Professional accountability of doctors in New Zealand

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In the good old days: 'A doctor (unlike a politician or an actor) [was] judged only by his patients and immediate colleagues, that is, behind closed doors, man to man.'[1] How times have changed. Medicine today is more effective, more dangerous and more expensive than ever before, and the public demand for professional accountability is (rightly) greater than ever. It may not have mattered much in the past if a doctor missed diagnosing a leaking aneurysm, because the outlook was bleak regardless, but today, because such patients can be treated and likely saved, making the diagnosis matters. With such power comes responsibility.

Responsibility may be considered synonymous with accountability, although responsibility implies being morally accountable for one's actions while accountability implies being merely accountable.[2] Accountability may be individual or collective, retrospective or prospective. Retrospective accountability is backward looking and is about holding someone to account for past actions and present consequences. The process of identifying risk is central to the process of accountability and allocating blame when things go wrong.[3] Prospective accountability, rather than looking back to assign blame, attempts to ensure that the right thing happens going forward.

There are a number of organisations in New Zealand with a role to play in satisfying the public demand for professional accountability. While in most countries a tort-based malpractice system is used to both provide compensation for medical injury and to hold doctors to account, in New Zealand suing is barred by the no-fault accident compensation scheme and doctors are held to account through separate accountability processes. As Douglas and Wildavsky[4] pointed out, the type of society generates the type of accountability.

Most medical professional accountability processes judge according to the process of care rather than the outcome. This might be appropriate, given the high degree of uncertainty in health care and the highly variable outcomes the same treatment can have in different individuals,[2] but it is important that there is also some outcomes-based accountability to ensure that medicine is delivering more good than harm overall, to ensure that doctors are not seeking to work perfectly in a system that is delivering more harm than benefit.

Medical professional accountability is important to maintain standards and to foster trust in the profession. To be accountable is to be responsible—for past actions and for future actions. To be accountable is to inform patients about (past or future) actions and decisions, to justify these decisions, and to suffer punishment in the case of eventual misconduct.[2]

Retrospective accountability

Retrospective accountability is about holding someone to account for something in the past.

The **ETHICS** column explores issues around practising ethically in primary health care and aims to encourage thoughtfulness about ethical dilemmas that we may face.

THIS ISSUE: Our guest ethicist and GP Katharine Wallis explores the various agencies that deal with retrospectively and prospectively holding doctors accountable for their actions.

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The Health and Disability Commissioner and the Code of Consumers' Rights

The Health and Disability Commissioner and the Code of Health and Disability Services Consumers' Rights 1996[5,6] (the Code) came into being following recommendations made by Judge Dame Silvia Cartwright in *The Report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters*.[7] Dame Silvia found the system of medical self-regulation in New Zealand wanting. She identified, among other factors, 'a failure of peer review and consequential dominance of clinical freedom', a collective abdication by medical staff of their collective ethical and professional responsibilities, and a 'pervading atmosphere of defensiveness and even arrogance'.[7] She concluded that she could not 'leave the encouragement of new habits and practices to the medical profession alone' and recommended legislative changes to increase awareness of patients' rights and public scrutiny of the medical profession. Hence the introduction of the Health and Disability Commissioner Act.[5] The Commissioner's role is to promote and protect the rights of consumers as set out in the Code:

1. Right to be treated with respect
2. Right to freedom from discrimination, coercion, harassment, and exploitation
3. Right to dignity and independence
4. Right to services of an appropriate standard
5. Right to effective communication
6. Right to be fully informed
7. Right to make an informed choice and give informed consent
8. Right to support
9. Rights in respect of teaching or research
10. Right to complain.[6]

The Commissioner has a number of available options for dealing with complaints, although his powers are limited to reporting, recommending, and referring.[8] The Commissioner may refer a complaint to the Medical Council for possible rehabilitation, and may investigate a complaint to determine whether there has been a breach of the Code. The Commissioner may find a breach even when a patient has suffered no harm. If the Commissioner finds a breach, the Commissioner may refer the complaint to the Director of Proceedings for possible discipline.

The Commissioner receives about 1300 complaints per year against all types of providers and investigates less than 10% of these. He refers few providers each year for either rehabilitation or discipline.[9] In recent years, the Commissioner has tended to reserve the disciplinary route for complaints raising ethical issues (such as boundary transgressions and inappropriate relationships) and the rehabilitative route for complaints raising competence issues. The Commissioner's decisions are final and neither consumers nor providers can appeal his decisions.

The Medical Council of New Zealand

In New Zealand, in contrast to many other countries, the competence and disciplinary processes have been separated so that the Medical Council is no longer prosecutor, judge, and beneficiary of fines. The Medical Council oversees competence issues while the Health Practitioners' Disciplinary Tribunal deals with disciplinary matters.

Colleagues have a discretion to report a doctor to the Medical Council if they believe the doctor poses a risk of harm to the public, but employers, the Health and Disability Commissioner, the Accident Compensation Corporation (ACC), and the Courts all have a duty to do so (s.34).[10] All patient complaints to the Medical Council must be referred to the Health and Disability Commissioner in the first instance. The processes for dealing with complaints and adverse events were streamlined following recommendations from the 2001 Cull Report, which inquired into repeated complaints and disciplinary proceedings against a Northland gynaecologist.[11]

In response to competence or fitness to practise referrals, the Medical Council may order interim suspension, and/or refer the doctor to its Health Committee, a Performance Assessment Committee (for possible performance assessment and rehabilitation), or to a Professional Conduct Committee (for possible discipline). The Medical Council receives 40 to 50 referrals per year, and conducts performance reviews on about half of these.[12]

The Health Practitioners Disciplinary Tribunal

Under the Health Practitioners Competence Assurance Act, the purpose of the disciplinary process is not to punish the doctor but to 'protect the health and safety of members of the public' (section 3).[10] Both the Director of Proceedings and a Medical Council Professional Conduct Committee have the power to bring a disciplinary charge against a doctor before the Health Practitioners Disciplinary Tribunal.

The Tribunal must consider the evidence placed before it and decide whether, on balance of probabilities, a charge of professional misconduct has been proven. If the Tribunal finds a charge proven, the Tribunal may order that the doctor be removed from the register, suspended for up to three years, censured, have conditions on practice imposed, be fined up to $30,000 and/or pay costs. All Tribunal hearings are held in public unless there are grounds for the Tribunal to order otherwise (usually charges of a sexual nature). There are only about 10 medical disciplinary hearings in New Zealand each year.[13]

The Privacy Commissioner

Issues to deal with health information privacy come under the Privacy Act 1993, which gives the patient control over access to his or her personal health information and imposes a duty of non-disclosure on health practitioners.[14] There are situations when disclosure is permitted to the extent necessary for the particular purpose to protect public interest considerations or the patient's own safety and these are set out in the Health Information Privacy Code.[15]

The Privacy Commissioner investigates complaints alleging a breach of information privacy. If the Commissioner finds a breach, she may settle the complaint through conciliation (most complaints end here) or refer the complaint to the Director of Human Rights Proceedings, who may bring a charge before the Human Rights Review Tribunal. This Tribunal has the power to award damages to the complainant for pecuniary loss suffered, loss of benefit, humiliation, loss of dignity, and injury to feelings.

The Coroner and the Courts

The Coroner and Courts play only a minor role in professional accountability in New Zealand. The Coroner has the power to investigate the circumstances and causes of a patient's death and to make recommendations, and the Courts may hear cases of medical manslaughter.[16,17] Following reform of the Crimes Act in 1997, when the threshold for medical manslaughter was lifted from ordinary negligence to gross negligence, defined as a major departure from the standard of care expected of a reasonable person, there have been very few cases of medical manslaughter in New Zealand.[18] There has been only one case of alleged medical manslaughter since 2000, when a midwife was found not guilty in 2006 for her management of a breech delivery which ended in the death of the baby.

Prospective accountability

Prospective accountability is about ensuring that the right thing happens going forward. Prospective accountability is linked to moral deliberation and extends beyond legal duty. It is concerned with the roles we occupy in society and the obligations these roles entail: as doctors we have a responsibility to safeguard the best interests of our patients and to work for the public good.[19]

While the aforementioned medical professional accountability processes might help a patient to choose wisely when to place and when to withdraw trust, these processes do not do away with the patient's need to trust. As Paul[20] has noted, external controls are 'blunt instruments in particular cases and require a functioning internal morality to interpret them'.

Ultimately, a patient must still rely on a doctor having a functioning internal morality, or a commitment to professionalism, to integrity, compassion, altruism, and continuous improvement.[21] According to Baier:

> Rights do define a sort of individualist tip of the iceberg of morality, one that takes no extra organisation to stay afloat, but that is because it is supported by the submerged floating mass of cooperatively discharged responsibilities and socially divided labour.[22]

New Zealand Medical Association

The New Zealand Medical Association (NZMA) attempts to capture the 'submerged floating mass' of cooperatively discharged responsibilities in its Code of Ethics.[23] The NZMA Code of Ethics sets out 67 recommendations to guide professional behaviour. The recommendations, unlike the duties imposed by the Code of Consumers' Rights, are not legally enforceable. The recommendations are based on the following 12 Principles of Ethical Behaviour:

1. Consider the health and wellbeing 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.
8. Honour the profession, including its traditions, values, and its principles, in the ways that best serve the interests of the patient.
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 the standards of the profession.

Medical Council of New Zealand

The Medical Council has developed a number of prospective accountability processes designed to protect the public and to ensure that the right thing happens going forward. The Council specifies scopes of practice, prescribes the qualifications and experience required for registration, and issues annual practising certificates to doctors whom the Council considers are competent and fit to practise. The Medical Council accepts satisfactory participation in approved continuing professional development (CPD) programmes as sufficient proof of a practitioner's competence and fitness to practise.

The Royal New Zealand College of General Practitioners

The Royal New Zealand College of General Practitioners (RNZCGP) has developed a CPD programme, the Maintenance of Professional Standards programme, for general practitioners. CPD programmes usually comprise continuing medical education, continuous quality improvement, and peer review activities.

Successful peer review entails being 'assessed by those who are both sufficiently informed to judge what they assess and sufficiently independent to judge it objectively.'[24] Peer review, if it is to be effective and to identify strengths and weaknesses and determine competence, must be judgmental and demanding while also being supportive, and must overcome self-protecting etiquette. Although New Zealand's professional accountability processes include elements of peer review, current peer review processes have more educational value and/or provide collegial support. They will need to be strengthened if they are to provide satisfactory accountability. It is to be hoped that the proposed practice visits are up to the task.

The RNZCGP does not confine itself to the ongoing competence of vocationally registered general practitioners, but is also interested in the context in which practitioners work. The RNZCGP has set out the standards expected in practices in its *Aiming for Excellence* publication and has developed the CORNERSTONE practice accreditation programme.[25]

There are a number of other organisations with a role to play in ensuring that the right thing happens in health care, including the now defunct

New Zealand Guidelines Group, the Health Quality and Safety Commission, the Best Practice Advocacy Centre, and Medsafe.

There is a risk that the processes established to provide accountability, especially those of a more bureaucratic nature, may overwhelm a doctor's professional commitment to patients. As Sharpe warned:

> The structure of 'accountability' orients an agent's behaviour to the rules established by an oversight body. The accountability relationship is, thus, one of agent to overseer. The risk of such a relationship is that both agent and overseer will, in their attention to each other, lose sight of the original sphere of action.[2]

Since professionalism is the patient's ultimate protector, it is important that our professional accountability processes are designed to foster, or to at least be compatible with, professionalism. Freidson[26] was one of the first to study and explain professionalism, and he considered the type of accountability:

> ...most compatible with professionalism [was] collegiate rather than hierarchical ... and loosely denoted by the term peer review.[27]

There is much hope for the proposed practice review visit process then.

In conclusion, the New Zealand public can rest assured that a practising doctor will be competent and fit to practise, guided by moral codes of behaviour, and practising in a context that fosters the delivery of safe and effective health care. But should these processes fail, there are a variety of means by which the public can hold a doctor to account for past wrongs.

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