honest and effective communication. This may require the services of an interpreter.
6. Consumers should receive the information that a reasonable consumer, in that consumer's circumstances, would expect to receive. That information includes an explanation of their condition, the options available, including an assessment of the expected risks, side effects, benefits and costs, and have any questions answered honestly. Consumers should be notified of any proposed participation in teaching and research and the results of tests and procedures.
7. Consumers have the right to make informed choices and give informed consent. They have the right to refuse services and withdraw consent.
8. Consumers have a right to have support person with them unless that affects safety or infringes another consumer's rights.
9. The Code rights apply if consumers are involved in research or teaching.
10. Consumers have a right to complain about a provider. The provider must facilitate the fair, simple and speedy resolution of complaints.

All doctors should be familiar with the Code of Rights and should take action to inform consumers about the rights in the Code of Rights and enable consumers to exercise their rights. Copies of the Code of Rights, as well as other educational materials, can be obtained from the Commissioner's website (www.hdc.org.nz) or by phoning 0800 11 22 33.

Complaints resolution

Any person (including the consumer, a family member or even another provider) may complain to the Commissioner alleging that any action of a provider is or appears to be in breach of the Code of Rights. Complaints made to an advocate that remain unresolved after advocacy assistance must be referred to the Commissioner. If the Medical Council receives a complaint about patient care, it must refer the complaint to the Commissioner in the first instance. The Commissioner is responsible for ensuring that each complaint about health care and disability services providers is dealt with appropriately.

Any person (including the consumer, a family member or even another provider) may complain to the Commissioner alleging that any action of a provider is or appears to be in breach of the Code of Rights.

On receipt of a complaint, the Commissioner is required to make a preliminary assessment of the complaint to decide what course of action, if any, is appropriate. The Commissioner may, among other things:

- refer the complaint to another agency or person, including a regulatory authority such as the Medical Council – complaints may also be referred to ACC, the Director-General of Health or the provider

- refer the complaint to an advocate
- call a mediation conference
- formally investigate the complaint
- take no action on the complaint.

The HDC Act supports resolution of complaints at the lowest appropriate level.

In the 2015/16 financial year, around 52 percent of the complaints HDC received were about doctors. Recurring themes in those complaints were failures to get the basics right, such as:

- reading the notes
- asking the questions
- talking with the patient
- listening to the patient and the patient's family
- ensuring continuity of care
- taking responsibility.

No further action

At any time after completing a preliminary assessment of a complaint, the Commissioner may, at their discretion, decide to take no action on a complaint if the Commissioner considers that any action is unnecessary or inappropriate. This may occur where, for example:

- the length of time that has elapsed between the incident and the making of the complaint is such that an investigation is no longer practicable or desirable
- the subject matter of the complaint is trivial
- the complaint is frivolous or vexatious

- the consumer does not want action to be taken
- there is an adequate remedy that it would be reasonable for the complainant to exercise
- the matter has been comprehensively reviewed, any recommendations of the review have been implemented and an HDC investigation is unlikely to shed further light on the matter.

In some circumstances, the Commissioner may decide to take no further action but will make recommendations for improvement to systems and practices. HDC will then follow up the recommendations to ensure any changes are appropriately implemented. In cases where the wider health sector may benefit from the learnings revealed by the assessment of the complaint, the Commissioner may publish an anonymised case note on the HDC website.

Case study

Parents complained about the care provided to their 8-year-old son when he died following an anaphylactic reaction to nuts. In particular, they were concerned with the quality of information provided by a paediatrician about his nut allergy, resulting reactions, and links between asthma and nut allergy. They were also concerned about the lack of planned follow-up or review when their son was discharged from paediatric overview.

The parents were concerned that their son's GP did not adequately review or update the management of their son's nut allergies or take the allergy into account when considering treatment for asthma.

The parents also complained that the health authorities did not provide national standards or consistent national delivery of advice and treatment on food allergies.

They were concerned about the availability of immunology services and direct links between paediatricians and immunologists. The parents considered that advice on when to prescribe and administer adrenaline auto-injectors was unclear and inconsistent across the country.

The Commissioner obtained a response from the paediatrician and GP concerned. He then requested preliminary expert advice from an expert GP and an expert general paediatrician, both of whom advised that the care provided was appropriate and reasonable in the circumstances.

Overall, the Commissioner was satisfied with the clinical decisions made and the care provided by the GP and the paediatrician in respect of the boy. However, the Commissioner suggested to the GP and the paediatrician that they reflect on the expert paediatrician's comment that the boy's long-term conditions, including his nut allergy, should have been under ongoing review. He recommended that the GP and paediatrician keep abreast of ongoing developments in this field, including the issue of health professionals working more closely together with families to ensure quality and continuity of services and cooperative monitoring of long-term conditions.

The Commissioner published a case study on the HDC website for educational purposes, and brought the case to the attention of the Royal New Zealand College of Practitioners, the Paediatric Society, Coronial Services, the New Zealand Clinical Immunology and Allergy Group, the Ministry of Health, PHARMAC, the National Health Board and the Health Quality & Safety Commission.⁴³⁹

439 This case can be accessed in full at <http://www.hdc.org.nz/media/192449/10hdc00458casenote.pdf>

Provider resolution

Often, the quickest and most satisfactory way of dealing with complaints is for the consumer to deal directly with the provider. That is particularly so if the consumer and provider will have an ongoing relationship.

A health or disability service provider who respects, listens to and involves the consumer (and family and whānau where appropriate) is more likely to deliver a better service and be able to resolve any concerns at an early stage.

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The Code of Rights requires providers to have a complaints procedure and sets out minimum requirements for keeping consumers informed about the progress of their complaint. Consumers are entitled to the assistance of a support person or an independent advocate when making a complaint.

The Commissioner may refer a complaint to the provider for resolution if the complaint does not raise public safety issues and can be appropriately resolved by the provider. In some cases, the provider may not have been aware of the complaint and may be well motivated to resolve the complaint directly with the consumer. All referrals to a provider are accompanied by requirements to report the outcome back to the Commissioner. This enables the Commissioner to review the outcome of referrals to ensure the matter is adequately resolved, any compliance issues are addressed and independent oversight is maintained. The Commissioner may take further action if not satisfied with the reported outcome.

Case study

A pregnant woman complained about her GP. She had arranged an appointment with the GP because she was concerned about her baby and wanted to be reassured by hearing the baby's heartbeat. The GP referred the woman for a scan and asked the practice nurse to listen to the baby's heart with a Doppler monitor.

The woman waited but then it was discovered that the practice did not have a Doppler monitor. The woman felt unheard during the appointment. HDC referred the complaint to the practice for resolution. The practice reviewed the care provided and made a number of changes, including the orientation of new doctors to ensure that they are aware of the practice's systems, resources and equipment and provided training for all staff on addressing the emotional needs of patients as well as their presenting issue.

Mediation

The Commissioner may call a mediation conference at any stage. Mediation can be a very effective way of resolving complaints and provides an opportunity for the parties to agree to a fair outcome with minimum delay and cost.

The parties meet across the table, with or without support persons, to discuss their concerns. Although the parties may have a lawyer present, this is not necessary. An impartial mediator assists the parties to define the issues in dispute, explore options for resolution of the complaint and find their own solutions to the dispute. All statements made during mediation are confidential and, if a deed of settlement is signed, it is a full and final settlement of the issue.

If a complaint is not resolved during the mediation, the Commissioner will decide what, if any, further action to take.

Case study

Mr E was admitted to a hospital emergency department after injuring himself in a car accident that morning. On assessment, his main complaint was abdominal and back pain. X-rays of his back and neck showed no fractures, and he was discharged around 5pm. Mr E's condition deteriorated, and he was readmitted to the emergency department at 10pm with pain in the kidney region and symptoms of shock. He was reassessed and discharged home with pain relief and treatment for a urinary tract infection. Four days later he deteriorated markedly, with disorientation, increased abdominal and back pain and weakening of his legs. He was admitted to intensive care and received treatment for a contusion of the small bowel. Mr E continued to complain of intermittent back pain, but another X-ray showed no fracture. However, a further X-ray and CT imaging taken a few days later indicated a fractured spine. Mr E experienced increasing heaviness in his legs and subsequently developed paraplegia.

This serious complaint concerned the standard of care Mr E received at the hospital. The primary issue was the failure of hospital medical staff to diagnose the fracture, which left Mr E paralysed. The complaint also concerned pain management, nursing care and communication.

The Commissioner commenced an investigation and, after reviewing the hospital's response, referred the matter for expert orthopaedic advice. The adviser considered that, overall, the care Mr E received was satisfactory. Mr E's fracture was not displaced at the time of initial X-ray investigation and was therefore hidden from view. The adviser stated that this was an exceptionally complex case and that Mr E had received good management and well-documented, compassionate care.

In light of the expert clinical advice and the unresolved communication concerns, the matter was considered appropriate for mediation. As Mr E's family was Māori, the Commissioner engaged a Māori mediator with knowledge of cultural issues.

The family and the DHB were provided with a copy of the expert advice prior to the mediation conference to guide them in their discussions.

The mediation conference resulted in a successful outcome. This included a written apology by the DHB to Mr E and his whānau, as well as the instigation of a process to restore his mana. In its letter of apology, the DHB commented that the mediation was a learning experience for all involved and that the knowledge gained would be applied for the benefit of all patients.

Investigations

Some complaints, for example, those involving allegations of serious professional misconduct, sexual impropriety, complex systems issues or public safety issues, are not appropriate for low-level resolution and proceed to a formal investigation. The Commissioner may commence an investigation in response to a complaint or on the Commissioner's own initiative. The investigation process is independent and impartial.

The provider is given a copy of the letter of complaint and asked to respond to the complaint and provide information such as clinical records. The provider's response is very important in informing the Commissioner's understanding of what occurred and the Commissioner's opinion as to whether an investigation is appropriate. Where the appropriate standard of care is in issue, expert independent clinical advice from a peer of the provider is obtained to assist the Commissioner. Relevant professional groups, such as the Royal New Zealand College of General Practitioners, nominate expert advisers, and the advisers are named in the Commissioner's reports.

If the Commissioner decides to commence a formal investigation, the provider and the relevant registration authority, such as the Medical Council, are notified of the investigation.

The HDC Act gives the Commissioner wide powers to gather relevant information. This includes the ability to summon witnesses, to take evidence under oath and to require the production of relevant documents. It is an offence to obstruct or hinder the Commissioner or any other person in the exercise of their powers under the HDC Act or to give false or misleading information. Once evidence has been collected, further expert advice may be required.

Most investigations end in a written report from the Commissioner to the parties. Before forming a final opinion, the Commissioner sends a copy of the information gathered to the parties. If any adverse comment is proposed to be made about a person, that person is given an opportunity to respond to the adverse comment prior to the report being finalised. The Commissioner considers the responses to the provisional report and sometimes seeks further expert advice before issuing a final report. The reports are usually published in a partially anonymised form on the HDC website.

An investigation can be a lengthy process, depending on the complexity of the issues under consideration and the number of people involved.

Relationships with other organisations

Complaints may be referred to other agencies or persons involved in the health and disability sector. For example, a complaint of a breach of patient confidentiality will be referred to the Privacy Commissioner, and a complaint of discrimination will usually be referred to the Human Rights Commission. Concerns about the conduct or competence of a registered health practitioner may be referred to the appropriate registration authority, such as the Medical Council.

Working with other agencies is an important part of promoting and protecting the rights of consumers. Where necessary, the Commissioner shares information with a number of other agencies and persons so that relevant information can be analysed and acted upon to identify public safety concerns and so that duplication can be minimised.

The Commissioner has wide discretion to refer a matter to an appropriate person or authority. For example, concerns about inappropriate prescribing may be referred to Medsafe.

The Commissioner must inform the appropriate authority or person if the Commissioner becomes aware that the practice or systems of a health care provider may pose a risk of harm to the public.

Nationwide Health and Disability Advocacy Service

A free independent advocacy service (the Nationwide Health and Disability Advocacy Service)⁴⁴⁰ is available throughout New Zealand. Advocates promote awareness of the Code of Rights and the HDC Act through networking and free education sessions to consumers and providers. They support and guide consumers to resolve complaints directly with providers at an early stage and encourage self-advocacy as well as providing more support as needed.

Advocates do not make decisions on whether there has been a breach of the Code of Rights. Rather, their role is to give consumers information about their rights and to support them to make decisions and take action to attempt to resolve the complaint. Most complaints that advocates handle are received directly rather than via the Commissioner, but in some cases, the Commissioner may decide that a complaint made to the Commissioner's office should be referred to an advocate to enable the parties to resolve the matter.

440 The Advocacy Service is provided by an independent charitable trust, the National Advocacy Trust, through a contractual arrangement with the Director of Advocacy at HDC. The Advocacy Service can be contacted by freephone on 0800 555 050, free fax on 0800 2787 7678 or at advocacy@advocacy.org.nz.

The majority of complaints referred to advocacy are successfully resolved, sometimes with face-to-face meetings with providers. Advocates must report back to the Commissioner with the results of a referral to advocacy and may also report on any matter concerning the rights of consumers that they consider should be brought to the Commissioner's attention.

Case study

A woman complained about communication from a fertility services provider. She had received conflicting advice about the waiting time for services. She complained to HDC but subsequently indicated her willingness to use the Advocacy Service. Given this, the nature of the issues complained about and the need for an ongoing relationship, HDC made a formal referral to advocacy. A teleconference was held with the woman and the provider during which the provider heard her concerns and agreed to a range of actions including provision of better information to consumers, reviewing ways of ensuring consumers received better information about waiting times and appointing a key person for each consumer to deal with.

Options where there is a breach of the Code of Rights

Where an investigation reveals a breach of the Code of Rights, the Commissioner has a number of options. Usually, the Commissioner's final report makes recommendations to improve systems or practices and help ensure that a situation similar to that which led to the breach of the Code of Rights does not recur. For example, the Commissioner may recommend that the provider offer the consumer a written apology, review their practice in the light of the Commissioner's report, undertake further education or implement appropriate systems to prevent a recurrence.

The Commissioner cannot order compensation but occasionally may recommend that the provider refund money paid for substandard services.

The Commissioner's opinion is reported to the provider's relevant registration authority, and in the case of a doctor, the Medical Council may be asked to consider the need for a competence review. Copies of the report may also be sent to the Minister of Health, funders or any other appropriate agency to enable them to take further action if necessary.

Reports with significant educational value are distributed to the appropriate colleges and posted on the Commissioner's website in a partially anonymised form. The Commissioner is empowered to name providers publicly. While the Commissioner will usually name group providers such as a DHB or a rest home, individual providers are only named in exceptional circumstances (for example, where the provider poses a risk of harm to the public). The Commissioner's naming policy can be accessed at www.hdc.org.nz.

The Commissioner uses individual complaints to promote wider systemic improvements. For example, in the cases below, the Commissioner made sector-wide recommendations.

Case study

A 77-year-old man presented to an emergency department (ED) of a regional hospital after suffering an ischaemic stroke. A decision was made by a house officer, in consultation with the consultant on call, that the man was an appropriate candidate for thrombolysis.

Thrombolysis is the breakdown of blood clots using types of drugs called tissue plasminogen activator (tPA) drugs and can be used in patients who have suffered an ischaemic stroke or a heart attack. There are a number of risks associated with thrombolysis, including intracerebral haemorrhage (bleeding in the brain).

The man consented to receiving thrombolysis, and the house officer decided to prescribe tenecteplase rather than alteplase. Tenecteplase and alteplase are both tPA drugs, but in New Zealand, tenecteplase is used for treatment of a heart attack (myocardial infarction) rather than ischaemic stroke. The house officer prescribed tenecteplase because she understood from nursing staff that there was no alteplase available at the hospital and was aware of studies that supported the use of tenecteplase in stroke.

Although it was usual practice for stroke thrombolysis to be administered in the intensive care unit (ICU), the house officer decided to treat the man in the ED. The house officer followed the New Zealand Formulary guidelines for the use of tenecteplase in heart attack. In doing so, she prescribed at least twice the dose of tenecteplase recommended for treatment of ischaemic stroke. In addition, the house officer prescribed tenecteplase to be administered as a 10 percent bolus with the remainder to be administered as an infusion over 1 hour (the correct mode of administration for alteplase), whereas tenecteplase should be given as a single bolus (all at once). The house officer did not discuss her prescription of tenecteplase or the fact that the drug was administered in the ED rather than the ICU with the consultant on call.

Partway through the administration of tenecteplase, the house officer was informed that alteplase was available at the hospital in the ICU. She telephoned the consultant on call for advice about whether or not to continue the infusion, and the consultant advised that the infusion should continue. Following the infusion of tenecteplase, the man initially showed signs of improvement, but a computed tomography (CT) scan showed that he had suffered a brain bleed (intracerebral haemorrhage). The man died a few days later.

The DHB's relevant policy (titled 'the Stroke Pathway') referred to alteplase in some places but did not explicitly specify alteplase as the tPA drug to be used in the case of stroke thrombolysis. There was also confusion amongst nursing staff about the correct process for administering thrombolysis, and the house officer had not been oriented to 'the Stroke Pathway' adequately.

It was held that the house officer breached Right 4(1) in failing to transfer the man to the ICU, in deciding to prescribe tenecteplase at the dose and via the mode of administration that she did and in failing to consult the consultant on call about the use of tenecteplase.

It was also held that the DHB breached Right 4(1) in failing to ensure its staff had the right tools, including adequate policies and training, to provide stroke thrombolysis safely.

Adverse comment was made about the consultant on call as she did not appear to have provided the man or his wife with a timely and clear explanation of what had occurred. Open disclosure about the error and its potential consequences needed to occur either to the man if he was competent or to another appropriate person, in this case, his wife.

As this was the second similar case about stroke thrombolysis, the Commissioner recommended to the National DHB Chief Medical Officers Group that it take steps to ensure that all DHBs' policies/guidelines in relation to stroke thrombolysis are clear and consistent, including in relation to the appropriate medication, dose and mode of administration and the level of supervision required, and report back to HDC. As a result, the CMO Group coordinated an approach to the National Stroke Network outlining a number of steps to further improve the safety and quality of services provided to stroke patients and, in particular, stroke thrombolysis.

Case study

A 27-year-old woman, pregnant with her first baby, booked a registered midwife as her lead maternity carer (LMC). The woman's body mass index (BMI) was high (44.6). The Ministry of Health (2012) Guidelines for Consultation with Obstetric and Related Medical Services (the Referral Guidelines)⁴⁴¹ require that, if the mother's BMI is above 40, the LMC must recommend to the woman that the responsibility for her care be transferred to a specialist. The LMC did not discuss this recommendation with the woman during her pregnancy or refer the woman to the obstetric team for specialist review.

The woman began experiencing back pain and then regular contraction pains. She sent two text messages and had two telephone conversations with her LMC that afternoon about the pains and one telephone conversation with the back-up midwife overnight, during which the woman was advised to stay at home. The woman's membranes ruptured spontaneously at 7am, and she was told to go to the hospital. On arrival, the woman was assessed as being 8cm dilated, and CTG monitoring was carried out for about 30 minutes. The CTG was non-reassuring. The LMC discontinued the CTG monitoring so that the woman could go to the toilet and did not recommence it.

441 <https://www.health.govt.nz/system/files/documents/publications/referral-guidelines-jan12.pdf>

When the LMC next tried to listen to the foetal heart rate (FHR) about 90 minutes later, she was unable to detect it and the baby was subsequently stillborn. A post mortem showed that the baby died as a result of infection with Group B streptococcus.

It was held that the LMC failed to provide adequate care to the woman in a number of regards as follows:

- The woman had clear risk factors. The LMC should have recommended to the woman that the responsibility for her care be transferred to a specialist at an early stage of her pregnancy, as required by the Referral Guidelines.
- The LMC did not document telephone assessments, including whether or not the baby was active, and the advice given.
- The LMC did not follow the RANZCOG Intrapartum Fetal Surveillance Clinical Guideline⁴⁴² and the DHB policy, which both recommend continuous FHR monitoring in labour when a woman has a high BMI. In addition, even if the LMC did not consider that a CTG was warranted, she failed to auscultate the FHR every 15 to 30 minutes, which the RANZCOG Guideline recommends as the minimum foetal assessment required for any woman at this stage of labour.

The LMC failed to provide services to the woman with reasonable care and skill and breached Right 4(1). By not recommending to the woman that the responsibility for her care be transferred to a specialist, the LMC failed to provide the woman with essential information that a reasonable consumer in the woman's circumstances would expect to receive, also breaching Right 6(1).

442 https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women's%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Intrapartum-Fetal-Surveillance-Guideline-Third-edition-Aug-2014.pdf?ext=.pdf

The Commissioner referred the LMC to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken and recommended that the LMC provide a written apology to the woman. The Director of Proceedings did not institute proceedings as the matter was resolved by way of a negotiated agreement.

The Commissioner recommended that the DHB provide an update to HDC on the implementation of the recommendations made in its root cause analysis report.

The Commissioner noted that, should the LMC wish to return to midwifery practice, the Midwifery Council of New Zealand would undertake a review of the LMC's competence prior to issuing a practising certificate. The Commissioner supported this approach.

Subsequently, the Commissioner recommended that the Midwifery Council of New Zealand reinforce to all midwives the importance of consistently and appropriately applying the Referral Guidelines. The Council has since published a reminder to all midwives.

Proceedings

Following a finding of a breach of the Code of Rights, the Commissioner may refer a provider to the independent Director of Proceedings to decide whether legal proceedings will be issued against that provider. Before referring a provider, the Commissioner must give the provider an opportunity to comment on the proposed referral. The Commissioner must also have regard to the wishes of the consumer and complainant and the public interest (including any public health or safety issues).

Following a finding of a breach of the Code of Rights, the Commissioner may refer a provider to the independent Director of Proceedings to decide whether legal proceedings will be issued against that provider

The Director of Proceedings may take proceedings before the Human Rights Review Tribunal and/or the Health Practitioners Disciplinary Tribunal or may decide to take no further action. An aggrieved person may themselves bring proceedings before the Human Rights Review Tribunal where the Commissioner, having found a breach of the Code of Rights, decides not to refer the matter to the Director of Proceedings or where the Director of Proceedings decides not to take proceedings.

The functions of the Health Practitioners Disciplinary Tribunal are outlined in [Chapter 24 – The complaints and disciplinary process](#).

The Human Rights Review Tribunal

Where proceedings are brought before the Human Rights Review Tribunal, the Tribunal has the power to award a number of remedies, including:

- a declaration that the provider's action is in breach of the Code of Rights
- an order restraining the provider from continuing or repeating the breach
- an order that the provider perform any specified acts with a view to redressing any loss or damage suffered by the consumer as a result of the breach
- damages of up to \$200,000 (including damages awarded in respect of loss suffered, expenses reasonably incurred, humiliation, loss of dignity, injury to the feelings of the consumer and punitive damages for any action that was in flagrant disregard of the consumer's rights)
- any other relief the Tribunal thinks fit.

An important limitation is that, where a person has suffered personal injury covered by the Injury Prevention, Rehabilitation, and Compensation Act 2001, no damages other than punitive damages (where the provider's action was in flagrant disregard of the consumer's rights) may be awarded.

Conclusion

The Commissioner promotes resolution of individual complaints and systemic improvements in health and disability services. The Commissioner's focus is on a consumer-centred system, with particular emphasis on organisational culture.

CHAPTER 29

Medical Council of New Zealand

Philip Pigou is the CEO of the Medical Council of New Zealand.

Cite this as Pigou P. Medical Council of New Zealand.

In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	441
Protecting the public	441
Independence and accountability	442
Common misunderstandings about our role	443
Our governance	444

Introduction

Our main purpose is to promote and protect public health and safety in New Zealand. We are governed by a Council, and our funding comes from the registration and practising fees paid by all practising doctors in New Zealand.

Protecting the public

The Health Practitioners Competence Assurance Act 2003⁴⁴³ defines our role and purpose.

We are responsible for:

- registering doctors
- setting standards of clinical competence, cultural competence and ethical conduct
- promoting competence and lifelong learning for doctors
- assessing or investigating practising doctors where there are concerns about their performance, professional conduct or health.

We also:

- accredit training institutions including medical schools, colleges and DHBs
- maintain a medical register of all registered doctors (practising and non-practising)
- issue practising certificates to doctors who have maintained their competence to continue practising medicine
- set the requirements of training and education for prevocational trainees to ensure their medical education is appropriate

443 <http://www.legislation.govt.nz/act/public/2003/0048/latest/DLM203312.html>

- establish the vision, principles and policy for recertification
- require doctors to receive treatment if they are suffering from an illness that is affecting their practice
- suspend or place conditions on a doctor's practice if appropriate.

We have strong and effective legal powers that allow us to maintain the standards the public have a right to expect of doctors.

We are not here to protect or represent doctors – their interests are protected by others. Our job is to protect the health and safety of patients.

Where any doctor fails to meet our standards, we act to protect patients from harm – if necessary, by removing the doctor from the medical register and removing their right to practise medicine.

Independence and accountability

We believe patients' interests are best served by independent, open and accountable regulation.

The Medical Council must be independent of government as the dominant provider of health care in New Zealand, independent of domination by any single group and publicly open and accountable for the discharge of its functions.

Independent, open and accountable regulation must:

- put patient health and safety first
- support good medical practice

The Medical Council must be independent of government as the dominant provider of health care in New Zealand, independent of domination by any single group and publicly open and accountable for the discharge of its functions.

- promote fairness, equality and value diversity.
- respect the principles of good regulation: proportionality, consistency, openness and accountability, and agility.

Common misunderstandings about our role

Sometimes, members of the public look to us to investigate a complaint about a doctor or to take disciplinary action against a doctor. By law, we are required to refer complaints from or about health consumers to the Health and Disability Commissioner.

If the complaint relates to the conduct of a doctor, we cannot investigate the complaint while the Health and Disability Commissioner is investigating it.

If the complaint relates to a doctor's competence, we do not investigate the actual complaint but we are able to take action to assess and manage that doctor's competence in order to protect the health and safety of the public. This may be at the same time the Health and Disability Commissioner is investigating.

In either situation, competence or conduct, we can put conditions on the doctor's practice or suspend the doctor where there is a risk of serious harm to the public.

The Health and Disability Commissioner deals with complaints about a doctor from patients, their families and other support people and from third parties such as concerned staff members in a health or disability service (see [Chapter 28 – The role of the Health and Disability Commissioner and the Code of Rights](#)).

The Health Practitioners Disciplinary Tribunal determines any disciplinary action to be brought against doctors and other health practitioners (see [Chapter 24 – The complaints and disciplinary process](#)).

Our governance

We are governed by a 12-member council appointed by the Minister of Health.

The Council comprises:

- four doctors elected by the profession (who are then appointed by the Minister of Health)
- four doctors appointed directly by the Minister of Health
- four laypersons, also appointed by the Minister of Health – a layperson is someone who is not registered (or qualified to be registered) as a health practitioner.

By law, the majority of Council members must be doctors. The membership must include a minimum of three laypersons when the Council has nine or more members.

Council members are appointed for a 3-year term and can be reappointed for additional terms.

The full Council meets up to 12 times a year. However, Council committees (Audit, Education and Health Committees) may meet more (or less) frequently.

CHAPTER 30

Accident compensation

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***Cite this as Jansen P, Fernando K. Accident compensation.
In: Morris KA, editor. Cole's Medical Practice in New Zealand,
13th ed. Wellington: Medical Council of New Zealand; 2017.***

Introduction	446
Accident claims to ACC	447
Personal injury	448
Mental Injury	448
Definition of accident	449
Hearing loss	450
Complex claims	450
› Sensitive claims	451
› Work-related mental injury	452
› Treatment injuries	452
› Work-related gradual process claims	453
Lodging a claim with ACC	454
Entitlements	455
Criminal injuries and self-inflicted injuries	455
Time off work – work incapacity certificates	456
Obligations of treatment providers	457
Resources and where to go for more information	458

Introduction

The Accident Compensation Corporation (ACC) has provided comprehensive, no-fault cover for people injured from accidental causes since 1974. Levies from workers, employers, vehicle registrations and taxpayers are applied to facilitate the recovery of those injured and to fund the future needs of those injured long term.

The scheme applies to all New Zealand residents and temporary visitors to New Zealand. New Zealanders who are ordinarily resident may also be covered if they are injured while overseas. ACC, a Crown entity, administers the scheme according to the Accident Compensation Act 2001.

The right to take legal action for personal injury covered by ACC is removed other than for exemplary damages.

Once a claim is approved by ACC, the injured person may have access to a range of entitlements, from treatment and rehabilitation aids to weekly compensation and lump-sum compensation, depending on the person's injury and circumstances. The information that follows relates to current legislation and new claims. Changes to legislation since 1974 mean that the criteria for continuing cover and entitlements on existing claims may vary from that available on new claims.

The scheme applies to all New Zealand residents and temporary visitors to New Zealand. New Zealanders who are ordinarily resident may also be covered if they are injured while overseas.

Accident claims to ACC

Most of the nearly 2 million ACC claims made each year are lodged through general practitioners. Other health providers such as osteopaths, counsellors and physiotherapists also lodge claims alongside their role in providing treatment or assisting in the rehabilitation of those who are injured. ACC has a network of call centres, branch offices and specialist units to assess claims and administer entitlements.

Once a claim has been approved by ACC, the injured person may be entitled to a range of assistance such as contributions towards the costs of treatment by medical practitioners and other health providers. These contributions are usually claimed by the treating practitioner on the patient's behalf (bulk billing) under the treatment costs regulations, which specify the amount ACC will contribute. This may not equate to the full cost of treatment so the treatment provider may request a co-payment from the patient.

ACC also contracts for a range of services from elective surgery to psychological services and rehabilitation. In general, these contracts are intended to meet the full cost of the service, and no co-payment can be charged.

The legislation also supports good clinical practice – stating that ACC should fund services that are necessary and appropriate for the person's injury and of the quality required to achieve a return to independence. To ensure that the health services ACC purchases meet these legislative requirements, the Corporation monitors the delivery of health services.

More information on ACC's performance and monitoring framework is available at www.acc.co.nz.

Personal injury

Accident Compensation (AC) cover is available for personal injury that is caused by:

- an accident
- a work-related gradual process, disease or infection
- treatment provided by or at the direction of a registered health professional (treatment injury).

Personal injury is defined in the Act as:

- death
- physical injury
- damage to dentures or prostheses that replace a part of the human body.

With limited exceptions, wear and tear is not covered by ACC. One example where cover may be available is a work-related gradual process.

Mental Injury

Cover is also available for mental injuries that result from:

- a physical injury
- sexual abuse or assault (sensitive claims)
- first-hand experience of sudden traumatic events in the workplace .

A mental injury is a clinically significant behavioural, cognitive or psychological dysfunction. It does not include emotional effects such as hurt feelings, stress or loss of enjoyment. When a mental injury is caused by a physical injury, the claim will usually be lodged by a medical practitioner or nurse practitioner. However, the disorder must be diagnosed by a psychiatrist or psychologist or other approved mental health specialist.

Definition of accident

The definition of an accident is important if claims are to be lodged appropriately. Those definitions include a specific event (or series of events) that:

- involves the application of a force (including gravity) or resistance external to the human body or involves the sudden movement of the body to avoid such a force or resistance external to the human body
- is not a gradual process
- involves inhalation or oral ingestion of any solid, liquid, gas or foreign object on a specific occasion, except for inhalation or ingestion of a virus, bacterium or protozoan, unless it is as a result of criminal conduct by another person
- involves a burn or exposure to radiation on a specific occasion (other than exposure to the elements)
- involves the absorption through the skin of any chemical for a period of not more than 1 month
- involves exposure to the elements or to extreme temperatures for a defined period (not exceeding 1 month) where the exposure results in death or an inability for more than 1 month to perform an activity in a normal manner.

Specifically excluded by legislation as not either accidents (unless work-related) or personal injuries are:

- any ectoparasitic infestation
- contraction of a disease through an arthropod as the active vector
- cardiovascular and cerebrovascular events
- conditions caused wholly or substantially by the ageing process.

Hearing loss

Cover for hearing loss may be available where it is:

- a personal injury caused by accident
- the result of a work-related gradual process, disease or infection
- a treatment injury.

For hearing loss claims lodged after 1 July 2010, the person must have suffered at least a 6 percent hearing loss from accidental causes for the claim to be approved. Ear, nose and throat specialists are engaged by ACC to assess claims including the apportionment of accidental and non-accidental causes for the loss of hearing.

Complex claims

AC legislation describes some claims for cover as ‘complicated’. Generally, these claims require additional information before ACC can make a cover decision, and ACC may take more time to assess the claim. These claims are for:

- mental injuries caused by certain criminal acts (sensitive claims)
- work-related mental injuries as a result of witnessing a traumatic event while working
- personal injuries caused by treatment (before 1 July 2005, this was called medical misadventure)
- personal injuries caused by work-related gradual process, disease or infection
- claims that are lodged more than 12 months after the date the personal injury occurred.

When assessing complicated claims, ACC may contact treatment providers seeking additional information. This is done with the consent of the patient. By responding in a timely fashion and providing all relevant information, the patient's claim can be processed quickly, including arranging any expert assessments that are required.

Sensitive claims

Sensitive claims are mental injuries caused by sexual assault or sexual abuse. The events that amount to sexual abuse/assault are included in a list of crimes contained in Schedule 3 of the Act. Claims approved as sensitive claims have entitlement to the full range of ACC services, although the main treatment offered is counselling or psychotherapy for the mental injury suffered as a consequence of the criminal activity.

Sensitive claims are managed by ACC's Sensitive Claims Unit in a confidential process. When a mental injury is caused by sexual assault or abuse, the person can lodge their claim through either a medical practitioner, nurse practitioner or an ACC-registered counsellor. Once ACC receives the claim, a case owner (service coordinator) may contact the client to facilitate the collection of relevant information or to arrange for any ACC-funded assessments that may be required. Any information collected is treated as highly confidential and is only seen by the Sensitive Claims Unit staff or the expert assessor unless the client provides consent for the sharing of information such as when the client has both a sensitive and physical injury claim.

Further information and guidance can be obtained from the Sensitive Claims Unit on 0800 735 566.

Work-related mental injury

Since 1 October 2008, claims for work-related mental injury can also be considered, providing the injury was first treated on or after this date and the mental injury:

- was caused by a single, sudden traumatic event
- has been directly experienced, seen or heard during the course of their work
- resulted from an event that could reasonably be expected to cause mental injury in people generally.

Treatment injuries

A treatment injury is a physical injury caused as a result of treatment from a registered health professional, but some exclusions apply. There is no requirement to find fault, although in some cases, the cause of the injury will be treatment that is inappropriate in the circumstances. Both the underlying disease and other pre-existing diseases are not covered, although a significant worsening of disease that causes a new physical injury might attract cover. Also excluded are:

- a necessary part or the ordinary consequences of treatment (for example, hair loss following chemotherapy or radiotherapy burns would be unlikely to be covered)
- injury caused solely by decisions about allocating health resources
- injury caused because a patient unreasonably delayed or refused to give consent for treatment.

A treatment injury is a physical injury caused as a result of treatment from a registered health professional, but some exclusions apply. There is no requirement to find fault, although in some cases, the cause of the injury will be treatment that is inappropriate in the circumstances.

The fact that treatment did not achieve the desired result does not in itself constitute a treatment injury. Examples of treatment injuries could range from a post-operative wound infection to operating on the wrong limb.

ACC must report to relevant agencies that are responsible for patient safety where the investigation of the claim leads to a conclusion there is a risk of harm to the public. All treatment injury claims and similar claims are reviewed for reporting of harm whether they are approved or declined.

Work-related gradual process claims

From 1 July 2010, claims for WRGPDl returned to the provisions in effect before 1 August 2008. There are two types of claims under this heading:

- A person is exposed at work to one of the substances or agents listed in Schedule 2 of the ACC Act and then develops the listed occupational disease.
- Other work-related gradual process claims that meet the three-part test, namely:
 - there must be a particular property about the person's work task or work environment that has caused or contributed to the injury
 - the property or environment must not be found to any material extent outside the workplace
 - the risk of suffering the injury must be significantly greater for people who perform that task or work in that environment.

To investigate these claims, ACC will collect additional information from the patient, their employer and their treatment provider. The patient may also be assessed by an occupational medicine specialist before a decision is made.

Lodging a claim with ACC

Only registered treatment providers can lodge a claim with ACC. This simply involves completing an ACC45 Injury Claim Form or an engagement form (sensitive claims) and submitting this to ACC. The form is available in both paper and electronic format.

Electronic forms can be submitted from a patient management system or via the web.

Only registered treatment providers can lodge a claim with ACC. This simply involves completing an ACC45 Injury Claim Form or an engagement form (sensitive claims) and submitting this to ACC. The form is available in both paper and electronic format.

Once the ACC45 information is processed by ACC, a decision is made as to whether or not cover is granted or if further investigation is required. In most cases, the decision takes no more than 2 days.

Treatment injury, work-related gradual process, work-related mental injury and sensitive claims each have specific processes. Information on these are available from the ACC website.

If more information is needed ACC, may contact the treatment provider lodging the claim, the patient or their employer or arrange for further assessment. Complicated claims require investigation, so the Act allows ACC more time to make decisions in some circumstances.

Once the claim is approved, ACC will pay the treatment provider's invoices and assign appropriate entitlements to the patient. If cover is declined, the treatment provider and the patient will not receive any payments. In that event, the treatment provider is entitled to bill the patient for services provided.

The ACC45 also acts as a 'sick note' for the patient, and this part should be filled in as accurately as possible. Only a registered medical practitioner or a nurse practitioner can certify work incapacity.

Entitlements

Patients who suffer injuries that are covered by the Act may be entitled to a number of financial, treatment and rehabilitation benefits depending on their injury and circumstances. Types of assistance include:

- rehabilitation – treatment (including pharmaceuticals, imaging, elective surgery, public health acute services), home-based care, transport, equipment, consumables and other services aimed at restoring the patient to maximum health and independence
- compensation for lost earnings – patients may be eligible for weekly compensation for earnings lost as a result of their injury
- death benefits such as funeral grants and payments to dependants
- an independence allowance for injuries that occurred before 1 April 2002
- lump-sum compensation for injuries that happened on or after 1 April 2002.

Criminal injuries and self-inflicted injuries

ACC is required to disentitle patients whose injuries are sustained after 1 July 2010 during the course of committing a serious offence. The circumstances require that the offence is punishable by a maximum term of imprisonment of 2 years or more and the patient is sentenced to a term of imprisonment or home detention. In such cases, ACC is only permitted to contribute to the cost of treatment. Special provisions apply to surgery.

From 1 July 2010, similar levels of disentanglement apply to those who commit suicide or a wilfully self-inflicted injury. This provision does not apply to those whose injury is the result of a covered mental injury and there is a link between the covered mental injury and the wilfully self-inflicted injury. The wilful self-inflicted provisions will not apply when the person was unable to form intent or appreciate the consequences of their actions.

Time off work – work incapacity certificates

Patients who require time off work because of their injury will need a medical certificate from a medical provider. Some injuries necessitate time off work. The certificate used by a registered medical practitioner or nurse practitioner (the only treatment providers who can issue these certificates) is:

- ACC45 for the first visit
- ACC18 medical certificate if an ACC45 has already been lodged.

This form should be filled in carefully with regard to the person's work capacity, the tasks involved in their job and the alternative tasks they might still be able to do at their work. At times, it may be appropriate to talk, with the patient's consent, to their employer.

For that reason, it is preferable when completing the forms to focus on the capacity of the patient to undertake work, whether that means their usual tasks or alternative duties or limited hours.

All patients should be examined before they are issued with a new medical certificate. The patient should be asked relevant questions such as:

- the type of work they do and the tasks involved
- how long they have been doing that job
- what their working conditions are like
- any problems or injuries they had before the accident
- any concerns or fears they have about returning to work
- the tasks they are still able to do.

The treatment provider should use this information and other findings to estimate the time in which they expect the patient to be fit for normal work and the range of tasks they can do now as well as the number of hours the patient can attend work.

A certificate that reports on fitness to work (work capacity) helps case managers to negotiate with employers on behalf of the patient and to develop rehabilitation programmes that best suit their needs.

The maximum time off work allowable on the first certificate (usually the ACC45) is 14 days. After that, the maximum time off a treatment provider can certify is 13 weeks before another certificate is due. Many patients will return to work sooner, and guidelines are available for expected time off related to specific injuries.

Retrospective certification is not good practice.

Obligations of treatment providers

Before a treatment provider can lodge claims for or treat under ACC, they must register with ACC and maintain relevant practising certificates. Information about registering, including application forms, is available online at www.acc.co.nz within the 'For Providers' section. Once accepted, a treatment provider can claim and treat under the AC scheme.

All treatment must:

- be necessary and appropriate
- match the quality required
- be given the appropriate number of times
- be given at the appropriate time and place
- normally be provided by that type of treatment provider.

ACC has policies and procedures designed to ensure appropriate treatment and rehabilitation. Treatment providers are monitored, and ACC can investigate if there are any concerns about the treatment being provided.

Resources and where to go for more information

ACC has produced several publications to assist, including:

- the ACC Treatment Provider Handbook, which is a comprehensive guide to working with ACC
- treatment profiles, which provide a guide to managing individual injuries.

This and additional information is available on the ACC website www.acc.co.nz and through the provider helpline 0800 222 070.

CHAPTER 31

Doctors and the Ministry of Social Development

David Bratt is the medical adviser to the Ministry of Social Development and previously a general practitioner.

Cite this as Bratt D. Doctors and the Ministry of Social Development. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

The Ministry of Social Development is the government department charged with providing support to the disadvantaged and vulnerable members of the New Zealand population – including the unemployed, people limited by disabilities or health conditions, at-risk families and the elderly. The Ministry's stated purpose is: 'We help New Zealanders to help themselves to be safe, strong and independent.'

But what has the Ministry of Social Development (MSD) got to do with health? A quick reminder of the widely accepted social determinants of health – income, employment, education, housing and access to health services – will give a clear indication of MSD's importance to the health of New Zealand.

MSD has involvement in all of these determinants:

- **Income:** For those people who currently lack a source of income, MSD provides welfare benefits through Work and Income to working-age families, while those aged over 65 receive superannuation through Senior Services.
- **Employment:** Work and Income is a major provider of employment opportunities for those out of work
- **Education:** MSD administers student loans through StudyLink.
- **Housing:** Although MSD does not provide housing, it is responsible for the assessment of need for those seeking social housing.
- **Access to health services:** MSD can offset the financial barrier to accessing services through the Disability Allowance.

As this list clearly shows, MSD is a very large government department and is responsible for administering nearly a third of government expenditure through its various divisions – Work & Income, StudyLink, Senior Services, Policy and Community Investment, and until 1 April 2017, it also included the child protection agency Child, Youth and Family. This is now a stand-alone ministry renamed the Ministry for Vulnerable Children Oranga Tamariki (most commonly referred to as Oranga Tamariki since its launch). Although a separate entity, it continues to work closely with MSD.

With such a large and complex organisation, it is neither practicable nor possible to know all the services that may be available for your patients. It is therefore valuable to establish a point of contact within the organisation. The most appropriate people for this role are the Regional Health and Disability teams who can ensure you have a direct dial contact point for you to use (not your patients, please note). You may well be very surprised at just how many different services are available – particularly in terms of supporting people with disabilities or health conditions that impact on their work capacity to find suitable work.

There are 11 such teams spread across New Zealand, and your local one should be known by your practice manager.

With one in eight working-age adults living on a welfare benefit and one in five New Zealand children growing up in households with no one in paid work, there is inevitably a significant number of your patients whose health will be affected by the absence of paid employment in their lives. The adverse health outcomes of worklessness have been well documented in recent years – see the Australasian Faculty of Occupational and Environmental Medicine’s position paper *Realising the Health Benefits of Work*.⁴⁴⁴

The most common interaction between doctors and MSD is in the provision of medical certificates to support your patients being able to access appropriate support from MSD. While this support is often financial, it can also be to enable the person to consider suitable employment when and where this is possible. The professional responsibilities around medical certification are very well documented in the Medical Council’s Statement on medical certification⁴⁴⁵ and this is mandatory reading. A medical certificate is a legal document and represents your best clinical assessment based on what you know and have observed.

A medical certificate is a legal document and represents your best clinical assessment based on what you know and have observed.

444 <http://igps.victoria.ac.nz/WelfareWorkingGroup/Downloads/Working%20papers/Realising-the-health-benefits-of-work-May2010.pdf>

445 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Medical-certification.pdf>

It is useful to consider all medical documents as prescriptions and to apply the same criteria – is this the best treatment for the condition, is it evidence-based, what are the potential side effects, what are the potential interactions and what are the potential adverse effects?

Doctors often find themselves taking the role of advocate on behalf of their patients in a wide variety of situations – be it to access particular health services or to clarify a person's condition or situation.

In advocacy, it is important to be both professional and responsible, ensuring the desired outcome is going to be the best one for your patient. For the working-age adult who is out of work, supporting a road to independence to the extent this is possible should be the outcome goal. It is important not to put a medical barrier in the way unless this is clearly clinically indicated.

CHAPTER 32

Doctors and the transport sector

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Cite this as Griffiths R 2017. Doctors and the transport sector. Chapter 32 in Morris KA (ed.). Cole's Medical Practice in New Zealand, 13th edition. Medical Council of New Zealand, Wellington.

Introduction	464
The transport sector	465
› Government agencies	465
› Transport industry	469
› Employers	471
Impairment versus incapacitation	473
What if I am asked to provide a medical certificate for a patient?	475
Pilot with a health problem	476
› CAA licence or medical certificate holders (level 1)	482
Driver with a health problem	486
Locomotive engineer or train controller with a health problem	487
Seafarer with a health problem	488
Privacy Act 1993	488
Health Information Privacy Code	491
How to approach a patient who is unlikely or unwilling to voluntarily disclose a health problem with public safety implications	493
Conclusion	494
Acknowledgement	494

Introduction

A number of safety-sensitive occupations require personnel to hold medical certificates of a statutory nature because of the public safety implications of medical impairment or incapacitation while acting in those roles. Many of these occupations are in the transport sector. There are a small number of doctors appointed to conduct certification examinations for certain occupational groups in each transport sector. However, every doctor working in New Zealand is obliged to consider the public safety implications of the physical and mental health of their patients employed in safety-critical roles. There are occasions when this may conflict with the imperative to maintain patient confidentiality. The Medical Council of New Zealand acknowledges that there will be times when a doctor's duty to their patient to maintain confidentiality and their duty to the public of New Zealand are at odds and that difficult decisions occasionally need to be made. Guidance on certification can be found in the Council's Statement on medical certification.⁴⁴⁶

Every doctor working in New Zealand is obliged to consider the public safety implications of the physical and mental health of their patients employed in safety-critical roles.

These concerns relate to two aspects of the health of your patient – could your patient's illness, treatment or some other aspect of their health status render them vulnerable to either being chronically impaired or liable to sudden loss of ability to perform the tasks that their safety-critical transport crew job requires?⁴⁴⁷

446 <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Medical-certification.pdf>

447 The CAA publishes guidance on this, available at http://www.caa.govt.nz/assets/legacy/medical/Med_Info_Sheets/MIS012.pdf

The transport sector

Government agencies

There are a number of government agencies that are involved in health and safety issues in the transport sector, including the following.

Ministry of Transport/Te Manatū Waka

Ministry staff support and advise the Minister of Transport and draft policy and legislation related to transport with the goal of improving transport in New Zealand, enhancing and monitoring the performance of public sector agencies and local authorities responsible for transport and ensuring value for money in investment in public transport. There are no medical staff at the Ministry of Transport.

Civil Aviation Authority of New Zealand/Te Mana Rererangi Tūmatanui o Aotearoa

CAA staff establish, maintain and monitor compliance with aviation safety standards, promote aviation safety and oversee the Aviation Security Service and Airways New Zealand. The CAA Medical Unit⁴⁴⁸ establishes medical systems and standards for pilots and air traffic controllers, monitors the performance of aviation medical examiners and conducts accredited medical conclusions concerning the fitness of aviation licence holders who do not meet the statutory medical standards.

Medical standards are published in Civil Aviation Rule Part 67, which defines three tiers of medical fitness:

- Class 1 for professional aircrew.
- Class 2 for private pilots.
- Class 3 for air traffic controllers.

448 The Medical Unit can be contacted at 04-560 9400 or <http://www.caa.govt.nz/medical/medical-home/>

There are also detailed resources and the CAA Medical Manual⁴⁴⁹ for the information of medical practitioners and the aviation industry. Medical examiners appointed by the CAA hold a delegation from the Director of Civil Aviation to assess the fitness of pilots and air traffic controllers and receive information on medical aspects of licence holders. Some pilot medical certification is undertaken under delegation from the CAA by industry bodies such as Gliding New Zealand, Recreational Aircraft Association of New Zealand and Sports Aviation Corp. Each has its own medical adviser (see below for details).

Maritime New Zealand/Nō te rere moana Aotearoa

MNZ staff establish and maintain standards for ships, ports, marine operational environmental protection, seafarers, recreational boating and visiting vessels. Ships' crews, known as seafarers, have two levels of medical certification – national certificates, the medical examinations forms⁴⁵⁰ for which can be completed by any doctor, and international Maritime Labour Convention (MLC) STCW and STCW-F-aligned certificates, which must be completed by a Maritime New Zealand-approved doctor. The medical standards for the various classes of certificates are specified in Maritime Rules Part 34.⁴⁵¹

New Zealand Transport Agency/Waka Kotahi (NZTA)

Agency staff have a wide range of functions that support land transport network planning, safety issues such as fatigue and alcohol and driver medical certification. NZTA publishes Medical Aspects of Fitness to Drive,⁴⁵² which deals with medical standards for commercial and public service drivers and the health assessment of older drivers.

449 <http://www.caa.govt.nz/medical/medical-manual/>

450 <https://www.maritimenz.govt.nz/commercial/certification/documents/Medical-Examination-Form-Seafarers.pdf>

451 <http://www.maritimenz.govt.nz/rules/part-34/>

452 <https://www.nzta.govt.nz/resources/medical-aspects/>

NZTA has retained medical advisers who can provide advice to doctors with concerns for drivers with health problems – call 0800 82 24 22 extension 8089. NZTA has an experienced full-time health team, including clinical, medical and mental health specialists.

NZTA also has the principal objective of facilitating the safe operation of rail transport services across New Zealand. This is achieved through regulation of the rail industry in accordance with the Railways Act 2005 and basic regulatory functions of issuing licences to rail participants and a range of compliance functions to assess the safety approach and performance of rail participants. In order to obtain a rail safety licence, rail operators are required to submit a safety case to NZTA detailing how they will manage the safety requirements prescribed by the Act. One of these requirements is to detail the policies in place to ensure that the rail operator's rail personnel:

- are fit for duty
- are not suffering impairment or incapacity as a result of fatigue, illness, medication, drugs, alcohol or any other factor.

All train operators who operate on what is known as the National Rail System (KiwiRail-owned rail network) use the Australian NTC National Standard for Health Assessment of Rail Safety Workers 2012⁴⁵³ as a key standard to manage health and fitness requirements for rail safety workers.

The NTC standard has been approved by the National Rail Systems Standards Executive (NRSS-E), the body used by KiwiRail to manage interoperability standards with train operators using its lines. Train operators are bound to the National Rail System Standards through access agreements with KiwiRail.

453 <http://www.kiwirail.co.nz/uploads/Publications/NTC%20National%20Standard%20for%20Health%20Assessment%20of%20Rail%20Safety%20Workers%202012.pdf>

NZTA approves both KiwiRail and TransDev's safety cases, which reference the use of the NTC standard. TransDev Auckland holds the contract to operate the Auckland Metro trains on behalf of Auckland Transport.

The requirements for rail safety worker health assessments are determined by a risk management approach. This approach aims to ensure that the level and frequency of health assessments conducted is commensurate with the risk associated with the tasks performed by rail safety workers. Train operators must establish systems and procedures to ensure that rail safety workers receive the appropriate level and frequency of health assessment that corresponds with the risks associated with the tasks they perform.

The risk categorisation applied is based on a consideration of a key question: for any aspect of the worker's tasks, could action or inaction on the part of the worker lead directly to a serious incident affecting the public or the rail network?

KiwiRail and TransDev require their train drivers to meet the category 1 standard – these are workers whose action or inaction may lead directly to a serious incident. Their vigilance and attentiveness to their task is critical, therefore they are the main focus of the NTC standard. Category 1 workers are the highest level of safety-critical worker. These are workers who require high levels of attentiveness to their tasks and for whom sudden incapacity or collapse (for example, from a heart attack or blackout) may result in a serious incident. The standard cites single-operator train driving as an example of a category 1 task. Train controllers and other safety-critical staff are required to meet a category 2 standard, reflecting the slightly lower potential impact of health on rail safety.

Transport Accident Investigation Commission/Te Komihana Tirotiro Aitua Waka

A standing Commission of Enquiry employs investigatory staff to evaluate accidents and incidents where there are secondary prevention opportunities in the aviation, rail and commercial maritime sectors. The Commission has a dedicated medical consultant who evaluates the medical aspects of safety breaches with the aim of preventing medical and human factor causes or contributory factors in future potential accident and incidents.

Transport industry

There are a number of industry bodies who provide important resources and online/phone advice to medical practitioners who have concerns about the public safety aspects of their unwell patients working in transport.

New Zealand Gliding

Gliding is generally considered medically less demanding than many other flying environments as flight does not normally involve extended flights across multiple time zones or physiologically demanding high-G environments. However, the very high cabin altitudes in generally unpressurised cockpits that can be achieved by gliders mean that the cardiorespiratory performance of glider pilots is a critical determinant of whether the patient is fit to fly. A medical declaration (OPS 1)⁴⁵⁴ is required, which has to be countersigned by the applicant's general practitioner or CAA medical examiner. This should not be signed unless the treating doctor is confident that the applicant meets the medical safety standard or appropriate operational limitations are imposed.

454 http://www.gliding.co.nz/sites/gliding.co.nz/images/downloads/MOAP/Forms/OPS/OPS_percent201.pdf

NZ Gliding publishes advice on medical standards⁴⁵⁵ and has a medical adviser.⁴⁵⁶

Recreational Aircraft Association of New Zealand (RAANZ)

RAANZ uses the NZTA Medical Aspects of Fitness to Drive⁴⁵⁷ class 1 private vehicle standard as their medical standard for the recreational pilot's licence (RPL) issued by the CAA. The medical certificate can be issued by the RPL holder's usual general practitioner or a CAA medical examiner. The medical declaration and medical certification form can be downloaded from the RAANZ website at www.raanz.org.nz. Alternatively, RPL licence holders may use a CAA class 2 medical certificate or an NZTA DL9 medical certificate. Contact information for the RAANZ medical adviser is on the back of the RAANZ form.

Sports Aviation Corp

SAC is the primary organisation regulating microlight flying. The microlight pilot licence medical standard is based on the NZTA Medical Aspects of Fitness to Drive⁴⁵⁸ class 1 private vehicle standard. Pilots must complete a medical certificate and declaration form.⁴⁵⁹ Medical fitness standards and procedures are specified in the SAC Exposition section 5.⁴⁶⁰ Sports Aviation Corp has a medical adviser who can be contacted through the main SAC website.

455 <http://gliding.co.nz/wp-content/uploads/2017/02/MOAP-AL-26.pdf>

456 They can be contacted via the link on their website at www.gliding.co.nz/executive-contacts.

457 <https://www.nzta.govt.nz/assets/resources/medical-aspects/Medical-aspects-2014.pdf>

458 See footnote 457.

459 http://www.sportflying.co.nz/uploads/8/8/2/4/8824800/sacform_8.2_medical_form_rev_0.pdf

460 http://www.sportflying.co.nz/uploads/8/8/2/4/8824800/sac_expo_section_5.0_rev.0.pdf

Balloon Aviation Association of New Zealand (BAANZ)

Commercial balloon companies must 'operate to similar safety standards to small airlines'.⁴⁶¹ For this reason, any balloon operator who carries fare-paying passengers must hold a CAA commercial pilot licence (balloon) and hold a class 1 medical certificate issued by a CAA aviation medical examiner. Non-commercial balloon pilots require a CAA class 2 medical certificate under recent changes to ballooning safety standards.

Employers

Some employers have their own in-house medical services that deal with occupational health and safety and medical fitness for duty.

Major airlines

Air New Zealand and comparable airlines have in-house aviation medicine and occupational health services that conduct CAA and other medical examinations and provide medical advice to the airline about the health and safety of their staff. They also deal with issues relating to possible mental health or substance use by personnel. The medical service also takes part in fatigue risk management system design, rehabilitation, medical clearance of impaired passengers to travel and occupational health. Concerns about an airline employee may be addressed in the first instance to the airline medical services.

⁴⁶¹ <https://www.caa.govt.nz/public-and-media-info/caa-releases/ballooning-background/>

Airways New Zealand

Airways New Zealand provides air navigation services including aviation systems engineering and air traffic control to New Zealand and the international airspace surrounding it. It also contracts to send experienced staff to provide expert and consultancy services worldwide, so some staff travel overseas extensively. Airways New Zealand has a dedicated corporate medical adviser who can be contacted via medicaladvisor@airways.co.nz. Medical standards setting and certification of air traffic controllers, who must meet the New Zealand class 3 standard, are conducted by the Civil Aviation Authority. Medical standards for other staff are general pre-employment standards or standards for working at heights. Training for air traffic controllers does not require a medical certificate, but applicants are screened by the Airways Talent team and, where necessary, the Corporate Medical Adviser.

Any doctor who has a patient who wants to apply to be an air traffic controller but has a health problem that may render them unfit for a class 3 medical certificate is welcome to consult the Corporate Medical Adviser. If there is some uncertainty that the CMA can't give a definite opinion on, the applicant is best advised to undergo a full CAA class 3 medical certificate issue examination to obtain a clear decision from the CAA, even though the certificate will not be required until starting their on-the-job training.

Aviation Security Service

There are employment medical standards for aviation security service personnel but no statutory medical certification process. Aviation Security has a dedicated medical adviser who can be contacted through the Human Resources section.

KiwiRail

KiwiRail sets its own medical standards for operating rail crew and has appointed regional medical officers (RMOs) to conduct medical examinations and surveillance and advise the company about the health and safety of its safety-sensitive employees. It has a chief medical officer and a devolved RMO service. A doctor who has concerns about a locomotive engineer, train controller or other safety-sensitive staff member should in the first instance contact the local RMO who will be familiar with health issues and operating demands in their region, via the local manager.

Auckland Transport

AT provides or oversees the provision of transport for the Auckland region, including the light rail system run by TransDev, bus services and wharf and ferry services.

Impairment versus incapacitation

The critical factor for the transport sector is that the decisions of one individual, whether a pilot, air traffic controller, truck driver, school bus driver or train driver, directly impact on the safety of others – most importantly, the travelling public. This may arise either from progressive chronic impairment or sudden medical incapacitation. Chronic impairment may arise from chronic illness, such as cardiorespiratory disease, head injury, musculoskeletal problems, or mental illness, such as depression.

The critical factor for the transport sector is that the decisions of one individual, whether a pilot, air traffic controller, truck driver, school bus driver or train driver, directly impact on the safety of others – most importantly, the travelling public.

Impairment is easier to assess unless the effect on performance is variable, as is often the case with mental illness or traumatic brain injury. However, a range of best and worst-case scenarios can be evaluated, and decisions on whether someone is fit to work in the transport sector should be based on their performance on their worst day. Likewise, if impairment is likely to be progressive, decisions on safety should be based on the likely performance throughout the period for which a medical certificate is issued. Impaired performance is a hazard due to the risk of errors, impaired cognition, mishandling, unsafe behaviours or misperception. Research shows that medically related performance impairment in the transport sector is most likely to be due to the effects of drugs, whether prescribed medication, recreational drugs or alcohol.

Sudden incapacitation is much more complex to assess, as it relates to the probability of immediate loss of function occurring as the result of illness or injury or on the basis of risk factors for disease. Examples would be a convulsion, loss of consciousness, collapse with myocardial infarction, renal colic or migraine. Many such conditions are specifically mentioned in the medical declarations that safety-sensitive transport workers have to submit for confirmation by a government-appointed medical examiner or sometimes their general practitioner. Paradoxically, quite serious chronic diseases like cancer and diabetes may carry a relatively low risk of sudden incapacitation, as they are only slowly progressive and unlikely to come on suddenly in flight.

Assessing the probability of suddenly incapacitating symptoms requires a careful and expert risk assessment, and a doctor who does not feel capable of doing this should refer to the appropriate guidelines such as the Medical Aspects of Fitness to Drive, CAA Medical Manual or Maritime Rules Part 34. Sudden incapacitation is categorised as obvious or subtle, and some agencies add cognitive incapacitation. Obvious incapacitation is most commonly a pilot with diarrhoea and vomiting or ENT problems, less often acute myocardial infarction.

Examples of subtle incapacitation would include a pilot with a cerebrovascular accident who becomes vague and erratic. The International Civil Aviation Organisation (ICAO) has safety rules to protect a pilot not flying who takes over control from an incapacitated or impaired pilot in command if there is a concern about the safe operation of the aircraft.

What if I am asked to provide a medical certificate for a patient?

In some cases, such as pilots and air traffic controllers with CAANZ medical certificates, railway medicals and for SCTW international seafarers' licences, only approved medical practitioners can conduct medical examinations for medical certification of fitness to use a licence. Other pilots and national seafarer licence medicals can also be certificated by their normal general practitioner. If you are approached by a patient applying for a medical certificate who is unknown or unfamiliar to you, you should exercise caution because of the risk of 'doctor shopping'.

It pays to check whether the patient is registered with another GP, as there is a high risk that the patient's normal doctor is aware of a health problem that would be disqualifying. Using the 'Find My Patient' function may identify the normal treating doctor, and if your practice has electronic health records, you may be able to identify consultations suggestive of medical conditions, risk factors, substance use or prescribed medication that may mean that the patient is applying for a medical certificate for which they are unfit.

If you believe that the patient's normal GP has been bypassed or has declined to issue a medical certificate, you should ask the patient for background on why they come to you for a certificate, check your concerns with the normal GP, conduct the requested examination if you think appropriate or notify the appropriate authority if you think the patient has a disqualifying health condition and/or you think the patient has been 'doctor shopping'.

If you believe that the patient's normal GP has been bypassed or has declined to issue a medical certificate, you should ask the patient for background on why they come to you for a certificate, check your concerns with the normal GP, conduct the requested examination if you think appropriate or notify the appropriate authority if you think the patient has a disqualifying health condition and/or you think the patient has been 'doctor shopping'. If you decline to issue a medical certificate, it is likely that the patient will try to find a doctor who will.

Pilot with a health problem

CAA-appointed medical examiners have the CAA Medical Unit medical staff to give them advice on fitness of CAA medical certificate holders with a deviation from normal health. This includes airline transport pilot licence and commercial pilot licence holders who are required to meet the highest standards for a class 1 CAANZ medical certificate. It is a mistake to regard this as a homogeneous group, however. Airline pilots fly in a multicrew environment as a team of captain and a crew of one or more first or second officers. The captain rank is a measure of seniority rather than being synonymous with acting as pilot in command of the aircraft, which is the term used for the person assigned to operate and manage the aircraft. Non-operating crew on the flight are monitoring, cross-checking and supporting the PIC and are termed pilot not flying. Roles will often change in that the most senior pilot on type will often conduct the take-off and departure and the subsequent approach and landing, which are the crucial phases of flight.

During the cruise, the experienced pilot in a national airline may leave the flight deck on long flights for the crew rest area so that they are refreshed for arrival. Since the Germanwings murder-suicide by aircraft, there should always be two crew on the airliner flight deck as a safety measure.

In two-crew operations involving long flights or time zone changes, one pilot may nonetheless deliberately take planned sleep on the flight deck, known as cockpit napping. The crucial thing is that there is always a second person on the flight deck, providing an additional level of safety but also redundancy in the event of a medical misadventure. An exception might be in the event of an active medical incapacitation such as a psychotic episode where other crew cannot maintain control. While this has caused catastrophic accidents, this is extremely rare. Some ATPL medical certificates are endorsed with a multicrew-only limitation, which provides protection in the event of some medical risk or limitation. Similar multicrew protection is in place for crews on regional airlines who fly smaller aircraft to smaller destinations from major hubs.

The most vulnerable area of flight safety is in the sphere of what is known as third-level operators – single-pilot scheduled or chartered air transport operations where safety standards are relaxed due to the smaller passenger loads. Reliance on the health and performance of a single pilot means that medical standards for class 1 CAANZ medical certificate holders operating in this sector have to be the most rigorous. Accidents involving impairment or incapacitation in these sectors are evidence of the importance of risks from poor health in such pilots.

Commercial pilot licence holders with class 1 CAANZ medical certificates also work in aerial work operations, such as firefighting, hunting, commercial helicopter flights, adventure flying, agricultural aviation, logging industry and so on. They are often involved in operations that are moving things rather than people, which reduces the public safety risk, but operations where groups of people are carried in sometimes demanding and unpredictable conditions make this an area of flying operations where public safety is very vulnerable to pilot impairment or incapacitation, and any concerns should be most carefully considered.

The high-G acceleration environment of agricultural aeroplane and aerobatic pilots requires greater attention to cardiovascular fitness. Helicopter flying is more demanding of pilot performance than fixed-wing flying and the consequences of pilot incapacitation is more catastrophic due to the handling characteristics of helicopters. Flight instruction is another crucial group, where high levels of fitness are paramount. The experience of the other pilot is also crucial to the outcome – instructional flights where the student pilot is unable to recognise impairment of the instructor or effectively take over control in the event of sudden incapacitation of the instructor effectively renders instructional flying as a single-pilot operation.

As commercial ballooning involves high levels of mental, perceptual and physical performance, it is an area that is quite susceptible to pilot health risks.

Included in adventure aviation is commercial ballooning, requiring pilots to hold a commercial pilot licence (balloon) and a class 1 CAANZ medical certificate. As commercial ballooning involves high levels of mental, perceptual and physical performance, it is an area that is quite susceptible to pilot health risks. The Carterton balloon tragedy illustrates that many passengers can be fatally injured in a single accident.

The private pilot licence requires a class 2 CAANZ medical certificate but still a relatively high level of mental, physical and perceptual fitness. Private pilots are able to carry non-fare-paying passengers, engage in aerobatic or display flying and engage in more complicated flying such as flight in instrument flight rules conditions, in multi-engined aircraft, over built-up areas, in dense or mixed air traffic and so on.

Air traffic controllers are required to hold a class 3 CAANZ medical certificate. These standards recognise that mental and perceptual performance are more important than physical performance for ATC staff when compared to pilots. They also take into account the wider range of possible responses for controllers who become impaired or incapacitated. An affected controller can close the radar sector or airfield or call for an immediate substitute controller where one with suitable ratings is available or where another controller is available to be called in at short notice. This is important for conditions such as migraine and so on. Controllers work in three main operational environments – in airfield control towers around the country in airports that range in size, traffic and complexity, in the Christchurch Radar Centre and in the long-reach Oceanic Centre in Auckland. Each has its specific demands, and any concerns can be discussed with the Airways Corporate Medical Adviser who is familiar with individual controller health concerns, operating environments and risk mitigation.

A student pilot does not require a CAA licence but primarily relies on a class 2 CAANZ medical certificate. These are usually based on an issue medical examination, which should be more extensive and rigorous than subsequent medical surveillance, as it is the primary entry point into the aviation system and where the highest proportion of applicants will be found unfit until advancing years take their toll.

Standards for CAANZ medical certificates are specified in Civil Aviation Rule Part 67, and guidance on their applicability in a range of situations is given on the CAA website.⁴⁶² These standards are not absolute, and the CAA or one of its delegated medical examiners may exercise ‘flexibility’ – an ICAO term where the risks of any deviations from normal health can be mitigated with appropriate responses.

462 <http://www.caa.govt.nz/medical>

This requires an accredited medical conclusion where a panel of experienced aviation medicine doctors and usually the medical examiner consider that a deviation does not impose an aeromedical risk or can be mitigated by appropriate limitations on the use of the licence.

Part 67 medical examinations can only be conducted by aviation medical examiners who have undergone academic (by Otago University or similar) and procedural (by CAANZ) training in aviation medicine to a standard set by the ICAO. Medical examiners carry a range of delegations from the Director of Civil Aviation to act on CAANZ's behalf to examine and receive information, and medical examiners can also conduct other medical examinations for pilot licences not administered by the CAA in lieu of the patient's general practitioner. They are also a useful source of advice to other health professionals on what might be a reasonable concern about the fitness of a pilot. A list of aviation medical examiners is published on the CAA website.⁴⁶³

The CAA also administers the recreational pilot licence (RPL), which is intended for private pilots to fly normal (not microlight) aircraft under limited conditions. This enables pilots with limited experience or less than pristine health to fly with little public safety impact. It is issued under Civil Aviation Rule Part 61, Subpart H (2011 consolidation). Recreational pilots, however, hold a medical certificate, issued in accordance with Rule 44(1), that meets the medical requirements of the Land Transport (Driver Licensing) Rule 1999, which is applicable for a class 2, 3, 4 or 5 driver licence with passenger endorsement. There are requirements for certain experience and training, and the licence is limited to flying aircraft in visual meteorological conditions, weighing less than 2,000kg, for flight away from built-up areas.

463 <http://www.caa.govt.nz/medical/amenz/>

The RPL pilot must tell any passenger carried that they do not hold a CAANZ medical certificate. The medical certificate is the NZTA DL9 form. If, once the DL9 is issued, there is a change in health, the pilot is obliged to stop flying until cleared to do so as prescribed:

61.359 Changes in medical condition of RPL holder

If a holder of a recreational pilot licence (aeroplane) is aware of, or has reasonable grounds to suspect, any change in his or her medical condition or the existence of any previously undetected medical condition that may interfere with the safe exercise of the privileges of the licence, the licence holder must not exercise the privileges of the licence unless a medical practitioner confirms the licence holder is fit to hold a medical certificate referred to in rule 61.355(a)(2).⁴⁶⁴

There is advice about the medical standards for a CAANZ recreational pilot licence in CAA Advisory Circular 61-20.⁴⁶⁵ Because the CAANZ recreational pilot licence is issued on the basis of the DL9, for a doctor aware of a health condition in a CAANZ RPL medical certificate holder that may affect flight safety, the obligation is to notify the NZTA as required by section 18 of the Land Transport Act 1998 rather than the CAA.

The Land Transport Act 1998 also provides that a medical practitioner or registered optometrist who gives notice in good faith under section 18 will not be subject to civil or professional liability because of any disclosure of personal medical information in that notice. A number of RPLs will be members of the Recreational Aircraft Association of New Zealand (RAANZ) or Sports Aviation Corp, who can be contacted for advice if you have concerns about the medical fitness of one of their members.

464 https://www.caa.govt.nz/assets/legacy/rules/Rule_Consolidations/Part_061_Consolidation.pdf

465 https://www.caa.govt.nz/assets/legacy/Advisory_Circulars/AC061_20.pdf

CAA licence or medical certificate holders (level 1)

So what are the obligations of a general practitioner or other treating doctor where they become concerned about the safety implications of a health condition or health change in a patient holding a CAA licence or medical certificate?

The answer lies in the Civil Aviation Act 1990. Amendments to the original Act added a number of new provisions under section 27C, which confusingly deals with accidents. There are a number of new sections that deal with medical certification changes that were introduced in 2002. This is reproduced in full below:

27C Changes in medical condition of licence holder

- (1) Subject to any directions that the Director may issue under section 27G(1)(b), if a licence holder is aware of, or has reasonable grounds to suspect, any change in his or her medical condition or the existence of any previously undetected medical condition that may interfere with the safe exercise of the privileges to which his or her medical certificate relates, the licence holder—
 - (a) must advise the Director of the change as soon as practicable; and
 - (b) may not exercise the privileges to which the licence holder's medical certificate relates.
- (2) Subject to any directions that the Director may issue under section 27G(1)(b), if an aviation examiner or medical examiner or operator is aware of, or has reasonable grounds to suspect, any change in the medical condition of a licence holder or the existence of any previously undetected medical condition in the licence holder that may interfere with the safe exercise of the privileges to which the licence holder's medical certificate

relates, the aviation examiner or medical examiner or operator must advise both the licence holder and the Director of the change as soon as practicable.

- (3) Subject to any directions that the Director may issue under section 27G(1)(b), if a medical practitioner has reasonable grounds to believe that a person is a licence holder and is aware, or has reasonable grounds to suspect, that the licence holder has a medical condition that may interfere with the safe exercise of the privileges to which the licence holder's medical certificate relates, the medical practitioner must, as soon as practicable,—
 - (a) inform the licence holder that the Director will be advised of the condition; and
 - (b) advise the Director of the condition.
- (4) An aviation examiner or medical examiner or a medical practitioner is not subject to any civil or criminal liability for—
 - (a) doing an indemnified act in good faith in the course of carrying out his or her functions under this Part; or
 - (b) doing an indemnified act in good faith in the course of answering any questions put to him or her by the Director that—
 - (i) concern a licence holder; and
 - (ii) are relevant to any action the Director may take under this Part.

- (5) In this section, **indemnified act** means any of the following acts:
- (a) advising the Director, whether in writing or otherwise, that a licence holder—
 - (i) may not meet the medical standards prescribed in the rules; or
 - (ii) may be unable to exercise safely the privileges to which the licence holder's medical certificate relates:
 - (b) expressing to the Director, whether in writing or otherwise, an opinion that the licence holder who the aviation examiner or medical examiner or medical practitioner has examined or treated may be unable to exercise safely the privileges to which the licence holder's medical certificate relates because of—
 - (i) illness or any bodily or mental infirmity, defect, incapacity, or risk of incapacity suffered by the licence holder; or
 - (ii) the effect on the licence holder of treatment for any illness, infirmity, defect, incapacity, or risk of incapacity:
 - (c) stating to the Director, whether in writing or otherwise,—
 - (i) the nature of a licence holder's illness, infirmity, defect, incapacity, or risk of incapacity; or
 - (ii) the effect on a licence holder of treatment for any illness, infirmity, defect, incapacity, or risk of incapacity.

27D Medical examination, report, and disclosure

- (1) Before the Director issues a medical certificate, an applicant must have a medical examination by a medical examiner who must forward his or her report to the Director.
- (2) The Director may, by written notice, require any applicant to disclose, or authorise the disclosure of, any information relevant to his or her medical condition or history for the purpose of determining whether or not the applicant is eligible for a medical certificate under section 27B.

So, in addition to the provisions of the Health Information Privacy Code, there are additional legal obligations that require a medical practitioner to notify any health concerns about a pilot and indemnities for the notifying practitioner from most adverse outcomes. The Act is likely to be amended soon to extend the obligation to all health professionals as defined by the Health Practitioners Competence Assurance Act.

Compliance with the NZTA class 1 medical standard may not always be appropriate for a microlight or glider pilot. The person to speak to for advice is the RAANZ Medical Adviser, whose contact details are published on the back of the RAANZ medical certificate. The same applies to notifications to the Gliding New Zealand Medical Adviser. While there is no specified indemnity for or obligations on doctors about notifying a pilot about whom they have concerns, the Health Information Privacy Code (see below) will provide protection for appropriate notifications to an appropriate agency (like RAANZ or SAC) if there are reasonable concerns about the patient's health and public safety.

In addition to the provisions of the Health Information Privacy Code, there are additional legal obligations that require a medical practitioner to notify any health concerns about a pilot and indemnities for the notifying practitioner from most adverse outcomes.

Driver with a health problem

This may apply to a commercial or public service vehicle driver with a health problem, but most common dilemmas arise from older private vehicle licensed drivers who require regular medical examinations of their fitness to drive. Older drivers are more likely to develop illnesses that cause impairment or risk of sudden incapacitation and are also more likely to develop illness in between routine medical examinations. Where there is concern, a certifying doctor can specify that the driver should undergo a road safety test or an occupational therapy test or have a range-restricted licence.

Older drivers are more likely to develop illnesses that cause impairment or risk of sudden incapacitation and are also more likely to develop illness in between routine medical examinations. Where there is concern, a certifying doctor can specify that the driver should undergo a road safety test or an occupational therapy test or have a range-restricted licence.

Section 44A of the Land Transport Act 1998 requires a medical practitioner to advise NZTA if a person is judged not fit to drive any motor vehicle. Section 18 of the Act states that a medical practitioner must advise NZTA if a person has been advised not to drive but is likely to do so or has been issued a DL9 with specific restrictions with which the driver is expected not to comply. Section 18 also provides that a medical practitioner or registered optometrist who gives notice in good faith under section 18 will not be subject to civil or professional liability because of any disclosure of personal medical information in that notice. This will commonly apply in the event of cognitive impairment in older drivers or a driver with convulsions or following severe traumatic brain injury. Severe mental illness may also be a hazard that requires action. Section 19 of the Act requires that the person in charge of a hospital must notify NZTA if a licence holder becomes subject to a compulsory inpatient treatment order.

Guidance on fitness to drive safely is given in the Medical Aspects of Fitness to Drive.⁴⁶⁶ The appropriate group who can act where a doctor expresses concerns about the fitness of their patient to drive is the NZTA Medical Team, who can investigate a referral of concern. The team comprises nurses, doctors and mental health professionals. It is unlikely that a referral where there is reasonable concern to the NZTA Medical Team could be considered as inappropriate or a breach of health information privacy.⁴⁶⁷

Locomotive engineer or train controller with a health problem

If you have a patient who has developed a disqualifying health problem, need for medication or substance use disorder who is a locomotive engineer or train controller, you should advise them to stop working immediately or within a reasonable timeframe, depending on the nature and likely effects of the problem. If you are in doubt, detailed medical standards are specified in the KiwiRail standard.⁴⁶⁸

A locomotive engineer or train controller patient with a health problem that may have rail safety implications should be advised to consult the KiwiRail regional medical officer or Transdev medical adviser for a determination. It may be that the RMO is already aware of the problem through regular routine medical examinations and will also be familiar with the safety-sensitive aspects of the patient's work role. If you have concerns that the patient is unlikely to disclose a safety-related health problem to the RMO, you should contact the RMO or national Corporate Medical Officer through 0800 801 070 or the Transdev Medical Adviser on +64 (9) 969 7777. All of these doctors hold part-time roles with KiwiRail or Transdev but can call you back or email you to discuss your concerns.

466 See footnote [457](#).

467 The NZTA Medical Team can be contacted on 0800 822 422 extension 8089 or medical@nzta.govt.nz.

468 See footnote [453](#).

Seafarer with a health problem

If you have concerns about the fitness of a patient to work as a seafarer, you should refer to the Maritime New Zealand (MNZ) website for a patient who holds a national certificate. If you are concerned about the fitness of a patient holding an MLC or STCW Certificate, there is a reference ILO requirement guideline.⁴⁶⁹

MNZ does not have dedicated medical adviser, but any doctor with concerns about the health implications of a seafarer can consult an MNZ-approved doctor,⁴⁷⁰ who would advise on an appropriate course of action. Alternatively, there is an MNZ seafarers helpline at 0508 225 522 or email seafarers@maritimenz.govt.nz.

Privacy Act 1993

When concerns about a patient's health that might impact on transport safety, you should consider the balance between personal privacy and public safety.

There is specific and detailed guidance for when a medical practitioner may release personal information in the Privacy Act itself. Section 6 of the Act details the 12 principles for privacy. Principle 11 permits discretion in the disclosure of private information.

Limits on disclosure of personal information

An agency that holds personal information shall not disclose the information to a person or body or agency unless the agency believes, on reasonable grounds,— ...

469 http://www.ilo.org/wcmsp5/groups/public/@ed_dialogue/@sector/documents/normativeinstrument/wcms_174794.pdf

470 <http://www.maritimenz.govt.nz/commercial/certification/approved-medical-practitioners.asp>

- (f) that the use of the information for that other purpose is necessary to prevent or lessen a serious threat (as defined in section 2(1)) to—
 - (i) public health or public safety; or
 - (ii) the life or health of the individual concerned or another individual;...

When evaluating the need to disclose information to an appropriate agency, there are a number of considerations:

- Is there a serious threat as defined by the Act? The seriousness of the threat is determined by the imminence of some adverse consequence of the threat, the likelihood that the adverse consequence might occur and the severity of that consequence.
- Is there a reasonable belief that the serious threat exists? It is vital to make sure that all reasonably available information is collected, collated and taken into account when evaluating the reasonableness of your belief. It helps to check your objectivity by discussing this with a peer. If in doubt, the Office of the Privacy Commissioner is available to give expert advice.⁴⁷¹

Caution needs to be exercised when considering the discretion to disclose. Section 7.1 of the Privacy Act states:

7 Savings

- (1) Nothing in principle 6 or principle 11 derogates from any provision that is contained in any enactment and that authorises or requires personal information to be made available.

471 They can be contacted on <https://privacy.org.nz/further-resources/knowledge-base/> or 0800 803 909.

If you have shown that you have considered all 12 Privacy Act principles and Health Information Privacy Code rules (vide infra), you would be considered to have taken all reasonably practicable steps.

In addition, section 7(2) states:

- (2) Nothing in principle 6 or principle 11 derogates from any provision that is contained in any other Act of Parliament and that—
 - (a) imposes a prohibition or restriction in relation to the availability of personal information; or
 - (b) regulates the manner in which personal information may be obtained or made available.

This is particularly relevant when a medical practitioner (and in future, all health professionals as defined by the Health Practitioners Competency Assurance Act) must notify the appropriate agency, as required by the Civil Aviation Act s27C or the Land Transport Act.

The source of information may be relevant when personal information is collected for the purpose of obtaining a medical certificate. The application often contains an authorisation to disclose or obtain personal information as appropriate, which the applicant must sign as a condition of the application, and so access to information is appropriately transparent.

Health Information Privacy Code

The 12 privacy rules in the Health Information Privacy Code and its application are described in [Chapter 6 – The purpose of medical records and notes](#). What Health Information Privacy Code considerations do you need to take into account when disclosing information about a patient to an agency who can act on your transport safety concerns?

- How was the information collected? Was the information provided voluntarily and in a normal doctor-patient relationship or for some other purpose?
- Why was the information being provided, and was there any discussion about the uses to which the information would be put?
- How transparent is the process that you followed when making a decision that you were obliged to disclose personal information to an appropriate agency? Good documentation is essential.
- Who did you consult about the decision to disclose? Peers? Medical Protection Society? Privacy Commission? A government agency?
- Did you evaluate the reasonable belief criteria against the information in your possession?
- How did you assess the seriousness of the concern? How imminent was it? What is the probability that your feared outcome might happen? Were the consequences of any concern of severe intensity to justify disclosure? How many people were involved? A smaller effect on many people might nonetheless be serious.
- Check out the consequences of your disclosure. Sometimes, the effects for your patient will not be as adverse as you fear. Revealing severe depression or substance use disorder may enable the initiation of treatment that eventually allows them back to their normal occupation safely.

- If you are able to discuss the necessity of notification with the patient, it is also helpful to discuss risk mitigation interventions available to them that might reduce the severity of a public safety threat. This includes seeking treatment, the availability of support from the airline or New Zealand Airline Pilots' Association (NZALPA) Pilot Advisory Group or, in the case of substance use disorder, the Human Intervention Motivation Study (HIMS) service. This service, which is available in New Zealand and can be contacted via the airline or Civil Aviation Authority, is an occupational substance use disorder treatment and rehabilitation programme specifically for aviation personnel, supported by NZALPA and CAANZ, with the goal of getting dependent pilots back on the flight deck.
- What was said to the patient about your concerns and your decision that health information needed to be disclosed? What was the patient's response when you suggested that they disclose important health information to the appropriate agency directly? What steps did you take to make sure that the patient followed through on an undertaking to self-disclose safety critical information? If you decided to make a disclosure without notifying the patient, you should document your reasons, on the grounds of their personal safety, why you did not do so.
- Did you take steps to limit the information you disclose to the absolute minimum relevant to the threat to personal or public safety?
- Did you ensure that the appropriate medium was used to minimise unintended consequences?

How to approach a patient who is unlikely or unwilling to voluntarily disclose a health problem with public safety implications

How do we make sure that we keep ourselves, our patients and the general public safe when confronted with a patient in a safety-sensitive role?

- Be vigilant to the work your patients do. If they are in a safety-critical occupation, consider whether there are serious wider health and safety concerns
- Make sure of your facts. Document the facts about the patient's health, occupation, beliefs or behaviours that concern you and confirm your diagnosis and your reasoning on the background to your reasonable belief that serious harm might occur if you do not identify the appropriate agency who can act on your concerns
- Discuss your concerns with the patient where it is safe for them (or you) to do so. Be honest and clear about your concerns and intentions. Discuss what you hope will happen following disclosure and what help might be available for them. Airline pilots have a Pilot Advisory Group or the HIMS group to assist with substance use disorder to get them back on their feet, and the employer will usually fund an employee assistance programme.
- Seek advice – check the facts out with someone you trust and work with – even more importantly, anyone for whom you work.
- Seek professional advice – ring the Medical Protection Society on 0800 225 5677 or use the Privacy Commission Health Information Privacy Code Toolkit.⁴⁷²

472 <https://www.privacy.org.nz/news-and-publications/guidance-resources/health-privacy-toolkit/>

- Identify who is the appropriate person or appointee within the appropriate organisation who can act for you to approach to disclose information. If in doubt, contact the chief executive to find out who that person might be. It won't always be another doctor. Information on who to contact is available from the Medical Protection Society or Medical Council of New Zealand.
- Ensure that the tone, purpose, content and medium provide a balance between the need to act on public safety concerns and your desire to protect the medical confidentiality of personal information.
- Ensure that all envelopes, letters or emails are labelled 'Medical in Confidence'.

Conclusion

The dilemma faced by a medical practitioner when confronted with conflict between personal privacy and public health and safety arising from concerns about a patient who works in the transport sector is complex and intense. Taking a methodical approach to evaluation, seeking advice from peers, taking into account all relevant considerations and disclosure in an appropriate manner will help the practitioner to work through the issues and arrive at the correct solution.

Acknowledgement

I am grateful for advice from Drs Ian Gourlay and Tim Jefferies on rail and maritime contexts.

CHAPTER 33

New Zealand Medical Association

Lesley Clarke is the CEO of the New Zealand Medical Association.

Cite this as Clarke L. New Zealand Medical Association. In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Introduction	496
Key roles	496
Values	497
Member services	498
History and structure	499
Advocacy	500
› Leadership of the profession	500
› Statement on the role of the doctor	501
› Health equity	503
› Public health issues	504

Introduction

The New Zealand Medical Association (NZMA) (Te Hauora mō ngā Iwi Katoa) is the professional medical organisation for all New Zealand doctors. Its members come from all disciplines within the medical profession, including specialists, general practitioners, doctors in training and medical students.

Key roles

The NZMA aims to provide leadership of the medical profession and to promote professional unity and values and the health of all New Zealanders. The NZMA is completely independent and receives no government funding but is fully owned by the profession. It provides a platform for doctors to come together to focus collectively on issues for the profession and for New Zealanders. It also provides professional connectivity, support and collegiality.

The NZMA's key roles are to:

- provide advocacy on behalf of doctors and their patients – the NZMA is a strong advocate on medico-political issues, with a strategic programme of advocacy with politicians and officials at the highest levels
- to provide support and services to members and their practices
- to publish and maintain the Code of Ethics for the profession (see [Chapter 2](#))
- to publish the *New Zealand Medical Journal*.

The NZMA aims to provide leadership of the medical profession and to promote professional unity and values and the health of all New Zealanders. The NZMA is completely independent and receives no government funding but is fully owned by the profession.

The NZMA works closely with many other medical and health organisations – including the medical colleges – and provides forums that consider pan-professional issues and policies.

Values

As an organisation, the NZMA is committed to a strong set of values that guide the organisation's advocacy.

- **Integrity and honesty:** The NZMA models the highest standards of personal and professional behaviour in all its activities and interactions and is open and transparent in representations and in the way it works.
- **Respect:** NZMA members treat each other and all people with respect and dignity and value individual and cultural differences and diversity.
- **Fairness:** The NZMA upholds the principles of social justice and the creation of a fair and equitable society.
- **Inclusive:** The NZMA encourages the active participation and contribution of all members and seeks engagement and collaboration with the wider health sector and the communities it serves. The NZMA is guided by the Treaty of Waitangi in its obligations to Māori as tangata whenua and partners.
- **Quality and excellence:** The NZMA believes that quality is the foundation of good health policy, systems and delivery and is committed to developing, promoting and recognising excellence.
- **Caring and nurturing:** The NZMA shows concern for people's wellbeing and supports others in the pursuit of their goals.
- **Responsible:** NZMA members are accountable for their individual and collective actions, are conscientious in their work and use time, money and resources wisely.

- **Responsive:** The NZMA is proactive in meeting new challenges and is open to change.

Member services

As a membership organisation, the NZMA offers its members a range of services, including publications, advisory services (both online and over the phone) and financial benefits.

The member advisory service includes advice on the interpretation and practical application of legislation of key importance to doctors, such as the Privacy Act, the Employment Relations Act, the Health and Disability Consumers' Rights Code and much more. It provides advice about managing staff, employee and employer rights and obligations, individual employment agreements, hiring locums, structuring a practice, retention of medical records plus much more.

The NZMA is also the employer advocate on behalf of general practices in negotiations with the New Zealand Nurses Organisation on the Primary Health Care Multi-employer Collective Agreement for primary care nurses and receptionists.

Members have access to the members-only section of the NZMA website (www.nzma.org.nz) and a subscription to the New Zealand Medical Journal, the New Zealand medical profession's leading scientific journal, which is published by the NZMA. Other publications include The Digest (digest.nzma.org.nz), a digital magazine, and Vital Signs, a weekly email bulletin with news and information about NZMA activities and medical issues and the opportunity for member feedback.

The NZMA also administers the New Zealand Medical Benevolent Fund, established in 1896 to provide aid to NZMA members and families of NZMA members who are in financial hardship or distress. Applications can come from any NZMA member or family of an NZMA member. NZMA members can also recommend applications from non-NZMA doctors and their families. Medical student members are not eligible.

History and structure

The New Zealand Medical Association was formed more than a century ago. Its inaugural meeting was held in Otago in 1886. Ten years later, the Association became affiliated with the British Medical Association (BMA) and remained a branch of the BMA until 1967. The Association's motto is *Scientia et Concordia: Knowledge and Accord*.

The NZMA retains strong links with the British, Australian and many other medical associations throughout the world and is also a member of the World Medical Association. Unlike many similar institutions worldwide, the NZMA is not a union but exists solely to provide leadership for the profession and support for its members and patients. The NZMA is a registered charity.

Members elect the NZMA Board, which provides governance and policy for the NZMA, as well as representatives for the three advisory councils: the General Practitioner Council, the Specialist Council and the Doctors-in-Training (DiT) Council. The Board comprises the Chair, Deputy Chair, up to five elected members and the chairs of the advisory councils. Elections for the NZMA Board and positions on the advisory councils are held at least every 2 years.

The NZMA Ethics Committee offers guidance on ethical issues and leads the review of the profession's *Code of Ethics*, which occurs every 5 years.

The NZMA also has a Council, which has the prime roles of providing advice to the Board and approving the *Code of Ethics*. The Council comprises the President, the NZMA Board, elected members of the GP Council, Specialist Council and DiT Council, delegates from local divisions, the immediate past-Chair, the Chair of the Ethics Committee, the NZMJ Editor and medical student representation.

The NZMA's National Office is in Wellington and the business of the Association is carried out by National Office staff, which currently includes the Chief Executive Officer, Operations Manager, Policy Manager, Communications Manager and support staff. Editor-in-chief of the New Zealand Medical Journal is Professor Frank Frizelle, based in Christchurch, while the NZMJ's production is managed out of National Office.

Professionalism describes the skills, attitudes and behaviours expected from doctors during the practice of their profession.

Advocacy

The NZMA undertakes both proactive and reactive advocacy work, including participation in a wide range of consultation processes, making about 50 submissions annually. Proactively, the Association undertakes considerable policy work and produces regular position statements and policy briefings. The Association also has a substantial media presence and is frequently asked to comment on health-related matters in mainstream media as well as specialist publications.

The advocacy function of the organisation is managed from National Office, with the Policy Manager seeking input from the Board and representative councils as appropriate, as well as from the wider membership. The NZMA Board approves and signs off submissions, which are issued under the Chair's name. The Chief Executive, NZMA Chair and council chairs meet regularly with representatives of other health sector organisations and other stakeholders, as well as with government officials.

Leadership of the profession

Professionalism describes the skills, attitudes and behaviours expected from doctors during the practice of their profession. It includes concepts such as maintaining competence, ethical behaviour, integrity, honesty, altruism, compassion, service to others, adherence to professional standards, justice, respect for others and self-regulation.

External challenges to professionalism include increasing bureaucratisation, commercialism and systems that erode clinical autonomy. On behalf of its members, the NZMA upholds the values and ideals of professionalism within the medical profession and promulgates these both to members and more widely to the general public.

The NZMA also advocates strongly on workforce issues and is represented on Ministry of Health governance and taskforce groups addressing workforce issues and inappropriate behaviour.

Doctor wellbeing is also a key concern for the Association. The NZMA has developed a website resource to assist doctors to monitor and take care of their own mental and physical wellbeing, which aligns with the position statement Doctors' Health, Wellbeing and Vitality⁴⁷³ released in 2013.

Statement on the role of the doctor

As well as submissions, the NZMA also issues occasional position statements and policy briefings. Key among these in recent years is a consensus statement on the role of the doctor in New Zealand,⁴⁷⁴ formulated during an international seminar hosted by the NZMA. An important driver of its development was to ensure that patient care was not compromised in a health sector undergoing significant change. The statement sought to identify the skills and attributes required of doctors to deliver quality health care and to reaffirm the medical profession's commitment to patients.

The statement was endorsed by the medical colleges and published in the New Zealand Medical Journal. It reflects the greater role of the patient in making decisions about their health care and considers the role of the doctor within the wider health care team.

473 https://www.nzma.org.nz/_data/assets/pdf_file/0010/21007/Doctors-Health-and-Wellbeing-2013.pdf

474 https://www.nzma.org.nz/_data/assets/pdf_file/0006/16980/Consensus-statement-on-the-role-of-the-doctor-in-New-Zealand-November-2011.pdf

It reinforces the role and the responsibility of doctors as leaders of the health care team and as public health advocates.

The process for developing the statement was as important as the outcome. The seminar included key stakeholders such as Health Workforce New Zealand, the Medical Council, medical schools, medical colleges, district health boards, primary health organisations and health organisations such as the Association of Salaried Medical Specialists, the New Zealand Resident Doctors' Association, General Practice New Zealand and the New Zealand Nurses Organisation.

This collaborative approach highlighted what can be achieved with a collective, unified voice for the medical profession. Developing the statement gave the profession the opportunity to work cohesively towards a common goal that will positively affect both the profession of medicine and patients.

The statement places a strong emphasis on the importance of doctors advocating not only for individual patients but for population health and the health of all New Zealanders. It calls on doctors to be leaders in our communities to advance health outcomes.

Doctors are encouraged to embrace the concepts of clinical leadership and clinical governance and to take on leadership roles within health care teams and the broader health sector. Doctors must show leadership in making day-to-day clinical decisions and base these decisions on their medical knowledge and training – to apply their skills in the development of policy, strategy, service design, models of health care and clinical processes. As leaders, doctors must ensure patient safety and monitor the health outcomes of both the individual and wider health population.

The statement on the role of the doctor continues to serve as the foundation for ongoing discussions and advocacy with government and the wider health sector to deliver optimal health care to New Zealanders. It will guide future workforce planners. In terms of medical education, the statement will help to shape the selection and training of future doctors so that their skills match the needs of providing patient care in the twenty-first century.

As the professional organisation for all doctors, the NZMA has incorporated the statement on the role of the doctor in its advocacy, and it serves as a strong foundation when advocating on issues such as health equity, the medical and health workforce (particularly as it pertains to new health care roles and changes in existing health care roles), medical training, public health and clinical leadership.

The statement on the role of the doctor continues to serve as the foundation for ongoing discussions and advocacy with government and the wider health sector to deliver optimal health care to New Zealanders.

Health equity

In 2011, the NZMA published a statement on health equity.⁴⁷⁵ In health, equity is not about equal access or equal services but about equal outcomes. To achieve this, some individuals and families must receive more support to enjoy health status equal to others. New Zealand has long held on to the principles of universal health services, with everyone entitled to the same with no inclusion or exclusion criteria because it is accepted that everyone will benefit.

⁴⁷⁵ https://www.nzma.org.nz/_data/assets/pdf_file/0004/32449/consensuscontent.pdf

Health inequities cannot be addressed by targeted health funding alone. Social determinants (housing, employment and so on) have a strong influence on health and require interdepartmental thinking and coordination. The principles of health equity are an important foundation for the NZMA's stand on public health issues.

Public health issues

Public health issues such as smoking rates, reducing alcohol-related harm and tackling obesity are key areas of advocacy for the NZMA, as they are major drivers of poor health in New Zealand and have wider social impacts.

The NZMA is also a strong advocate on climate change and the effects of free trade agreements on health policy and outcomes.

Health literacy is another key area of focus, starting with understanding what health literacy is. Health literacy is not just about educating people about their treatment, their health conditions and how to live well and stay well. It is also about system design and developing health professionals' skills to ensure that information and knowledge is imparted in a way that can be received.

CHAPTER 34

A brief history of Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA)

Rawiri Jansen is a general practitioner and Clinical Director in Auckland. He is a past Chairperson of Te ORA (2006–2011, 2014–2016).

Donna Clarke is a psychiatrist and a founder of Te ORA.

Cite this as Jansen R, Clarke D. A brief history of Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA). In: Morris KA, editor. Cole's Medical Practice in New Zealand, 13th ed. Wellington: Medical Council of New Zealand; 2017.

Pioneers	506
Initial efforts to establish a national association of Māori doctors	506
Māori Medical Practitioners Association	508
Te ORA purpose	509
Growth in Māori in medical training	510
Indigenous health internationally	511
Influential contributions to the medical profession	513
Near future	514

Pioneers

The history of Māori doctors begins over 100 years ago when Sir Maui Pōmare (Ngāti Mutunga, Te Āti Awa, KBE, CMG, 1875–1930) graduated from the medical programme at the American Missionary College in Chicago in 1899. Sir Peter Buck (also known as Te Rangi Hiroa, Ngāti Mutunga, KCMG, QSO, 1877–1951) was the first Māori graduate from the medical programme of the University of New Zealand in Otago. He was followed soon after by Dr Tutere Wirepa (Te Whānau a Apanui, Ngāti Porou, 1877–1945) and Dr Pohau Ellison (Ngāi Tahu, Te Āti Awa, OBE, 1884–1963). The first Māori woman doctor was Dr Rina Moore (nee Ropiha, Ngāti Kahungunu, Te Whānau a Apanui, Ngāti Rangitāne, 1923–1975), graduating in 1946. They were the pioneer Māori medical practitioners, and each began remarkable efforts in public and community health to improve the health of their own peoples.

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Initial efforts to establish a national association of Māori doctors

The first attempt to establish a national Māori doctors' association was centred around Professor Eru Pōmare (Te Āti Awa, Ngāti Toa, Ngāti Kahungunu, Rongomaiwahine, Rongowhakaata, FRACP, MD, 1942–1995) at the Wellington Clinical School in the early 1980s. Eru, grandson of the first Māori doctor, was another Māori medical pioneer and mentor – “a quiet revolutionary”.⁴⁷⁶ Eru was a gastroenterologist and helped establish the Wellington Clinical School, later becoming Dean.

⁴⁷⁶ https://www.eastonbh.ac.nz/1995/02/a_quiet_revolutionary_eru_woodbine_pomare/

He established the Māori Health Research Unit that was later named in his honour, and in 1980, he published a foundation text for Māori health research.⁴⁷⁷ *Hauora* established patterns of mortality for Māori and non-Māori from 1955 to 1975 and that, for Māori, incidence and mortality from most of the common amenable diseases were appreciably higher compared with non-Māori. He went on to co-author two subsequent volumes in the series – *Hauora II* and *Hauora III* – that extended the time periods analysed and took a broader view of factors influencing health, including the Treaty of Waitangi and socioeconomic factors. The final volume⁴⁷⁸ covers the years 2000–2005, with an exceptionally distinguished list of authors and contributors.

Dr Paratene (Pat) Ngata (Ngāti Porou, Te Aitanga a Hauiti, FRNZCGP Dist, LLD Hon, 1946–2009) was also based in Wellington at that time, and together, he and Eru created a stimulating, nurturing mentorship environment for Māori medical students coming through their clinical years in Wellington. Pat is well known for his significant contributions to Māori health nationally and directly in communities he served over decades. Pat was convinced to join the very first Māori group practice established by his great friend and colleague Dr Anthony (Tony) Ruakere (Taranaki, Te Āti Awa, FRNZCGP Dist, MNZM) in Opunake.

Eru and Pat joined with another Māori medical leader and psychiatrist Professor Sir Mason Durie (Rangitāne, Ngāti Kauwhata, Ngāti Raukawa, FRANCP, KNZM, FRSNZ) and others in initiating Hui Whakaoranga.⁴⁷⁹ Hui Whakaoranga was held at Hoani Waititi Marae in West Auckland and was a watershed in terms of Māori aspirations for improved health outcomes.

477 Pōmare E, de Boer G. *Hauora: Māori standards of health: a study of the years 1970–1984*. Wellington: Department of Health; 1988.

478 Robson B, Harris R, editors. *Hauora: Māori standards of health IV: a study of the years 2000–2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare; 2007.

479 [http://www.moh.govt.nz/notebook/nbbooks.nsf/0/199037C1AB3E7B724C2565D700185DBD/\\$file/Hui%20Whakaoranga%20Māori%20Health.pdf](http://www.moh.govt.nz/notebook/nbbooks.nsf/0/199037C1AB3E7B724C2565D700185DBD/$file/Hui%20Whakaoranga%20Māori%20Health.pdf)

The hui recommendations include the call for ethnicity data collection, for involvement of Māori in all parts of the health system including health professions and equitable resourcing for improved health outcomes. It was also an early venue for Mason in discussing and disseminating the Whare Tapa Whā model – the four cornerstones of Māori health.

In 1984, Eru called a meeting for Māori doctors and medical students, and the discussions at that hui included plans for future meetings and a potential work programme. Eru's untimely death while walking the Milford Track in 1995 was a very significant loss.

Māori Medical Practitioners Association

In 1995, two Auckland 6th year medical students, Elana Curtis (Te Arawa, FACP, FNZCPHM) and Donna Clarke (Te Arawa, Tainui, Ngāti Kahungunu, FANZCP) called a meeting for Māori doctors. Elana had recently returned from her elective in Hawai'i and had noticed the active association of Hawai'ian medical doctors.⁴⁸⁰ Elana and Donna had both experienced the supportive environment of the Māori and Pacific Island medical students' collective during their undergraduate studies, and they sought to emulate this for those moving into their medical careers. They recognised that a mentoring and networking approach would facilitate ongoing connection and support future cohorts of Māori doctors. They called on all of the senior Māori doctors they knew and recruited Māori medical students from the Auckland School of Medicine. The meeting was held at the Boyle Crescent villa then occupied by the Department of Māori and Pacific Health, Auckland School of Medicine (which has since been removed).

480 'Ahahui o nā Kauka, the Association of Native Hawaiian Physicians, is a non-profit organisation that was formally incorporated in 1998.

The Department of Māori and Pacific Health at that time was led by Professor Colin Mantell (Ngāi Tahu, FRACOG) and Dr David Tipene-Leach⁴⁸¹ (Ngāti Kahungunu, FRNZCGP Dist, FNZCPHM Hon). The Māori doctors and medical students filled the room, overflowing into the corridor, and demonstrated that a critical mass of Māori doctors existed sufficient to establish an association.

Waipapa Marae at Auckland University was the venue for the first formal meeting of the association. The decisions that came out of that first meeting were pivotal in setting the foundations for the future. The name of the organisation⁴⁸² and the key statements describing the purpose were contributed by Professor Sir Mason Durie. With those key decisions made, the assembly elected Dr Tipene-Leach as inaugural chairperson. Dr Tipene-Leach initiated the practice of holding a Scientific Conference in association with the annual meeting, and this practice continues to this day. The Scientific Meeting is an important platform for Māori doctors and medical students to publish and discuss their clinical, research, academic and education work.

Te ORA purpose

Te ORA has consistently maintained dual purposes. Supporting the development of the Māori medical workforce through the undergraduate years, early career and vocational training and continuing professional education is one pillar of Te ORA's vision. Leadership and influence to improve health outcomes for Māori is the other pillar, and Te ORA maintains an ambitious work programme. Māori medical practitioners contribute across the breadth of the New Zealand health system from community and primary care to public policy and population health.

481 Currently Professor of Māori and Indigenous Research, Eastern Institute of Technology, Hastings.

482 The name translates roughly as 'the working group of doctors of Aotearoa', the acronym Te ORA cleverly signifies 'health and a state of wellness'.

A significant early project was an examination of expectations of the emerging Māori medical workforce Kōkiritia⁴⁸³ by Dr Joanne Baxter (Ngāi Tahu, FAFPHM). Kōkiritia covered a broad range of issues relevant to the training needs of Māori doctors and medical students and described the essential skill sets Māori doctors have identified in their work, including te reo Māori and tikanga Māori, peer support and peer review, gaining advanced Māori health knowledge and awareness of health policy.

Similarly, the establishment of the Henry Rongomau Bennett Foundation scholarships was an early achievement. Henry Bennett (Te Arawa, FRACP, QSO, CBE, 1918–2000) was the first Māori psychiatrist. He had a distinguished career over 50 years, and his contribution is honoured with the very successful Foundation scholarships that support Māori doctors to take up a career in psychiatry.

Growth in Māori in medical training

Professor Mantell initiated the remarkable growth in Māori inclusion in medical training in association with the then Dean of the Auckland School of Medicine, Professor Peter Gluckman.⁴⁸⁴ Vision 2020⁴⁸⁵ had the aspirational target for Māori to make up 10 percent of the medical workforce by 2020. The proposal had three components including an admissions scheme, a recruitment strategy and an academic bridging programme.⁴⁸⁶

483 Baxter J. Kōkiritia: An analysis of Māori doctors' training needs. A report prepared for Te Ohu Rata O Aotearoa. 2000. Kōkiritia means to thrust forward and to champion a cause.

484 Professor Sir Peter Gluckman, KNZM FRSNZ FMedSci FRS, Prime Minister's Chief Science Advisor – see <http://www.pmcas.org.nz/a-short-biography-of-peter-gluckman/>

485 Gluckman P, Mantell CD. Vision 2020 proposal. Auckland: Faculty of Medicine and Health Science; 1997.

486 Ratima M, et al. Review of the Ministry of Health hauora Māori scholarship programme. Auckland: AUT University; 2007.

The success is best seen in the record number of Māori medical graduates in recent years, with the world-leading result of achieving indigenous demographic proportionality in the New Zealand medical school graduates. That success has been constructed through the leadership of the Māori medical education teams at both Auckland and Otago Universities (Associate Professor Papaarangi Reid (Te Rarawa, FAFPHM, FNZCPHM) and Associate Professor Joanne Baxter) and the partnerships within those academic institutions.

The success is best seen in the record number of Māori medical graduates in recent years, with the world-leading result of achieving indigenous demographic proportionality in the New Zealand medical school graduates.

Indigenous health internationally

Māori and non-Māori medical educators are contributing significantly to and collaborating with LIME⁴⁸⁷ (Leaders in Indigenous Medical Education – an international network of medical educators). There are unique circumstances for vocational colleges in New Zealand – most medical colleges⁴⁸⁸ are bi-national institutes that reach across both New Zealand and Australian jurisdictions. The exceptions are the Royal New Zealand College of General Practitioners, New Zealand College of Public Health Medicine and Royal New Zealand College of Urgent Care.

LIME led the development of an indigenous health curriculum, which has been endorsed by the Medical Deans of Australia and New Zealand and has been adopted by the Australian Medical Council (AMC).

487 <http://www.limenetwork.net.au/>

488 <http://www.cmc.org.nz/>

AMC has an accreditation role for both New Zealand medical schools and medical colleges that includes a focus on Māori health and training for Māori through undergraduate and vocational training pathways. Additionally, many medical colleges and the medical schools have developed their own position statements about Māori health, cultural competence and addressing inequity. Foremost in this is RNZCGP, which established the first indigenous faculty – Te Akoranga a Maui – in 2001.⁴⁸⁹ NZCPHM, RACP and RACS have similarly established representational structures and policy positions for Māori membership and improving Māori health outcomes. This includes the establishment of awards, scholarships, committees and specific Māori academic or organisational positions.

Te ORA is often consulted and provides advice about these developments, and given the increasing number of Māori medical graduates, most colleges are seeing a growth in the number of Māori fellows and trainees and beginning preparation for that increase.

Te ORA has also been instrumental in establishing the Pacific Region Indigenous Doctors Congress (PRIDoC). This congress meets biennially and provides indigenous space for publication and collaboration across medical education, policy, research and clinical work.

489 Additionally, RNZCGP has constitutionally adopted a Māori alternate name – Te Whare Tohu Rata o Aotearoa.

Influential contributions to the medical profession

The Māori medical luminaries already mentioned in this chapter have provided a substantial body of writings to New Zealand and international audiences. The four volumes of *Hauora: Māori Standards of Health* are worthy of repetition. Māori medical practitioners have also contributed (along with many others) to the corpus that has been published by Te Kete Hauora (formerly the Māori division of the Ministry of Health) and the Māori health research centres including Te Rōpū Rangahau Hauora a Eru Pōmare (University of Otago, Wellington School of Medicine) and Tōmairora Māori Health Research Group (the research division of Te Kupenga Hauora Māori, Faculty of Medicine and Health Sciences, University of Auckland).

Consider just a single thread – Durie and others at Hui Whakaoranga in 1984 made a clear call for robust ethnicity data. Later, that call is revisited consistently by Te Kete Hauora and is then evidenced by Reid and others in publications such as *Ethnicity Matters*⁴⁹⁰ and *Mana Whakamārama – Equal Explanatory Power: Māori and non-Māori sample size in national health surveys*.⁴⁹¹ This has been repeated across most clinical disciplines (especially general practice, psychiatry and population health) and across most health conditions.

490 Robson B, Reid P. Ethnicity matters: Review of the measurement of ethnicity in official statistics: Māori perspectives paper for consultation. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare for Statistics NZ; 2001.

491 Robson B. Mana whakamarama – equal explanatory power: Māori and non-Māori sample size in national health surveys. Wellington: Ministry of Health; 2002.

Near future

We are entering the era of ‘big data’, and questions about how Māori data is being collected, analysed and utilised are resurfacing. The narratives recorded at Hui Whakaoranga again resonate more than three decades on, albeit in the modern idiom of indigenous data sovereignty.⁴⁹²

Many doctors working in New Zealand will be involved in or affected by discussions and decisions about how Māori data is governed. Issues of data ownership, control, access and protection are discussed in several other chapters of Good medical practice (see [Chapter 1](#)). For Māori, these issues have an additional dimension relating to how Māori collective rights may be expressed. Through Te ORA, Māori doctors are pursuing a Waitangi Tribunal claim⁴⁹³ beginning May 2017 that addresses the persistent disparities in Māori health outcomes and seeks comprehensive and constructive recommendations on actions for urgent remediation.

The growing Māori medical practitioner workforce along with growing capacity in other Māori health professions and in Māori health research are likely to precipitate some remarkable opportunities in the near future.

Te ORA has some critically important roles, firstly supporting the growing Māori medical workforce entering the profession, navigating their journeys through vocational training and supporting them in their professional contributions. Additionally, Te ORA will have a significant partnership role working with MCNZ, medical colleges and with Crown agencies involved in the broader health and social system. Te ORA has a contribution to make in supporting the cultural competency development of New Zealand’s health workforce.

The challenges have clearly been laid – kua takoto te mānuka.

492 Jansen R. Indigenous data sovereignty: a Māori health perspective. In: Kukutai T, Taylor J, editors. Indigenous data sovereignty – toward an agenda (pp. 193–211). Canberra: ANU Press; 2016.

493 Wai2499 claimants include past Chairpersons of Te ORA and other leading Māori doctors. The claim is part of Wai2575: Health Services and Outcomes Kaupapa Inquiry.

Statements – standards for doctors

Our statements outline the standards expected of doctors. They aim to assist doctors to provide good medical practice and may be used by the [Health Practitioners Disciplinary Tribunal](#), the [Council](#) and the [Health and Disability Commissioner](#) as a standard by which doctors can be measured.

Good medical practice	516
Medical care	516
Good prescribing practice	516
Communication and consent	516
Cultural competence	517
Management	517
Professionalism	517
Patients	518

Good medical practice

[Good medical practice](#) (December 2016)

Medical care

[Complementary and alternative medicine](#) (March 2011)

[A doctor's duty to help in a medical emergency](#) (August 2006)

[HRANZ joint guidelines for registered health care workers on transmissible major viral infections](#) (November 2005)

[Cosmetic procedures](#) (October 2011)

[Safe practice in an environment of resource limitation](#) (August 2008)

Good prescribing practice

[Statement on good prescribing practice](#) (November 2016)

[Doctors and performance enhancing medicines in sport](#) (February 2017)

Communication and consent

[Information, choice of treatment and informed consent](#) (March 2011)

[Use of the internet and electronic communication](#) (December 2016)

[Telehealth](#) (December 2016)

[Ending a doctor-patient relationship](#) (March 2011)

[Maintenance and retention of patient records](#) (August 2008)

[Disclosure of harm following an adverse event](#) (December 2010)

[When another person is present during the consultation](#) (March 2004)

[Statement on advertising](#) (December 2016)

Cultural competence

[Cultural competence](#) (August 2006)

[Best practices when providing care to Māori patients and their whānau](#) (August 2006)

[Best health outcomes for Māori: practice implications](#) (October 2006)

[Best health outcomes for Pacific peoples: practice implications](#) (May 2010)

[Cultural competence, partnership and health equity: professional obligations towards Māori health improvement](#) (September 2015)

Management

[Responsibilities of doctors in management and governance](#) (March 2011)

Professionalism

[What to do when you have concerns about a colleague](#) (December 2010)

[Unprofessional behaviour and the health care team: protecting patient safety](#) (August 2009)

[Medical certification](#) (September 2013)

[Sexual boundaries in the doctor-patient relationship – a resource for doctors](#) (October 2009)

[Providing care to yourself and those close to you](#) (November 2016)

[Non-treating doctors performing medical assessments of patients for third parties](#) (December 2010)

[Doctors and health-related commercial organisations](#) (July 2012)

Patients

[What to expect from your doctor when you have a cosmetic procedure](#)
(June 2008)

[You and your doctor: a guide to your relationship with your doctor](#)
(March 2008)

[The importance of clear sexual boundaries in the patient-doctor relationship: a guide for patients](#) (October 2006)

[Principles for assessment and management of complaints and notifications](#)
(July 2014)

Guides and booklets

Other Council publications on a variety of topics, for example registration, fitness to practise and prevocational training can be found at www.mcnz.org.nz/news-and-publications/guides-and-booklets.



Cole's Medical Practice in New Zealand

2017: Edited by Kevin A Morris

Published by the Medical Council of New Zealand