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# Performance review of the Medical Council of New Zealand

Promoting improvement in regulation through  
international collaboration

June 2010

## About CHRE

The Council for Healthcare Regulatory Excellence promotes the health and well-being of patients and the public in the regulation of health professionals. We scrutinise and oversee the work of the nine regulatory bodies<sup>1</sup> that set standards for training and conduct of health professionals.

We share good practice and knowledge with the regulatory bodies, conduct research and introduce new ideas about regulation to the sector. We monitor policy in the UK and Europe and advise the four UK government health departments on issues relating to the regulation of health professionals. We are an independent body accountable to the UK Parliament.

## Our aims

CHRE aims to promote the health, safety and well-being of patients and other members of the public and to be a strong, independent voice for patients in the regulation of health professionals throughout the UK.

## Our values and principles

Our values and principles act as a framework for our decision making. They are at the heart of who we are and how we would like to be seen by our stakeholders.

### *Our values are:*

- Patient and public centred
- Independent
- Fair
- Transparent
- Proportionate
- Outcome focused.

### *Our principles are:*

- Proportionality
- Accountability
- Consistency
- Targeting
- Transparency
- Agility.

## Right-touch regulation

Right-touch regulation is based on a careful assessment of risk, which is targeted and proportionate, which provides a framework in which professionalism can flourish and organisational excellence can be achieved. Excellence is the consistent performance of good practice combined with continuous improvement.

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<sup>1</sup> General Chiropractic Council (GCC), General Dental Council (GDC), General Medical Council (GMC), General Optical Council (GOC), General Osteopathic Council (GOsC), Health Professions Council (HPC), Nursing and Midwifery Council (NMC), Pharmaceutical Society of Northern Ireland (PSNI), Royal Pharmaceutical Society of Great Britain (RPSGB)

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# 1. Introduction

- 1.1 This report follows a request in late 2009 from the Medical Council of New Zealand (MCNZ) for CHRE to undertake a full performance review of that organisation. The performance review was carried out in March and April 2010.
- 1.2 CHRE undertakes annual performance reviews of the nine health professional regulatory bodies in the UK under Section 26 of the National Health Service Reform and Health Care Professions Act 2002 and Section 114(6) of the Health and Social Care Act 2008. We publish the outcome of those reviews annually to the UK Parliament and the devolved administrations in the UK.
- 1.3 Although CHRE has no statutory oversight of the MCNZ, we considered that it would be valuable to undertake this review. There would be benefits to the MCNZ in having an independent assessment benchmarking their performance in relation to regulators in the UK and CHRE would learn about different approaches to regulation and regulatory practice, which could be shared with regulatory bodies in the UK. Conducting this review with the MCNZ at this time has also allowed us to test out our revised, more outcome directed standards.

## 2. The performance review process

- 2.1 CHRE has an established process for undertaking performance reviews. This is based on a set of standards, which we developed in liaison with the UK health professional regulators and other stakeholders including patients and the public. These are called the *Standards of Good Regulation*.
- 2.2 In undertaking this review we used our revised procedure and standards for undertaking performance reviews of the health professional regulators in the UK<sup>1</sup>.
- 2.3 In brief, the procedure followed in this review involved the following steps:
  - Consideration of the written evidence which the MCNZ provided in relation to the *Standards of Good Regulation*, together with information which we received from third parties (see appendix 2)
  - A week working at the MCNZ in Wellington during April 2010, when staff from the MCNZ provided further evidence and background information about the organisation
  - Auditing six MCNZ fitness to practise cases chosen as a random sample by CHRE
  - Attending a 'senior officers of Council' meeting at MCNZ which considered and made decisions on nine possible fitness to practise cases
  - Attending meetings in New Zealand with people who had given third party feedback, including representatives of the Health and Disability Commissioner (HDC) and the Health Practitioners Disciplinary Tribunal (HPDT)

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<sup>1</sup> CHRE, June 2010. *The Performance Review Standards: standards of good regulation*. London: CHRE.

- Giving initial informal feedback to the chair, chief executive and senior management team of the MCNZ and considering their responses
  - Sharing a draft report with MCNZ for comment
  - Completion of this final report.
- 2.4 In addition, while they were in New Zealand the CHRE staff presented at a seminar for the MCNZ, representatives of other regulators and the Ministry of Health on right-touch regulation and the UK approach.
- 2.5 We are very grateful to the chair and chief executive of the MCNZ and its staff for their help in enabling us to undertake this review. They readily provided all the information we asked for and answered all of our questions. We found them open and helpful. We should also like to thank all of the other people who provided information (see appendices 1 and 2).

### 3. The role of the MCNZ and the regulatory environment in New Zealand

- 3.1 Although the structure of healthcare regulation in New Zealand is markedly different from the UK in both philosophy and organisation, the MCNZ's role and responsibilities are similar to those of the General Medical Council and other UK healthcare professional regulators. In brief, it has five main functions, which are to:
- Set and promote standards that doctors must meet before and after they are admitted to the register
  - Maintain a register of those doctors who meet the standards. Only registered practitioners with a current practising certificate are allowed to work as doctors
  - Take appropriate action where a doctor's fitness or competence to practise has been called into question
  - Ensure high standards of education for those training to be a doctor, including hospital internship placements and new vocational scopes of practice
  - Recognise, accredit and set programmes to develop the competence of doctors.
- 3.2 The MCNZ is an independent organisation, which is accountable to the New Zealand Parliament. It is funded entirely by doctors' practising certificates and registration application fees. The Council is made up of 12 members, eight of whom are doctors and four of whom are not doctors. Four of the doctor members are elected by the profession and the rest of the members are appointed by the Minister of Health. The New Zealand legislation (Health Practitioners Competence Assurance Act 2003) specifies that there should be a majority of doctors on the MCNZ. The Council has three standing committees: the Audit Committee, the Education Committee and the Health Committee. There are currently about 12,500 doctors registered with the MCNZ.

- 3.3 The MCNZ works closely with the Health and Disciplinary Commissioner (HDC) and the Health Practitioners Disciplinary Tribunal (HPDT). All three organisations have different but complementary roles in regulating doctors. The Health and Disability Commissioner Act 1994 (HDCA 1994) and the Medical Practitioners Act 1995 (MPA 1995) set in motion this multilayered process for receiving and dealing with complaints about doctors and other health professionals. Further refinements were achieved by the introduction of the Health Practitioners Competence Assurance Act 2003 (HPCAA 2003). This separation of roles and powers between the three bodies is an important aspect of the New Zealand system of regulation.
- 3.4 New Zealand also has a no-fault compensation scheme administered by the Accident Compensation Corporation (ACC). This scheme also plays a part in establishing the consensual style of regulation.
- 3.5 The HDC is responsible for the initial consideration and investigation of all complaints about doctors where a patient has been affected and when appropriate refers them on to the MCNZ. The HDC receives about 1,300 complaints a year. In the event of a finding that the provider breached the *Code of Health and Disability Consumers' Rights*, the Commissioner may refer that provider to his independent Director of Proceedings, to decide whether to bring disciplinary and/or Human Rights Review Tribunal proceedings.
- 3.6 The Commissioner weighs the complainant's wishes, the provider's submissions and the overall public interest in deciding whether to refer a provider found in breach of the Code to the Director of Proceedings. As a general rule, cases must be considered to be willful, reckless, unethical or criminal before they are seen as so serious as to warrant referral. The Director then decides whether to issue proceedings taking into account the public interest and the likelihood of success. For registered health professionals the usual avenue is proceedings before the HPDT.
- 3.7 The HDC and MCNZ encourage doctors to settle most cases through a conciliatory and remedial approach designed to get them back into effective practice as quickly as possible. Although most HDC investigations do result in a finding of breach of the *Code of Health and Disability Consumers' Rights*, investigations are undertaken in only 10% of complaints. The HDC generally settles most complaints (including many that lead to an investigation and breach finding) through an apology from the doctor or hospital. The HDC will also note changes the doctor has made in their practice and recommend any further improvements, for example re-education.
- 3.8 The MCNZ can initiate immediate action in respect of complaints about the competence of individual doctors and does not have to await the outcome of the HDC's consideration. Very few clinical negligence complaints are referred to the HPDT either by the HDC or MCNZ. In most cases considered by the MCNZ, under its competence procedures, the doctor is required to undertake a performance assessment. Where a doctor is found to be working below the required standards of competence the usual outcome is for the MCNZ to order the doctor to go through a structured educational programme. This may include supervision and some form of retraining. When the MCNZ places conditions on a doctor's practice these will be recorded on their publicly available register. The MCNZ also uses voluntary undertakings in circumstances where greater urgency is needed to

protect public health and safety. Such undertakings are rare, with an average of two per year. The general philosophy aims to be one, we were told, of 'learning not lynching and resolution not retribution'<sup>1</sup>, and the MCNZ has a strong focus on rehabilitation.

- 3.9 The HPDT, which was set up in 2004 (its predecessor, the Medical Practitioners Disciplinary Tribunal was set up in 1995), has similar functions to the new Office of the Health Professions Adjudicator (OHPA) in the UK. It adjudicates on final conduct cases of all of the healthcare professional regulatory bodies in New Zealand. It is rare for competence cases to be referred to the HPDT although it does have jurisdiction to hear such cases.
- 3.10 The HPDT can impose the following range of sanctions, which the doctor can appeal to the High Court:
- Fines
  - Conditions
  - Suspensions
  - Cancellation of registration (striking off).
- 3.11 In addition, the ACC provides no fault compensation for people who have suffered harm or unintended consequences of medical treatment. On occasions the ACC refers cases to the HDC and the MCNZ for further consideration.
- 3.12 The MCNZ also works closely with the newly established Health Workforce New Zealand (HWNZ), which is a government agency, whose role includes ensuring that the country has sufficient doctors with the necessary skills. This is seen as appropriate by the MCNZ because of the medical education and training interface with workforce planning and the high turnover of doctors in the country. About 39% of doctors working in New Zealand are international medical graduates (IMGs). About 29% of IMGs leave New Zealand within five years. Most give promotion, training or family reasons for going. A similar percentage of New Zealand graduates also leave within 5 years of graduating<sup>2</sup>.
- 3.13 Research conducted for MCNZ in 2007 shows relatively low levels of trust in doctors amongst the New Zealand public. Only 9% of the public thought that doctors in general were very trustworthy and the mean score for trustworthiness out of seven was 4.9. Patients' trust in their own regular doctor was considerably higher at 5.5/7 with 43% finding their own doctor 'very trustworthy'.<sup>3</sup> These levels of trust appear to be lower than comparable surveys conducted in other countries. In this context it is worth considering the role of regulation in building public trust in professions and whether the New Zealand approach is succeeding in that particular objective.

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<sup>1</sup> Ron Paterson, *Inquiries into health care: learning or lynching?*, Nordmeyer Lecture, University of Otago, September 2008

<sup>2</sup> New Zealand Medical Workforce 2008 MCNZ 2008 *Research on Orientation, acculturation and retention of international graduates* Page 3 Sue Ineson Consultation for MCNZ 2009

<sup>3</sup> *Awareness, Trust and Information: Research with New Zealand Medical Consumers* TNS social Research 2007

## 4. Overall assessment

- 4.1 We were impressed with many aspects of the approach to regulation that has been adopted in New Zealand. In particular, the philosophy of attempting to deal with concerns about fitness to practise in a collaborative, non-adversarial way appears to work effectively in protecting the public in the majority of cases. There are aspects to this approach that could usefully be applied by regulators in other countries. As the majority of fitness to practise concerns are dealt with as competence cases, the MCNZ has developed strong mechanisms for assessing doctors' clinical competence. These mechanisms have also been applied in other areas of the MCNZ's work including recertification processes and vocational practice assessments. The MCNZ began implementing recertification requirements in 1997 and made recertification mandatory for all doctors in 2001. The MCNZ is now implementing strengthened recertification requirements, including regular practice reviews.
- 4.2 The division of roles between the HDC, the MCNZ and the HPDT, while providing an effective framework for the management and resolution of concerns about doctors, also requires a high level of commitment to communication between the organisations and people who work in them. Cases may be referred between the HDC and the MCNZ and both may refer to the HPDT. Sometimes the ACC also refers cases to the HDC or the MCNZ. Within each organisation there are numerous steps to be taken and different ways of reaching a resolution. We noted that MCNZ staff and colleagues from the HDC and others who sent us written information spoke about being in regular and daily contact with each other. This tripartite approach does therefore have considerable resource implications both within and between organisations.
- 4.3 From our discussions with the staff of the MCNZ and, in particular their response to our initial feedback, we consider that the organisation has a commitment to continuous improvement. The MCNZ appears to be receptive to new ideas including from organisations in different countries. It has close links with the Australian Medical Council (AMC), particularly on medical education, the GMC and similar bodies in the USA, Canada and Singapore. The MCNZ is also a member of the International Association of Medical Regulatory Authorities (IAMRA) and of the International Physician Assessment Coalition (IPAC), which promote learning and good practice. Staff readily discussed different approaches to medical regulation with us.
- 4.4 Overall we report that the following areas of the MCNZ's work are particularly impressive:
- The comprehensiveness and quality of the standards and guidance documents
  - The approach to resolving fitness to practise concerns about doctors in a non-adversarial way with the intention of protecting the public quickly through rehabilitating the doctor back to effective practice



- The proposals for strengthening the process of recertification of doctors. The proposals are focused on improving the quality of the profession and continue to build on the current processes and tools of competence reviews
- The quality of relationships with the other bodies who have an interest in the regulation of doctors in New Zealand, although we are aware there has been some criticism of the MCNZ by the HDC in relation to one recent fitness to practise case.

4.5 There are also some areas where we consider that the MCNZ would benefit from exploring some of the practices of regulators in other countries, including the UK. These areas include:

- Increasing the level of openness of its work particularly in decision making, in relation to the fitness to practise function and to the information that appears on its register. This includes publishing on the register more information about conditions imposed or voluntary undertakings (except health) agreed with doctors
- Building better links with employers in relation to fitness to practise issues including more routine mutual exchange of information about doctors where there are concerns. However, we did note that the MCNZ is currently carrying out a review of the *Memorandum of Understanding with District Health Boards*.
- Developing a patient and public involvement strategy, and enabling patients and the public to have much greater engagement with all areas of the MCNZ's work
- Ensuring that when a doctor has demonstrated serious incompetence, and in particular where this might not be amenable to remediation, the case is dealt with as a conduct issue rather than through competence procedures. The MCNZ should have a greater regard to the impact on the public's confidence in the profession when making all fitness to practise decisions
- Developing a greater commitment to organisational diversity and equality issues, including ensuring that people are appointed to the Council and to its committees including performance assessment committees on the basis of fair and open competition and against defined roles and competencies
- Reviewing the composition of the Council and its committees, although the former would require legislative change, as would professional conduct committees. At present these have a majority of doctor members, but good practice from the UK would suggest that at least parity of public membership is important in ensuring unbiased decision-making and a focus on patient safety and in maintaining public confidence in regulation.

4.6 Several of the points above bear on the public face of the MCNZ and on the engagement of patients and the public in its work. Patient and public engagements with health systems at every level is becoming an increasingly important aspect of health quality improvement around the world. In the UK regulation has moved from self regulation to shared regulation with public members of councils having at least parity with professional members and with the

majority of councils having a publicly appointed lay chair. This makes clear that public not professional protection is the first priority of a regulator.

- 4.7 Below we outline in more detail our views on the MCNZ's work in each of the main areas of its four main functions.

## 5. Standards

- 5.1 The MCNZ has a comprehensive set of standards and guidance documents. We understand that the core standards document 'Good Medical Practice' was based to a large extent on the UK General Medical Council's document. The MCNZ have also taken account of standards produced by other country's regulators in developing its own standards.
- 5.2 The MCNZ has also published a detailed manual called *Cole's Medical Practice in New Zealand* which covers the main legislation, ethical standards and guidelines relating to medical practice in New Zealand.
- 5.3 The MCNZ has a wide range of additional guidance for doctors on issues such as communication and informed consent, prescribing and other clinical matters. It has also produced documents specifically for patients on sexual boundaries, cosmetic procedures and a very clear and well written leaflet called *You and your doctor - A guide to your relationship with your doctor*. In addition, there is an impressive booklet for doctors entitled, *Best health outcomes for Maori: Practice implications*. It will also this year be publishing similar resources for doctors in relation to pacific island peoples.
- 5.4 The standards and guidance documents are clearly written and presented. They are supported by regular supplementary statements and advice notes to doctors. These are dated and include a date when they will be reviewed, which we consider is good practice. The MCNZ accepts there is some work to be done, however, on regularising the format and descriptions of the guidance and advice statements and, in particular, in making the distinction clear between things that are requirements for doctors and things that are guidance.
- 5.5 We were informed that the team that is responsible for the development of the standards and guidance review fitness to practise cases to identify emerging issues and then apply this knowledge to reviewing standards. This is good practice and should become easier to do routinely when the new case management system (see below) is fully operational. In addition, we understand that the standards are used as the basis for most of the fitness to practise decisions made by the MCNZ and the HPDT.
- 5.6 The standards and guidance documents are sent to all doctors and employers, such as the district health boards, and are published on the website. However there is scope for the MCNZ to ensure greater public awareness of these documents. The MCNZ has used the media to publicise some new standards documents but these still do not seem to have the level of public visibility of, for instance, the HDC's *Code of Health and Disability Services Consumers' Rights*. We wonder, for example, whether doctors could be encouraged or required to make them available to patients in their place of work.

- 5.7 Although the content of the standards and guidance documents is good, there is considerable scope for more active patient and public involvement in their development. We note that patient organisations may comment in response to formal consultations but it would not appear that they are actively engaged in the process of formulating draft documents.

### **Matters for consideration by the MCNZ**

- 5.8 We would suggest that the MCNZ should consider the following:
- How to ensure greater public knowledge and understanding of the standards and guidance documents
  - How to involve patients and the public in the development of standards, including but not confined to publications written for patients.

## **6. Registration**

- 6.1 Although the MCNZ's processes for registration appear to be reasonably efficient and thorough, the current target of 20 days from receipt of application to registration decision should be more testing. All of the UK health professional regulators would normally complete this process within a shorter timescale. The MCNZ registers around 1,200 IMGs every year. Fewer than 50 IMGs in the last year were required to sit a registration examination. Thorough checks of qualifications, training, experience, good standing and identity are carried out which the MCNZ considers contributes to ensuring fitness to practise. We noted that a small sample of IMGs interviewed for the MCNZ were fairly critical of their experience of application and of their communications with the MCNZ. The MCNZ may find it helpful to discuss with other regulators such as the GMC how they undertake identity checks at initial registration stage.
- 6.2 We understand that an online registration system is being introduced in 2010/11. This should improve the effectiveness of the system overall but will require significant commitment from management to ensure effective project planning and delivery. Staff will need to be trained and supported through this change and to know that they have the full commitment of management to new ways of recording data and using it if the full potential of the system is to be realised.
- 6.3 With regard to the online public register, as with some other areas of the MCNZ's work, there is room for greater openness and transparency. When recording fitness to practise outcomes only formal conditions appear on the register. Where a doctor is suspended or removed they do not appear on the register at all. We suggest that the names of doctors should remain on the register but with their entry annotated to show that they have been suspended or removed. This is clearer and easier for patients, employers and the public to understand.
- 6.4 Voluntary undertakings do not appear on the MCNZ register. It was put to us that doctors might be less likely to agree to such undertakings if they were to be put into the public domain. However, we feel that the public should know that a doctor is subject to such restrictions (apart from those relating to the doctor's health) and

certainly all employers should know of them. Patients should be able to choose their doctor and should be able to find out about limitations to their practice, for instance, requirements that they work with a chaperone or that they do not perform certain procedures. Only where employers and the public know what restraints have been imposed on a doctor are they able to report when a doctor has acted beyond them. Employers in particular should be encouraged to work with the MCNZ in ensuring compliance from doctors under supervision arrangements.

- 6.5 We understand that employers are normally informed about voluntary undertakings. However, we think this should happen in all cases as a matter of course. We also think that employers should normally be informed if a doctor is under investigation, whether for competence or conduct matters.
- 6.6 We received concerns from the HDC about difficulties they had encountered in obtaining information from the MCNZ about certain cases. It would appear that the current legislation may be too inflexible to allow the level of exchange of information that would benefit public protection. Even within the restraints of legislation there should be a general commitment on all to share information in the interests of patients and the public.
- 6.7 The regulatory system in New Zealand lacks openness and transparency. This is reflected in the MCNZ's working practices. The system is based on the principles of investigation, apology where appropriate, re-training and no-fault compensation. There is much attention paid to the rights of health professionals and much less stress on the public's right to know what regulators are doing in their name. The HDC does not usually include the names of doctors in their published investigation reports. We also note that the HPDT normally grants interim suppression of the doctor's name when charges are laid, although permanent name suppression has only been granted in six of 25 cases. We think that these matters should be reviewed at a system-wide level.
- 6.8 The MCNZ has strong powers in respect of the registration of international medical graduates (IMGs) and can require them to undergo additional training, supervision and assessment once they have been provisionally registered. Assessments are undertaken in relation to IMGs applying for vocational registration in New Zealand. These have replaced the requirement for IMGs to pass specialist College examinations, which are roughly equivalent to the Royal Colleges in the UK. The MCNZ provides extensive information for IMGs and employers on the supervision arrangements, which includes guidance about induction to practice in New Zealand and all the standards documents. The aim of the additional supervisory and assessment arrangements for IMGs is to increase public protection, especially as studies suggest that the IMGs are subject to a higher level of complaints than other doctors. However, we have some concerns about whether the additional supervision and assessment requirements could be seen as inequitable and potentially discriminatory. We do not think that a higher level of complaints is necessarily indicative of poorer quality of practice<sup>1</sup>.

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<sup>1</sup> GMC 2009. *Non-UK qualified doctors and Good Medical Practice: the experience of working within a different professional framework*. London: GMC.

- 6.9 The MCNZ is also proposing to extend regulation to the registration of doctors working for overseas agencies carrying out diagnostic work under contract to service providers in New Zealand. This would, for example, require a radiologist working outside New Zealand for a company contracted by a district health board in New Zealand to register with the MCNZ and be subject to its fitness to practise procedures. This appears to us to be disproportionate and to be more appropriately managed through quality assurance written into the service contract.
- 6.10 The MCNZ has already made considerable progress in strengthening processes for recertification, which appear to be thorough and proportionate. These are based on the general principle of using regulation as a way of solving problems; identifying need and obstacles and resolving issues safely. They include audit of continuing professional development and the introduction of regular practice reviews run by branch advisory boards (BABs) The regular practice review is a formative programme of assessment and feedback for the doctor to help improve practice. The MCNZ's experience in assessing doctors' competence and putting in place effective supervision arrangements will prove valuable in implementing the strengthened recertification scheme.

### **Matters for consideration by the MCNZ**

- 6.11 We suggest that the MCNZ should consider the following:
- Committing itself to greater openness of information, if necessary reviewing the legislation relating to disclosure of information that is made available to employers, other organisations and the public. Serious consideration should be given to whether voluntary undertakings should appear on the register. Also, where a doctor has been suspended or removed their name should remain on the register but it should be clear that they have been suspended or removed. The MCNZ might wish to consider the sort of legislation which currently applies to the UK GMC in respect of disclosure of fitness to practise information
  - Whether the current arrangements requiring additional supervision and assessment of IMGs are proportionate, equitable and non-discriminatory
  - Whether the work in collaboration with HWNZ on trying to ensure the retention of IMGs and New Zealand graduates is a legitimate regulation function focused on the health and safety of the public
  - Reviewing the risks presented by overseas doctors carrying out diagnostic work under contract for health services in New Zealand and considering alternative forms of quality assurance before proceeding with the current plans for requiring registration.

## 7. Fitness to Practise

- 7.1 The MCNZ has powers to take fitness to practise action in relation to misconduct, poor competence or a health condition. However, while doctors have a legal responsibility to report on other doctors where they feel that they are suffering from a health condition, this does not apply in relation to conduct or competence. Until the legislation can be changed, we feel the guidance in *Good Medical Practice* should be strengthened in this respect. At present it says only that doctors 'should' tell the MCNZ about incompetence or disruptive behaviour by another doctor that risks causing harm to patients. We note the UK GMC's guidance on this matter states that doctors 'must' take action to report such concerns 'without delay.'<sup>1</sup>
- 7.2 Complaints about doctors, where a patient has been affected, have to be referred to the HDC in the first instance and the MCNZ cannot instigate a conduct inquiry in relation to that complaint until the HDC has finished considering the case. The MCNZ can, however, take immediate action on competence or health matters arising in such cases. This means that the MCNZ often tend to consider the competence issues in cases immediately and start action under their competence procedures. We suspect as a result fewer cases are taken forward as conduct cases than would be otherwise.
- 7.3 We are confident that the MCNZ's communications with complainants at the beginning of the process are appropriate and feel there is no reason why complainants should feel discouraged from making complaints. The MCNZ does much to facilitate complainants, such as outlining the process at the beginning and where appropriate offering access to counselling, particularly in cases where there are allegations in relation to breaches of sexual boundaries.
- 7.4 The MCNZ rarely takes action in relation to anonymous complaints, but reserves the right to do so where the allegations are serious and it is felt that information could be obtained to substantiate them. Such complaints are assessed by the senior officers of Council, who will make an initial judgment on the potential seriousness of the anonymous complaint and whether further action is possible. We think it important that even anonymous allegations should be assessed for seriousness and validity; there may be a legitimate reason why a person wishes to remain anonymous.
- 7.5 All new complaints received, either from the HDC, employers or other complainants, are considered at a weekly meeting of the 'senior officers of Council'. This consists of the Chair, the Chief Executive, the Registrar, the medical advisers and other senior managers. This means that all cases receive thorough and quick consideration, with input from a clinical specialist, which we consider is good practice. From our observation of one such meeting we felt assured that cases were given thorough consideration and clear follow up action was always agreed. We suggest however that to ensure the patient perspective is always properly considered one member of the team is charged with putting that point of view in each case.

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1 GMC, 2006. *Good Medical Practice*, p23. London:GMC.

7.6 The processes followed under competence, conduct and health procedures are set out briefly in the following paragraphs.

### *Competence procedures*

7.7 Where the 'senior officers of Council' meeting decides that the case should be considered under the competence procedures their recommendation is considered at the next full Council meeting. If the Council agrees with the recommendation, they will order a performance assessment. If the doctor fails to agree to undergo a performance assessment, and the MCNZ believes the doctor's practice poses a risk of serious harm to the public, the MCNZ can determine that the doctor does not reach the required standard of competence and can impose conditions or suspend, on an interim basis, their practising certificate.

7.8 This assessment is undertaken by a performance assessment committee (PAC), which consists of two doctors from the specialty of the doctor under assessment and one lay member. The assessments last for one or two days and include peer reviews, interviews with colleagues and a practical assessment of skills within a clinical setting. The PAC provides a report, which categorises the doctor's competence according to a three point scale:

- Category 1 – there are no serious concerns about the doctor's competence
- Category 2 – the doctor's practice is generally adequate but there is a need for some re-training
- Category 3 – there are serious weaknesses in the doctor's practice.

7.9 We understand that this process is normally completed within four to six months which is an impressive timescale.

7.10 The MCNZ can do a less rigorous assessment if they consider that the competence issues raised are not likely to be serious. This seems to be a proportionate approach, as full performance assessments are expensive and onerous. We feel this is an example of right-touch regulation.

7.11 The PAC's report is considered at a full meeting of the Council. If the doctor is considered not to have met the required standards of competence the MCNZ must order one or more of the following outcomes:

- A programme of re-education
- Formal mentoring
- Interim suspension
- Examination or assessment
- Conditions on, or alteration of, the doctor's scope of practice.

7.12 At any time once competence concerns have been raised the MCNZ may take interim steps to ensure public safety. The MCNZ will consider if the doctor poses a risk of serious harm to the public by practising below the required standard of competence. If so, the MCNZ may propose an interim suspension of the doctor's practising certificate or interim conditions of practice. If the Council decides at its

meeting that conditions are necessary, these have to be proposed to the doctor, who has a right of response. This is then considered at the next meeting. The doctor has a further right of appeal to the District Court against the final decision. We consider that the legislation is too protective of doctors in this regard and that if the Council believes that conditions are necessary it should be able to impose them immediately rather than propose them to the doctor at the first meeting. The MCNZ's primary purpose is to protect the safety of patients not the rights of doctors and the legislation needs to reflect this better.

### *Conduct procedures*

- 7.13 All patient complaints have to be referred to the HDC in the first instance. The HDC can then refer the matter to the MCNZ, usually following investigation and/or attempts at reconciliation.
- 7.14 Where the MCNZ consider the case is serious enough it makes a referral to a professional conduct committee (PCC). All doctors convicted of an offence punishable by 3 months or more imprisonment will automatically be referred to a PCC. The PCC consists of two doctors and one public member (a requirement under the HPCAA), who work on contract to the MCNZ. They are responsible for investigating the case. The doctor has the opportunity to object to the membership and terms of reference of the PCC.
- 7.15 We understand that it takes on average 23 weeks for a PCC to report back to the MCNZ on their investigation. We consider this is a reasonable timescale. There should be a service standard and we were concerned that the PCC seem to be given almost completely free reign over the conduct of the investigation. We note that the legislation provides that PCCs regulate their own procedure and are subject to an overarching requirement to follow the principles of natural justice. PCCs have statutory independence of the MCNZ and the Act prescribes the PCC's powers to obtain information and keep parties informed of progress. The MCNZ maintains a panel of experienced legal assessors, one of whom will be selected by the PCC convener to assist the PCC. Normally doctors are legally represented before PCCs.
- 7.16 There appeared to be little management of the investigation by the staff at the MCNZ at this stage to ensure that the process is moving forward quickly and in the right direction. The MCNZ receives reports on the progress of PCCs and may offer advice on technical aspects of PCC process but the PCC remains independent of the MCNZ.
- 7.17 Doctors referred to PCCs have a statutory right to comment on and challenge the PCC membership, and regularly exercise that right. We were also concerned that PCC members appear to be recruited by word of mouth or closed nomination by professional bodies rather than through public advertisement and open competition against a job description and person specification. This is not good practice. The MCNZ told us that in selecting the PCC, it takes care to avoid over committing panel members, and where possible appoints members from near the locality of the doctor. This seems to make it more likely that the doctors on the PCC will know the doctor under investigation. Doctors referred to PCCs have a statutory right to comment on and challenge the PCC membership, and regularly



exercise that right. Again it appears to us that the New Zealand approach is balanced in favour of the health professional.

- 7.18 The PCC is required to produce a report, which is referred to the Council. The decisions of PCCs fall into two categories: recommendations to the Council, and determinations. Possible recommendations are that the Council:
- Review the doctor's competence
  - Review the doctor's scope of practice
  - Refer the matter to the police.
  - Counsel the doctor.

Determinations may be that:

- No further action be taken
- A charge be brought against the doctor before the HPDT
- That the complaint be submitted to conciliation.

- 7.19 The MCNZ has to consider the PCC's recommendation(s) but may form its own view on what action to take. By contrast, determinations are final and are outside the jurisdiction of the MCNZ to amend or reject.

### *Health procedures*

- 7.20 The health procedures are administered by the Health Committee, which consists of four Council members, three of whom are medical and one public. They consider cases where a doctor's fitness to practise may be impaired due to a health condition on entry to the register, when a doctor is applying for an annual practising certificate and where there has been a notification about a doctor already on the register.
- 7.21 The majority of cases are dealt with through the informal procedures, resulting in voluntary undertakings, usually providing for medical supervision of the doctor. In the more serious cases, and when a doctor fails to comply, the MCNZ can impose formal conditions on their scope of practice or suspend the doctor.
- 7.22 We judged that there was a lot of good practice in this area of the MCNZ's work. From the small sample of cases we reviewed doctors were brought under supervision quickly where this was necessary. Cases were dealt with sensitively resulting in a high degree of compliance from doctors. However, where necessary the MCNZ takes strong action to protect the public.
- 7.23 We were impressed that in cases of addictions the doctor would remain under the jurisdiction of the Health Committee for at least five years. Also, in cases of drink drive convictions the MCNZ would routinely require the doctor to undertake a health assessment.

- 7.24 From our consideration of cases we were impressed with the way in which the MCNZ attempts to resolve fitness to practise cases through non-adversarial means. The aim is to resolve cases by rehabilitating the doctor back into effective practice as quickly as possible. We agree with the former Health and Disability Commissioner Ron Paterson's view that the approach emphasises 'rehabilitation of practitioners, rather than punishment, and is consistent with modern understanding of the nature of error and the importance of a culture of learning to improve patient safety'.<sup>1</sup>
- 7.25 The MCNZ has managed to secure a high level of co-operation from doctors under investigation. This is undoubtedly partly a result of the sensitive and effective handling of the cases by the staff. We were impressed with the quality of the correspondence with the doctors that we examined.
- 7.26 The speedy resolution of cases by agreement with the doctor leading to support and supervision may well be the most effective means of protecting the public in the majority of cases where concerns have been raised about a doctor's competence. However, there are risks involved with how this is currently put into operation. Our two main areas of concern are:
- The risk that cases that should be considered under the conduct procedures are dealt with as competence cases
  - There is very little transparency in the processes as virtually all decisions are being taken in private and without public reporting.
- 7.27 It is important that the non-adversarial and rehabilitative approach does not result in doctors who have committed acts of misconduct being dealt with too leniently or too comfortable a relationship developing between the profession and the regulator. Complaints must be taken seriously, cases of misconduct must be dealt with appropriately through the conduct procedures and, if necessary, referred to the HPDT for a formal hearing. It is also important that the MCNZ takes quick action where a doctor fails to comply with its procedures, by for example, refusing to undergo assessment or not complying with voluntary undertakings. All of this is essential not just to protect patients and the public from harm but also to maintain public confidence in the profession and the system of regulation.
- 7.28 We were concerned that there was a tendency to deal with some cases purely as competence cases when there might be elements of misconduct. We wonder, therefore, whether the MCNZ might be adopting too high a threshold for referral to the conduct procedures. This observation is, however, based on our review of a small number of cases.
- 7.29 Since 1995 there has been a marked reduction in the number of cases referred to the HPDT both by the MCNZ and the HDC. As noted in the HDC's Annual Report of 2003 'The introduction of the Code of Health and Disability Services Consumers' Rights...and the Health and Disability Commissioner complaints system in 1996, combined with the implementation of competence reviews by the Medical Council, have resulted in a four-fold reduction in the number of medical practitioners facing disciplinary proceedings.'<sup>2</sup>

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1 Annual Report of the HDC 2003

2 Annual Report of the HDC, 2003

- 7.30 In the last year just five cases involving doctors have been heard by the HPDT. It would appear that only cases involving very serious misconduct, such as sexual misconduct and dishonesty, go to the HPDT. Very few cases involving clinical issues are referred by the HDC or the MCNZ.
- 7.31 The majority of the HPDT's hearings are held in public. However, all decisions made under the MCNZ's procedures are made in private and, as mentioned above, only where formal conditions are imposed is the outcome made public. This lack of transparency is a considerable weakness, particularly in terms of accountability and maintaining public confidence in the system of regulation of doctors in New Zealand.
- 7.32 Under the MCNZ's fitness to practise procedures there is very little scope for input from complainants or other members of the public. While an initial complaint is usually shared with the doctor, the doctor's response to the complaint is not shared with the complainant. Also, the complainant is not normally informed of the outcome of their complaint unless the doctor is made subject to formal conditions, suspended or has their registration cancelled.
- 7.33 The MCNZ has recently introduced a new case management system which integrates both the fitness to practise and registration functions. This system appears to us to have the technical capacity to meet the needs of the organisation. However, the system is not yet fully utilised nor being used as well as it could to deliver effective management and performance data. Some staff appeared to feel that there was a need for more training on the system and for managers to give more attention to its implementation.
- 7.34 From our small audit of cases we were satisfied that the current case files are well managed. Most documents are signed and the files appear to be a complete record. We feel, however, that there is scope for more exacting service standards. This could be especially important in relation to the PCC investigations as we felt there were risks associated with the lack of quality control that the MCNZ has over the conduct of these investigations or their outcome for patient safety.
- 7.35 There is also scope for more quality assurance of the fitness to practise work, including audits, either undertaken internally by the managers or by an external organisation. There is however an internal process of review and the full Council reviews all decisions by PACs, PCCs and the Health Committee.
- 7.36 We were concerned that the Health Committee, PAC and PCC all contain a majority of doctors. This allied to the lack of transparency and accountability for their decisions could result in a lack of public confidence in regulation. There could be a feeling that the profession is looking after its members, rather than focusing on the protection of patients and the public.
- 7.37 Regardless of whether the members of these committees should be predominantly public or medical, we were concerned that the members are not recruited through open competition. In addition, it would seem that there are not currently any arrangements for the assessment or appraisal of such members against competencies and we saw little evidence of a well developed training strategy. The independence and competence of panels and their absolute focus on patient safety and public protection are essential to effective professional regulation.

7.38 The MCNZ has been giving consideration to whether they should extend their functions to include the registration of student doctors. They will be undertaking research before making a decision on this. The important issue is whether the extension of regulation in this way will result in greater public protection.

### **Matters for consideration by the MCNZ**

7.39 We recommend that the MCNZ consider the following issues:

- How the fitness to practise procedures can be revised to ensure greater transparency of decision making without losing the values of the current non-adversarial approach
- How to achieve greater public involvement in decision making, especially by the Health Committee, PAC and PCC
- Reviewing the current legislation with a view to:
  - Obtaining the power to impose interim conditions or suspensions in serious cases at any stage in the fitness to practise procedure
  - Reducing some of the doctor's rights to object to legitimate actions, such as their power to object to the composition of the PCC and to conditions proposed by the Council
  - Defining more clearly the thresholds of 'risk of harm' and 'serious risk of harm'
  - Allowing the Council greater discretion in how it is able to respond in relation to a PCC report. This could include allowing it to refer to the HPDT even if the PCC does not recommend this.
- Whether to strengthen *Good Medical Practice* to make it clear that doctors are required to report concerns about another doctor's conduct or competence without delay
- Putting in place robust and fair procedures for the selection, recruitment, training, assessment and appraisal of fitness to practise committee members
- Developing a more transparent mechanism for auditing and quality assuring decisions made by staff and committees
- Ensuring that the case management system is utilised to the maximum possible effect. This will require training for staff and management being clear about exactly what level of management information they need from the system in order to manage the caseload and performance manage the staff effectively.

## 8. Education

- 8.1 There are only two medical schools in New Zealand, which are at the University of Auckland and the University of Otago. The MCNZ works with the Australian Medical Council (AMC) in setting standards for medical education and accrediting the two medical schools. Indeed, it would appear that the majority of the quality assurance and accreditation work is carried out by the AMC. This appears to be a sensible and pragmatic approach, which ensures that the New Zealand schools are assessed against other institutions, that is the medical schools in Australia.
- 8.2 The MCNZ inspects and accredits all hospitals, which provide placements for interns. They usually visit such hospitals every three years. The visiting team normally consists of three members one of whom is lay and one member of staff. We understand that on occasions the MCNZ has threatened to remove accreditation but has not needed to do so as yet. The MCNZ also visits and accredits Branch Advisory Boards (BABs) in relation to their vocational training and recertification programmes.
- 8.3 We understand that the MCNZ intends to publish the reports on medical schools, hospitals and courses from the end of this year but not the BAB courses. We would strongly support the publication of all such reports.

### **Matters for consideration by the MCNZ**

- 8.4 We would suggest that the MCNZ consider the following issues:
- Ensuring that patient views are taken into account in the assessment and accreditation of medical schools, hospitals and BAB courses
  - That all reports on education and training courses are published.

## 9. Conclusion and summary

- 9.1 Other countries could learn much from the rehabilitative and collegiate approach to regulation that has been adopted in New Zealand. However this approach needs to be augmented by greater openness and accountability and by increased public and patient involvement.
- 9.2 The MCNZ has to operate within the New Zealand legislative framework and in accordance with its own legislation. In some matters therefore its ability to change its ways of working is limited. The sometimes separate and sometimes parallel roles of the HDC and the MCNZ and their relationship to the HPDT plus the internal independence of the Director of Prosecutions at the HDC and the of PCC at the MCNZ create a complicated matrix of procedures, rules, responsibilities and rights.

- 9.3 The legislation also gives many rights to health professionals to contest and challenge their regulators. We recognise that in practice the majority of doctors co-operate with the HDC and the MCNZ but we consider that in a system as positively committed to education and rehabilitation as the New Zealand one there could be a greater requirement of health professionals to co-operate with regulators and a reduction in their right to challenge the process at every point.
- 9.4 The cases we examined and the evidence given to us enables us to conclude that the current approach to fitness to practise most usually provides effective public protection. However, the MCNZ needs to be careful to ensure that cases of serious misconduct are identified and dealt with appropriately and if necessary through referral to the HPDT. The MCNZ also needs to be able to take speedy action to impose interim orders (suspensions or conditions) at any stage in such cases. We note that the test for referral to the HPDT, 'reckless, willful, unethical or criminal' behaviour, is very high.
- 9.5 The lack of detail on the register in relation to doctors under the fitness to practise procedures, such as voluntary undertakings (except in relation to health concerns) is a serious weakness in our view, as is the fact that employers are not routinely made aware of such undertakings.
- 9.6 The lack of openness in much of the MCNZ's work is a concern. Openness and accountability should be the basis of public trust. The Council's values include 'openness and accountability' but it is not apparent to us that there is indeed openness in all of the Council's practices and procedures. We note, for example, that the protocol for decision making principles is marked 'internal document only' although the MCNZ published it in the December 2009 issue of *Medical Council News* and has generally made it available to stakeholders. More could be done to provide assurance that decision making is transparent. We also note that the minutes of the Council meetings are not published on the website. Openness is a prerequisite for public accountability.
- 9.7 In the introduction to this report we noted the MCNZ's own research that suggests a relatively low level of public trust in New Zealand in doctors as a profession. One role of regulation is to engender public confidence and trust in the competence and conduct of health professionals. We suggest that the MCNZ considers how it could engage much more openly with patients and the public to explain its role, to protect the public and to build trust.
- 9.8 Although legally the MCNZ is independent from government some of its priorities appear to be based on government priorities rather than strict public protection. The attention that the MCNZ's puts on IMGs including arranging supervision and additional assessments appear to be primarily focused on workforce issues rather than patient safety. In our view it is important that the MCNZ should ensure that it maintains its independence as a regulator and that all its decisions and priorities should be directed towards maintaining patient safety and improving the quality of medical practice. It is right for it to work closely with government and with workforce planning but only where regulation has a proper contribution to make.

9.9 The Council and its committees, such as the fitness to practise committees all have a doctor majority in their membership. We do not think this is good practice and in our view it is not likely to engender public confidence. We note, however, with disappointment that the MCNZ does not accept that parity or a public member majority would bring benefits in terms of governance.

9.10 We suggest that the MCNZ should consider the following:

1. How to ensure greater public knowledge and understanding of the standards and guidance documents
2. How to involve patients and the public in the development of standards, including but not confined to publications intended for patients and the public
3. Reviewing the legislation relating to disclosure of information that is made available to employers, other organisations and the public. Serious consideration should be given to whether voluntary undertakings (except health) should appear on the register. Also, where a doctor has been suspended or erased their name should remain on the register but it should be clear that they have been suspended or erased. The MCNZ might wish to consider the sort of legislation which currently applies to the GMC in respect of disclosure of fitness to practise information.
4. Whether the current arrangements requiring additional supervision and assessment of IMGs are proportionate and equitable. This review should include considering whether the work on trying to ensure the retention of IMGs and New Zealand graduates is a legitimate regulation function focused on the health and safety of the public.
5. Reviewing the risks presented by overseas doctors carrying out diagnostic work for employers in New Zealand before proceeding with the current plans for registration
6. How the fitness to practise procedures can be revised to ensure greater transparency of decision making without losing the values of the current non-adversarial approach
7. How to achieve greater public involvement in the MCNZ particularly in its the decision making, especially by the Health Committee, PAC and PCC
8. Reviewing the current legislation with a view:
  - To obtaining the power to impose interim conditions or suspensions in serious cases at any stage in the fitness to practise procedure
  - To taking away some of the doctor's rights to object to legitimate actions, such as their power to object to the composition of the PCC and to conditions proposed by the Council
  - To defining more clearly the thresholds of 'risk of harm' and 'serious risk of harm'
  - To allowing the Council greater discretion in how it is able to respond in relation to a PCC report. This could include allowing it to refer to the HPDT even if the PCC does not recommend this.
9. Whether to strengthen *Good Medical Practice* to make it clear that doctors are required to report concerns about another doctor's conduct or competence without delay

10. Putting in place robust procedures for the recruitment, training, assessment and appraisal of fitness to practise committee members
11. Developing a mechanism for auditing and quality assuring decisions made by PACs and PCCs
12. Ensuring that the case management system is utilised to the maximum possible effect. This will require training for staff and management being clear about exactly what level of management information they need from the system in order to manage the caseload and performance manage the staff effectively
13. Ensuring that patient views are taken into account in the assessment and accreditation of medical schools, hospitals and BAB courses.



## 10. Appendix 1: People we met and spoke with

John Adams	Chair, MCNZ
Philip Pigou	Chief Executive, MCNZ
David Dunbar	Registrar
Lynne Urquhart	Health Manager
Daniel Eakins	Registration & Standards
George Symmes	Communications
Joan Crawford	Strategic Programme Manager
Valencia van Dyk	Business Services
David Low	Finance
Michael Thorn	Senior Policy Analyst

and other members of the MCNZ staff.

Ron Paterson	former Health & Disability Commissioner
Nicola Sladden	Chief Legal Adviser, HDC
Aaron Martin	Director of Proceedings, HDC
Sue Ineson	former CEO MCNZ
Bruce Corkill QC	Chair HPDT
Gay Fraser	Senior Executive Officer HPDT

## 11. Appendix 2: Written submissions we received

Health and Disability Commissioner

Health Practitioners Disciplinary Tribunal

Health Sciences

Mid Central District Health Board

New Zealand Medical Association

The Royal Australasian College of Physicians

The Royal New Zealand College of General Practitioners

Womens Health Action

## 12. Annex 3: Background reading

*Health Practitioners Competence Assurance Act 2003*

*Good Medical Practice: a guide for doctors MCNZ 2008*

*Cole's Medical Practice in New Zealand MCNZ 2009*

*You & Your Doctor MCNZ 2008*

*Legislative requirements about patient rights and consent MCNZ 2006*

*Statement on the employment of doctors and the Health Practitioners*

*Competence Assurance Act 2003 MCNZ 2005*

*Protocol for decision-making principles MCNZ 2009*

*Medical Registration in New Zealand MCNZ 2009*

*Continuing Professional Development and Recertification MCNZ 2008*

*Annual Practising Certificate MCNZ 2007*

*The Importance of Clear Sexual Boundaries in the Patient-Doctor Relationship; a guide for patients MCNZ 2006*

*Sexual Boundaries in the Doctor-Patient Relationship: a resource for doctors MCNZ 2009*

*What to expect from your doctor when you have a cosmetic procedure MCNZ 2008*

*Statement on Cultural Competence MCNZ 2006*

*Best Health Outcomes for Maori: practice implications MCNZ 2007*

*Definition of Fitness to Practise MCNZ 2004*

*Definition of clinical practice and non-clinical practice MCNZ 2004*

*Assessing doctor's performance MCNZ 2005*

*What you can expect; the performance assessment MCNZ 2005*

*Handbook for Performance Assessment Committee Members MCNZ 2008*

*Doctors' Health MCNZ 2004*

*Disclosure of harm; Good medical practice MCNZ 2004*

*What to do when you have concerns about a colleague MCNZ 2010*

*Education and supervision for interns MCNZ 2008*

*Code of Health & Disability Services Consumer's Rights HDC nd.*

*Annual Report HDC 2003*

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