



Performance Assessment: A guide for doctors being assessed

June 2011

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Foreword

This handbook is intended as a guide for doctors undergoing performance assessments. It is designed to complement information you receive from Council staff during the process.

This handbook aims to provide you with an understanding of how performance assessments work, and to ensure that there are no surprises for you throughout the assessment process.

The Council is committed to ensuring that performance assessments are carried out in a consultative and educational manner. Council staff will provide you with an opportunity to comment on any information relating to your competence before that information is put before Council.

Standardised tools and trained assessors are used in all performance assessments to ensure that each doctor is fairly assessed. The tools used are periodically reviewed by the Council's Medical Adviser to ensure that they continue to meet international standards of assessment. Assessors attend annual training workshops with Council staff in order to maintain a high level of knowledge and understanding with regard to the assessment of medical practitioners.

The Medical Council realises that this can be a stressful time for doctors and I understand that a performance assessment can be seen by some doctors as a punitive measure. I urge you to try and view it as an educational visit from your peers, at the end of which, you may receive some helpful advice on how to improve your practice.

If, after reading this handbook, you have further questions about what to expect in the coming weeks, please don't hesitate to contact a Performance staff member, who will be happy to answer any questions you have. You may also wish to look at the Council's website, which holds further information, including statistics relating to the performance process.

Yours sincerely

A handwritten signature in black ink, appearing to read 'John Adams', written in a cursive style.

John Adams
CHAIRMAN

Legal issues

The Health Practitioners Competence Assurance Act 2003 (HPCAA)

If you have received a copy of this handbook, you will already have been advised that the Council has decided to undertake an assessment of your performance. You will also have been provided with the reason(s) for Council's decision.

As the authority that regulates the medical profession in New Zealand (under the HPCAA), Council has the responsibility to ensure that medical practitioners are competent and fit to practise medicine. Part of this responsibility includes undertaking performance assessments of doctors about whom there is a competence concern.

The competence provisions of the HPCAA can be found in Part 3 (sections 34 – 44) **(Appendix 2)**.

Council's experience in assessing performance

As the competence provisions of the HPCAA were based on the Medical Practitioners Act 1995, the Council has been involved in the assessment of doctors' performance for nearly a decade. Over that period, Council has learned that consultation with the doctor involved, throughout the process, results in reduced stress for the doctor. If, at any stage during the process, you are unsure what is required of you, or you feel that you have been treated unfairly by staff or Council, we urge you to contact a professional standards coordinator to discuss your concerns.

The performance assessment process

What is a performance assessment?

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 in the following domains of competence:

- medical care
- communication
- collaboration
- management
- scholarship
- professionalism.

The HPCAA emphasises the maintenance of professional standards in medical practice. Under the HPCAA, doctors can have their competence reviewed at any time, though it is usually in response to concerns about their practice.

The purpose of a performance assessment is to determine whether:

“the health practitioner’s practice of the profession meets the required standard of competence.” (HPCAA 2003 s36(5))

As Council has decided that an assessment of your performance is required, you will no doubt wish to know what this means, and what is expected of you. This handbook aims to guide you through the process so that there are no surprises on the assessment day. You should read the handbook thoroughly, and contact a professional standards coordinator if you have any questions.

Terms of Reference (TOR)

Within the next month you will be provided with the draft TOR for your performance assessment. The draft TOR will include:

- a brief background to Council's decision to require a performance assessment
- the scope of the assessment (i.e. the areas of practice to be assessed)
- the tools to be used in the assessment (e.g. interview, case based oral, record review)
- the names and brief biographies of the proposed PAC members
- reporting requirements for the PAC.

You will be given the opportunity to comment on the draft TOR and proposed PAC. If you object to any proposed member of the PAC you will need to give specific reasons why you believe this person should not assess your performance.

Once you have been given a reasonable opportunity to respond (usually 10 working days), Council will decide whether to approve the draft TOR and proposed PAC. Please note that if you make no submission within the timeframe provided, you will have been deemed to have unreservedly accepted the draft TOR and proposed PAC.

Contact with the PAC

Once Council has approved the draft TOR and proposed PAC, a professional standards coordinator will write to advise you of this, and of when you can expect to hear from the convenor of the PAC (usually within 3 weeks of the date of the letter). When the convenor first contacts you (usually by phone) to arrange the PAC's visit, he or she is likely to discuss with you:

- which dates are most convenient for you within the next 4 to 6 weeks for the PAC visit

- whether anybody else at your practice knows about the assessment (the convenor may be able to suggest some wording to assist you in communicating this information to colleagues)
- the process of obtaining patient records
- what dress code is appropriate for your practice
- whether you wish to have a support person present during the PAC visit.

Once the convenor has this information, they will probably want to settle a date with the other PAC members and arrange a draft timetable for the visit. They will then contact you again with the proposed date and timetable. Much of this communication may be done via email.

You should expect fairly regular communication with the PAC convenor until the assessment visit. We ask convenors to be available for questions, and to ensure that doctors being assessed remain informed of any changes to plan.

The PAC visit

The PAC will arrive at your practice at the agreed date and time, and advise reception staff that they have an appointment with you. If you have not told reception staff the purpose of the PAC's visit, you should at the very minimum notify them that you are expecting visitors that are carrying out an educational exercise.

Please note that Council encourages doctors being assessed to discuss the matter with at least one trusted colleague. This provides a support system leading up to, and on the day of the assessment. It can also make arranging cover easier for times when the PAC wishes to meet with you. A colleague who is aware of the reason why you are unavailable to patients is likely to offer support.

If access to patient records is required by the PAC, the Council requires the doctor being assessed to advise their employer that an assessment is taking place.

The convenor will have provided you with a timetable for the day, which will be similar to the following, but may vary depending on the tools that are to be used during your assessment:

| | |
|---------|---|
| 9am | All three PAC members at interview (30 minutes) |
| 9.30am | Lay member and one medical member observe consultations while other medical member checks the records for the record review, and in preparation for the case based oral (CBO) (2 hours) |
| 10.45am | Break |
| 11am | Medical members swap roles – consultation observation and record review continue |
| 12.30pm | Lunch |
| 1pm | CBO (best done after observing consultations) |
| 3pm | Break |
| 3.15pm | Final interview with doctor – all three PAC members present |
| 4pm | Private wrap-up between PAC members, including general consensus on category rating and recommendations to be made |

Note: Occasionally, the professional interactions tool will be suggested for use. This tool generally requires an extra day of assessment to allow for interviewing colleagues.

Don't be afraid to ask for a 5 or 10 minute break if you need one during the day. The PAC understands that this can be a stressful day for you, and will be happy to accommodate you.

You will be expected to arrange your appointment book so that you are unavailable to patients during the interviews and case based orals, but have consenting patients booked in for the observation of communication skills. A copy of the patient consent form is attached as **Appendix 3**.

After the PAC visit

The PAC will not advise you of its findings at the end of its visit. However the convenor will advise you that a report will be written and sent to Council staff (usually within 2 weeks of the visit). Once the report is received at the Council offices, the professional standards team will send you a copy of the report. You will be given reasonable opportunity to make submissions and be heard on the matter, either personally or by a representative.

The report will include a summary of the day. Any examples of good or poor performance will be given in such a way that the patient is identifiable to you and the PAC only. The PAC will give you a rating on a scale of 1 to 3, under the following guidelines:

| | |
|-------------------|--|
| Category 1 | Performing at an acceptable level for a doctor working within a general/vocational scope in <branch>. |
| Category 2 | Meets the required standard of competence in some but not all areas for a doctor working within a general/vocational scope in <branch> - may require education and/or other actions to meet the overall required standard of competence. |
| Category 3 | Not performing at an acceptable level for a doctor working within a general/vocational scope in <branch> – further action by Council is recommended. |

If there are any areas that the PAC think could be improved they will make recommendations in your PAC report.

Once you have been given the opportunity to respond to the PAC's report, Council will decide how to proceed with your case. Council's options include:

- taking no further action
- providing you with an educational letter requesting that you attend to a particular aspect of your practice (this may be followed up in the following months)
- requiring you to undertake an educational programme
- placing conditions upon your scope of practice
- requiring you to sit an examination or undertake an assessment
- requiring you to be counselled or assisted by one or more nominated persons.

Tools used in performance assessments

You can expect several of the following tools to be used in your performance assessment. These tools have been developed in line with international research, and are regularly reviewed by the Council's Medical Adviser, in consultation with experts in the given area of assessment.

Interview

This tool will be used in most performance assessments, as it gives the PAC a clear picture of the environment in which the doctor is working. The questions in the interview will also focus on adherence to recertification requirements. It will usually be separated into an initial interview at the start of the day, and a closing interview at the end of the day, where the PAC can clarify any issues that have arisen during the day.

Case Based Oral (CBO)

The objective of the CBO is to explore the clinical reasoning process. It is usually carried out in conjunction with a records review. The PAC may select records from those reviewed and discuss with the doctor the reasons for a diagnosis or management plan.

Records Review

This tool is designed to assess the standard of the doctor's record keeping with regard to:

- summary of patient health information
- details of last encounter
- record systems.

The PAC will select a sample of records. If the assessment is focused on one content area, such as the management of childhood asthma, then the records assessed would contain concerns of that nature.

Communication

The communication tool is designed to assess the doctor's interaction with his or her patients, understanding of social/cultural issues facing the patient, and his or her process for obtaining informed consent for any procedures or management.

This is assessed largely via **observation of consultations**. In general practice, at least six patients should be observed. In other clinical settings, at least two hours of consultations should be observed. Patients should be asked by the receptionist when they book their appointment whether they are willing to have an observer present. Patient consent forms will be sent directly to the practice, and should be signed by the patient before the consultation. Patients should be discouraged from leaving the practice with the consent form.

Peer Ratings

This tool may also be conducted as part of the assessment of the doctor's communication skills. Other doctors, practice staff and allied health professionals are asked to fill in a questionnaire giving their opinions on the doctor's communication with colleagues and patients. The doctor has input into the names of the people who will be sent the questionnaire, but the responses are sent directly to the convenor. The doctor may be told of comments made, but does not see the completed questionnaires.

Practice Systems

The objective of this tool is to assess:

- premises
- equipment and its safe use and maintenance
- access and availability
- record systems
- patient privacy.

A checklist is provided, and it is often helpful if the practice manager or equivalent is available to answer questions.

Prescribing of Addictive Drugs

The objective of this tool is to assess the doctor's prescribing of addictive drugs such as benzodiazepines and narcotics, as well as systems for storage of narcotics and links with agencies working with drug related problems.

The convenor will have received a printout of prescriptions for narcotics from Medsafe, provided by the professional standards team. The printout will include patient names, formulation, amount dispensed and the date of the prescription. A similar printout can be obtained for Ritalin. The patient files will be reviewed to assess the appropriateness of the prescription.

General Prescribing

This tool is to be used in assessments on general practitioners. The objective of the tool is to assess general practitioners prescribing of all drugs, or of a specified group of drugs. The purpose is to ensure safe prescribing, but over and under prescribing, recording of prescribing, and the cost of prescribing may also be issues.

The convenor will be sent the doctor's latest Best Practice Advocacy Centre (BPAC) report from the professional standards coordinator. Consent is gained from the doctor undergoing the assessment prior to the BPAC report being sent and a copy of the report is also provided to the doctor.

Complementary and Alternative Medicine (CAM) toolkit

This toolkit is designed to assess:

- general competence
- adherence to *'Statement on complementary and alternative medicine.'*

Tools used will include **interview, CBO, communication, records review**. Please see above for synopses of these tools.

Professional Interactions

This tool is used to assess whether attitudes or behaviours of the doctor may be impacting on patient health and safety. Prior to the PAC visit, the doctor will be asked to provide the Council with a list of names of work associates (approximately 10 colleagues comprised of doctors and allied health professionals). The PAC will ask these people to fill in a questionnaire giving their opinions on the doctor's communication with colleagues and patients. The PAC will also conduct brief interviews with the work associates either in person or via teleconference facilities. This tool can also be used to assess whether an individual doctor's behaviour is disruptive.

Audit

This tool will usually be used as a secondary assessment. A PAC may have visited a doctor's practice and recommended that a thorough audit into a particular aspect of that doctors' practice is necessary to determine whether there are any deficiencies. A full audit will usually take longer than 1 day.

Direct Observation of Procedural Skills (DOPS)

The objective of this tool is to assess the doctor's procedural skills by direct observation. For instance, a general practitioner's minor procedures, a cardiologist's catheterisations, a radiologist's procedures. It is not designed for the assessment of major surgical technique.

PAC members

The pool of PAC members

To be considered for inclusion in the pool of PAC members, a doctor must:

- be perceived by peers to be clinically competent
- have credibility within the profession
- have good interpersonal skills
- have the capacity and willingness to work with others
- be registered within the vocational scope in which they wish to assess
- be endorsed by the relevant College or Branch Advisory Body
- be in good standing with the Council (i.e. have no outstanding competence, disciplinary or health issues).

To be considered for inclusion in the pool of PAC members, a lay member must have:

- an interest in the health sector
- a breadth of life experience
- lateral thinking skills
- good communication skills
- the capacity and willingness to work with others.

Professional standards coordinators aim to include any new appointments to the pool of PAC members in at least one training day before appointing that member to a PAC, however this is not always possible. At all times, a new PAC member is placed on a PAC with at least one other experienced PAC member, either lay or medical.

Selecting PAC members for individual assessments

When selecting medical members for a PAC, professional standards coordinators attempt to appoint at least one medical member who works in a similar type of practice. For example, for an assessment of a rural general practitioner, at least one of the PAC members will also be a rural general practitioner.

Council is currently in the process of seeking and appointing PAC members of various ethnicities. If specifically requested to do so by a doctor being assessed, professional standards coordinators will attempt to find a PAC member of similar ethnic background to that doctor. However, it is expected that doctors who practise in New Zealand should be culturally competent when interacting with patients. Furthermore, Council believes that it is equally important to find a PAC member who works with a similar patient base to that of the doctor being assessed. For example, if a doctor being assessed works with a high number of non-English speakers, it would be appropriate for Council to endeavour to appoint a PAC member with similar experience.

When asking whether a PAC member is available to join a particular assessment, the professional standards coordinator advises the PAC member of the doctor being assessed to ensure there is no possible conflict of interest, before confirmation of the appointment is made. All PAC members have signed a confidentiality agreement (**Appendix 4**) which states that the PAC member:

- will not disclose the name or any other identifying information of the doctor who is to be assessed, even if not ultimately appointed to the PAC for any reason
- will not reveal or release personal or health information about doctors or their patients, except as reasonably required for the performance assessment
- information will only be provided to Council and Council staff in a form in which individual patients are not identified
- only individual health or personal information relevant to the assessment will be copied, reproduced, or stored in a retrieval system or database, and will be returned to the Council at the completion of the assessment

- may receive feedback from the professional standards team after the completion of the assessment, but that this information is for educational purposes, and specific information regarding the doctor assessed remains confidential.

Assessing doctors in small specialties

In some small sub-specialties it may not be possible to appoint a PAC member within the same sub-specialty from within New Zealand. In cases such as these, Council has an arrangement with the New South Wales Medical Board (NSWMB), who have agreed to assist in identifying possible assessors on a case by case basis. The NSWMB runs a similar programme to the Council's, so doctors recommended by them are usually trained in assessment processes.

Assessing doctors practising complementary and alternative medicine (CAM)

When assessing doctors practising CAM, Council's main aim is to determine whether the doctor is practising in accordance with '*Council guidelines on complementary, alternative or unconventional medicine.*' In Council's view, competencies assessed with the CAM tool, including patient management, patient communication, informed consent, record keeping and prescribing, are all key competencies required of any medical practitioner, regardless of the modality of their practice.

All general practice and lay PAC members have advised the professional standards team of their position with regards to CAM, and Council aims to appoint at least one general practitioner who has experience integrating CAM with conventional medical practice, or has an open mind towards CAM. Council's view is that as all medical practitioners are assessed on core competencies which are inextricably linked to the practice of medicine, a doctor who practises solely in CAM is not required on the assessment, however Council does acknowledge that an appreciation of CAM is desirable.

The role of the lay member on the PAC

The lay member, like the medical members, has been fully trained on the performance assessment process, and is a professional member of the PAC. Council accepts that it may not be appropriate for the lay member to observe intimate examinations, but expects that they are involved in all other aspects of the assessment.

The lay member also provides a healthcare consumer's viewpoint on the service provided by you, particularly with regard to your use of language when communicating with a patient or obtaining consent from a patient. In some cases, usually when the PAC is looking at a specific aspect of your communication with patients, the lay member may participate in a role play with you by taking on the role of the patient, and asking questions about a particular procedure or treatment you provide.

Getting support during the process

The possible impact of the assessment on your personal and professional life

Council understands that the assessment process may impact on you, both on a professional and personal level. It is normal for people, wherever they work, to feel angry or upset when they receive a complaint or a concern about their professional ability.

Dr Wayne Cunningham has undertaken research through the Department of General Practice at the Dunedin School of Medicine regarding the effect of complaints on doctors practising in New Zealand.

1200 doctors who participated in Dr Cunningham's research advised that, upon receipt of a complaint, they experienced a variety of feelings, including:

- anger (72%)
- depression (65%)
- loss of joy (38%)
- shame (36%)
- guilt (32%).

In addition, doctors reported that the complaint immediately impacted negatively on their interaction with all patients, including reduced:

- trust (38%)
- goodwill (28%)
- commitment (18%).

On a long term basis, these feelings reduced, but some doctors continued to have difficulties with trust of, and commitment to, their patients.

With regard to the practice of medicine, some doctors also noted reduced:

- tolerance of uncertainty (42%)
- confidence in judgement (30%)
- ability to consult well (28%).

Again, these feelings reduced, but did not altogether disappear, with the passage of time.¹

For other research on this issue, please also refer to Dr Ian St George's paper, *Understanding stress due to complaints*, published in NZ Doctor on 29 June 2005.

Peers

As mentioned, Council encourages doctors being assessed to seek support from trusted colleagues. The Council acknowledges that some doctors feel a sense of shame at being subjected to an assessment. The PAC convenor can, to some extent, listen to your concerns, but is required to keep a certain professional distance from you because of the assessment.

Anecdotal evidence from doctors who have undergone the process suggests that their stress is somewhat alleviated after discussing the matter with a trusted colleague. For some, this has been the doctor who provides them with a collegial relationship, for others, it might be their best friend from medical school.

¹ Cunningham, Dr W, *The immediate and long-term impact on New Zealand Doctors who receive patient complaints* New Zealand Medical Journal 23 July 2004, Vol 117 No 1198.

If you prefer that your colleagues do not know about the assessment, but still feel you need support, the Medical Assurance Society have joined with the Medical Protection Society to offer a confidential helpline at 0800 CALLMPS which is available to all members.

Council staff

There are a total of seven Council staff members working in the professional standards team at the Council offices; the Professional Standards Manager, the Senior Professional Standards Coordinator, and the Professional Standards Coordinators. The Council's Registrar and Medical Advisers also work closely with the professional standards team.

The professional standards coordinators are each responsible for a number of performance cases at any one time. You have probably already been in contact with the staff member managing your case. It is usual for one staff member to manage an individual doctor's case from start to finish. This means that the staff member is familiar with your specific circumstances and can advise you as appropriate.

Professional standards coordinators are available to answer any questions you might have about the assessment process. Council's main telephone number is 0800 286 801 or 04 384 7635. The receptionist will be able to transfer you to a member of the professional standards team.

Glossary

Clinical practice

A medical practitioner is engaged in clinical practice if he or she assesses, diagnoses, gives advice, treats or makes reports, whether face-to-face or otherwise, with a patient, or with a group of patients or a population. (This definition includes the activities of public health medicine and medical administration: medical practitioners registered within a vocational scope of practice in these branches should be involved in recertification programmes).

Collegial relationship

If a medical practitioner is registered within a general scope of practice, they must:

- establish a collegial relationship with a doctor registered within the same or a related vocational scope as the one he or she works in, and either
- participate in an approved branch advisory body recertification programme
- or
- arrange his or her own continuing professional development (CPD) with the help of his or her colleague.

Competence

Council defines the standard of competence expected of a doctor as the knowledge, skills, attitudes and judgement to practise within his or her scope to a standard acceptable to reasonable peers and to the community.

Conditions

Some doctors will have conditions limiting their scope of practice.

Continuing Professional Development (CPD) / Continuing Medical Education (CME)

This is the continuing medical education, peer review and quality audit aimed at ensuring medical practitioners are competent to practise medicine. Also known as Maintenance of Professional Standards (MOPS).

Credentialing

The process of granting authorisation ('privileges') to an individual doctor by the employing/governing body of the health or hospital service to provide specific patient care and related services within specific limits.

Cultural competence

Cultural competence requires an awareness of cultural diversity and the ability to function effectively and respectfully when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge that:

- New Zealand has a culturally diverse population

- doctors' culture and belief systems influence their interactions with patients and may impact on the doctor-patient relationship
- a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding.

Domains of medical practice

Council requires doctors to maintain CPD and to maintain competence to perform to an acceptable standard within all the domains of medical practice; these include:

| | |
|------------------------|---|
| Medical Care | diagnostic and management skills (skills that may be specific to each branch of practice, but may be generic to several - such as prescribing, surgical skills, psychotherapy, and expert adviser skills) |
| Communication | with patients and families, with colleagues, medical record keeping |
| Collaboration | teamwork |
| Management | personal management (including insight and recognising limits), management within systems, use of time and resources |
| Scholarship | lifelong learning, teaching, research, critical appraisal |
| Professionalism | honesty, integrity, probity, respect and advocacy for patients (including cultural competence with respect to gender, race, boundaries, and New Zealand's biculturalism), respect for colleagues, moral reasoning and ethical practice. |

Fitness to practise and the inability to perform required functions for the practice of medicine

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
- not risking infecting patients with whom he or she comes in contact
- behaving appropriately
- acting or omitting to act in ways that impact adversely on patient safety.

General scope of practice

Allows the doctor to work within Council's definition of the practice of medicine. The doctor must work within a collegial relationship to ensure appropriate CPD takes place.

Generalist

A doctor with training and experience across a broad spectrum of medical practice, usually found in provincial New Zealand hospitals.

Letter of standing (LOS)

Where it is not possible to issue a certificate of good standing because there is an investigation or proceedings before Council, the HDC or the Tribunal in relation to fitness of practise (including health, competence or discipline) of a medical practitioner, a letter of standing may be provided, confirming the said practitioner is registered in New Zealand.

Maintenance of professional standards (MOPS)

See “Continuing Professional Development”.

Mentor

A professional peer appointed by Council due to discipline or health matters. The role of the mentor is to assist and support the medical practitioner in predetermined areas of practice.

Non-clinical practice

Doctors are practising non-clinical medicine if they are not engaged in clinical practice as defined above, but are engaged in such activities as medical informatics, contributing to medical media, teaching to members of the profession and students (without direct patient contact), research not involving humans, or Medical Advisory board or committee work (this list is not exhaustive) for which an annual practising certificate is required. These doctors may recertify via forming a relationship with an educational supervisor within an organisational appraisal system that includes requirements for CPD, or a collegial relationship with another doctor to ensure the doctor is maintaining their competence and taking part in CPD.

Peer review

A group activity where peers systematically review aspects of a doctor’s work, e.g. a review of the first six cases seen, or a presentation on a given topic. It would normally include guidance, feedback and a critique of the doctor’s performance.

Performance

Council defines performance as practising to a standard acceptable to reasonable peers and to the community. This includes making safe judgements, demonstrating the level of skill and knowledge required for safe practice, behaving appropriately and acting in a way that does not impact adversely on patient safety within all domains of medical practice.

Practice of medicine

Council defines the practice of medicine as including any of the following:

- advertising, holding out to the public, or representing in any manner that one is authorised to practise medicine in New Zealand
- signing any medical certificate required for statutory purposes, such as death and cremation certificates
- prescribing medicines, the sale or supply of which is restricted by law to prescription by medical practitioners
- assessing, diagnosing, treating, reporting or giving advice in a medical capacity, using the knowledge, skills, attitudes and competence initially attained for the MB ChB degree (or equivalent) and built upon in postgraduate training and CME, wherever there could be an issue of public safety.

“Practice” in this context goes wider than clinical medicine to include teaching, research, medical or health management, in hospitals, clinics, general practices and community and institutional contexts, whether paid or voluntary.

Emergency care is so much a part of a doctor’s professional ethic that, in the opinion of the Medical Council of New Zealand a qualified doctor who is not registered may render medical or surgical aid to any person in an emergency when a registered medical practitioner is unavailable.

Primary care

Primary care provides patients with their first point of contact with health services and the system of medical care. Also provides diagnosis and management of all problems presenting, either through immediate treatment or by skilled referral to the most appropriate secondary or tertiary care providers. An example is general practice, which provides continuing, comprehensive care for individuals, families, whanau and communities, delivering and coordinating the response to individual health care needs as they arise.

Provisional general scope

Most doctors must complete a minimum of 12 months working under supervision, during which time they will complete Council's requirements for registration within a general scope.

Provisional vocational scope

A minimum of 12 months working under supervision to complete requirements for registration in a vocational scope. Doctors who work within a provisional vocational scope and are then registered within a vocational scope once requirements are met, will not be registered within a general scope.

Quality assurance (QA) activity (under HPCAA, sections 54-63)

An activity that consists of, includes, or results in an assessment or evaluation of any health service provided by a doctor in order to improve his or her practice or competence. It might include:

- (i) a study of the incidence or causes of conditions or circumstances that may affect the quality of health services provided
- (ii) recommendations about the provision of services as a result of such a study or
- (iii) monitoring the implementation of any recommendations. The HPCAA encourages effective QA activities by protecting the confidentiality of information and documents developed solely for QA activity, and giving immunity from civil liability to people who engage in such activities in good faith (a 'declared quality assurance activity').

Quality Audit

The process used by doctors to assess, evaluate and improve the care of patients in a systematic way in order to enhance their health and quality of life. It involves objectively measuring performance against previously set standards and when the actual performance does not meet the standard, making recommendations for change. This may include altering the standards if they are found to be inappropriate.

Recertification

Recertification is the term given to the process by which all medical practitioners demonstrate their competence as a condition of holding an annual practising certificate.

Registration

Doctors will be registered within a scope of practice.

Required standards of competence

Required standards of competence in section 5 of the HPCAA means the standard of competence reasonably to be expected of a medical practitioner practising within that medical practitioner's scope of practice.

Risk of harm

Risk of harm may be indicated by:

- a pattern of practice over a period of time that suggests the practitioner'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 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 the 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.

In notifying the agencies of risk of harm and risk of serious harm as set out in section 35 of the HPCAA Council will ensure that the risk:

- is indicated by a recognised factor as set out in Council definitions and
- should not be fanciful; and
- that the context and circumstances of the doctor and his or her practice are included in any determination.

Scope of practice

Any health service that forms part of a health profession and that is for the time being described under section 11 of the HPCAA; and in relation to a health practitioner of that profession, means one or more of such health services that the practitioner is, under an authorisation granted under section 21, permitted to perform, subject to any conditions for the time being imposed by the responsible authority.

Self-directed learning programmes and learning diaries

An individualised programme which, as a minimum, will include recording in a diary or spreadsheet, the following: educational needs identified, educational activities carried out to fulfil that need, what was learnt/what is now done differently as a result of this process.

Special purpose scope

Doctors who do not satisfy the requirements for registration within either a general or vocational scope, who will be in New Zealand for emergency, limited, defined and specific reasons.

Specialising career medical practitioners

A doctor in a health or hospital service who works across a number of branches, at an advanced level in a narrow scope of practice or with a specific population, usually found in provincial hospitals or metropolitan accident and medical services.

Supervision - educational supervision

Educational supervision is provided by a senior medical practitioner in the same branch of medicine as a doctor participating in an educational programme. The supervisor oversees the doctor's educational activities and has a facilitative, supportive counselling role.

A positive relationship between the supervisor and the doctor is an important prerequisite for the success of the educational programme.

Supervision - disciplinary supervision

Supervision is provided by a senior medical practitioner holding a vocational scope of practice in the same branch of medicine as a doctor who has conditions on his or her practice as a result of a disciplinary hearing.

Supervisors providing disciplinary supervision are appointed to monitor doctors to ensure the conditions are being complied with, and they report to Council as required. Supervisors in this role are appointed by Council, and are not accountable to the disciplined doctor.

Supervision of doctors on temporary or probationary registration

Supervision is usually provided by a doctor registered within a vocational scope of practice as the doctor being supervised. This is a supportive, professional relationship between doctor and supervisor who reviews the doctor's medical practice and assists in developing objectives for the doctor's improvement. The supervisor monitors the doctor's performance and provides full reports to Council.

Vexatious

A vexatious proceeding is a proceeding instituted maliciously and without probable cause.

There is an inherent power in every court to stay and dismiss actions or applications that are frivolous and vexatious and abusive of the process of the court. In order to bring the case within the description it is not sufficient merely to say that the plaintiff has no cause of action. It must appear that the alleged cause of action is one which, on the face of it, is clearly one which no reasonable person could properly treat as bona fide and contend that he or she had a grievance which he or she was entitled to bring before the court.

An action brought merely for the sake of oppression or annoyance.

Vocational scope of practice

Allows the doctor to work within a specific branch of medicine, for which he or she has completed appropriate vocational training, qualifications and experience. The doctor may work independently, but must participate in an approved continuing professional development programme to maintain registration in a vocational scope.

Health Practitioners Competence Assurance Act 2003

The following are the relevant sections of the HPCAA for PAC members.

3 Purpose of Act

- (1) The principal purpose of this Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.
- (2) This Act seeks to attain its principal purpose by providing, among other things,—
 - (a) for a consistent accountability regime for all health professions; and
 - (b) for the determination for each health practitioner of the scope of practice within which he or she is competent to practise; and
 - (c) for systems to ensure that no health practitioner practises in that capacity outside his or her scope of practice; and
 - (d) for power to restrict specified activities to particular classes of health practitioner to protect members of the public from the risk of serious or permanent harm; and
 - (e) for certain protections for health practitioners who take part in protected quality assurance activities; and
 - (f) for additional health professions to become subject to this Act.

Part 3 – Competence, fitness to practise, and quality assurance

34 Notification that practice below required standard of competence

- (1) If a health practitioner (**health practitioner A**) has reason to believe that another health practitioner (**health practitioner B**) may pose a risk of harm to the public by practising below the required standard of competence, health practitioner A may give the Registrar of the authority that health practitioner B is registered with written notice of the reasons on which that belief is based.
- (2) If a person holding office as Health and Disability Commissioner or as Director of Proceedings under the Health and Disability Commissioner Act 1994 has reason to believe that a health practitioner may pose a risk of harm to the public by practising below the required standard of competence, the person must promptly give the Registrar of the responsible authority written notice of the circumstances on which that belief is based.
- (3) Whenever an employee employed as a health practitioner resigns or is dismissed from his or her employment for reasons relating to competence, the person who employed the employee immediately before that resignation or dismissal must promptly give the Registrar of the responsible authority written notice of the reasons for that resignation or dismissal.
- (4) No civil or disciplinary proceedings lie against any person in respect of a notice given under this section by that person, unless the person has acted in bad faith.

35 Authority must notify certain persons of risk of harm to public

- (1) Whenever an authority that a health practitioner is registered with has reason to believe that the practice of the health practitioner may pose a risk of harm to the public, the authority must promptly give the following persons written notice of the circumstances that have given rise to that belief:
 - (a) the Accident Compensation Corporation:

- (b) the Director-General of Health:
 - (c) the Health and Disability Commissioner:
 - (d) any person who, to the knowledge of the authority, is the employer of the health practitioner.
- (2) Whenever an authority that a health practitioner is registered with has reason to believe that the practice of the health practitioner may pose a risk of harm to the public, the authority may give written notice to any person who works in partnership or in association with the practitioner of the circumstances that have given rise to that belief.
 - (3) If, after giving notice under this section in respect of a health practitioner, the authority forms the view that the practice of the health practitioner never posed, or no longer poses, a risk of harm to the public, the authority must promptly notify every recipient of the notice under this section of the current position in respect of the health practitioner.
 - (4) Promptly after giving a notice under this section about a health practitioner, the Registrar of the authority must give a copy of the notice to the practitioner.

36 When authority may review health practitioner's competence

- (1) Promptly after receiving a notice of the kind described in subsection (2), an authority must make inquiries into, and may review, the competence of a health practitioner who is registered with the authority and who holds a current practising certificate.
- (2) The notices referred to in subsection (1) are—
 - (a) a notice of a professional conduct committee's recommendation under section 80(2)(a) or section 79(b), so far as that recommendation relates to competence; or
 - (b) a notice given under section 34.
- (3) Subsection (1) does not apply if the authority has reason to believe that a notice given under section 34 by a health practitioner is frivolous or vexatious.
- (4) The responsible authority may at any time review the competence of a practitioner who holds a current practising certificate, whether or not—
 - (a) there is reason to believe that the practitioner's competence may be deficient; or
 - (b) the authority receives a notice of the kind described in subsection (2).
- (5) In conducting a review under this section, the authority must consider whether, in the authority's opinion, the health practitioner's practice of the profession meets the required standard of competence.

Compare: 1995 No 95 s60

37 Matters to be observed in reviewing competence

- (1) The form of a review under section 36 is at the authority's discretion, but in every case the authority must give the health practitioner under review—
 - (a) a notice containing sufficient particulars to inform that health practitioner clearly of the substance of the grounds (if any) on which the authority has decided to carry out the review; and
 - (b) information relevant to his or her competence that is in the possession of the authority; and
 - (c) a reasonable opportunity to make written submissions and be heard on the matter, either personally or by his or her representative.
- (2) When a health practitioner exercises the right under subsection (1)(c) to be heard personally, the practitioner is entitled to the presence of a support person of his or her choice.
- (3) Subsection (1)(b) is subject to section 154.

38 Orders concerning competence

- (1) If, after conducting a review under section 36, the authority has reason to believe that a health practitioner fails to meet the required standard of competence, the authority must make 1 or more of the following orders:
- (a) that the health practitioner undertake a competence programme;
 - (b) that 1 or more conditions be included in the health practitioner's scope of practice;
 - (c) that the health practitioner sit an examination or undertake an assessment specified in the order;
 - (d) that the health practitioner be counselled or assisted by 1 or more nominated persons.
- (2) If the authority is unable to conduct or complete a review of a health practitioner under section 36 because of the health practitioner's failure to respond adequately to a notice under section 37, the authority has, for the purposes of subsection (1), reason to believe that the health practitioner fails to meet the required standard of competence.
- (3) The Registrar of the authority must ensure that, after the making of an order under subsection (1),—
- (a) a copy of the order is given within 5 working days after the making of the order to—
 - (i) the health practitioner concerned; and
 - (ii) any employer of the practitioner; and
 - (iii) any person who works in partnership or association with the practitioner; and
 - (b) all administrative steps are taken to give effect to the order.
- (4) An order made under subsection (1) takes effect on a date stated in the order, which, if the order is sent to the health practitioner by post, may not be earlier than 4 days after it is posted.

Compare: 1995 No 95 s61

39 Interim suspension of practising certificate or inclusion of conditions in scope of practice pending review or assessment

- (1) This subsection applies to a health practitioner if—
- (a) the health practitioner has been, or is to be, reviewed under section 36; and
 - (b) there are reasonable grounds for believing that the health practitioner poses a risk of serious harm to the public by practising below the required standard of competence.
- (2) If subsection (1) applies to a health practitioner, the responsible authority may order that—
- (a) the practising certificate of the health practitioner be suspended; or
 - (b) the health practitioner's scope of practice be altered—
 - (i) by changing any health services that the practitioner is permitted to perform; or
 - (ii) by including any condition or conditions that the authority considers appropriate.
- (3) The authority may not make an order under subsection (2) unless it has first—
- (a) informed the health practitioner concerned why it is considering making the order; and
 - (b) given the health practitioner a reasonable opportunity to make written submissions and be heard on the question, either personally or by his or her representative.
- (4) An order made under subsection (2) takes effect from the day on which the health practitioner receives a copy of the order or from any later date stated in the order.
- (5) An order under subsection (2) ceases to have effect on the later of—
- (a) the completion of the review; or
 - (b) the attainment of a pass in any examination or assessment specified in the order under section 38(1)(c).

40 Competence programmes

- (1) For the purpose of maintaining, examining, or improving the competence of health practitioners to practise the profession in respect of which an authority is appointed, the authority may from time to time set or recognise competence programmes in respect of health practitioners who hold or apply for practising certificates.
- (2) Any competence programme may be made to apply generally in respect of all such health practitioners, or in respect of a specified health practitioner, or in respect of any specified class or classes of such health practitioners.
- (3) Any competence programme may require a health practitioner to do any 1 or more of the following, within a period, or at intervals, prescribed in the programme:
 - (a) pass any examinations or assessments, or both:
 - (b) complete a period of practical training:
 - (c) complete a period of practical experience:
 - (d) undertake a course of instruction:
 - (e) permit another health practitioner specified by the authority to examine the clinical records of the health practitioner in relation to his or her clients:
 - (f) undertake a period of supervised practice.
- (4) The authority may specify a period within which the health practitioners to which a competence programme applies must comply with the requirements of the programme.
- (5) The authority may exempt any health practitioner or class of health practitioner from all or any of the requirements of a competence programme.
- (6) Within 20 working days after a competence programme is set or recognised by the authority, the Registrar must notify every health practitioner who is required to undertake the programme of that fact and of the details of the programme.

Compare: 1995 No 95 s62

41 Recertification programmes

- (1) For the purpose of ensuring that health practitioners are competent to practise within the scopes of practice in respect of which they are registered, each authority may from time to time set or recognise recertification programmes for practitioners who are registered with the authority.
- (2) A recertification programme may be made to apply generally in respect of all health practitioners, or in respect of a specified health practitioner, or in respect of a specified class or classes of health practitioner.
- (3) A recertification programme may require a practitioner to do any 1 or more of the following at intervals (if any) prescribed in the programme:
 - (a) pass any examinations or assessments, or both:
 - (b) complete a period of practical training:
 - (c) undertake a course of instruction:
 - (d) permit a health practitioner specified by the authority to examine—
 - (i) any or all of his or her clinical and other practices:
 - (ii) any or all of his or her relations with other health practitioners:
 - (iii) any or all of the clinical records of the practitioner in relation to his or her patients or clients:
 - (e) undergo an inspection:
 - (f) adopt and undertake a systematic process for ensuring that the services provided by the practitioner meet the required standard of competence.
- (4) Every recertification programme must allow a reasonable time for a practitioner to whom it relates to comply with its requirements.

- (5) The authority may exempt any health practitioner or class of health practitioner from all or any of the requirements of a recertification programme.
- (6) Within 20 working days after a recertification programme is set or recognised by the authority, the Registrar must notify every health practitioner who is required to undertake the programme of that fact and of the details of the programme.

Compare: 1995 No 95 s63

42 Health practitioners may be required to make records available

An authority that is reviewing the competence of a health practitioner or that has set a competence programme or recertification programme for a health practitioner may, for the purposes of the review or programme, inspect all or any of the clinical records of the health practitioner, and that health practitioner must make those records available for those purposes to any person duly authorised by the authority.

43 Unsatisfactory results of competence programme or recertification programme

- (1) If a health practitioner who is required to complete a competence programme or a recertification programme does not satisfy the requirements of the programme, the responsible authority may make either of the following orders:
 - (a) that the health practitioner's scope of practice be altered—
 - (i) by changing any health services that the practitioner is permitted to perform; or
 - (ii) by including any condition or conditions that the authority considers appropriate:
 - (b) that the practitioner's registration be suspended.
- (2) If the authority proposes to make an order under subsection (1), it must give to the health practitioner concerned—
 - (a) a notice stating—
 - (i) why the authority proposes to make the order; and
 - (ii) that he or she has a reasonable opportunity to make written submissions and to be heard on the matter, either personally or by his or her representative; and
 - (b) a copy of any information on which the authority is relying in proposing to make the order.
- (3) The notice under subsection (2)(a)(i) must contain sufficient detail to inform the person clearly of the particular grounds for the proposal to make the order.
- (4) Any order made under subsection (1) remains in effect until the health practitioner concerned has satisfied all the requirements of the competence programme or, as the case requires, the recertification programme, and for that purpose the authority may, on the application of the practitioner, extend the period within which the practitioner is required to satisfy those requirements.
- (5) The failure of a health practitioner to satisfy the requirements of any competence programme or recertification programme that applies to the health practitioner is not, of itself, a ground for taking disciplinary action under Part 4 against that health practitioner.
- (6) Subsection (2)(b) is subject to section 154.

Compare: 1995 No 95 s64

44 Confidentiality of information

- (1) No person who examines any clinical records of any health practitioner under a requirement of a competence review, competence programme, or recertification programme may disclose any information (being information about any identifiable individual) obtained by that person as a result of that examination, except for 1 or more of the following purposes:
 - (a) for the purpose of making a report to the authority in relation to the health

- practitioner concerned:
- (b) for the purposes of any criminal investigation or any criminal proceedings taken against that health practitioner:
 - (c) for the purpose of making the information available to the person to whom the information relates in any case where—
 - (i) the authority directs that the information be made available; or
 - (ii) the person requests access to the information.
- (2) Subsection (1)(c)(ii) does not affect the Privacy Act 1993.
- (3) Every person commits an offence and is liable on summary conviction to a fine not exceeding \$10,000 who discloses any information in contravention of subsection (1).
- (4) No information, statement, or admission that is disclosed or made by any health practitioner in the course of, or for the purposes of satisfying the requirements of, any competence review, competence programme, or recertification programme and that relates to any conduct of that health practitioner (whether that conduct occurred before or during that review or programme)—
 - (a) may be used or disclosed for any purpose other than the purposes of that review or programme; or
 - (b) is admissible against that person, or any other person, in any proceedings in any court or before any person acting judicially.

Compare: 1995 No 95 s 65

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| Continuing Quality Assessment |
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Observation consent form

Dear patient

I have an assessor with me today, helping me to provide a high quality service.

I will be advised on what I am doing well and where I could improve. The assessor is a qualified doctor specially selected for this task.

The assessor has signed a confidentiality agreement. He or she will not repeat any information about you to others. The only notes written down will be about my skills.

If you do not wish the assessor to be present during your surgery, please just hand this form unsigned to the receptionist. You do not need to explain why and it will make no difference to your surgery.

If you agree to have an assessor observe during your surgery, please sign below.

Yours sincerely (doctor to sign)

I agree to have the assessor observe my surgery:

Signed: _____

Name (print): _____

Date: _____

Please hand this form to the receptionist now.



CONFIDENTIALITY AGREEMENT

The Medical Council of New Zealand expects assessors to agree to non-disclosure of information acquired during the course of their Performance Assessment Committee reviewing activities by signing this confidentiality agreement.

I, _____ understand that in the course of assessing doctors' performance in the practice of medicine, under part 3 of the Health Practitioners Competence Assurance Act 2003, I will have access to information concerning these doctors. Also, my participation in these assessments may involve me viewing patient records and consultations.

- 1 I agree that if I am unable to conduct or complete a performance assessment for any reason that I will not disclose any information that has been disclosed to me about the doctor being assessed.

- 2 I undertake not to reveal or release any personal or health information obtained by me about doctors or their patients, except as reasonably required in the course of conducting performance assessments, or discussing performance assessment findings with the doctor concerned or other members of the Performance Assessment Committee.

- 3 If it is necessary to discuss specific cases with Council or Council members or Council staff, I will ensure that the information used will be in a form in which individual patients are not identified.

- 4 I will not, except in the course of this assessor relationship, copy, reproduce or store in a retrieval system or database, any documents or records of any nature containing personal information or health information about any individual obtained during the course of the mentoring.

- 5 At the completion of an assessment I agree to return forthwith to the Medical Council of New Zealand all information provided to me, or obtained by me, during the course of the performance assessment, or relating to the performance assessment.

- 6 I understand that any feedback provided to me after completion of the performance assessment may be used by me for educational purposes, but that specific information regarding the doctor assessed must be kept confidential.

Signed
Date