AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

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HDC Annual report: the case of the GP sexual predator

In December 2013 Health & Disability Commissioner Anthony Hill released his annual report covering the period from 1 July 2012 to 30 June 2013.

The new format that appeared in last year's report is repeated in the 2013 report with the Commissioner's "foreword" followed by a section on the role of the Commissioner and the HDC office. The third section focuses on the HDC's key activities and includes 12 case studies.

The case study on the GP

One of these case studies concerns a GP who can only be described as a sexual predator. The Auckland GP has a history of complaints made by female patients about the intimate examinations of them that he had undertaken.

In June 2005, as a result of one such complaint the NZ Medical Council (NZMC) had received concerning a breast examination on a young female patient, the Medical Council imposed conditions on this GP's practice. The GP was not to see any female patients without a third person being present, and he was to have a health professional chaperone present during any intimate examinations of female patients, "intimate" meaning any breast or pelvic examinations.

Towards the end of 2006 the GP asked the Medical Council to remove the requirement for him to have a third person present whenever he saw a female patient. The Medical Council agreed to his request in December 2006.

In February 2007 the Medical Council was notified that the GP's employment at a medical centre in Auckland had been terminated following a complaint from a female patient on whom the GP had performed an unchaperoned breast examination.

Chaperone requirement reinstated

In March 2007 the NZMC placed a number of conditions on the GP's practice, including the requirement that he have a chaperone present when seeing female patients for any intimate examinations, that he have in place at all times a notice to inform patients of the chaperone requirement, and that he notify any prospective employer of this requirement. His future employment must also be approved by the NZMC's Registrar and Medical Advisor.

In May 2007 the GP began work at an Auckland practice which had strict policies regarding the need for a chaperone to be present during intimate examinations on female patients as well as those on young people under the age of 16 years.

In May 2008 after receiving another application from the GP the Medical Council removed all conditions from his practice. However, the Council required the doctor to sign a voluntary undertaking to use a chaperone for every intimate examination on a female patient. In May 2009 the GP applied to have that voluntary undertaking removed. The Medical Council agreed, but strongly recommended that he continue to use a chaperone. On two occasions in 2009 the practice's clinical co-ordinator emphasised to the doctor that he must adhere to the practice's chaperoning policy.

Another complaint
In February 2011 the GP conducted abdominal and breast examinations on a 22-year-old female patient without a chaperone. Upon leaving the consultation room the patient appeared upset, and after speaking with a nurse and the clinical co-ordinator she made a written complaint to the practice.

The case was subsequently brought by the Director of Proceedings to the Health Practitioners Disciplinary Tribunal. The GP pleaded guilty to a disciplinary charge of professional misconduct for undertaking an intimate examination without first offering the young female patient a chaperone to be present.

Conditions re-imposed
However, in an extremely worrying decision the Health Practitioners Disciplinary Tribunal stated that it was prepared to give the GP one further chance to demonstrate that he can be rehabilitated. The Tribunal censured the doctor, fined him $1,000 and ordered him to pay costs. They also imposed conditions on his practice, including that he have a female chaperone present when seeing female patients for any intimate examination, and display notices to this effect.

This despite the Tribunal's stated concerns that the GP "is likely to be working with patients from an economically deprived area who may be more vulnerable than other patients" and that "there might be a recurrence of the offending."

This case reveals that there are problems and a lack of willingness to take due responsibility in the agencies put in place to protect patients – in this instance, the need to protect female patients from creepy doctors.

There will undoubtedly be other women who have been groped by this particular GP. Only a few will have been brave enough to complain to the appropriate authorities, presumably with the expectation that this doctor will have his licence to practice removed in the interests of ensuring that he doesn't get the opportunity to use his status at a doctor to continue behaving badly. The question this verdict raises is why should there have to be other victims before he is struck off? The Tribunal cannot guarantee that the next woman this doctor gropes will be brave enough to complain. There may well be a number of other victims before one of them decides to make a complaint.

Women know instantly when something is not right about the way a doctor is examining them. However, the overwhelming feelings of shock, distress and revulsion will often give way to doubt and uncertainty about what really happened. Many choose not to say anything at the time and subsequently decide not to make a complaint for a variety of reasons.

Given the history of repeat offending by this particular GP it is totally unacceptable for the Medical Council to continually agree to his requests to have the requirement removed for a chaperone during intimate examinations on female patients. It is equally difficult to understand the Tribunal's decision in this case.

Named and shamed
Fortunately for women, Dr Chebbi, GP is named in the Tribunal's decision – *www.hpdt.org.nz/portals/0/med12223ddecisionweb.pdf*

WHY LEAVE WOMEN'S HEALTH TO CHANCE?

In a thought-provoking talk available on the TED talks website, a website devoted to ideas that are worth spreading, pioneering doctor Paula Johnson describes how women's health has been and, despite new knowledge, still is left to chance.

Every cell in the human body has a sex, which means that men and women are different right down to the cellular and molecular level. Yet research has until relatively recently ignored this fact. It wasn't until 1993 when the US National Institute of Health's Revitalisation Act was signed into law which insisted on women and minorities being included in clinical trials funded by the NIH that information on the huge differences between men and women's health began to be acknowledged. Until then there was hardly any data on women's health beyond our reproductive functions.

While there is now more information on the many differences in the ways in which women and men experience disease and respond to treatment, there is still a great deal that remains unknown. Even when differences are known these are often overlooked and are not applied to clinical care.

In her talk Paula Johnson lists three examples of these differences. The first is heart disease which is the number one killer of women in the USA today. The second is lung cancer which is the number one cancer killer of women. Dr Johnson describes how even in women who do not smoke, they are three times more likely to be diagnosed with lung cancer, which is partly due to the fact that certain genes in tumour cells are mainly activated by oestrogen. The third example is depression which is the number one cause of disability in women in the world.

She argues that by lumping everyone in together we essentially leave women's health to chance. It is time to do something about this.

Her 20-minute talk is well worth listening to and can be found on the TED talks website –

www.ted.com/talks/paula_johnson_his_and_hers_healthcare.html?utm_source=newsletter_weekly_2014-01-25&utm_campaign=newsletter_weekly&utm_medium=email&utm_content=top_right_button

REVIEW OF THE HDC ACT & CODE OF CONSUMERS' RIGHTS

In December 2013 the Health & Disability Commissioner announced that he was undertaking the 5-yearly review of the HDC Act and Code of Consumer's Rights as required by the Health & Disability Commissioner Act 1994. The review will consider whether any amendments are necessary or desirable, and then report the findings to the Minister of Health.

The 3-page consultation document can be found on the HDC website. (1) The Commissioner says he supports four of the proposed amendments arising out of the 2009 review and lists them, and also requests feedback on three questions. Submissions are due by 5 February 2014.

Reference

1. www.hdc.org.nz/the-act--code/review-of-the-act-and-code-2014

ABORTION SUPERVISORY COMMITTEE REPORT

The Abortion Supervisory Committee's 36th annual report to Parliament for the year ending 30 June 2013 arrived in the mail just before Christmas.

Abortion numbers decline
The ASC's report reveals that the numbers of induced abortions in New Zealand continue to decline with the numbers for the 2012 year being the smallest since 1995.

Access to services
The primary goal of the committee's work is to improve the quality of abortion services by improving access to certifying consultants, counsellors and licensed abortion clinics throughout the country. The committee also spends a great deal of time responding to requests for information and general correspondence from individuals and groups who are interested in abortion in New Zealand. The issues raised more than once included local access to services, the referral system and sex selection abortion.

Local access to services
It is vital that women have access to local services as having to travel to access services in main centres can delay consultations with certifying consultants, counselling and abortion procedures. As the ASC notes: "This unnecessarily complicates what is already a stressful time for many people. We believe that requiring woman to travel for services outside her community adds time and cost pressures creating a non-optimal environment that can hinder a woman's ability to make a careful and considered decision."

The referral system
Concerns were also raised that almost every woman who is referred will end up having an abortion. However, information received from licensed institutions reveals that many women do choose to continue with the pregnancy at various stages along the abortion decision-making pathway.

Sex selection abortion
Some of those who wrote to the ASC were concerned about the possibility of sex-selection abortion in New Zealand. The ASC report states that their inquiries revealed that requests for abortion on the grounds of sex, which is illegal, is not an issue in New Zealand.

Statistics
The total of induced abortions performed in 2012 was 14,745 compared to 15,863 in 2011, 16,630 in 2010, and 17,550 in 2009, a significant and continuing decrease given the increase in the population over those four years.

The report states that the Committee is especially encouraged that the numbers have fallen dramatically in the 11-14 and 15-19 age groups. The number of abortions for 11 – 14 year olds has declined from a high of 105 in 2006 to 68 in 2011 and 51 in 2012. The number of abortions for 15 – 19 year olds has declined from a high of 4,173 in 2007 to 2,822 in 2011 and 2,49 in 2012.

The number of medical abortions as opposed to surgical abortions has remained much the same with a rate of 6.4% (943) in 2012.

Women aged between 20-24 years accounted for 4,560 of the abortions performed in 2012, a drop from 5,160 in 2011, women aged 25-29 years accounted for 3,240 abortions in 2012, a drop from 3,340 in 2011, and women aged 30-34 accounted for 2,248 abortions in 2012, a slight increase on 2,220 in 2011. There were 61 abortions for women over 45 years, compared to 55 in 2011.

Contraception Used

A total of 7,802 women (52.9%) were not using any form of contraception, 4,140 (28.1%) were using condoms, 1,551 (10.5%) were using combined oral contraceptives, and 438 (3%) were using progesterone only contraceptives. A total of 207 women (1.4%) had used emergency contraception, 242 were using natural family planning (1.6%), 212 (1.4%) were using an intra-uterine device, and 98 (0.7%) were using depo provera injections.

The ASC remains concerned at the lack of improvement in the proportion of women having an abortion who were not using any contraception at the time of conception. Last year the Committee recommended that some research be conducted in this area, and noted in this year's report that a study in now underway on the use of post abortion contraception in New Zealand. The ASC now requires every operating surgeon to record the type of contraception provided to women at the completion of the procedure.

Repeat terminations

The Committee remains concerned that there is still no decline in the number of terminations of pregnancy sought by women who have already had three or more abortions. This group now represents more than one in every 8 New Zealand women having an abortion.

Ethnicity

The ethnicity graphs revealed that there were 8,266 abortions for European women, 3,596 abortions for Maori women, 1,985 for Asian women, 2,480 abortions for Pacific women, and 169 for Middle Eastern, Latin American and African women.

The Committee notes the continued sharp decline in the abortion ratio in Asian women although it is not known what is causing this positive trend.

Harassment

The ASC remains very concerned at the harassment of those seeking or providing abortion services. "In addition to ensuring that services are not affected as a result of harassment, the safety and autonomy of medical staff and patients is paramount. Our aim is to ease the concern and vulnerability of staff around the country and we are considering what support and preventative measures can be put in place to prevent further harassment."

Consultant fees

The report reveals that the fees paid to the 166 certifying consultants totalled $4,096,464 (excluding GST) in the year ended 30 June 2013.

Further statistics are available on the Statistics New Zealand website:
www.stats.govt.nz/browse_for_stats/health/abortion.aspx

The full report is not yet available on the Ministry of Justice website:
www.justice.govt.nz/tribunals/abortion-supervisory-committee/about-the-abortion-supervisory-committee

INCREASING PAID PARENTAL LEAVE

While it is heartening to see some positive statements coming from the National government about the need to extend paid parental leave, it is depressing that it is not coming from a real understanding of why this is so important for mothers, babies, their families, and the whole community – financially, physically, emotionally and socially. New Zealand cannot afford not to do this and the current government does not appear to understand this.

There are considerable long term costs to society when mothers are not supported in the work of giving birth and becoming a parent, which may then result in problems developing with the parent-child relationship.

The benefits to the family and to society as a whole of providing six to twelve months of paid parental leave to enable the mother and/or her partner to establish a strong bond with the new baby have been researched and are now recognised internationally. One study of OECD countries found that paid parental leave is a cost effective method of improving child health. New Zealand has fallen well behind the rest of the world and it is time to catch up.

"SAVING NORMAL"

Anyone living a full, rich life experiences ups and down, stresses, disappointments, sorrows, and setbacks. These challenges are a normal part of being human, and they should not be treated as psychiatric disease. However, today millions of people are being diagnosed as having a mental disorder and are receiving unnecessary treatment.

In his book, "*Saving Normal*," Allen Frances, one of the world's most influential psychiatrists, warns that mislabelling everyday problems as mental illness has shocking implications for individuals and society. It leads to the prescribing of unnecessary, harmful medications, the narrowing of our horizons, the misallocation of medical resources and shifts responsibility for our mental wellbeing away from our own naturally resilient and self-healing brains, which have kept us sane for hundreds of thousands of years.

This book is a fascinating and important critique of the widespread medicalisation of normality, and a must read.

AWHC NEWSLETTER SUBSCRIPTION

The newsletter of the Auckland Women's Health Council is published monthly.

COST: $30 waged/affiliated group
$20 unwaged/part waged
$45 supporting subscription

If you would prefer to have the newsletter emailed to you, email us at awhc@womenshealthcouncil.org.nz

Send your cheque to the Auckland Women's health Council, PO Box 99-614, Newmarket, Auckland 1149.

UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for February 2014:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 26 February 2014 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 5 February 2014.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 19 February 2014 followed by the Full Board meeting at 2pm. Both meetings will be held at the Marion Davis Library, Building 43, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Counties Manukau DHB Full Board meeting will be held at 1pm on Wednesday 5 February 2014 at 19 Lambie Drive, Manukau City.

The Hospital Advisory Committee meeting will be held at 9am on Tuesday 25 February 2014 and will be followed by the Community & Public Health Advisory Committee meeting at 1pm at 19 Lambie Drive, Manukau.

2014 PREVENTING OVERDIAGNOSIS CONFERENCE at Oxford University, UK on 15-17 September 2014. Early bird registrations are about to close – there are limited places for a fee currently set at **£345.** For further information go to: www.preventingoverdiagnosis.net/

The NZ Lactation Consultants Association is running a series of three seminars on 27th and 28th February and 1st March 2014 – "***Breastfeeding: Bright Ideas for Tomorrow's Stars***" at the Waipuna conference centre in Mt Wellington, Auckland.

Further information is available at:
http://campaign.r20.constantcontact.com/render?ca=2f1df843-5ed0-4c41-8a2d-66751bd81500&c=ce5007d0-528b-11e3-a354-d4ae529a863c&ch=cef7e090-528b-11e3-a3fe-d4ae529a863c