



MEDICAL COUNCIL NEWS

Protecting the public, promoting good medical practice

Te tiaki i te iwi whānui me te whakatairanga pai i te mahi e pā ana ki te taha rongoā

Chairperson's foreword



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“The primary purposes of the visits would be to enhance the clinical practice of most of us and also to help identify and remedy situations where a colleague's practice has become unsafe...”

During May, Council members and staff took as many opportunities as possible to speak to doctors about two major initiatives: periodic assessment of performance and new supervision arrangements. We have had very valuable feedback from the profession and appreciate the good number of doctors who have turned out for the roadshow meetings, often on some pretty chilly evenings.

Enhancing doctors' clinical practice

The Council is proposing that a periodic assessment of performance be incorporated into the continuing professional development programmes of medical colleges and branch advisory bodies. This would be a supportive and collegial review of a doctor's practice by two peers. The primary purposes of the visits would be to enhance the clinical practice of most of us and also to help identify and remedy situations where a colleague's practice has become unsafe.

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Supporting doctors new to New Zealand

We are also trying to establish simpler supervision arrangements to support doctors new to New Zealand and provide them with the information needed to adjust to a new country and health service. Under the Health Practitioners' Competence Assurance Act 2003, the Council is required to have in place supervision arrangements that as far as possible ensure safe practice.

After the discussions from the first round of consultation, we are proposing another method of supervision as an alternative to the one-on-one supervision available now. In this new option, a service would be accredited for supervision. The Council would recognise that the doctor was working in an accredited service and would receive periodic reports from the service. The service may be a clinical practice group within a DHB, across two or more DHBs, or a general practice organised group.

Next steps

The meetings around the country have given us valuable feedback and insights into the proposals. For the periodic assessment of performance to progress we need the involvement of all Colleges. It still requires considerable ongoing work and the constructive comments we received have been very useful in shaping the proposal further.

So where to next? At the time of writing, submissions on the two initiatives have just closed and are about to be fully analysed. The Council will discuss feedback from all the consultation, as well as written submissions, at its August meeting.

We are meeting with the Colleges and branch advisory bodies in August and also wish to meet with professional groups such as the New Zealand Medical Association, the Association of Salaried Medical Specialists, and the Resident Doctors Association.

To make progress with the periodic assessment of performance proposal, we need all the Colleges to be involved,

volunteers who are willing to assess and to be assessed, and robust qualitative research on the process and its effects. We also need to work closely with those Colleges and Associations already involved in practice assessments to make best use of their experience.

'Quality control' of the Council's registration processes

A recurring concern raised with members of Council is the difficulties doctors have getting registered in New Zealand and the length of time the Council takes to process registration applications.

Our objective is to turn around complete applications for general or special purpose scopes of practice in 20 working days. Over the last year we have added three additional staff to registration to better meet our service agreements associated with the processing of applications. Most applications from comparable health systems are processed within 20 working days of a complete application being received. More information is



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provided below on the comparable health system pathway for registration.

Unfortunately very few applications – less than 10 percent – arrive at our office complete, which leads to delays in processing. In talking to staff, I’m told the documents that they have to chase most often are curriculum vitae (CVs), references, and supervision plans.

Doctors’ CVs are often not comprehensive or have unexplained gaps in employment history. Incomplete information makes it difficult for us to assess an application.

References that are vague, too old, or not verified, are unreliable. The responsibility for checking references rests with employers and recruiters for general and special purpose scope applicants. The risk to patients and the cost to public health and safety of not undertaking adequate reference checking by employers is set out in the Health and Disability Commissioner’s opinion on *Dr Roman Hasil and the*

Whanganui District Health Board 2005–2006.

Another issue for us is supervision plans that do not meet the requirements set out in the Council’s Induction and Supervision Handbook. We find that employers will at times focus on workforce shortages with less regard for ensuring the newly registered doctor they are employing is adequately supervised and supported.

The Council’s proposed new framework for the supervision of international medical graduates will, I believe, make the supervision process less cumbersome for everyone involved.

Applications for vocational scopes of practice

Applications for registration in vocational scopes of practice usually take about 6 months to process, as the applications are referred to the relevant College branch advisory body (BAB) for assessment and recommendation. These sometimes take much longer if more discussion is necessary with the BAB – a year is not unusual for difficult

applications. For this reason, we suggest to doctors that they do not arrange employment until their eligibility for registration in a vocational scope has been determined.

If applicants expect to be employed before the results of their application are available, they may, if eligible, apply for registration within a provisional general scope or through the special purpose scope locum tenens pathway.

Annual practising certificates

Delays in doctors receiving their APCs are another issue of concern both to doctors and the Council.

Currently 10–12 percent of all APC applications need to be returned because they are incomplete or contain incorrect information. Missing details range from incomplete employment details, or providing the wrong credit card details, to not signing the application form declaration.

Another reason for delays is that doctors may not receive their application form because we do not have their correct postal address. You can change your contact details on line at www.mcnz.org.nz >> **Registration >> Currently registered doctors >> Change your personal details.**

Renewal forms are sent 6 weeks before the APC expiry date. Please contact Council staff if you have not received an application to renew your APC by the first of the month in which your APC expires. Because of the cost and time involved in follow-ups, the Council is considering sending only one reminder to doctors who have not returned their APC application.

If you do not hold a current APC, you risk:

- your patients not being covered by their health insurers or ACC

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- not being covered by your own medical indemnity insurer
- pharmacies not filling scripts for your patients
- your employer being at risk of investigation by the Health and Disability Commissioner if a complaint is received about you.

Simplifying our processes

Medical workforce shortages are a major issue for New Zealand. With these shortages in mind, the Council simplified its registration processes in September 2004 by creating a comparable health system pathway. Council delegated approval of applications to the office for doctors with full registration and relevant and comparable experience from certain countries to 'fast track' their registration.

A complete list of comparable health system countries is available on our website at www.mcnz.org.nz

Registration >> How to become a registered doctor >> General scope >> Comparable health system criteria.

Fewer than 5 percent of international medical graduates (IMGs) applying for registration in New Zealand have to sit a registration examination. The situation is quite different in many other countries with which we are competing for IMGs.

Before the comparable health system pathway was set up, registration applications were subject to a considerably longer process. Feedback on this 'new' registration pathway has been very positive.

Registration workshops

Every year the Council holds registration workshops to brief recruitment agencies and district health boards on our registration processes. These workshops inform recruiters about our policies and processes to help streamline registration applications.

In addition, Council staff are available to provide training to employers and recruiters. Please contact the Council's registration team if your recruitment team needs more information about the registration options for international medical graduates.

Medical migration – a strategic direction


I have written before about our health system's reliance on IMGs and issues about their retention. Medical migration is one of our four strategic goals. To achieve this strategic goal, we are:

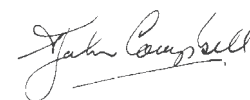
- undertaking research about orientation, cultural transition to New Zealand, and retention of IMGs

- reviewing and improving orientation standards and processes for new IMGs
- implementing a new framework for the supervision of IMGs
- participating in a review of current DHB and other employers' credentialing processes
- reviewing our policies on the registration of IMGs
- assisting in the development of international standards.

Online applications on the way

Within the next 12 months, doctors will be able to apply online for registration in New Zealand. They will also be able track the progress of their application online. We are working towards a system that will allow doctors to apply for their APC online from February 2010.

If you have any comments on our registration processes, or ideas about how they could be improved, I would welcome your comments. 



John Campbell
Chairperson

Lost doctors

In this issue of *Medical Council News*, we list several 'lost' doctors whom we cannot trace because they have not let us know their new addresses. If you change your address, please let us know your new address within a month. You can change your address online at [>>Registration>>Currently registered doctors>>Change your personal details.](http://www.mcnz.org.nz)

The following doctors will be removed from the medical register unless we receive their new addresses. If you know how to contact any of these doctors, please email apc@mcnz.org.nz or phone 0800 286 801 ext 785.

- Dr Christopher Bampton
- Dr Elizabeth Grace Bannister
- Dr Pauline Mary Byrne
- Dr Chia-ti Cheng

- Dr Lyall Graham Clyne
- Christie P Evans (Chris)
- Dr Hanna Kupiec
- Dr Tanya Hanh Lam
- Dr Gideon Lurie
- Dr Hamish Stevens McLaren
- Stephen James Monteith
- Dr Trevor John Palairt 

Results of the Medical Council election

Professor John Campbell, chairperson of the Council, has forwarded the names of the four highest polling candidates to the Minister of Health, Tony Ryall, for appointment as members of the Medical Council. The four successful nominees are:

- Dr Richard Hugh Acland
- Dr Jonathan Edward Mark Fox
- Dr Katherine Anne O'Connor
- Dr Richard Sainsbury.

The Minister has given the profession a commitment that the Medical Council election results will be binding and has gazetted the necessary changes.

Elected members of the Council will be appointed for a 3-year term from 1 July 2009.

Membership of the Council

The Council is made up of four members appointed after standing for election, four members appointed by the Minister, and four public members who are also appointed by the Minister.

Who are the members of the Council?

The members of the Council as at 1 July 2009 are:

Professor John Campbell,
chairperson

Dr Richard Acland

Dr John Adams

Dr Barnett Bond

Dr Jonathan Fox

Dr Allen Fraser

Ms Judith Fyfe

Ms Jean Hera

Ms Liz Hird

Dr Kate O'Connor, deputy
chairperson

Dr Richard Sainsbury


Ms Heather Thomson.



“The Council decides governance and quasi-judicial matters independently of any stakeholder interest, personal interest or relationship, and professional interest or relationship...”

What does the Council do?

The purpose of the Council is to protect public health and safety. Council members work collectively to achieve this purpose by ensuring all doctors maintain high professional standards. The Council works with and supports doctors who may have a health impairment, or are facing professional conduct, performance, or educational issues.

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

Annual practising certificate fee increase – a reminder

Your annual practising certificate (APC) fee will increase from \$540 to \$640 (GST inclusive) from 1 July 2009. The APC fee has increased only once since 1997/98 (from \$485 to the current fee of \$540 in 2005/06).

Order your free folder

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

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

We encourage you to order a free folder for yourself or your practice. As new statements are produced, or others are updated, we will send them to you automatically with the Council newsletter. You can then file them in

the folder for quick reference.

You can place your order at folder@mcnz.org.nz or phone 0800 286 801 extn 793.

Statements are also on our website at www.mcnz.org.nz >> [Publications & guidance](#) >> [Statements](#). 📎



Medical Council of New Zealand 2008 Annual Report

The Council's 2008 annual report can be either read or downloaded online at www.mcnz.org.nz >> [Publications](#)» (see 'Medical Council annual reports, highlights and strategic plan'). Or you can request a copy by emailing info@mcnz.org.nz. 📎

Coroner's recommendation on uplifting of medications

A coroner's report sent to the Council included the following recommendation.

Where a general practitioner (GP) has decided that a patient must uplift medication from a pharmacy on a weekly basis, the GP and the pharmacist should set up an alert to

contact the patient if the medicine is not uplifted for that week.

The coroner's recommendation concludes by noting that this process should only apply to patients with a known mental health issue or patients whose health may be in serious jeopardy if the prescription is not uplifted. 📎

Fiji-registered medical practitioners

The Fiji Medical Council has asked us to tell doctors who are or have previously been citizens of Fiji the following information.

The Fiji Medical Council asks that all Fiji-registered doctors let the Council know their contact address.

The Fiji Medical Council is working through its register to make sure all entries are correct and up to date. The names of doctors who do not respond to this notice and whose current addresses are not known will be removed from the active section of the register, and lodged in an archival register. Doctors need to apply to continue active registration by 1 October 2009.

For more information

Doctors who have at any time been registered in part II (General Registration) of the register of the Fiji Medical Council should consult the notice published on the Fiji Ministry of Health website. For information about their Fiji registration go to www.health.gov.fj.

Updates on registration status and application forms are available from the Fiji Medical Council at medical.council@health.gov.fj. 📎

The tension between public commitment and private work

by Dr Steven Lillis, Medical Adviser

A case was recently brought to the Council's attention. An elderly man was admitted to a peripheral public hospital and clearly needed an urgent procedure. The registrar attempted the procedure several times, but eventually had to abandon it due to unforeseen complications.

During this time, the on-call consultant was operating in private and, although available for phoned advice, was not able to leave the private hospital to assist the registrar. Unfortunately, phoned advice was ineffectual. What was needed was for the consultant to undertake the procedure. The patient died within a matter of days.

An investigation by the Health and Disability Commissioner found that factors contributing to the patient's death were the failed procedure and lack of direct consultant input at a critical time. The coroner also raised similar concerns.

The outcome was a tragedy for all concerned. The family of the patient, the registrar, and consultant involved in the case have gone through difficult times during and after the investigation. Doctors will also face those quiet times when they will ask themselves, 'What if...?'

The issue of proceduralist specialists booking time in private while on call for a public hospital is not new. Indeed, I can remember such problems occurring when employed as a junior doctor some 20 years ago. The district health board (DHB) in the case described above noted that the consultant could have been equally unavailable if involved in a complex procedure in the public hospital.


However, if the consultant is undertaking a private work

commitment and is on call for the public system, it is very likely that they will be unavailable for urgent public system work.

At a recent Council meeting, the issue was discussed along with the notification and the response of the relevant DHB. The Council issued the following statement, 'Council considers the issue of procedural specialists undertaking elective private lists when on call for a public hospital to be a matter of public safety and the responsibility of the doctor concerned.'

Council has also agreed that the availability of procedural specialists

undertaking private lists when on call for a public hospital should be specified in their employment contract and no activity should prevent their attendance within that time.

In the coming months, the Council will also discuss the issue with branch advisory bodies, chief medical officers, and at the Council of Medical Colleges. The Council will seek their help to ensure adequate consultant cover is available at all times when consultants have shared responsibilities between private and public commitments. 

Dr Steven Lillis
Medical Adviser

“Council considers the issue of procedural specialists undertaking elective private lists when on call for a public hospital to be a matter of public safety and the responsibility of the doctor concerned...”



Obtaining patient consent when prescribing unapproved medicine – a reminder

Recently, concerns were raised by a New Zealand coroner regarding guidelines provided to medical practitioners on prescribing unapproved medicine to patients.

Medsafe provides information on prescribing unapproved medicines. These are medicines that have not been assessed by Medsafe against regulatory standards for safety, efficacy, and quality. Medsafe states that, if clinicians are considering prescribing unapproved medicines, they must satisfy themselves that the medicine is of appropriate safety, quality, and efficacy before deciding to prescribe it.

Medsafe considers that, for clinicians

“...if clinicians are considering prescribing unapproved medicines, they must satisfy themselves that the medicine is of appropriate safety, quality, and efficacy before deciding to prescribe it...”

to comply with the Code of Health and Disability Services Consumers' Rights, the patient should be advised during the consultation about:

- the unapproved status of the medicine
- the information that led the clinician to decide why that particular unapproved medicine is the most appropriate treatment for the patient.

The patient's informed consent for treatment with an unapproved medicine can be considered to have been obtained only after they have been given this information.

For more guidance, please visit the Medsafe website at www.medsafe.govt.nz.

Working or intending to work overseas?

APC applications

The Council may grant an annual practising certificate (APC) to doctors who have been working for three or more years overseas, provided that they meet the criteria listed below. The applicant has:

- previously been registered in New Zealand
- worked in medical practice in a comparable health environment
- continued to participate in continuing professional development (CPD)
- provided relevant certificates of good standing (CGSs)
- entered into a branch advisory body recertification programme, a collegial relationship, or supervision arrangement

- obtained satisfactory reference reports from their time outside New Zealand
- received an offer of employment.

Certificate of good standing

The Council will need to provide you with a certificate of good standing (CGS) if you are applying for registration to work in another country. The certificate shows that no legal barriers exist to your being currently registered on disciplinary, competence, criminal, or health grounds.

We strongly recommend you apply for a CGS before leaving New Zealand.

Staying on the New Zealand medical register

Your name will remain on the medical register unless:

- you ask for your registration to be cancelled
- you do not notify us of a reliable contact address
- we do not receive a response to mail sent to you from the Council office.

You do not need to pay a fee to keep your name on the register if you are not practising.

Let us know your change of address

You can change your contact details online at www.mcnz.org.nz >> Registration >> Currently registered doctors >> Change your personal details.

Ethics 101 – encouraging dialogue on ethical issues

Do you know when it's inappropriate to accept a gift from a patient? What do you do if you hear that one of your colleagues is limiting patients to one medical complaint for each visit? Can you refuse to accept a new patient if they have a complex medical history?

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

This column is designed to encourage dialogue – we hope it will create interest and generate further discussion among the profession about practical ethical issues. In each newsletter we'll outline an ethical issue and ask for opinions from the profession. We'll publish a selection of answers giving various viewpoints in the next Medical Council News. We'll also publish the answers on our website.

There are no right or wrong answers – rather we aim to discuss the pros and cons of various approaches and to allow doctors to benefit from their colleagues' ideas.

What would you do?

It's 2009 and the Prime Minister has issued an epidemic notice in response to a new strain of influenza. All the signs are that the number of cases in your community is increasing rapidly.

You have two school-aged children and are responsible for aging parents who live with you. You work at a public hospital and are aware that it is very busy and that many of the other staff who work there are away sick. You are about to leave to start a shift at the hospital when your daughter arrives home from school. She tells you that she has been sent home because her teacher suspects that some of her classmates may have influenza.

What would you do?

Email your suggestions to Michael Thorn, Senior Policy Analyst, at mthorn@mcnz.org.nz (use the subject line 'Ethics 101'). If you have ideas for topics for future columns, please send them to us as well.

Responses to our previous column

Our last question was posed by Dr Jenny Pearson, GP.

In your role you often see patients who are unable to work and want you to sign a form that will allow them to receive a sickness benefit. One such patient suffers from gout, but he won't comply with treatment that could help to control his symptoms, and is unwilling to change unhealthy aspects of his lifestyle. If this patient followed your recommendations, he

could almost certainly improve his health and return to work.

Would you complete this patient's sickness benefit form? If so, what would you write on it? What else would you do?

This question struck a chord with many doctors, and several contacted the office to find out what advice their colleagues had provided. Unfortunately only one doctor was willing to express her own views and she simply replied, 'too hard'. So we've asked Donald Evans, Professor of Biomedical Ethics at the University of Otago, and the medical members of the Council for their views.

Professor Evans stated that the doctor's responsibility is to provide all the information to Work and Income New Zealand (WINZ) or ACC, including adherence to treatment and advice after letting the patient know that they are doing so. That way the decision on payment is left to the funder.

Dr Peter Moller, physician, advised that a condition like gout can take a week or two to settle, and so a short term on the sickness benefit may be appropriate. He stated that the doctor should ask the patient to return for a review. If non-compliance continues to be a problem, then the doctor should refer the patient to a rheumatologist or psychiatrist.

Dr Ian St George, GP, and Dr Allen Fraser, psychiatrist, provided comprehensive responses that we've posted on our website (www.mcnz.org.nz) under the heading 'News / Ethics 101'. Both of these responses expand on the topic and address the wider ethical dimensions – they are well worth reading.

Dr St George pointed out that people's health beliefs, their need to seek help, and compliance are highly complex intra-psychic and social issues. They should not be dealt with by simply making a moral judgement that the patient is wrong. In this case, the patient is sick, so the doctor should complete a sickness benefit form.

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Dr Fraser stated that he often faces similar situations in his own field and his general approach is:

...to attempt to establish a trusting relationship, and give the information about treatment options and what the person may expect. If the person (as some have done) refuses to take my advice, my clinical approach is to continue to offer the patient appointments and continue the attempt to treat (the clinical approach), and advise the company (my duty due to contractual issues) who will make their own decision about continuing, or not, the benefit.

This is a little bit different from the scenario you have given, as the involvement of [an] insurance company occurs with the full written consent of the patient/client.

Nevertheless, I would suggest a similar approach for the GP. She should say to the patient that the certificate can only be completed by advising WINZ of treatment recommendations, and the expected outcome from treatment, and that the patient is refusing that treatment. If he is disabled and cannot work with the acute gout, he is entitled to apply for a WINZ benefit. The decision to deny him that benefit is for WINZ to make, not the GP.

The GP needs to try and separate the clinical issue (he will be much better if he takes the treatment I recommend) from the benefit issue. He cannot work when he has acute gout, and therefore an application to WINZ is not inappropriate. Remaining disabled deliberately is inappropriate. If the GP knows that it is deliberate, she should inform WINZ after informing the patient of her intention to do so. 🗑️

Reference

Toon P D, 'Practice pointer. "I need a note, doctor": dealing with requests for medical reports about patients.' BMJ 2009 Feb 3 338:b175

General practice CPD now available online



The Council has approved an online continuing professional development and recertification programme (CPD online) for doctors who are registered in a general scope and who work in general practice.

The programme will be administered by the Royal New Zealand College of General Practitioners. The CPD online programme complies with the current Council CPD requirements. Registration in this programme will be available from 1 June 2009.

The programme offers you an easier way to:

- record your CPD activities
- check how many hours you have completed or need to complete to meet the Council requirements
- inform the Council of your progress as required.

Please encourage other doctors with whom you have a collegial

relationship to contact the College for more information about the CPD online programme.

The CPD online programme will cost \$400.00 (excluding GST). However, it is free to members of the College.

General Practice Educational Programme (GPEP2) participants who currently have to provide their CPD information to the College manually will be able to use this online facility.

Visit the College's website at <http://www.rnzcgp.org.nz> or email cpdonline@rnzcgp.org.nz for further information. 🗑️

A tribute to Dr Paratene Ngata

Ngāti Ira, Hauiti, Ngāti Porou

General practitioner, Uawa.

Founding member Te ORA and Te Ngākau Mentoring Programme, champion health scientist, husband of Ngāroma, father, grandfather, friend.

MBChB, Dip ComH, Hon. LLD, DFRNZGP Te ORA Maarire Goodall Award 1997; Ngāti Porou Achievement Award 2000; Public Health Champion of the Year 2000.

Dr Paratene (Pat) Ngata passed away on 12 January 2009. He chose, in inimitable style, to hold an e-tangi. 'I thought it was the most ridiculous thing I'd heard when he told me he was going to have his tangi on the internet,' said Dr Tony Ruakere. 'He pushed the boundaries and broke flawed conventions assumed as traditional, but in fact colonial,' said Dr Papāangi Reid. 'He prescribed no black clothing, but coloured or white to symbolise breaking the cycle of violence in his own whānau,' said Dr Sue Crengle.

Paratene was a lifelong friend of Māori, medical students, and doctors alike. In the 1980s, he was asked to inject a Māori element into medical training, mentoring young medical students and encouraging Māori to enter the profession. The Wellington and Otago clinical schools called him a friend.

'I was one of the students fortunate enough to have made the pilgrimage from Otago to the East Coast to work with Paratene and to live with him and Ngāroma at Uawa,' said Dr Lily Fraser.

In 1984, Paratene, Eru Pomare, and Mason Durie initiated the Hui Whakoranga along with George Salmond and Lorna Dyal. The hui rejected the notion that culture was

irrelevant to health. Hauora was then established as the relevant brand for Māori health.

In 1996, he helped found Te ORA – the Māori Medical Practitioners Association. This led to the establishment of the Māori GP Peer Group and later Te Ngākau – Te ORA's flagship mentoring programme.

'Paratene had such enduring concern for the personal growth and development of Māori doctors. That's evidenced by the growth in Māori GPs over the last two decades. Nearly a third of all Māori doctors are GPs,' said fellow mentor Dr Peter Jansen. With the support and leadership of Te ORA, the pair persuaded the College of General Practitioners to support the establishment of Te Akoranga a Māui to provide general practice vocational training by and for Māori practitioners.

At the 2000 Hui ā-tau of Te ORA, Paratene determined the theme 'Te Uranga o te Ra' and the location was Uawa. 'He wanted to stimulate discussion about being involved in developing new medical technologies and how they might impact on how care is delivered in primary care settings,' said Dr Rees Tapsell.

'Paratene was always up for a challenge

personally and professionally,' said Te ORA Chair, Dr David Jansen. 'At a Te Ngākau workshop in 2008 he took the role of being mentored in a role play. It was a huge challenge for him because at the time he was falling ill,' said Dr Matire Harwood.

'We worked together for many years and his quips were reflective,' said Dr Jan Bryant. 'Typically he would say that kai, korero, and a smile were the true signs of happiness.'

There is little that escaped Paratene's wit or wisdom. Heather Thomson suggested Te ORA write something about Pat for this newsletter. 'A snapshot of Pat's wonderful support for Māori doctors, his sense of humour, and his infinite wisdom could be written about. Something other than the usual old obituary.' Kia kore ai tātou e noho mokemoke, me mahitahi tātou, a ko te awhi, ko te aroha, ko te korerotahi. Haere ra Paratene. 🌺

This article was contributed by Te ORA, or Te Ohu Rata o Aotearoa, the Māori Medical Practitioners Association of Aotearoa/New Zealand. 🌺

Stop Press


Pandemic advice for doctors

The Council has prepared some pandemic advice for doctors (see: [>>www.mcnz.org.nz](http://www.mcnz.org.nz)) which may assist doctors during the current swine flu pandemic.

One issue that the Council has recently become aware of is that the requirement that doctors

clinically observe a patient before issuing the medical certificate (in the Council's statement on Medical certification – see: [>>www.mcnz.org.nz](http://www.mcnz.org.nz)) is raising public health concerns. The Council does expect that in most circumstances a doctor should clinically observe a patient before issuing a certificate. However, the Council also expects that during a

pandemic doctors will take steps to ensure their own health and safety, and the health and safety of other patients.

Thus, during a pandemic and where it is clinically appropriate and where health or safety is at risk this may mean it is reasonable to conduct a telephone assessment rather than a physical examination before issuing a certificate. 



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