

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

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NEWSLETTER OF THE MEDICAL COUNCIL OF NEW ZEALAND

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Good afternoon

In this issue of *Medical Council News*, Dr Mark Peterson, Chair, The New Zealand Medical Association has contributed a thought provoking article on the Association's revised Code of Ethics. I would strongly urge you to read both Dr Peterson's article, 'Medical ethics at heart of the profession' and take the opportunity to also read the Code of Ethics.

Dr Kevin Morris, one of our medical advisers writes of the need for all doctors, whether in clinical or nonclinical practice, to hold a current practising certificate.

We again look at another chapter from *Cole's Medical practice in New Zealand* – this time about medical records and patient access to information.

Several months ago, we consulted with the profession on a proposal to increase the practising certificate fee. One of the consistent themes of the feedback I received was that many in the profession were not fully aware of the range of activities the Council undertakes. With this in mind, I thought it would be useful if this issue of *Medical Council News* gives you a snap shot of our strategy and directions for 2015 and beyond.

Our core purpose that underpins our day to day work is, '... to protect the health and safety of members of the public by providing for mechanisms to ensure that (doctors) are competent and fit to practise ...'. This is set out in the Health Practitioners Competence Assurance Act 2003. ►

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OUR FIVE STRATEGIC GOALS

To achieve this objective, we have five strategic goals which are to:

- Optimise mechanisms to ensure doctors are competent and fit to practise.
- Improve Council's relationship and partnership with the public, the profession, and stakeholders to further Council's primary purpose – to protect the health and safety of the public.
- Promote good regulation of the medical profession by providing standards of clinical competence, cultural competence and ethical conduct and ensuring that the standards reflect the expectations of the public, the profession and stakeholders.
- Improve medical regulatory and workforce outcomes in New Zealand by the registration of doctors who are competent and fit to practise and their successful integration into the health service.
- Promote good medical education and learning environments throughout the undergraduate/postgraduate continuum to help ensure all doctors have achieved the necessary practice standards for their practice.

Over the past 6 years we have achieved much, including the development of regular practice review principles, implementing *Inpractice* for general scope doctors, training over 500 international medical graduate supervisors, implementing the *New Zealand Curriculum Framework for Prevocational Training*, agreeing Memorandum of Understandings with District Health Boards (DHBs) and the New Zealand Private Surgical Hospitals Association, and establishing a Consumer Advisory Group.

CHALLENGES THE COUNCIL FACES

Despite these achievements, we continue to face a multitude of challenges as a regulator. There are three main challenges – continuing to improve the quality of the profession; identifying and reducing risk as a quality assurance approach; and building a network of relationships to share information and manage doctors with a competence, conduct or health concern.

The General Medical Council in the United Kingdom speak of investing in more 'upstream' regulation, rather than waiting for something to go wrong, and then having to address it 'downstream'. It's analogous to our quality improvement approach and has considerable merit for protecting public health and safety. 'Upstream' regulation is designed to be proactive and preventative rather than reactionary and corrective. As some examples, we have both focused on new and improved professional standards; improved standards for accreditation; and recertification.

Identifying and reducing the impact of different risk factors on competence is also a challenge for the Council. Two areas that we are looking at are the aging doctor and doctors who work in isolation. Aging is an important consideration. Obviously aging affects us all differently and having one rule would not be appropriate. ►

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Nevertheless there is growing international evidence linking aging with competence concerns and as a regulator we need to pay attention to this. It is something we are researching and will be discussing with the profession in the future.

Everyday Council assesses and manages doctors who have a competence, conduct or health concern. Council interacts with approximately 2.5 percent of doctors at any given time, yet literature indicates up to five percent may not be practising at the appropriate standard at any one time. Worryingly, our experience is that colleagues, more often than not, knew of concerns well before us. It is important that we continue to build a network of relationships – with the profession, DHBs, Primary Health Organisations (PHOs), private hospitals, and Vocational Education and Advisory Bodies (VEABs) – to help identify individual doctors who are a risk to the public and mitigate that risk. We also want to work with stakeholders on strategies to allow concerns to be raised early and addressed without Council needing to be formally involved.

OUR STRATEGIC PRIORITIES

A major 'upstream' initiative is recertification. The *Inpractice* programme has now been operating for over 2 years. We continue to encourage the VEABs to consider their continuing professional development programmes and look particularly at both regular practice reviews and multi source feedback. We are continuing to work with VEABs to define the 'best-value' activities and approach to recertification for specialists.

In the area of medical education we'll continue to implement changes to prevocational training including the introduction of a mandatory community-focused attachment. We will also be undertaking accreditation of training providers such as hospitals and general practice.

Another key priority for 2015 is to build our relationships with PHOs and the Colleges (we already have effective relationships with DHBs and have finalised a Memorandum of Understanding with the private hospitals). What we aim to achieve is agreement on sharing information where the public is at risk from an individual doctor – managing that risk – and helping the doctor get back to a level of competence and health to work effectively.

As part of our accountability to the public and stakeholders we'll be undertaking a survey of the public, profession and stakeholders. We are also reviewing our principles for the assessment and management of complaints.

If you have any thoughts on our priorities and work plan for the coming year I would value your feedback which you can email to me at chair@mcnz.org.nz



Andrew Connolly
Chairman
Medical Council of New Zealand 

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Viewpoint – ‘Medical ethics at heart of the profession’

Dr Mark Peterson
Chair, New Zealand Medical Association

The Code of Ethics is at the heart of the contract the medical profession has with the society we operate in: in return for the trust that patients and the community place in doctors, this Code exists to guide the profession and protect patients.

The New Zealand Medical Association (NZMA) has traditionally undertaken the task of providing a Code of Ethics for the medical profession, and our members see this as a core function of the Association.



The Code is not intended as a set of rigid rules, but as a moral framework, which has been developed over the centuries and remains relevant today. While guidelines for professional behaviour must reflect the changing social and cultural environment in which doctors practise, the Code's framework is founded on the profession's core principles of:

- autonomy – the right of patients to make decisions for themselves
- beneficence – requires a doctor to achieve the best possible outcomes for individual patients, while recognising resource constraints
- non-maleficence – do no harm, including considering the risks versus benefits of particular procedures
- justice – includes the concept of equity, and of the fair distribution of resources.

The Code's principles of ethical behaviour apply to all doctors, including those not engaged directly in clinical practice. It includes recommendations for ethical practice that seek to protect the trust that is fundamental to the patient-doctor relationship.

Its value cannot be overstated – it not only provides an ethical framework for doctors, but is established in case law and serves as an essential reference for others, such as patients, the Medical Council of New Zealand and the Health and Disability Commissioner.

Today's health sector environment – reform, constrained funding, rationing of services and new models of care – places great pressure on the medical profession. Our obligation, however, is to continue to act on behalf of our patients and communities. A sound basis in medical ethics provides us with the guidance we need to respond appropriately to these challenges, while working to ensure that good medical care is not compromised. ►

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Doctors must always have a core advocacy role to ensure that the system remains committed to the well-being of patients.

The NZMA's Consensus Statement on the Role of the Doctor in New Zealand encompasses professionalism and ethics, including this statement: *'Doctors accept responsibility for maintaining the high standards of the medical profession to uphold the trust placed in them by patients and the community, and demonstrate this through adherence to relevant declarations including the NZMA Code of Ethics and the Code of Health and Disability Services Consumers Rights.'*

A LIVING DOCUMENT

The Code is very much a living, evolving document. The most recent revision includes new recommendations on the provision of culturally safe and competent care, remote consultations (eg, telemedicine) and social media, and a new section on 'Doctors in a Just and Caring Society'. This section pulls together recommendations previously in other parts of the Code and expands on the role of doctors in health advocacy.

The section on inappropriate patient–doctor relationships has been broadened to include all breaches of sexual boundaries. Clarification was provided that where the Code refers to family, it also encompasses whānau.

The NZMA's Ethics Committee also recommended some minor additions regarding confidentiality, informed consent, security when transferring data, and providing support to families involved in organ donation. The order of the Code has been revised, to better group clauses on similar topics.

“The relevance of the Code to a doctor's practice of medicine is regularly referenced by the NZMA Ethics Committee in response to individual issues that arise.”

CODE OF ETHICS IN PRACTICE

The relevance of the Code to a doctor's practice of medicine is regularly referenced by the NZMA Ethics Committee in response to individual issues that arise. The Committee, chaired by GP and former NZMA Chair, Dr Tricia Briscoe, makes an integral contribution to the NZMA's work, and is regularly called on by the NZMA Board to comment on issues and to provide clarity on the ethical position of particular situations.

For example, last year the Committee provided comment to the Board supporting the World Medical Association's proposed revision of the Declaration of Helsinki, which provided for more protection for research participants and a more systematic approach to the use of placebos.

It also provided comment to the Board on a World Medical Association request for comment on a UN Special Rapporteur report on torture in health-care settings, and feedback on The National Ethics Advisory Committee draft advice on advance care planning. ►

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It is encouraging to see a growing recognition of the importance of professionalism in producing quality health care. Today, there are increasing calls from many countries for doctors to reassert the core values of medical professionalism in health-care system reform.

The NZMA's Code of Ethics clearly sets out the doctors' role, and this is also emphasised in the NZMA's Role of the Doctor Consensus Statement: *'The profession of medicine has a duty to maintain and improve the health of people and reduce the ravages of disease. Its knowledge and consciousness must be directed to these ends.'*

The NZMA's advocacy on the importance of the wider determinants of health, and public health overall, clearly aligns with these goals and our members have strongly supported our work in these areas. One of the reasons new overseas trained doctors give for coming to practise in New Zealand is that we have a 'moral health system.' An enduring objective of our medical association, with the support of our members, is to ensure that this continues. 🎁

Quick link: [New Zealand Medical Association Code of Ethics](#)

Ethics 101

Is it inappropriate to accept a gift from a patient? Can I limit patients to one medical complaint per visit? Is it okay to refuse to accept a new patient if his medical history is complex?

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

There will be no 'right' or 'wrong' answers – but rather we aim to hold a thoughtful discussion about the pros and cons of various approaches. We hope that this approach will allow doctors to benefit from the wisdom of their colleagues, and also create interest amongst the profession about practical ethical issues.

WHAT WOULD YOU DO?

A new patient comes to see you and although she is now well she has a history of an anxiety disorder and had a pregnancy termination as a young woman. She is very sensitive about this information and wants assurance that it is being kept in a confidential fashion.

At her second visit, the patient expresses concern regarding her information being stored in an electronic medical record (EMR). ►

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Despite not having raised this issue at the first appointment and assurances that your office has fulfilled all of the necessary privacy and security requirements, including staff privacy training, the patient does not feel that computers systems are secure enough to safeguard her medical information. As a result, she asks that her medical information be removed from the EMR, that no future information be added to her EMR chart and has requested that you keep a paper-based medical record instead.

Your office has not used paper processes for several years, nor do you wish to revert to paper charting but you also want to respect your patient's right to control their own information. **What do you do?**¹

Email your answers to George Symmes, the Council's Communication Manager at gsymmes@mcnz.org.nz (use the subject line 'Ethics 101'). If you have ideas for topics for future columns, please feel free to send them to us as well.

RESPONSES TO OUR PREVIOUS COLUMN

Our last column asked what you would do in the following situation:

You work in a private clinic as part of a close knit, high functioning team, and have become very close with the other team members. The most senior member of the team, who founded the clinic 40 years ago, has been a mentor and a teacher to you and most of your colleagues.

Over the past year you have noticed that he often forgets to do things, and that the quality of his record-keeping has declined considerably. Your attempts to raise concerns with him were met with denial. The doctor had intended to retire at the end of the year so you and your colleagues decided to keep a close watch on him, hoping that there would be no further decline in his practice prior to retirement. During this time there haven't been any incidents that have resulted in harm to patients, but you do feel that his memory problems are getting worse.

Your colleague has recently revealed to you that he lost most of his savings in a finance company failure, and that he can no longer afford to retire. He told you that he is now planning to stay on at the clinic for at least 5 more years.

What would you do?

Unusually we didn't receive any responses to this question. Although, in retrospect perhaps this is something we should have expected. It can be very hard to act on concerns you have about a colleague. You might not want to get a friend in trouble, you might worry that it will damage other relationships within a high-functioning team, and you might be concerned that others might stop trusting you.

A survey of 1662 physicians in the United States found that 96 percent stated that physicians should report impaired or incompetent colleagues to relevant authorities. However, 45 percent of respondents who had encountered such colleagues had not reported them. ►

¹ This scenario was first posed by the College of Physicians and Surgeons of Alberta. We are grateful for their permission to reprint it here.

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While it can be difficult to act, doctors do have a responsibility to protect patients from risk of harm. In some circumstances, such as where you think patient safety is at risk because of a colleague's declining competence or health, you should contact the Medical Council. Raising a concern is not necessarily the same thing as making a complaint, and most of the Council's processes are intended to provide support or rehabilitation rather than administer discipline. The Health Practitioners Competence Assurance Act also provides you with legal protection from victimisation, dismissal or disciplinary proceedings as a result of raising a concern in good faith.

There are also some other steps that you might consider taking. Often the effects of age on cognition can be mitigated by a change in approach. There is good evidence that as we grow older our ability to solve novel problems declines, and that we start to rely more and more on pattern recognition instead. Taking a more deliberate approach to practice appears to help some doctors to overcome the problems associated with this change in cognition. You might encourage your colleague to slow his diagnostic process and undertake more formulaic questioning when obtaining a patient history. You might also look at providing him with longer consultations, extra nursing support, 'Just in time' web access to clinically useful information, assistance from an advanced rather than junior registrar, or changing the nature of his work so that he works more as part of a team rather than in isolated practice. Look also at reducing the complexity of his case mix and reducing any emergency or on-call work.

Dr Steven Lillis, one of the Medical Council's medical advisers, has recently conducted a literature review on the effects of ageing on doctors. His paper is still in draft form, but it promises to help doctors and the Council to better identify the effects of ageing on medicine – and to provide tools which will help to mitigate those effects. We hope that we will be able to publish this paper shortly.

Do you need a practising certificate (PC)?

by Dr Kevin Morris, Council's Medical Adviser

Following our recent consultation on the proposed increase in the practising certificate fee, we received feedback that there may be doctors who do not hold a PC who should.

Council's current definition of the practice of medicine includes any of the following:

- advertising, holding out to the public or representing in any manner that one is authorised to practise medicine in New Zealand
- signing any medical certificate required for statutory purposes, such as death and cremation certificates
- prescribing medicines whose sale and supply is restricted by law to prescription by medical practitioners ►

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- assessing, diagnosing, treating, reporting or giving advice in a medical capacity, using the knowledge, skills, attitudes and competence initially attained for the MB ChB degree (or equivalent) and built upon in postgraduate and continuing medical education, wherever there could be an issue of public safety.

The practice of medicine goes wider than clinical medicine, and includes teaching, research, medical or health management, in hospitals, clinics, general practices and community and institutional contexts, whether paid or voluntary.

All doctors who are practising medicine are required by law to hold a practising certificate. If your practice of medicine is viewed as posing more than a low risk to the health and safety of the public, then in addition to requiring a practising certificate, you may need to be enrolled in an approved recertification programme. If your practice of medicine is a low risk to the health and safety of the public then you will need to establish a collegial relationship or nominate a continuing professional development associate.

If you think that you may fall within the above definition then please make contact with the Council's practising certificate team by emailing pc@mcnz.org.nz so that we can discuss your particular circumstances with you. 

Quick links: [Definition of the practice of medicine](#)

Looking at *Cole's Medical Practice in New Zealand*

In this issue of *Medical Council News* we present an abridged version of the chapter on medical records and patient access to information from *Cole's Medical practice in New Zealand*. *Cole's* is an ebook published by the Council, and is available as a free download from the Council's website.

The chapter was written by Robert Stevens, an Auckland barrister and a consultant in the management of personal information and privacy.

PURPOSE AND CONTENT OF THE RECORD

An all too common finding of bodies with statutory rights to investigate doctors is that of inadequate clinical records. The clinical note is a tool for management, 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. To fulfil these tasks, the record must be comprehensive and accurate. A good medical record can also be helpful for the doctor if there is any question or complaint about the care of the patient. ►

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There is a long established tradition in medicine that the ‘notes’ that form the main part of the record contain something about the patient’s symptoms, signs, diagnosis and treatment plans. It is useful to differentiate between what is reported, what is observed, and what is diagnosed. These different features of a record entry are often abbreviated as (S) subjective, (O) objective, (Dx) diagnosis 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.

There are some useful principles that apply to clinical notes:

- write legibly
- write the date and time
- sign legibly
- do not use ambiguous abbreviations
- do not alter notes or disguise additions
- do not use offensive or humorous comments
- check what you have written.

Consider the difference between a record on one day which says ‘Repeat meds Metoprolol 47.5 daily 3/12’ and one which says ‘Repeat meds, well, 130/80, pulse reg 64/min, Metoprolol 47.5 mg daily 3/12, buying Cartia’. Although not a lot longer, the second form shows considerably more of the process the doctor is going through and records important findings for monitoring the patient’s health and the results of the doctor’s interventions. 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, if only because such amendments might later raise suspicion of covering up an error in treatment or diagnosis.

With modern computer systems in both primary and secondary care, test results such as bloods and imaging are an important part of the clinical record.

LEGAL AND ETHICAL OBLIGATIONS

The management of all personal information is covered in New Zealand by the Privacy Act 1993. Where health information is concerned, a special code of practice issued under the Privacy Act adapts the usual rules at the centre of the Privacy Act to health care. It is called the *Health Information Privacy Code 1994* (HIPC). It has the force of law. The rules of the HIPC are designed to ensure that people retain a degree of autonomy when others are dealing with health information about them.

ELECTRONIC RECORDS

The obligations around medical records exist regardless of the form in which they are kept. Medical records are very often made and held in electronic form, and existing paper records converted to electronic media. To the extent that an electronic record captures everything which was in the original paper version, there is no need to retain that original. However, if scanned copies of images would miss detail of potential significance, the original films should not be destroyed inside of the normal minimum retention period. ►

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THE RULES OF THE HEALTH INFORMATION PRIVACY CODE (HIPC)

The HIPC 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.

HEALTH RESEARCH

Most health research in New Zealand has to be approved by an official Ethics Committee, which will inquire into any privacy issues apparent in the scope and conduct of the proposed programme and may set limits in those areas. Health information can then be used in, and disclosed for, a research programme which has received Ethics Committee approval, but even so any disclosure for the purpose of such a research programme can only go ahead in the absence of the individual's authorisation if it is not practicable or not desirable to obtain that authorisation.

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 which 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 which might permit or require the doctor to provide that information.

CERTAIN PROTECTED DISCLOSURES

There are provisions under the Children, Young Persons, and their Families Act 1989 which allow and protect the reporting to Police or to a social worker of suspected neglect or abuse of a young person. There is a duty on a doctor under the Land Transport Act 1998 to report to the Director of Land Transport Safety any person they know of who is likely to drive a vehicle but whose mental or physical condition makes it unsafe for them to do so. In those cases the legislation allowing or requiring the disclosure will protect the doctor who made the disclosure in good faith from any legal or disciplinary action being taken against the doctor on account of that disclosure.

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. ►

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The record to be transferred would usually be the whole folder of notes or print out of the electronic file, but at the minimum 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. 

Quick links:

To read the unabridged chapter on **Medical records and patient access to information**

Cole's Medical practice in New Zealand

The Health Information Privacy Code 1994


Medical Council of New Zealand statement on The maintenance and retention of patient records

Security of electronic medical records

Doctors are reminded that with most medical records being recorded electronically it is essential that there are reliable and robust systems in place to ensure not only security from unauthorised access or disclosure, but from accidental loss through hardware failure.

This can only be achieved by having a secure, reliable and regular routine for the backup of the records.

It is important to be sure that in the case of physical damage or loss through fire, for example, that the original files and the backup are stored in such a way as to minimise the risk of both the original and backup being lost in a fire.

This may involve the use of fireproof storage for backup media, offsite storage or storage in the cloud. All these require that you have taken steps to be assured that the transmission and/or storage is secure and robust. 

Quick links:

Cole's Medical Practice in New Zealand – Chapter 13 – Medical records and patient access to information

Health Information Privacy Code 1994

The maintenance and retention of patient records

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Is your email address the right one?

The Council is increasingly sending correspondence to doctors by email, as it is the quickest and most cost effective way of communicating with doctors. If you have changed or have a new email address please do let us know, so we can keep in touch.

EMAIL ADDRESSES – A WORD OF CAUTION

Occasionally we may need to send you confidential, personal or private information by email.

Because of this, it is vital that the email address you provide to the Council is suitable for receiving confidential and private information. We strongly recommend that the email address you provide to us should be personal to you and not shared with other people or doctors. We suggest it should not be accessible by anyone you would not be comfortable seeing confidential, personal or private information about you or other doctors. 

Quick link: [Change your personal details](#)



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The following article has been provided by the Department of Internal Affairs



Increasing early and correct birth registrations a priority for Births, Deaths, Marriages and Citizenship (BDM+C).

More than 1,348 babies have been registered using the new online birth registration form since it was launched in May this year.

The interactive smart-form allows parents to complete the form on their computer, before printing it to sign and post to BDM+C.

'The feedback we've had has been really positive,' says Registrar-General, Jeff Montgomery.

'Parents are finding this easy to use and complete, and staff report that less errors occur as a result of tricky handwriting.'

However, some confusion exists among the registration process for stillborn babies, or for those who have passed away shortly after birth.

'Our contact centre is receiving calls from grieving parents, requesting a copy of the printed form rather than using the online version,' Jeff says. 'These parents are free to register their child any way they wish - whichever method is easiest for them is the one they should use.'

'Some health professionals keep surplus copies of the printed form for grieving parents so that they can complete it in their own time and post it when they are ready. If others would like to do this we are happy to supply them with a small number of hardcopy forms.'

'Birth registration is really important and needs to be done correctly. However, we're also very conscious that this is a difficult time for grieving parents and we want to make the registration process as simple as possible for them. The last thing we want is for these parents to have to make any additional effort to correctly register their baby.' ►

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Other health professionals assist parents to complete the form correctly, either online or in hardcopy, to ensure they get it right first time: 'It's a great service some professionals are providing. By assisting these parents to complete the necessary paperwork correctly, there's no need for us to contact them down the track for additional information. This leaves parents free to focus on spending time with their Whānau. We're grateful to health professionals and support services that are able to offer this level of assistance to parents.'

Another focus for BDM+C is decreasing the number of late birth registrations, with a particular focus on rural Māori.

'A late birth registration is where we receive the completed registration form more than 1 year after the birth,' says Mr Montgomery.

'Our records show that that Māori proportionally have the highest number of late birth registrations, so we're really eager to see what we can do to help bring that number down.'

Registration of birth is the first official recognition of a baby born in New Zealand and one of the first steps in creating a baby's identity. It gives babies rights, privileges and official status under the law. Later, it will allow them to start school, open a bank account and obtain a New Zealand passport.

'It's vitally important that it gets done as soon as possible. Legally, there's an obligation to register the birth as soon as practical, but the emphasis is really on helping parents to ensure that their baby has access to things important things, such as healthcare, before they really need it.'

For more information please email bdm.nz@dia.govt.nz or Freephone 0800 22 52 52 (New Zealand only) 📞

Quick link: [Department of Internal Affairs - Births, Deaths and Marriages](#)



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The following article has been provided by the Health Quality & Safety Commission



Serious adverse events report reflects DHBs' improved reporting and commitment to learning

The work and resources the health sector has put into getting better at reporting incidents of patient harm are reflected in the Health Quality & Safety Commission's latest annual report into serious adverse events (SAEs), released today.

Commission Chair Professor Alan Merry says the improved reporting is encouraging: 'Patients who are harmed during health care have a right to understand what happened and to expect that everything possible will be done to prevent the same thing from happening to someone else in the future.'

The 2013/14 report shows a four percent increase in events reported by district health boards (DHBs), with 454 SAEs, up from 437 in 2012/13 – the rise a consequence of steadily improving reporting systems and DHBs' commitment to learning from events, the Commission believes.

There is also a growing range of non-DHB providers reporting their SAEs, with 104 from private surgical hospitals, aged residential care facilities, disability services, the National Screening Unit and hospices.

For the full 2013/14 SAE report, summary report and FAQs, visit <http://www.hqsc.govt.nz/our-programmes/reportable-events/publications-and-resources/publication/1832/> 

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Stop Press – Professor John Nacey has been awarded the 2014 Geoffrey Marel Medal

The Confederation of Post-graduate Medical Education Councils (CPMEC) has honoured Professor John Nacey with the 2014 Geoffrey Marel Medal.

Professor Nacey is a Council member and chair of the Council's Education Committee.

The Medal 'is awarded by CPMEC to honour the exceptional national and trans-Tasman contribution that the recipient has made to promoting prevocational training'. The award is made annually, first being presented in 2002.

The medal is named in honour of Dr G. M. Marel, FRACP, who was a physician, educationalist, and champion for the educational needs and standards of doctors as they left medical school and entered practice. Dr Marel died suddenly in 1999, just hours after being appointed by the State Premier to head the Post-graduate Medical Education Council in New South Wales, he was 47.

Mr Connolly, the Council's chairman says, 'The award has never before been made to a New Zealander, therefore this is a high honour for John and one richly deserved. Obviously we have been fortunate to witness first-hand John's outstanding leadership of the Education strategy of Council, but John has contributed to many aspects of medical education including through his work over many years on committees of the AMC and in his previous role as Dean of the Wellington Clinical School'.



Contact details

Medical Council of New Zealand
Level 6, 80 The Terrace
Wellington 6011

PO Box 10509
The Terrace
Wellington 6143

PHONE 0064 4 384 7635
FREEPHONE 0800 286 801
FAX 0064 4 385 8902
EMAIL mcnz@mcnz.org.nz
WEBSITE www.mcnz.org.nz

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