Medical Council of New Zealand and District Health Boards
HPCAA and the Employment of Doctors
Memorandum of understanding

Section 1 – Introduction

The Parties

This memorandum of understanding (MOU) is between the Medical Council of New Zealand (MCNZ) and the District Health Boards (DHBs) of New Zealand (the parties).

Introduction

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

- providing the context for the operation of the MOU
- clarifying the objectives and intentions of the parties and,
- describing how the DHBs and MCNZ intend to interact with each other.

Purpose

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

The MOU contains information relevant to the MCNZ and DHBs in the employment of doctors within the service of the DHB. This includes Chief Medical Officers (CMO), doctors, MCNZ supervisors, DHB management, medical administration units and HR departments.

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

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

Values and principles

We recognise that DHBs and employers have responsibility to provide health and disability services within their contractual obligations and the MCNZ has a responsibility to ensure the competence and fitness to practice of doctors. Failure to provide services, and the registration of doctors who are not competent to practice, are both specific risks to health and safety of the public.

We agree to foster a long term collaborative relationship to enable us both to achieve our respective organisational objectives efficiently and effectively. The following relationship principles will guide each of us in our mutual dealings:

(a) We will communicate with each other in an open and timely manner (including in relation to any request to review any aspect of this MOU).
(b) We will work in a collaborative and constructive manner and where agreed, undertake joint work initiatives.
(c) We will comply with the provisions of legislation relevant to respective roles and responsibilities.
(d) The MCNZ will make decisions within its decision-making principles (refer Appendix 1 to this MOU).
(e) We acknowledge that MCNZ and each DHB have their own respective strategic and policy directions.
(f) We will work in good faith to resolve any disagreements in a timely fashion.

(g) We will support the need for clinical governance and leadership in the planning and delivery of health services in New Zealand.
(h) We will recognise and value the other's skills, expertise and commitment to high quality performance.
(i) We will encourage continuing quality improvement and business development to achieve our respective organisational objectives.

Meetings

The MCNZ and DHBs will form a joint oversight group to monitor, evaluate, and report on the performance of the MOU. MCNZ will be represented on the oversight group by the Chief Executive and relevant senior staff. DHBs will be represented by a nominated Chief Executive, Chief Operating Officer (COO), CMO, General Manager – Human Resources (GM – HR), and a primary care advisor.

We agree that holding regular meetings is important for developing an effective working relationship. Accordingly we agree to meet at least quarterly to discuss matters of mutual interest, including:
(a) how the MOU relationship is working and how our mutual roles and responsibilities are being delivered,
(b) opportunities for improvement,
(c) how such improvement might be implemented, and
(d) wider medical regulation issues.

This oversight group will report on the above items to the CMO meeting on a quarterly basis, and the COO and GM – HR groups annually.

Review

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

Signatures

Don Mackie
Chair, DHB Chief Medical Officer Group

12/8/10
Date signed

Philip Pigou
CEO, Medical Council of New Zealand

12/08/2010
Date signed

For further information about this statement, please contact:

Chair, DHB Chief Medical Officer Group
And
CEO, Medical Council of New Zealand

Section 2 - Roles and Responsibilities

The respective roles and responsibilities of the MCNZ and DHBs are outlined under key headings below. The left hand column outlines the MCNZ role. The DHB role is shown in the matching column on the right.

Medical Council of New Zealand (MCNZ)	**District Health Boards (DHBs)**
1 Registration	
MCNZ	DHBs
1.1 Experience and qualifications • Checks CVs to identify gaps or concerns, and to assess fitness to practise and fitness for registration and that the IMGs qualifications, skills and experience meet the criteria for the pathway being registered under. • Verifies identity via a check of passport, sighting original certificates and qualifications at registration interview. • Obtains CGSs (where possible direct from source) for last 5 years from all jurisdictions in which the applicant has worked, to check for any concerns about health, competence, and conduct. • Seeks advice from the relevant branch advisory body (BAB) or medical college on applications for a provisional vocational scope on the training, qualifications and experience of the applicant, assessment requirements and proposed position and supervision plan. • Requires a declaration from the applicant in relation to conduct, competence, mental and physical health in the MCNZ's application form.	1.1 Experience and qualifications • Provides a complete application that includes all the relevant documentation listed in the checklist for registration in New Zealand. • Confirm the applicant is fit for the position via CV review and interview process. • Ensure the applicant has appropriate training, qualifications and experience for proposed position and final signoff is made by Clinical Director or HOD and finally CMO (two signatories). • Credential employee on appointment.
1.2 References • Reviews references and referee reports to ensure there are no competence, conduct or health issues for those applying for registration within a provisional general or special purpose scope of practice. The clinical leader from the immediate past employer is a critical referee. • Obtains and ensures satisfactory referee reports direct from source for those applying for a provisional vocational scope of practice.	1.2 References • Check confidential references to ensure experience validated and fitness for employment assessed, verifying references direct at source and checking verbal referee reports. The clinical leader from the immediate past employer is a critical referee. • Full employment checks will be undertaken for each applicant.
1.3 Information exchange • Shares with the DHB any relevant information identified during the assessment of an applicant. • Conducts registration workshops to inform employers and recruiters on registration processes. • Ensures that consent is received from the applicant so that information from	1.3 Information exchange • Shares with MCNZ any relevant information identified during the assessment of an applicant. This includes applicants that have not been accepted by the DHB. • Appropriate staff from the DHBs will be supported and encouraged to attend the registration workshops.

other persons and organisations can be considered (subject to notifying the applicant). Non-consent to contact, may affect the application.	
1.4 Timelines • Acknowledges receipt of applications within 5 working days. • Processes complete applications within 20 working days and issue a letter of eligibility (for special purpose and provisional general scope). Applicant disclosures about FTP issues will require a longer timeframe. • Completes the registration process and issues a practising certificate within 3 working days of attendance at registration interview, if all required documents are provided. • International Medical Graduates (IMG) vocational scope applications should be processed within 6 months upon receipt of a complete application. • Applicants that hold a recognised Australasian post graduate qualification should be processed within 4 months. • MCNZ will seek advice from medical colleges and BABs when assessing vocational applications. Medical colleges and BABs are expected to provide an initial paper assessment within 1 month of receipt of each application, or final advice following interview, within three months of receipt of each application (if doctor is in New Zealand and available for interview).	1.4 Timelines • Ensures the applicant or recruitment agency submits a complete application for registration at least 6 weeks prior to appointment date (to allow for processing time, travel to NZ, immigration processes, registration interview, and issuing of practising certificate) and longer if the application is outside MCNZ policy. • Ensure the applicant has all required documentation to complete their registration at the time of their registration interview.
Note: MCNZ is currently exploring ways to reduce these timeframes for registration applications.	
1.5 Assessment posts Requests assistance from individual DHBs and senior clinical staff with assessment for registration within a vocational scope of practice, under the auspices of the relevant BAB.	Help provide assessment posts - if possible in conjunction with other DHBs for smaller hospitals.
Clearly defined objectives and outcomes must be established where a doctor is required to go offsite for assessment.	Clearly defined objectives and outcomes must be established where a doctor is required to go offsite for assessment.

2 Practising certificates

MCNZ	**DHBs**
Will send out applications to the doctor at their postal address six to eight weeks prior to the practising certificate expiry date.	Ensure all IMGs employed in the DHB have a current practising certificate before commencing work in New Zealand.
Completes processing of applications and	Ensure that a system is in place for reviewing

issues practising certificates within 20 working days of receipt of the application if no issues are highlighted.

MCNZ will send lists of all doctors within the DHB whose practising certificate is to expire two weeks before expiry and immediately after expiry.

Note: Once the MCNZ has received an application for a practising certificate from a doctor, he/she is deemed to have a practising certificate unless notified otherwise by the Registrar.

MCNZ does not backdate a practising certificate if a doctor does not apply before the due date.

practising certificates annually to ensure that all doctors employed in the DHB are:

- practising with a current certificate, practising within the documented scope of practice and,
- meeting any conditions placed on their practising certificate or scope of practice.

3 Orientation, induction and supervision of IMGs

MCNZ	DHBs
3.1 Orientation and induction Will publish best practice guidelines on orientation and induction. Will develop an online portal and make resources available to assist with the orientation and induction of doctors into the NZ health system.	3.1 Orientation and induction Ensure all doctors entering the DHB are orientated to New Zealand medical practice and inducted to the organisation and individual service. Will resource and provide programmes for the orientation and induction of doctors that satisfy the requirements of MCNZ. DHBs may choose to collectively develop aspects of these programmes.
3.2 Supervision Will assess a service for accreditation as an approved practice setting (APS) or require an individual supervision plan for each doctor registered in a provisional or special purpose scope of practice.	3.2 Supervision **Note:** The DHBs have responsibility to ensure supervision takes place. Individual doctors also have a professional responsibility to ensure they are actively taking part in supervision. Will either meet the standards for accreditation as an approved practice setting (APS), or submit an individual supervision plan for each doctor registered in a provisional scope or special purpose scope of practice.
3.2.2 Approved practice setting Provide clear criteria and standards for accreditation as an APS. Assess applications for an APS and accredit DHB services against the APS criteria. Where the standards outlined in the criteria are not met, provide feedback and advice about the areas of deficiency.	3.2.1 Approved practice setting Where a service has been accredited as an APS, the DHB will be responsible for maintaining the standards the service has been accredited for and advising MCNZ if these standards change.
3.2.3 Individual supervision plans Provide clear guidance on the requirements for individual supervision plans.	3.2.2 Individual supervision plans Are responsible for ensuring appropriate supervision is in place for all doctors employed

Provide training and support for supervisors. Will work collaboratively with DHBs to find solutions in situations where supervision arrangements have broken down. Will work towards providing quarterly lists of doctors working in the DHB requiring supervision reports.	in the DHB registered within a provisional or special purpose scope of practice. Ensure the supervisor is able and has adequate non-clinical time allocated to: • review practice adequately • monitor the doctor's performance • report on progress (or lack of) to MCNZ. Will encourage and support supervisors to attend Council training and pass knowledge on to colleagues that have not attended training. Ensures 3 monthly reports are completed, signed by both the supervisor and doctor being supervised and are sent to MCNZ. Ensure systems are in place for managing situations where supervision arrangements have broken down. Appropriate steps will be taken including submitting a new proposed supervision plan to MCNZ. Assist smaller hospitals meet supervision needs.

4 Recertification	
MCNZ	**DHBs**
Sets requirements for recertification for doctors registered within a vocational scope of practice via accreditation of the BABs' and medical college continuing professional development programmes (CPD). The Council also sets CPD requirements for doctors registered within a general scope of practice. MCNZ audits a 10 percent sample each quarter to ensure compliance. MCNZ is continuing to develop policies around regular practice reviews (RPR) with the expectation that this will be an important mechanism for improving the overall standard of medical practice.	Provide an environment which supports learning and development and which allows the doctors employed in the DHB to fulfil their recertification and accreditation requirements. Contribute to the implementation and development of regular practice review (RPR). Ensure collegial relationship arrangements are in place and that doctors employed in the DHB have access to continuing professional development resource. Check that doctors employed in the DHB are participating in continuing professional development (CPD) at annual appraisals and/or credentialling. Clinical leaders engage with colleagues about the most appropriate and effective use of CME monies. Encourage progress through vocational training programmes.

5 Environment for intern learning	
MCNZ	**DHBs**
Accredits the hospital as a suitable place for intern learning. Contracts and pays an honorarium to intern supervisors for MCNZ work.	Ensure that the intern supervisor is allocated a minimum of one tenth protected time per 10 interns to carry out the functions of the intern supervisor role.

MCNZ will consult CMOs in the selection of intern supervisors.

Will provide training and support for intern supervisors.

CMOs have a role in the selection and ongoing oversight and support of intern supervisors.

Work within MCNZ requirements for interns in regards to:

- accreditation of runs
- orientation to the hospital and individual runs
- ensuring run objective setting is undertaken
- ensuring mid and end of run assessments are undertaken in a timely manner
- night cover arrangements
- emergency department arrangements
- informed consent
- Provide protected formal teaching time and informal teaching and training for interns.

6 Competence and conduct

MCNZ

Will notify the CMO and the supervisor (as Council agent) in the below circumstances:

- there is a risk of harm or serious risk of harm arising from a doctor's practise
- there is a suspension
- conditions or other limitations/requirements are placed on the doctor's practice including voluntary undertaking
- MCNZ decision to order a performance assessment
- PCC or conduct enquiry where the DHB is not the complainant.
- there is a need to access medical records.

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

Provide competence and conduct workshops for appropriate staff at DHBs.

6.1 Upskilling

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

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

Liaises with the employer to ensure that any

DHBs

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

Must also notify MCNZ of:

- changes or restrictions placed on a doctor's practice because of competency/conduct issues
- concerns about competence/conduct not able to be dealt with within the DHB system
- concerns if a doctor has left a DHB because of competence/conduct concerns.

Take responsibility to ensure patients are not at risk while competence/conduct concerns are being reviewed.

Have a system to exchange information on doctors' competence concerns with other hospitals that may employ a doctor.

Have an effective system to respond to concerns about practice.

6.1 Upskilling

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

proposed programme is achievable in a practical sense.

7 Management and sharing of information regarding doctors who are not employees of a DHB

MCNZ	DHBs
The MCNZ must comply with the HPCAA, particularly sections 35 and 157.	The DHB, on receipt of any order or notice, will confirm receipt to the MCNZ.
Where an order or direction is made by MCNZ, publication of the order will be made to the CMO.	The DHB will liaise with the MCNZ on a plan to monitor the order or notice and to determine if specific action is required to ensure public health and safety.
Where a notice is issued under section 35, the MCNZ will request that the Ministry of Health advise any effected DHBs of the notice.	The DHB will advise the MCNZ of all information it has or receives in relation to the doctor.
The Minister's office will be advised of any actions taken by the MCNZ under this part of the MOU.	
Should the MCNZ decide to publish an order in any public media, it will first consult with the relevant DHB(s).	
Will advise the CMO when representatives of Council are visiting a DHB for any reason.	

8 Health

MCNZ	DHBs
If there is a reason to believe a doctors is not fit to practise because of a mental or physical condition will notify the DHB where there is: • a risk of harm or serious risk of harm arising from a doctor's practise • a suspension • if conditions or other limitations placed on the doctor's practice • a review if agreed by MCNZ.	**Note:** Doctors and those that employ doctors have a duty to report to the MCNZ under section 45 HPCA Act 2003 if there is reason to believe the doctor is not fit to practise if, because of a mental or physical condition, he or she is not able to perform the functions required for the practice of medicine. Those functions would include: • the ability to make safe judgements • the ability to demonstrate the level of skill and knowledge required for safe practice • behaving appropriately • not risking infecting patients with whom the doctor comes in contact, and • not acting in ways that impact adversely on patient safety.
Ensures assessments are completed to ascertain if a doctor is fit to practise.	Each DHB will ensure concerns are identified and notified through their clinical governance process.
Agrees on voluntary agreements with doctor to maintain the doctor in safe practice and to ensure the DHB is aware of any relevant health issues requiring management.	Develop "back to work" programme and notify the MCNZ's Health Manager if required.
The CMO will be the key workplace contact for sharing information relating to health concerns.	Assist with monitoring in workplace.

	Ensure appropriate processes are in place to implement any changes in the scope of practice (including changes to practising certificate)

9 Statements and guidelines

A list of all MCNZ's statements and guidelines are attached as Appendix 2 to this MOU.

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

GLOSSARY:

Approved practice setting (APS):
A service that is accredited as an APS is recognised by MCNZ as having appropriate support and supervision available and provided to IMGs to ensure their safe integration into medical practice in New Zealand.

Brand Advisory Body (BAB):
A BAB is a specialist College, society or association that may be accredited by Council to carry out one or more of the following functions

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

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

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

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

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

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

Risk of harm may be indicated:

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

Serious risk of harm:

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

Protocol for decision-making principles

Background

1. The Council reviewed its governance model, structures and composition in 2007. The key conclusions at that time, which are relevant to the decision-making principles, are:
   - The Council's governance role is mainly based on agency theory, with three key accountabilities – the public, the Minister and the profession.
   - The Council recognises that employers and providers of health services also have accountability (vicarious) for the behaviour and performance of their employees, including doctors. Therefore the Council will work with employers and DHBs to meet these accountabilities.
   - The Council also has a quasi-judicial function that is distinct from its traditional governance role. This function must be exercised within the Council's powers and responsibilities under the HPCAA.

2. The Council's decision-making principles will need to reflect these differences in Council's roles. Although there are likely to be common principles for both roles, it is also likely that each role will have distinctly separate principles. The remainder of this protocol identifies common and separate principles, relevant to Council's roles.

Common principles – governance and quasi-judicial roles

- Accountability:
  Council is accountable for its decisions to the public, the Minister of Health and Parliament and, in relation to the efficient use of funds to achieve its purpose under the HPCAA, to the profession. This means that the Council will consider:
  - Whether the decision is consistent with its principal purpose – to protect the health and safety of the public.
  - Whether the decision is consistent with the principles of the HPCAA ie, setting standards, ensuring competence, promoting education and training, promoting public awareness, etc.
  - Whether the decision is the most efficient means of meeting Council's obligations under the HPCAA.

- Trust:
  Council will consider trust in key relationships when deciding governance and quasi-judicial matters. The key relationships are:
  - Between the profession and the public.
  - Between the public and the Council.
  - Between the profession and the Council.
  - Between the Council and employers of doctors

  Council will consider:
  - would the decision improve the trust in one or more of these relationships?
  - What would be the impact on the other relationship(s)?

- Independence:
  - Council members are independent and do not represent any profession or other bodies. Council will decide governance and quasi-judicial matters independently of any stakeholder interest, personal interest or relationship and

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

- Inquiry:
  - Council will inquire into and assess all relevant and available information in deciding governance and quasi-judicial matters. This would include examining critically all assumptions to determine opinion and fact.

- Consistency:
  - Council will aim to ensure consistency of decisions over time by giving consideration to earlier decisions in deciding governance and quasi-judicial matters.

- Cultural competence:
  - Council will respect and work towards the cultural nature and diversity of the New Zealand public and medical workforce.

Specific principles – governance roles

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

Specific principles – quasi-judicial roles

- HPCAA:
  - The Council will always act consistent with the purpose, principles and specific enabling provisions of the HPCAA.

- Principles of natural justice:
  - The Council will apply the specific provisions of the HPCAA regarding providing relevant information and giving reasonable opportunity to make written submissions and be heard.
  - Proceedings of Council will be conducted so that they are fair to all parties.
  - The Council will only take into account relevant considerations and extenuating circumstances and ignore irrelevant considerations.
  - All members of Council should act without bias (refer to Council's *Policy on conflict of interest*) and act in good faith.

- Risk of harm and Serious risk of harm
  - The Council, in considering individual cases, will expressly apply its definitions of risk of harm and serious risk of harm. The relevant definitions are:

    Risk of harm may be indicated by:
    - A pattern of practice over a period of time that suggests the doctor's practice of medicine may not meet the required standard of competence; or
    - A single incident that demonstrates a significant departure from accepted standards of medical practice; or
    - Recognised poor performance where local interventions have failed – this does not exclude notification of serious concerns where internal review or audit is inaccessible or unavailable to the person with the concern; or criminal offending.
    - Professional isolation with declining standards that 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 alleged criminal offending is of such a nature that the doctor poses a risk of serious harm to one or more members of the public.

Approved by Council: 13 May 2009

Definitions
- *Practice of* medicine, August 2004
- *Fitness to practice*, August 2004
- *Clinical practice and non-clinical practice*, August 2004

Administrative practice
- *Statement of safe practice in an environment of resource limitation*, October 2005
- *Responsibilities of doctors in management and governance*, June 2001 (revised in September 2004 for HPCA Act)
- *Statement on employment of doctors and the Health Practitioners Competence Assurance Act 2003*, March 2005
- *Non-treating doctors performing medical assessments of patients for third parties,* June 2003

General subjects
- *Disclosure of harm,* October 2004
- *Responsibilities in any relations between doctors and health related commercial organisations,* December 2003
- *The doctor's duty to help in a medical emergency*, August 2006
- *Medical certification*, December 2007
- *The maintenance and retention of patient records*, October 2005
- *Statement on use of the internet and electronic communication*, June 2006
- *Statement on complementary and alternative medicine*, March 2005
- *Confidentiality and the public safety*, April 2002
- *Information and consent*, April 2002
- *Legislative requirements about patient rights and consent*, February 2006
- *Improper prescribing practice with respect to addictive drugs*, June 2001
- *The use of drugs and doping in sport*, December 2000
- *Fitness for registration – statement for medical students*, June 2004
- *Ending a doctor-patient relationship*, March 2004
- *When another person is present during a consultation*, March 2004 (replaces the *chaperone statement* of June 1993)
- *Statement on cosmetic procedures* (October 2007)
- *Unprofessional behaviour and the health care team. Protecting patient safety,* August 2009

Health
- *HRANZ Joint guidelines for registered health care workers on transmissible major viral infections*, November 2005
- *Statement on providing care to yourself and those close to you*, August 2007

Cultural competence
- *Statement on cultural competence*, August 2006
- *Statement on best practices when providing care to Māori patients and their whānau*, August 2006

Other Council publications
The following may also provide useful guidance and advice and are available from the Council's office. Some are also available on the Council's website www.mcnz.org.nz

• *Continuing professional development and recertification,* Updated October 2005
• *Doctor's health,* a guide to how the Council manages doctors with health conditions, December 2004
• *Education and supervision for interns,* a resource for new registrants and their supervisors, 2005
• *Good medical practice,* standards for the profession, revised 2004 (currently under review).
• *Guidance for doctors working in supervised practice and their supervisors,* August 2004
• *Medical registration in New Zealand,* June 2005
• *Sexual boundaries in the patient-doctor relationship,* a guide for doctors, October 2006
• *The importance of clear sexual boundaries in the patient-doctor relationship,* a guide for patients, October 2006
• *What you can expect. The performance assessment,* Updated November 2005
• *You and your doctor,* guidance and advice for patients, 2002.

Media statement
For immediate release **18 August 2010**

The Medical Council and District Health Boards sign MoU

The Medical Council and the country's 20 District Health Boards (DHBs) today signed a Memorandum of Understanding (MoU).

The document signed by Dr Don Mackie, chair of the DHB chief medical officer group and Mr Philip Pigou, the Medical Council's chief executive enable DHBs and the Council to work collaboratively together, clarifying their respective roles and responsibilities on the regulation of doctors in New Zealand.

The Medical Council's, chief executive Philip Pigou said today, "The Council and the national Chief Medical Officer group have a very positive relationship which is critical to the success of this MoU.

"The signing of this MoU recognises the need for clinical governance and leadership between DHBs, the Council and clinicians.

"The MoU will help achieve our joint objective of ensuring the competence and quality of our medical workforce. It will also in turn benefit patients by contributing to quality and safety in our health system."

"It also recognises that DHBs and employers have responsibility to provide health and disability services and the Council has a responsibility to ensure the competence and fitness to practice of doctors."

"Failure to provide these services and the registration of doctors who may not be competent to practise, are both risks to public health and safety."

The MoU outlines several new joint initiatives between the Council and DHBs including the development of processes for international medical graduates to assist with their orientation and induction into the New Zealand health system.

A planned online portal will offer information and links on cultural issues, how the New Zealand health system works, as well as immigration and other support services.

Commenting on the signing of the MOU, Dr Mackie says because the roles and responsibilities are clearly set out both time and money will be saved.

"There are now very clear expectations about the registration, reference checking and sharing of any information or concerns we might have about a particular doctor with the Medical Council."

"We're also strongly committed to ensuring the orientation and induction of new doctors into our health system and to providing an environment which supports learning and development," said Dr Mackie.

Issues of competence and conduct are also addressed by the MoU.

"The notification process by DHBs (or other employers) to the Council of concerns about a doctor's competence is another step in safeguarding public health and safety. As is the exchange of information by Council to DHBs about competence and conduct processes," said Mr Pigou.

It also provides clear processes for sharing information about doctors who are not DHB employees but may pose a risk to public health and safety.

The MoU contains information relevant to the Council and DHBs in the employment of doctors within the service of the DHB. The next step is to work with the RNZCGP and other stakeholders to explore how the MoU can be extended to include those doctors working in primary care.

A copy of the MoU is attached.

- ENDS -

For more information

Dr Don Mackie
Chair of the DHB Chief Medical Officer Group
Ph: 021 656 000

Philip Pigou
Medical Council's Chief Executive
Ph: 021 575 587