

Medical Council of New Zealand and the Midlands Health Network Memorandum of Understanding



Section 1 – Introduction



C07601

The parties

This Memorandum of Understanding (MoU) is between the Medical Council of New Zealand (the Council) and the Midlands Health Network (PHO) (the parties).

Introduction

This section of the MoU is intended to assist with the interpretation and implementation of other parts of the MoU by:

- providing the context for the operation of the MoU
- clarifying the objectives and intentions of the parties, and
- describing how the PHOs and the Council intend to interact with each other.

Purpose

The objective of the MoU is to enable the PHO and the Council, working in a collaborative and equal relationship, to clarify our respective roles and responsibilities related to the regulation of doctors in New Zealand, including the management of any competence, performance, conduct and health issues.

The MoU does not provide a definitive legal interpretation of the Health Practitioners Competence Assurance Act 2003 (HPCAA).

The parties will use all reasonable endeavours to meet the obligations under this memorandum. The parties will hold each other accountable for their performance under the memorandum.

Nominated officer

A nominated officer will be the primary point of operational contact between the Council and the PHO.¹

Values and principles

We recognise that PHOs have differing contractual and/or employment relationships with general practitioners. PHOs have responsibility for the provision of quality health and disability services within their contractual obligations and funding. The Council has a responsibility to ensure the competence and fitness to practise of doctors. PHOs and the Council do need to communicate and share information to effectively manage situations where there may be specific risks to the health and safety of the public.

We agree to foster a long-term collaborative relationship to enable us both to meet our responsibilities and manage risks to the health and safety of the public. The following relationship principles will guide each of us in our mutual dealings:

- a) We will communicate with each other in an open and timely manner (including in relation to any request to review any aspect of this MoU).
- b) We will work in a collaborative and constructive manner and where agreed, undertake joint work initiatives.
- c) We will comply with the provisions of legislation relevant to respective roles and responsibilities.
- d) The Council will make decisions within its decision-making principles (refer to Appendix 2 of this MoU).
- e) We acknowledge that the Council and each PHO have their own respective strategic and policy directions.
- f) We will work in good faith to resolve any disagreements in a timely fashion.
- g) We will support the need for clinical governance and leadership in the planning and delivery of health services in New Zealand.
- h) We will recognise and value each other's skills, expertise and commitment to high quality performance.

¹ The nominated officer would potentially be the Clinical Lead in each PHO and be equivalent point of contact between Council and the PHO similar to the role of the CMO in the DHBs.

- i) We will encourage continuing quality improvement and business development to achieve our respective organisational objectives.

Meetings

The Council will host two meetings with PHOs and GP representatives each year. The first meeting will be held in the first half of the year and will be designated as an executive meeting. Topics will include reviewing the operation of the MoU, how our mutual roles and responsibilities are being delivered, and areas for improvement in the functioning of our business and relationship.

The second meeting will include invitations to PHO board members and executives. This meeting will be more strategic and focus on the policy and strategic direction of medical regulation.

The Council will also meet, from time to time, individually with PHOs to discuss any matters of particular interest between the two parties.

After each meeting between the Council and PHOs, each participant will report on the meeting and the above items to their respective PHOs and their contracted practices.

Review

A 2-yearly review will take place, or earlier, as and when models of care and service change.

Signatures

Midlands Health Network

Date signed

10/08/15

Philip Pigou
CEO, Medical Council of New Zealand

Date signed

23 July 2015

Section 2 - Roles and responsibilities

The respective roles and responsibilities of the Council and PHOs are outlined under key headings below. The left hand column outlines the Council's role. The PHOs role is shown in the matching column on the right.

Medical Council of New Zealand (the Council)

Primary Health Organisation (PHO)

1 Registration

The Council:

The Council will maintain its standard operating processes for the registration of doctors. These include:

1.1 Experience and qualifications

Checks CVs to identify gaps or concerns, and to assess fitness to practise and fitness for registration and that the international medical graduates (IMGs) qualifications, skills and experience meet the criteria for the pathway being registered under.

Verifies identity via a check of passport, sighting original certificates and qualifications at registration interview.

Obtains certificate of good standings (where possible direct from source) for last 5 years from all jurisdictions in which the applicant has worked, to check for any concerns about health, competence, and conduct.

Seeks advice from the relevant vocational education and advisory body (VEAB) on applications for a provisional vocational scope on the training, qualifications and experience of the doctor, assessment requirements and proposed position and supervision plan.

Requires a declaration from the doctor in relation to conduct, competence, mental and physical health in the Council's application form.

1.2 References

Reviews references and referee reports to ensure there are no competence, conduct or health issues for those applying for registration within a provisional general or special purpose scope of practice. The clinical director (or equivalent) of the doctor's previous employer is a critical referee, as may be the employer him/herself in the case of

PHO:

PHOs will consider what role and responsibilities, if any, they should have in the registration of doctors. Initially, PHOs will advise their contracted practices that they should:

- undertake appropriate recruitment processes for doctors including referee checks
- ensure appropriate orientation, induction and supervision for doctors on a provisional scope of practice, consistent with the Council's standards
- ensure a system is in place to receive information provided by the Council under clause 1.3 of this MoU
- credential the doctor on appointment and then at specified intervals consistent with national guidelines.

General Practice.

Obtains and ensures satisfactory referee reports direct from source for those applying for a provisional vocational scope of practice.

The Council will maintain up to date forms on its website.

1.3 Information exchange

Shares with the PHO or the contracted practice any relevant information identified during the assessment of an applicant.

Conducts registration workshops to inform employers and recruiters on registration processes.

Ensures that consent is received from the applicant so that information from other persons and organisations can be considered (subject to notifying the applicant). Non-consent to contact, may affect the application.

1.4 Timelines

Acknowledges receipt of applications within 5 working days.

Processes complete applications within 20 working days and issue a letter of eligibility (for special purpose and provisional general scope). Doctor disclosures about fitness to practise (FTP) issues will require a longer time frame.

Completes the registration process and issues a practising certificate within 3 working days of attendance at registration interview, if all required documents are provided.

IMG vocational scope applications should be processed within 6 months of receipt of a complete application.

Applicants that hold a recognised Australasian postgraduate qualification should be processed within 4 months.

The Council will seek advice from the relevant VEAB when assessing vocational applications. They are expected to provide an initial paper assessment within 1 month of receipt of each

application, or final advice following interview, within 3 months of receipt of each application (if doctor is in New Zealand and available for interview).

Note:

The Council is currently exploring ways to reduce these time frames for registration applications.

1.5 Change of Scope

Will consider all applications for change of scope within 20 working days unless there is a competence, conduct or health issue.

2 Practising certificates

The Council:

Will send out applications to the doctor at their email address 6–8 weeks prior to the practising certificate expiry date. Completes processing of applications and issues practising certificates within 20 working days of receipt of the application if no issues are highlighted.

Will record in the Council database all doctors working in practices with a contract to, or employment within, the PHO. Will advise the PHO of any doctors recorded who have not applied to renew their practising certificate two weeks prior to the expiry of the practising certificate.

Will advise the PHO of any doctors recorded who have not applied to renew their practising certificate and the practising certificate has expired.

At the same time it provides the PHO with those doctors who have not renewed their practising certificates, Council will provide a report to the PHO listing all the doctors contracted to the PHO who have conditions on their practice, detailing what those conditions are.

Note:

When a doctor has

- provided a completed application form (including any additional information specified by the Council), and
- paid the fee set by Council before the expiry of the previously-held

The PHO (and via them their contracted practices):

Will provide the Council with a list of all doctors working in practices with a contract to, or employment within, the PHO. Will provide an updated list to the Council quarterly.

Will have agreed standards that each practice contracted to the PHO is expected to achieve. The standards will include that:

- all doctors have a current practising certificate
- all doctors are meeting any conditions on their practising certificate or scope of practice
- all doctors are meeting their recertification requirements.

Will forward any information provided by the Council about doctors who have not renewed their practising certificate to the doctor concerned and the principal(s) of the relevant medical practice.

Will immediately advise the doctor to cease practise when the doctor does not hold a current practising certificate and will advise the principal(s) of the relevant medical practice.

The PHO will pass on to the relevant medical practice information regarding doctors who have conditions on their practice, detailing what those conditions are.

practising certificate, the doctor is *deemed by law to hold* a valid practising certificate until the practising certificate is issued or the Registrar notifies the doctor that the practising certificate will not be issued.

In any other circumstance, the doctor will not hold a practising certificate until Council formally issues it.

The Council's register to show the most recently issued practising certificates, so an employer can check to confirm that a doctor has renewed their practising certificate.

3 Competence and conduct

The Council:

Where the PHO or individual practice notifies the Council of any competence or conduct concerns, the Council will communicate directly with both the PHO and individual practice in accordance with the Council's communications guide (Appendix 3 to this MoU).

For the avoidance of doubt, in all other cases of competence or conduct where Council makes an order or direction involving a doctor working within a PHO or individual practice, the PHO and individual practice will be advised of the order. This will include Council's decision on the outcome of any individual education, recertification or counselling programme.

Will, upon receipt of formal notification of competence/conduct issues, act promptly to inquire into the matter and consider a performance assessment or referral to a professional conduct committee.

Will use reasonable endeavours to undertake a performance assessment within 6 months of referral.

Where there is a serious risk of harm, Council will consider conditions and interim suspension. Any conditions or interim suspension will be included on the public register.

All Council's communications to the PHO will be to the nominated officer.

Provide competence and conduct workshops for

The PHO (and via them their contracted practices):

The PHO will appoint a nominated officer (who must be a registered and practising doctor) who will be responsible for receiving and sharing information within the PHO and with contracted practices under this MoU.

The PHO will take reasonable responsibility to ensure patients are not at risk while competence/conduct concerns are being assessed and managed by the Council.

The PHO will liaise with the Council to agree what action, if any, the PHO and the relevant medical practice may take to ensure public and patient safety.

Note:

Under section 34(3) of the HPCAA, whenever a doctor resigns or is dismissed from his or her employment or partnership for reasons relating to competence, the employer of that doctor must notify the Council's Registrar.

Must also promptly notify the Council of:

- concerns about competence/conduct not able to be dealt with within the PHO or the contracted practice
- concerns if a doctor has left a PHO or the contracted practice because of competence/conduct concerns.

appropriate staff at PHOs.

3.1 Upskilling

Develops objectives for educational programmes required after a performance review shows that a doctor fails to meet required standards of competence.

Develops individual recertification programmes to address areas where upskilling may be required.

Liases with the PHO or the contracted practice to ensure that any proposed programme is achievable in a practical sense.

3.2 Monitoring of prescribing patterns

The Council will consider any referral from a PHO about an individual doctor at its complaints triage team and will notify the PHO of any action(s) in accordance with the Appendix 3 – Communication Guide.

3.1 Upskilling

Assist the Council with supervision and appropriate resources related to competence programmes and recertification programmes. Facilitate other steps (ie, leave to allow further retraining) to remedy the skill deficiencies.

3.2 Monitoring of prescribing patterns

Where the PHO does monitor prescribing patterns of the doctors working in practices contracted to the PHO, the PHO will notify the Council in cases where the prescribing may raise questions of risk of serious harm to the public, and will notify the practice of their intention to do so.

Where the PHO measures other quality of care indicators, such as note taking or informed consent, significant outliers will be discussed with the practice(s) concerned and where appropriate, notified to the Council.

4 Management and sharing of information regarding doctors who are not working within a PHO (or a contracted practice)

The Council:

Where an order or direction is made by the Council, or when the Council orders a PCC or PAC likely to impact on a PHO, publication of the order or direction will be made to the nominated officer. For the avoidance of doubt, the purpose of this provision is to ensure information reaches the PHO and individual practices so that any referrals are made only to legally practising doctors.

Where a notice is issued under section 35 of the HPCAA, the Council will request that the Ministry of Health advise any effected PHOs of the notice.

PHO (and via them their contracted practices):

The nominated officer, on receipt of any order or notice, will confirm receipt to the Council. Following receipt of information from Council the nominated officer will ensure relevant people within the PHO or the contracted practice are notified as appropriate. This includes the nominated officer liaising with the relevant Clinical Lead (or equivalent) of the PHO and/or the principal partner(s) (or equivalent) of the contracted practice and in all cases the supervisor (if the doctor is under provisional registration).

The nominated officer will liaise with the Council and the affected practice, on a plan to monitor the order or notice and to determine if specific action is required to ensure public health and safety.

The Minister of Health's office will be advised of any actions taken by the Council under this part of the MoU.

The PHO will advise the Council of all information it has or receives in relation to the doctor.

5 Health

The Council:

If there is a reason to believe a doctor is not fit to practise because of a mental or physical condition, the Council will notify the PHO where there is:

- a risk of harm arising from a doctor's practice
- a suspension
- conditions or other limitations placed on the doctor's practice
- a request that the employer be informed by the Council's Health Committee.

Ensures assessments are completed to ascertain if a doctor is fit to practise.

Agrees on voluntary agreements with doctor to maintain the doctor in safe practice and to ensure the PHO is aware of any relevant health issues requiring the PHOs management or oversight.

The nominated officer will be the key workplace contact for sharing information relating to health concerns.

PHO (and via them their contracted practices):

Note:

All registered health practitioners including doctors (and those that employ doctors) have a duty to report to the Council under section 45 of the HPCAA if there is reason to believe a doctor is not fit to practise if, because of a mental or physical condition, he or she is not able to perform the functions required for the practice of medicine.

Those functions include:

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

Each PHO will ensure concerns identified within the PHO, or by the relevant medical practice are notified through their clinical governance process.

The PHO working together with the relevant medical practice will develop appropriate back-to-work programme and notify the Council's Health Manager if required.

Assist with monitoring in workplace where appropriate and agreed.

Assist the practices to ensure appropriate processes are in place to implement any changes in the scope of practice (including changes to practising certificate).

6 Statements

The Council:

A list of all the Council's statements is attached as Appendix 4 to this MoU.

PHO (and via them their contracted practices):

The PHO will assist their contracted practices to ensure that each practice contracted to the PHO will be familiar with the Council's standards and

Each statement can be accessed on-line at www.mcnz.org.nz statements.

Approved practice setting (APS):

A service that is accredited as an APS is recognised by the Council as having appropriate support and supervision available and provided to IMGs to ensure their safe integration into medical practice in New Zealand.

Vocational education and advisory body (VEAB):

A specialist college, society or association that may be accredited by the Council to carry out one or more of the following functions

- deliver a postgraduate training programme
- deliver a recertification programme
- provide advice to the Council about the qualifications, training and experience of individual IMGs applying for registration within a vocational scope of practice.

Credentiailling:

Credentiailling is a process used by Health and Disability Service providers to assign specific clinical responsibilities to doctors on the basis of their training, qualifications, experience and fitness to practise within a defined context. This context includes the facilities and support available and the service the organisation they work in provides.

Fitness to practise (FTP):

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

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

Orientation and induction:

Orientation is viewed as a doctor's broad introduction to the New Zealand health system. Induction is viewed as the introduction to the specific DHB and individual service a doctor is employed in.

Recertification:

Recertification is the term given to the process by which all doctors demonstrate their competence to *practise within the scope of practice in which they are registered*, as a condition of holding an annual practising certificate.

Individual recertification:

Individual recertification programme means a one-off recertification programme under section 41 of the HPCAA for a specific doctor, or group of doctors, designed to address an identified weakness or deficiency in one or more specific competencies (or to develop additional competencies within their scopes of practice).

Performance assessment committee (PAC):

A performance assessment is a practice visit by two peers and a lay member. This group is called the Performance Assessment Committee (PAC). The PAC assesses the doctor's performance and provides a written report to Council on its findings. A performance assessment aims to ensure that a doctor is practising at the required standard.

Professional Conduct Committee (PCC):

A PCC is made up of three members appointed by Council, two doctors and one lay member. A PCC deal with complaints referred from the Health and Disability Commission and with referrals after certain convictions in a court of law. In addition, if the Council considers information in its possession raises questions about the conduct or safety of a doctor's practice, then it may refer those questions to a PCC.

Regular practice review (RPR):

RPR is a formative and supportive collegial review of a doctor's practice by peers, using a range of tools, in a doctor's usual practice setting. RPR is informed by a portfolio of information provided by the doctor, and includes 360° feedback and may also include audit outcomes and logbooks. RPR must include a component of external review that is by peers external to a doctor's usual practice setting.

Risk of harm may be indicated:

- a pattern of practice over a period of time that suggests the doctor's practice of medicine may not meet the required standard of competence; or
- a single incident that demonstrates a significant departure from accepted standards of medical practice; or
- recognised poor performance where local interventions have failed – this does not exclude notification of serious concerns where internal review or audit is inaccessible or unavailable to the person with the concern; or criminal offending; or
- professional isolation with declining standards that become apparent.

Risk of serious harm:

- an individual patient may be seriously harmed by the doctor; or
- the doctor may pose a continued threat to more than one patient and as such the harm is collectively considered 'serious'; or
- there is sufficient evidence to suggest that the alleged criminal offending is of such a nature that the doctor poses a risk of harm to one or more members of the public.



Protocol for decision-making principles

Background

- 1 The Council's governance role is to establish the strategic direction of the Council consistent with its purpose of protecting the health and safety of the public by ensuring doctors are competent and fit to practise.
- 2 The Council has a quasi-judicial function that is distinct from its strategic governance role. This function must be exercised within the Council's powers and responsibilities under the Health Practitioners Competence Assurance Act 2003 (HPCAA). These functions relate mainly to the exercise of the Council's powers of registration, competence, conduct and health in relation to a specifically identified doctor.
- 3 The Council's decision-making principles will need to reflect these differences in Council's roles. Although there are likely to be common principles for both roles, it is also likely that each role will have distinctly separate principles. The remainder of this protocol identifies common and separate principles, relevant to Council's roles.

Common principles – governance and quasi-judicial roles

- **Accountability:**
The Council is accountable for its decisions to the public, the Minister of Health and Parliament and, in relation to the efficient use of funds to achieve its purpose under the HPCAA, to the profession. This means that the Council will consider:
 - Whether the decision is consistent with its principal purpose – to protect the health and safety of the public.
 - Whether the decision is consistent with its functions under the HPCAA ie, setting standards, ensuring competence, promoting education and training, promoting public awareness, etc.
 - Whether the decision is consistent with its values and principles as expressed in the Business Plan.
 - Whether the decision is the most efficient means of meeting Council's obligations under the HPCAA.
- **Trust:**
The Council will consider trust in key relationships when deciding governance and quasi-judicial matters. The key relationships are:
 - Between the profession and the public.
 - Between the public and the Council.
 - Between the profession and the Council.
 The Council will consider:
 - would the decision improve the trust in one or more of these relationships?
 - What would be the impact on the other relationship(s)?
- **Independence:**
 - The independence of Council members is important to ensure the integrity of Council's decisions. The Council does not represent the profession and must be free from influence from external bodies. Council members will decide governance and quasi-judicial matters independently of any stakeholder interest, personal interest or relationship and

professional interest or relationship. (Please also refer to the Council's *Policy on conflict of interest*).

- Inquiry:
 - Council will inquire into and assess all relevant and available information in deciding governance and quasi-judicial matters. This would include examining critically all assumptions to determine opinion and fact.
- Consistency:
 - Council aims to ensure good decisions over time by giving consideration to earlier decisions when deciding governance and quasi-judicial matters. Council acknowledges that regulatory standards change over time and decisions will always be based on the standards existing at that time.
- Cultural competence:
 - Council recognises that doctors in New Zealand work with a population that is culturally diverse and therefore cross-cultural doctor-patient and doctor-clinical team interactions are common. Council will itself demonstrate and continue to promote awareness amongst all doctors of cultural diversity and the ability to function effectively, and respectfully, when working with people of different cultural backgrounds.

Specific principles – governance roles

- Responsibility:
 - Council, in relation to any regulatory intervention of a strategic or policy nature, has a responsibility to the profession to engage, consider comment and feedback fairly, and to make decisions that can be effectively implemented.

Specific principles – quasi-judicial roles

- HPCAA:
 - The Council will always act consistent with the purpose, principles and specific enabling provisions of the HPCAA.
- Principles of natural justice:
 - The Council will apply the specific provisions of the HPCAA regarding providing relevant information and giving reasonable opportunity to make written submissions and be heard.
 - Proceedings of Council will be conducted so that they are fair to all parties.
 - The Council will only take into account relevant considerations and extenuating circumstances and ignore irrelevant considerations.
 - All members of Council should act without bias (refer to Council's *Policy on conflict of interest*) and act in good faith.
- Risk of harm and risk of serious harm:
 - The Council, in considering individual cases, will expressly apply its definitions of risk of harm and risk of serious harm. The relevant definitions are:

Risk of harm may be indicated by:

- A pattern of practice over a period of time that suggests the doctor's practice of medicine may not meet the required standard of competence; or
- A single incident that demonstrates a significant departure from accepted standards of medical practice; or
- Recognised poor performance where local interventions have failed – this does not exclude notification of serious concerns where internal review or audit is inaccessible or unavailable to the person with the concern; or criminal offending.
- Professional isolation with declining standards that becomes apparent.

Risk of serious harm may be indicated when:

- An individual patient may be seriously harmed by the doctor; or
- The doctor may pose a continued threat to more than one patient and as such, the harm is collectively considered 'serious'; or

- There is sufficient evidence to suggest that alleged criminal offending is of such a nature that the doctor poses a risk of serious harm to one or more members of the public.

Approved by Council: 13 May 2009

Amended by Council: 16 May 2012



Key	NFA - no further action
VU - voluntary undertaking	PAC - performance assessment committee
CTT - complaints triage team	PCC - performance conduct committee
HDC - Health and Disability Commission	
HPDT- Health Practitioners Disciplinary Tribunal	

Purpose

1. This paper sets out a framework for communicating with people from whom we receive complaints or referrals and other people who should be informed. The purpose of this is to ensure our communication to those with an interest in Council decisions or actions is consistent with Council’s values of openness and accountability and its strategic goal of improving Council’s relationship and partnership with the public and the profession. Greater transparency also facilitates putting in place support for doctors about whom there are concerns, in order to protect public health and safety.

2. The statutory basis for this approach comprises:

- (1) obligations and powers to communicate information contained in specific sections of the HPCAA (eg, sections 35, 38) and
- (2) an overarching power provided in section 157(1) to publish that is, to communicate, Council decisions – orders, directions and findings.

The information communicated can include both information that is public information within the terms of the Act and/or a required notification under the Act and information that is not automatically public but which the Council may publish under section 157, or both.

3. In relation to our communication with DHBs, Southern Cross and identified private surgical hospitals, the communication given under the principles of this guide supplements the principles and agreements set out in the MOUs between Council and each DHB, Southern Cross and the New Zealand Private Surgical Hospitals Association.

Guiding principles

4. Decisions made under specific sections of the Act will, in some case, involve an assessment of the scope of communication (that is, the information to be shared and to whom), for example, a decision of who is an “associate” for the purposes of notification of section 38 orders. Decisions made under section 157 (the broader

power to notify) will always be case by case informed by public health and safety. This guide captures the communication that is most likely to be required but acknowledges that it will not cover every situation. There will be some occasions when it is appropriate and reasonable to do something different. Consideration of the risk of harm to public health and safety will always be a key principle. Other related considerations include the role that the person to whom the communication may play in monitoring a doctor's practice, or in ensuring that the person is able to take the matters into account in his or her future care of an affected patient. Some will have a key role in management of patient safety while facilitating Council processes.

5. Council also needs to maintain public and individual consumer/complainant confidence in Council processes. Council acknowledges that an affected consumer has a legitimate interest in subsequent review processes in Council, even if the processes are not directed to the individual complaint or event. The roles of the HDC and Council overlap, and our communication needs to reflect that. This occurs, for example, when the HDC refers to us several low level complaints he has received over several years. In such situations where what we should do is not obvious, the following principles will guide decision making in relation to whether and what we communicate:

- Whether the complaint is still likely to be alive in the mind of the consumer/complainant.
- The proximity in time of the event leading to the complaint and our communication with the consumer/complainant.

Internal communication within Council eg. between health and professional standards teams falls outside the scope of this guide. That communication does not require or rely on express powers provided in the Act.

Definitions

6. Unless otherwise stated "complainant" refers to complaints received under section 34 and section 64 of the HPCAA and includes:

- Colleagues, in primary and secondary/tertiary settings.
- Consumers where we are undertaking our process at the same time as the HDC is undertaking an investigation.
- Possibly ACC – we asked ACC what information about our response to a referral would be useful to them following their advice to us of a sentinel event but received no response.

7. "Informant" means any other person/organisation we don't regard as a complainant and includes information that comes to Council under section 68(3). (There is no equivalent section relating specifically to competence issues). Generally this will include people who have not been personally affected by the issue about which they are informing us. In the table below, it is proposed to tell the informant what action Council is to take, but not the outcome of the process.

8. "Working in association with" will not be limited to those working within the same practice as the subject doctor. In this case, the context is important and the paramount consideration is, again, public safety. The scope of this communication might reasonably extend to those who share the care of a patient, or to whom the patient has been referred for ongoing or associated care, or where that is an established practice. On the other hand, it might exclude those who only temporarily co-located with the doctor such as locums and/or who will not have any contact with, or influence on the care of, that doctor's patients.

Notes:

- 1) The need to communicate with the doctor who is the subject of the complaint at all stages goes without saying and is not included in this table.
- 2) In the table below the term “A & E clinics” is used to refer to clinics that may be called Accident and Emergency (A & E) or Urgent Care (UC) that are independently owned or directed and are not directly part of a hospital. They will often have a CEO and a clinical director but be staffed by many doctors including locums on a full time or part time basis. For these types of clinics we will usually notify only the CEO and the Clinical Director but the situation for each doctor needs to be considered individually.

	MCNZ Step in our process	Who should be told	What we tell them
1.	<p>Complaint or information (that we can act on) is received.</p> <p>Competence team: seek response from Dr first before going to CTT.</p> <p>Conduct: may go to CTT first then back to CTT once response is received.</p>	<p><u>Competence only – section 34 notifications from colleagues must go to Council</u></p> <ul style="list-style-type: none"> • Complainant. • Informant. <p><u>Conduct only</u></p> <ul style="list-style-type: none"> • Complainant. • Informant. 	<p>Acknowledge receipt to complainant/informant</p> <p>Next step is that we seek response from Dr.</p> <p>Complaint will be referred to Council.</p> <p>You will be advised of outcome of this step.</p> <p>Time frame – 1 to 2 months.</p> <p>Acknowledge receipt to complainant/informant.</p> <p>Complaint will be referred to Council.</p> <p>Provide deadline for any additional comments.</p>
1a.	Seek response from Dr (and if a GP ask for names of other Drs at that practise).		Personal information they provide is subject to disclosure under the Privacy Act. Ask if they consent to their response being released to the complainant.
1b.	Goes to CTT (if applicable).		
1.1	Evidence of a conviction received.	<ul style="list-style-type: none"> • CMO (if Dr is employed). • Clinical Head of Dept (if Dr is employed) if there is a risk that needs to be managed while the process is ongoing • Council appointed supervisor if Dr is prov gen or prov voc. • GP practice associates. • PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. 	<ul style="list-style-type: none"> • Act and section under which Dr is convicted. • A summary of the issue (under section 157). • If applicable, that it is not directly related to clinical practise so there is no reason to think there is a risk of harm. • PCC has its own independent process. • Time frame for PCC process.

		<ul style="list-style-type: none"> Southern Cross where we know the doctor is Southern Cross credentialled. The College of General Practitioners (if the doctor is a GP Registrar – GP’s Registrars are now ‘employees’ of the College as from the Dec 2012 intake). CEO and Clinical Director for independent A & E clinic. 	
2a.	If outcome of CTT is Educational letter or NFA:	<ul style="list-style-type: none"> Complainant. Informant. cc in the HDC. <p>(Rationale: Low level concern and not appropriate to inform everyone)</p>	The outcome and reasons for it as recorded at the CTT meeting.
2b.	If outcome is that it goes to Council: (If complaint is from a colleague, Competence have already stated that the matter will go to Council).	<ul style="list-style-type: none"> Complainant. Informant. <p>Where the doctor has gone overseas and CTT decides the matter should be referred to Council if the doctor seeks to return to practice in NZ. Generally we will not tell the people listed under 2c at this point but it can be considered by CTT on a case by case basis Exceptions might be (eg):</p> <ul style="list-style-type: none"> Where section 35 applies (see below). Where there is sufficient information of concern to warrant advising those people. Where the doctor works at places other than the place where the complainant works. 	<p>Update.</p> <p>That the matter will be referred to Council if the doctor seeks to return to practice in NZ (or whatever is decided).</p>
2c.	If the Registrar/CTT consider there may be a risk of harm and/or the doctor agrees to enter into a VU pending Council consideration.	<p>Note: Where a VU is put in place but no section 35 Notice issued, decisions as to who to advise should be made on a case by case basis, with discussion at least at Difficult Cases.</p> <ul style="list-style-type: none"> Those listed in section 35 (includes RNZCGP for GPEP doctors). 	<p>Existence of the VU.</p> <p>Our communications with the CMO (for employed doctors) should be proactive and more in the nature of liaison with a view to taking a cooperative approach to mitigating the risk while Council considers the matter.</p>

	<p>Or if there is a Registrar referral to a PCC.</p> <p>Section 35 may apply.</p>	<p>Others we may communicate with include:</p> <ul style="list-style-type: none"> • Complainant. • CMO (if DHB Dr). • Clinical HoD. • Council appointed supervisor if Dr is prov gen or prov voc. • GP practice associates • PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. • Southern Cross where we know the doctor is Southern Cross credentialled. • CEO and Clinical Director for independent A & E clinic. 	
3.	<p>Case goes to Council meeting and Council makes decision.</p>		
3a.	<p>If PCC ordered.</p>	<ul style="list-style-type: none"> • Complainant. • CMO (if Dr is employed). • Clinical Head of Dept (if Dr is employed) if there is a risk that needs to be managed while the process is ongoing • Council appointed supervisor if Dr is prov gen or prov voc. • GP practice associates. • PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. • Southern Cross where we know the doctor is Southern Cross credentialled. • Informant. • The College of General Practitioners (if the doctor is a GP Registrar – GP’s Registrars are now ‘employees’ of the College as from the Dec 2012 intake). • CEO and Clinical Director for independent A & E clinic. 	<p>Council’s decision including:</p> <ul style="list-style-type: none"> • PCC has its own independent process. • Complainant/informant may be contacted by PCC. • Time frame for PCC process. • A summary of the issue (under section 157) <p>Note: Discussion will also be held with Clinical HoD, supervisor (where applicable) and CMO around how any risk will be managed.</p> <p>Note: The “Clinical HOD” means wherever the Dr is working and this may change through the course of our processes.</p> <p>Note: Southern Cross will be providing us with this information.</p> <ul style="list-style-type: none"> • Council’s decision including: <ul style="list-style-type: none"> ○ Time frame for PAC process. ○ That PAC convenor will be in touch (told to
3b.	<p>If PAC ordered.</p>	<ul style="list-style-type: none"> • Complainant. • CMO and Clinical HOD if Dr is employed. 	

		<ul style="list-style-type: none"> GP practice associates. PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. Southern Cross where we know the doctor is Southern Cross credentialled. Informant. Council appointed supervisor if Dr is prov gen or prov voc The RNZCGP (if the doctor is in the 1st year of the GPEP – GP's Registrars are now 'employees' of the College as from the Dec 2012 intake). CEO and Clinical Director for independent A & E clinic. 	<p>CMO and HOD / private practice).</p> <ul style="list-style-type: none"> Ask for point of contact for the PAC convenor. <p>Note: PAC convenor is expected to also ask the doctor if there is someone the PAC should speak to.</p>
3c.	No further action or education letter is to be sent.	<ul style="list-style-type: none"> Complainant. Informant. <p>No one else to be advised on the basis complaint is 'low level' and Council is taking no action.</p>	
3d.	Recertification programme ordered.	<ul style="list-style-type: none"> Complainant. CMO and Clinical HOD if Dr is employed. RNZCGP for 1st year GPEP doctors. GP practice associates. PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. Southern Cross where we know the doctor is Southern Cross credentialled. Informant. CEO and Clinical Director for independent A & E clinic. 	<p>Council's decision including the time frame for any process.</p>
3e.	Referral to Health This can happen at any time in the process. It may be that Prof Standards have only communicated with the	<p>Prof Standards team to handover to Health team AND advise those who we have already communicated with:</p> <ul style="list-style-type: none"> CMO appointed supervisor. Southern Cross if credentialled. <p>Council</p>	<p>Dr has been referred to the Health team.</p>

	complainant or informant, or other people may have been told.	<ul style="list-style-type: none"> • RNZCGP for 1st year GPEP doctors. • GP practice associates. • CEO and Clinical Director for independent A & E clinic. • Consumer complainant. 	<p>Dr is not practising at present and so we have suspended any other process about the matter you raised.</p> <p>If they make further enquiries or if it is appropriate in the circumstances, then subject to us advising the Dr that we are intending to tell the complainant and asking if there is any reason why we should not, then we will tell the complainant the Dr has been referred to the health team. If the Dr resumes practice we will then re-look at the matter but we cannot at this time give them a time frame as to when this may occur.</p>
4.1	Performance assessment is completed and PAC report goes to Council meeting and Council makes decision.		
4.1a	Outcome of PAC is an education programme.	<p>As per section 38(3):</p> <ul style="list-style-type: none"> • CMO and Clinical HOD if Dr is employed. • RNZCGP for 1st year GPEP doctors. • PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. • Southern Cross where we know the doctor is Southern Cross credentialled. • Any other person who works “in partnership or association with” including GP practice associates. • CEO and Clinical Director for independent A & E clinic. <p>PLUS:</p> <ul style="list-style-type: none"> • Complainant. 	<ul style="list-style-type: none"> • Education programme has been ordered. • length of time • programme will be supervised • when appropriate, the possibility of a further follow up PAC or second education programme. <p>For complainant:</p>

			<ul style="list-style-type: none"> As above. No further communication will be made (even if the doctor is required to undergo a further process).
4.1b	Outcome of PAC is a recertification programme.	<ul style="list-style-type: none"> CMO and Clinical HOD if Dr is employed. RNZCGP for 1st year GPEP doctors. PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. Southern Cross where we know the doctor is Southern Cross credentialled. Any other person who works “in partnership or association with” including GP practice associates. CEO and Clinical Director for independent A & E clinic. <p>PLUS:</p> <ul style="list-style-type: none"> Complainant. 	<ul style="list-style-type: none"> Programme has been ordered. What it means (as per Council minutes). Length of time. Outcome will be monitored. When appropriate, the possibility of a further process. <p>For complainant:</p> <ul style="list-style-type: none"> as above <p>No further communication will be made (even if the doctor is required to undergo a further process).</p>
4.1c	Outcome of PAC is conditions.	<p>As per section 38(3):</p> <ul style="list-style-type: none"> CMO and Clinical HOD if Dr is employed. RNZCGP for 1st year GPEP doctors. PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. Southern Cross where we know the doctor is Southern Cross credentialled. Any other person who works “in partnership or association with” including GP practice associates. CEO and Clinical Director for independent A & E clinic. <p>PLUS</p> <ul style="list-style-type: none"> Complainant. 	<ul style="list-style-type: none"> What they are. When they take effect. That they will be on the online Register. <p>For complainant:</p> <ul style="list-style-type: none"> As above.

4.1d	Other PAC outcomes under section 38 (assessment or counselling).	<p>As per section 38(3):</p> <ul style="list-style-type: none"> • CMO and Clinical HOD if Dr is employed. • RNZCGP for 1st year GPEP doctors. • PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. • Southern Cross where we know the doctor is Southern Cross credentialled. • Any other person who works “in partnership or association with” including GP practice associates. • CEO and Clinical Director for independent A & E clinic. <p>PLUS</p> <ul style="list-style-type: none"> • Complainant. 	No further communication will be made (even if the doctor is required to undergo a further process).
4.1e	Doctor is required to undertake a follow up PAC or further education programme. (This does not apply to any further recertification programme).	<ul style="list-style-type: none"> • CMO and Clinical HOD if Dr is employed. • RNZCGP for 1st year GPEP doctors. • GP practice associates • PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. • Southern Cross where we know the doctor is Southern Cross credentialled. • CEO and Clinical Director for independent A & E clinic. 	<p>No further communication will be made with the complainant (even if the doctor is required to undergo a further process).</p> <ul style="list-style-type: none"> • Goals of programme. • Length of time. • Identity of supervisor. • Possibility of a further follow up PAC or further education programme.
4.2	PCC is completed and PCC report is referred to Council meeting for noting.		Note: the PCC send a copy of its report to the complainant as per section 81.

4.2a	Council notes outcome of PCC as per options in section 80.	<ul style="list-style-type: none"> • Complainant. • CMO and Clinical HOD if Dr is employed. • RNZCGP for 1st year GPEP doctors. • GP practice associates. • PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. • Southern Cross where we know the doctor is Southern Cross credentialled. • CEO and Clinical Director for independent A & E clinic. 	The outcome. Likely time frame for completion (unless NFA). That Doctor may be granted name suppression by HPDT.
5.	At end of PAC process (noting that steps in 5.1 may be repeated more than once).	<ul style="list-style-type: none"> • CMO and Clinical HOD if Dr is employed. • RNZCGP for 1st year GPEP doctors. • GP practice associates. • PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. • Southern Cross where we know the doctor is Southern Cross credentialled. • CEO and Clinical Director for independent A & E clinic. 	Process has been satisfactorily completed. OR Another process is required – return to step 4.1.
6	HPDT advised Registrar of outcome of hearing.	<ul style="list-style-type: none"> • CMO and Clinical HOD if Dr is employed. • RNZCGP for 1st year GPEP doctors. • GP practice associates. • PHO (possibly) and CMO of relevant DHB if Dr works in sole practice in primary care. • Southern Cross where we know the doctor is Southern Cross credentialled. • CEO and Clinical Director for independent A & E clinic. 	Summary of HPDT order. That Council will be administering and monitoring conditions (if applicable).

Examples of use of this framework with real situations (bearing in mind the principles of point 5 in the introduction and that this will be work-in-progress for a short period):

HDC refers to us an investigation that they are not taking any further action on, for our information.	We communicate with the complainant as to the outcome of Council's consideration.
HDC notifies us they have received a complaint (and we do not commence a process).	We do not communicate with anyone.
HDC notifies us they have commenced an investigation (and we do not commence a process).	We do not communicate with anyone.
A complainant copies in other organisations to their original concern to Council eg, MOH, a Medical College, any other professional organisation.	IF the other organisations follow up with us, we respond as to what action if any we are taking.
The HDC refers a series of low level complaints to us.	We would not advise each complainant on the basis that we are considering a trend in that doctor's performance rather than the individual issues.
The HDC refers a complaint to us without any investigation.	We treat the consumer the same as any other complainant as per the above process.
The HDC takes 2 or 3 years to complete an investigation before advising us of the outcome.	We communicate with the consumer on the basis that despite the time frame, the complaint is likely to be still alive in the consumer's mind. The consumer is treated as any other complainant as per the above process.
An HDC complainant has died.	If the family of the deceased has made a complaint we communicate with the family representative as per any other complainant.
Referrals to Council are made by colleagues and the consumer is not aware a complaint has been made.	We communicate with the colleague but not the consumer.

There is no foreseeable end to a competence process/PAC/Educational programme/follow up PAC/Education Programme: at what point do we stop updating the complainant?

We advise a consumer complainant of the first outcome. See 4.1a and 4.1d in the above table.

The Council's statements

Definitions for doctors

- Definition of clinical practice and non-clinical practice (Aug 2006)
- Definition of fitness to practise (Nov 2012)
- Definition of the 'practice of medicine' (Aug 2004)
- Definitions of risk of harm and risk of serious harm (Aug 2004)

Standards for doctors

Good Medical Practice

- Good medical practice (Jun 2008)

Medical care

- Complementary and alternative medicine (Mar 2011)
- A doctor's duty to help in a medical emergency (Aug 2006)
- HRANZ Joint Guidelines for registered health care workers on transmissible major viral infections (Nov 2005)
- Cosmetic procedures (Oct 2011)
- Safe practice in an environment of resource limitation (Aug 2008)

Good prescribing practice

- Good prescribing practice (Apr 2010)
- Prescribing drugs of abuse (Apr 2010)
- Prescribing performance enhancing medicines in sport (Apr 2010)

Communication and informed consent

- Information, choice of treatment and informed consent (Mar 2011)
- Ending a doctor-patient relationship (Mar 2011)
- Use of the internet and electronic communication (May 2006)
- Maintenance and retention of patient records (Aug 2008)
- Disclosure of harm following an adverse event (Dec 2010)
- When another person is present during the consultation (Mar 2004)
- Statement on advertising (Aug 2010)

Cultural competence

- Cultural competence (Aug 2006)
- Best practices when providing care to Māori patients and their whānau (Aug 2006)
- Best health outcomes for Maori: Practice implications (Oct 2006)
- Best health outcomes for Pacific Peoples: Practice implications (May 2010)

Management

- Responsibilities of doctors management and governance (Mar 2011)
- Employment of doctors in the Health Practitioners Competence Assurance Act 2003 (Dec 2005)

Professionalism

- What to do when you have concerns about a colleague (Dec 2010)
- Unprofessional behaviour and the health care team. Protecting patient safety (Aug 2009)
- Medical certification (Dec 2007)
- Sexual Boundaries in the Doctor-Patient Relationship - A resource for doctors (Oct 2009)
- Providing care to yourself and those close to you (Jun 2007)
- Non-treating doctors performing medical assessments of patients for third parties (Dec 2010)
- Doctors and health related commercial organisations (Jul 2012)

Patients

- What to expect from your doctor when you have a cosmetic procedure (Jun 2008)
- You and your doctor (Mar 2008)
- The importance of clear sexual boundaries in the patient-doctor relationship. A guide for patients (Oct 2006)

Guides & Booklets

- Cole's Medical Practice in New Zealand (2011)

Get Registered

Registration

- Medical Registration in New Zealand (Oct 2007)
- Medical Registration Handbook 2012 (Apr 2012)
- Orientation Induction and Supervision for International Medical Graduates (Jan 2011)

Maintain Registration

Practising Certificate

- Guide to completing a Practising Certificate application (Jul 2009)

CPD

- Continuing Professional Development and Recertification (May 2008)
- Education and Supervision for interns (Oct 2006)

Supervision

- Orientation Induction and Supervision for International Medical Graduates (Jan 2011)

Fitness to Practise

Conduct

- Sexual boundaries a guide for patients (Oct 2006)
- What to expect if your complaint is referred to a professional conduct committee (Apr 2011)
- What to expect if you are referred to a professional conduct committee (Apr 2011)
- You and your doctor (Mar 2008)

Competence

- Assessing Doctors' Performance (May 2005)
- Performance Assessment what you can expect (Apr 2010)

Health

- Doctors' health (Dec 2004)

Standards for assessment and accreditation

- Additional criteria for assessment of specialist medical training programmes of Australasian vocational colleges

This should be used in conjunction with the joint Australian Medical Council and Medical Council of New Zealand standards for assessment and accreditation

For the most recent versions of these documents please visit www.mcnz.org.nz.