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SETTLEMENT OF COMPLAINTS BY CONCILIATION:

Resolving Patient Complaints under the Health Practitioners Competence Assurance Act 2003

LAWS 538: NEGOTIATION AND MEDIATION

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I Introduction

Every patient has a legal right to complain about their health provider, and every health provider has a corresponding duty to facilitate the fair, simple, speedy and efficient resolution of such complaints.[1] But, if a patient is dissatisfied with the response, or feels unable to pursue a complaint directly with the provider, this may result in a formal complaint to an external agency. In particular, complaints may be made (or referred) to a responsible authority established under the Health Practitioners Competence Assurance Act 2003 (HPCA Act).

Responsible authorities, which regulate health practitioners of various health professions,[2] may appoint a Professional Conduct Committee (PCC) to investigate concerns about a practitioner's conduct or practice.[3] After completing an investigation a PCC may choose, among other options, to submit a complaint for settlement by conciliation.[4] Notwithstanding this, PCCs rarely, if ever, do so. Indeed, a review of the available annual reports of responsible authorities for the past 5 years reveals no reference to any complaints being submitted to (or resolved by) conciliation.

The reason why conciliation is underutilised has not previously been explored, although the apparent reluctance is arguably at odds with the perceived benefits of facilitated outcomes in patient complaints, particularly where there is an ongoing therapeutic relationship. With this in mind, this paper critically examines and comments on the statutory scheme for conciliation under the HPCA Act, with a view to identifying the possible reasons for its lack of use and to consider its future. It explores what is meant by conciliation, the reasons for its inclusion in the HPCA Act and the statutory model itself. It determines that little thought was given to the meaning, form or purpose of conciliation, or its interface with the role of the Health and Disability Commissioner in resolving patient

[1] Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, Right 10(1), 10(3).

[2] As at 21 March 2017 there are 21 health professions regulated by 16 responsible authorities. The professions include anaesthetic technicians, chiropractors, dentists, dental therapists and technicians, medical practitioners, medical laboratory scientists, medical radiation technicians, nurses, occupational therapists, optometrists, osteopaths, pharmacists, psychologists, psychotherapists, and physiotherapists. Responsible authorities include, for example, the Medical Council, Nursing Council, Dental Council, and Physiotherapy Board.

[3] HPCA Act, s 68(3).

[4] Section 80(3)(c).

complaints. Ultimately, it concludes that while conciliation may be suitable for some patient complaints, its lack of use points to the need for a fundamental reassessment of the statutory model, and possible legislative amendment. Robust theoretical analysis, which was lacking in its adoption, and empirical research into PCCs (and others) understanding of conciliation, is necessary to inform that process and to decide the future for conciliation.

II What is Conciliation?

It is appropriate to start with consideration of what is meant by 'conciliation.' In everyday usage, conciliation is defined as the "action of mediating between two disputing people or groups."[5] However, conciliation and mediation are somewhat different concepts:[6]

> The key distinction is that a mediator deals only with process and has no role in advising on, or determining, content or outcomes. A conciliator may advise on content and outcomes and usually has specialist knowledge in the subject area.

Notwithstanding this 'key distinction', confusion exists about the meaning of 'conciliation', and this is compounded by the term often being used interchangeably with mediation, particularly in statutory schemes.[7]

On one hand, it is arguable that when alternative dispute resolution (ADR) forms part of a statutory scheme Parliament has an obligation to clarify why a specific term is employed, and precisely what is meant by that term. This is particularly the case where, for example, 'conciliation' is intended to mean a process of "advocat[ing] for statutory rules", and where unsuccessful conciliation may result in alternative statutory processes.[8] One author has observed that: [9]

> …to achieve public acceptance and understanding of the various processes people must be clear about any significant differences. It is my belief, that in

[5] Oxford English Dictionary < https://en.oxforddictionaries.com/definition/conciliation> (accessed 21 March 2017).

[6] Grant Morris "Towards a History of Mediation in New Zealand's Legal System" (2013) 24 ADRJ 86, at 88.

[7] See Claire Baylis ""Reviewing Statutory Models of Mediation/Conciliation in New Zealand: Three Conclusions" (1999) 30 VUWLR 279, at 282.

[8] Peter Spiller (ed) *Dispute Resolution in New Zealand* (Oxford University Press, Auckland, 1999) at 58.

[9] Above n 7, at 285.

> New Zealand the public, many lawyers and even some mediator/conciliators are not clear about the distinctions drawn in statutory models.

That said, a number of common features may make the interchangeability of terms understandable. Importantly, conciliation is based on the principles of mediation. Both conciliation and mediation are nominally confidential, consensual, flexible and informal. Conciliators, like mediators, "have the primary function of facilitating decision-making" and play no role in imposing a solution upon the parties.[10] Moreover, conciliation is not unlike 'evaluative mediation', in which the mediator may use his or her expertise "in guiding parties to accept normative or standard outcomes."[11] Thus, evaluative mediation, like conciliation, permits the mediator to bring some independent assessment to the issue at hand, including by assessing typical outcomes having regard to precedent, experience or law. Indeed, the following description of evaluative mediation could readily be applied to conciliation:[12]

> …a dispute resolution process whereby a person with some expertise in a particular field meets with two or more disputants, encourages them to negotiate within and across their respective teams; and collects alleged facts, evidence and arguments, and gives information, opinion and advice...

While conciliation is used in dispute resolution practice, largely in consumer complaints regimes,[13] the blurred distinction between conciliation and 'evaluative' mediation in particular raises questions about why the term conciliation has been used at all in statutory schemes. Because conciliation appears to have been used indiscriminately it is not possible to contend that it was a deliberate decision, to differentiate a 'directive' form of ADR from

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[10] Laurence Boulle *Mediation: Principles, Process, Practice* (3rd ed., Lexis Nexis Butterworths, Australia, 2011) at 148.

[11] Laurence Boulle, Virginia Goldblatt, Phillip Green *Mediation: Principles, Process, Practice* (2nd ed., Lexis Nexis, Wellington 2008) at 48. See also the National Alternative Dispute Resolution Advisory Council's glossary of common ADR terms, which describes 'conciliation' and 'evaluative mediation' as similar processes involving input and suggestions from the facilitator: National Dispute Resolution Advisory Council "Dispute Resolution Terms: The use of terms in (alternative) dispute resolution" (September 2003) <www.ag.gov.au/LegalSystem/AlternateDisputeResolution/Documents/NADRAC%20Publications/Dispute%20Resolution%20Terms.PDF> (accessed 21 March 2017).

[12] John Wade "Evaluative and Directive Mediation: All Mediators Give Advice" (5 January 2012) < epublications.bond.edu.au/cgi/viewcontent.cgi?article=1427&context=law_pubs> (accessed 7 May 2017).

[13] See for example Utilities Disputes Limited: <www.utilitiesdisputes.co.nz/UD/Complaints/Conciliation_conferences/UD/Complaints/Conciliation_conferences.aspx> (accessed 4 June 2017).

the more traditional 'facilitative' mediation, although this would have been a reasonable explanation. However, a search across New Zealand legislation indicates that statutory schemes for conciliation are in decline. Generally, it is only older enactments that include provisions for resolving disputes with conciliation.[14] Just two statutes since the introduction of the HPCA Act include provision for 'conciliation,' and in both cases it is included in the context of resolving a complaint through "negotiation, conciliation, and mediation."[15] This more recent and express reference to three forms of ADR (with conciliation and mediation separately identified) acknowledges that there is some difference between them, and could well reflect an intention to allow for greater flexibility and choice as to the ADR methods employed to resolve a dispute, regardless of the terminology.

Terminological matters aside, statutory models of ADR do endorse it as a legitimate substitute for adversarial dispute resolution, or at least acknowledge it as a valid option for resolving differences. Arguably, requiring or permitting ADR also recognises its potential cost-efficiencies, and the potential benefits to participants, including (confidentially) acknowledging their respective interests. In the context of patient complaints, the availability of conciliation may have been intended to recognise the perceived value of patients being supported to participate in resolving their concerns. It may also reflect a desire for timely and flexible complaint resolution. To test whether these factors explain the inclusion of conciliation in the HPCA Act, it is necessary to consider the statutory scheme and its origins.

III The Statutory Scheme

The HPCA Act establishes a single regulatory regime for health practitioners practising in New Zealand. Its principal purpose is "to protect the health and safety of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions."[16] It includes provisions for dealing with complaints through investigations by a PCC.

[14] See for example, the Sharemilking Agreements Act 1937 and the Family Court Act 1980.

[15] Real Estate Agents Act 2008, s 87 and Lawyers and Conveyancers Act 2006, s 143. Note that s 46 of the Veterinarians Act 2005 provides for the resolution of complaints by *mediation*, then makes reference (within the same section) to *conciliation*. The rationale for this is unclear.

[16] HPCA Act, s 3(1).

A Professional Conduct Committees

Responsible authorities may refer information that raises questions about the appropriateness or the safety of a health practitioner's practice to a PCC.[17] A PCC is made up of two health practitioners registered with the authority and one lay person.[18] It conducts an independent investigation into the alleged conduct and is required to give the practitioner under investigation, and any complainant, an opportunity to make submissions and be heard on the matter.[19] PCCs may appoint legal advisers and investigators, and have extensive powers to call for information or documents relevant to the investigation.[20]

When a PCC has completed its investigation it must make one or more recommendations or determinations as provided for in the HPCA Act.[21] It may recommend that the responsible authority review the practitioner's competence or fitness to practise; refer the matter to the police; or 'counsel' the practitioner.[22] More significantly, a PCC may make a determination that no further steps be taken in the matter; that a disciplinary charge be laid before the Health Practitioners Disciplinary Tribunal (Tribunal);[23] or, relevantly, that the complaint be submitted to conciliation.[24]

B The Conciliation Model

Section 82 sets out the process for settlement of complaints by conciliation. It provides that a PCC must appoint an independent person (the 'conciliator') "to assist the health practitioner and the complainant concerned to resolve the complaint by agreement."[25] The conciliator is required, "within a reasonable time" after appointment, to provide the PCC and the responsible authority with a written report as to whether or not the complaint has been successfully resolved by agreement.[26] If, having considered that report, a PCC thinks the complaint has not been successfully resolved it must decide whether to lay a disciplinary charge; or to make any recommendations; or to take no further steps in the

[17] HPCA Act, s 68(3). Not all complaints will justify referral to a PCC, and where appropriate a responsible authority may instead review a practitioner's competence, or examine a practitioner's fitness to practise (see ss 36, 49).

[18] Section 71.

[19] Section 80(4).

[20] Sections 73 and 77.

[21] Section 80.

[22] Section 80(2).

[23] The grounds for discipline are found at s 100 and would form the basis for a disciplinary charge.

[24] Section 80(3).

[25] Section 82(1).

[26] Section 82(2).

matter.[27] If a PCC decides to lay a disciplinary charge it must provide a copy of the conciliator's report to the Tribunal.[28]

As can be seen, a PCC is empowered to use conciliation but it is not required to do so. And, it is clear that unsuccessful conciliation may result in alternative statutory processes, including formal disciplinary action.

C Why Conciliation?

The HPCA Act's conciliation provisions were modeled on the now repealed Medical Practitioners Act 1995 (MPA). The MPA was passed shortly after the enactment of the Health and Disability Commissioner Act 1994 (HDC Act), which in turn resulted from a significant patient-centred reform of the health system.[29] Those reforms sought to create a system of accountability that was external to the self-regulating health professionals, and led to the creation of an independent Health and Disability Commissioner (Commissioner). It is suggested that this timing was instrumental to the more transparent complaints and disciplinary processes adopted by the MPA.

Although the MPA provided for conciliation, it is notable that there was no discussion or debate on its inclusion. Rather, the apparent emphasis of the MPA's complaints processes generally was on dealing with complaints that were not suitable for resolution through the Commissioner:[30]

> The emphasis of [the HDC Act] is to try to resolve at the lowest possible level, in a non-confrontational and constructive way, disagreement and concerns of patients. Clearly, the provisions in this particular Bill are looking at the process of the next step, where in fact there…has not been a satisfactory resolution, or where indeed the office of the commissioner highlights professional misconduct.

Because no active consideration was given to the role of conciliation in the MPA it is difficult to determine the true rationale for its inclusion. But, on the basis of the above comments, conciliation appears to have been intended as one of a range of options when the Commissioner had already failed to resolve a complaint, or where the Commissioner

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[27] HPCA Act, s 82.

[28] Section 82(4)(b).

[29] See the report of the public inquiry by Dame Silvia Cartwright *The Report of the Cervical Cancer Inquiry* (1988). The inquiry was prompted by a Metro magazine article entitled "An Unfortunate Experiment at National Women's", authored by Sandra Coney and Phillida Bundle and published in June 1987.

[30] (5 December 1995) 552 NZPD 10372.

had raised concerns about alleged wrongdoing. That said, the model adopted by the MPA did not constrain the use of conciliation to those circumstances. Instead, conciliation was available at the conclusion of an investigation into any complaint.

The Medical Council's annual reporting during the relevant period indicates that conciliation was indeed utilised, but only in a small proportion of complaints and in declining numbers over the years. The highest number of conciliations in any one year was in 1998, when 15 of 211 complaints were referred for settlement by conciliation. In contrast, of the 651 complaints between 2000 and 2002, only 8 were referred to conciliation.[31]

The reason for the decline is unclear. The available data suggests that approximately one third of complaints referred to conciliation were successfully resolved,[32] although the confidential nature of conciliation means that the nature of the complaint and the settlement achieved is unknown. Most cases where settlement was not achieved resulted in 'no further action' (as opposed to a disciplinary charge), and a search of decisions of the Medical Practitioners Disciplinary Tribunal (MPDT)[33] reveals only one case in which reference was made to unsuccessful conciliation.[34] In that case, the decision to lay a charge following an unsuccessful conciliation was the subject of a judicial review, although the review was apparently not pursued and the charge was ultimately withdrawn on the basis that the complainant had (later) settled a civil claim against the doctor arising from the same set of facts.

Notwithstanding its declining use, in 2003 the conciliation provisions of the MPA were largely replicated in the HPCA Act without any obvious consideration of whether or not it had proven a useful model. The Health Select Committee made no remarks about conciliation whatsoever when reporting on the Bill,[35] and no mention was made of conciliation in any debates prior to the HPCA Act's enactment. Remarkably, there is no

[31] Historical Annual Reports of the Medical Council, available at </www.mcnz.org.nz/news-and-publications/annual-reports/#historicannualreports> (accessed 21 May 2017).

[32] The reporting is inconsistent on outcomes, however available data indicates that there were 1,232 complaints between 1997 and 2002. 35 complaints were referred to conciliation: 10 were successful; 9 unsuccessful; and 11 reported as "ongoing" (with no obvious outcome found).

[33] Established under the MPA to hear and determine disciplinary charges against medical practitioners brought under that Act.

[34] *Dr M* 115/98/59C < http://mpdt.org.nz/decisionsorders/decisions/9859cfindingslaw.PDF> (accessed 16 April 2017).

[35] See Health Practitioners Competence Assurance Bill 2002 (230-2) (reported from the Health Committee).

indication that the Medical Council was invited to comment on when and how conciliation was employed under the MPA.

While some changes were made to the MPA's conciliation model, including to require the appointment of an independent conciliator,[36] it seems that Parliament fundamentally failed to turn its mind to the meaning, form and purpose of conciliation under the HPCA Act. Moreover, in adopting conciliation no apparent thought was given to the role of the Commissioner in resolving patient complaints. This context is relevant and requires closer consideration.

IV The Role of the Commissioner

The "main enforcement mechanism for aggrieved [health] consumers" is to complain to the Commissioner, who is regarded as the "single entry point" for complaints alleging a breach of the Code of Health and Disability Services Consumers' Rights (Code of Rights).[37] Notably, those rights include the right to services that comply with legal, professional, ethical and other relevant standards.[38] Therefore, the Commissioner has jurisdiction to deal with, and resolve, complaints about a practitioner's compliance with professional standards set by a responsible authority.[39]

The express purpose of the HDC Act, under which the Commissioner operates, is to promote and protect the rights of health consumers and "to facilitate the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights."[40] The Commissioner acts as the "initial recipient"[41] of complaints about providers and, consistent with this, the HPCA Act requires a responsible authority to forward to the Commissioner any complaint alleging that the practice or conduct of a practitioner has affected a patient.[42] The Commissioner is required to ensure that complaints are

[36] Under the MPA a complaints assessment committee (the equivalent of a PCC) was itself required to attempt to assist the persons concerned with resolution of the complaint: s 94(1).

[37] Ron Paterson "The Patients' Complaints System In New Zealand" (2002) 21(3) Health Affairs 70, at 72-73.

[38] Code of Rights, Right 4(2).

[39] Responsible authorities are required to set standards of ethical behaviour to be observed by practitioners (HPCA Act, s 118(i)).

[40] HDC Act, s 6. Note that this purpose is replicated as a patient right under the Code of Rights, and therefore is a corresponding duty on all health providers (Right 10).

[41] HDC Act, s 14(1)(da).

[42] HPCA Act, s 64.

"appropriately dealt with."[43] To that end, the Commissioner must make a preliminary assessment of all complaints to decide what, if any, action to take.[44] Among other things, the Commissioner can decide to investigate a complaint, following which a report may be issued setting out the Commissioner's opinion as to any breach of the Code of Rights and any recommendations the Commissioner thinks fit.[45]

A Mediation Conferences

The Commissioner has a statutory discretion to call a mediation conference to endeavour to "resolve the matter by agreement" between the parties.[46] The trigger for mediation is the Commissioner's opinion as to whether it would be "appropriate" in the circumstances."[47] It has been said that mediation may be 'appropriate' where formal investigation is considered unnecessary "because the key issues are agreed and there are no further safety issues."[48]

If mediation is pursued, the HDC Act specifies that the parties may be represented at mediation; that the Commissioner may invite any other persons who could assist with the resolution of the complaint; and that the parties, or their representative, may be paid fees and allowances to enable adequate representation during the mediation conference.[49]

However, despite the Commissioner's stated "support [for] resolution of complaints at the lowest appropriate level,"[50] and notwithstanding that mediation offers a 'low-level' dispute resolution mechanism, the Commissioner's annual reports for the past 4 years make no mention of 'mediation' when reporting on the key activity of complaints resolution.[51] Similarly, complaints resolved by mediation in earlier years are a very small proportion of total complaints received:[52]*

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[43] HDC Act, s 14(1)(da).

[44] Section 33.

[45] Section 45(2)(a).

[46] Section 61.

[47] Section 61(1).

[48] Ron Paterson "Assessment and Investigation of Complaints" in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015), 903 at 909.

[49] HDC Act, s 61.

[50] Anthony Hill "The Role of the Health and Disability Commissioner and the Code of Rights" in *Coles Medical Practice in New Zealand* (12th ed, Medical Council of New Zealand, Wellington, 2013), 231 at 234.

[51] Health and Disability Commissioner, Annual Reports 2013-2016 at <www.hdc.org.nz/publications/other-publications-from-hdc/annual-reports?resultsPerPage=-1> (accessed 16 April 2017).

[52] Health and Disability Commissioner *Annual Report for the year ended 30 June 2012* <www.hdc.org.nz/media/224275/hdc%20annual%20report%202012.pdf> at 17. (accessed 26 March 2017).

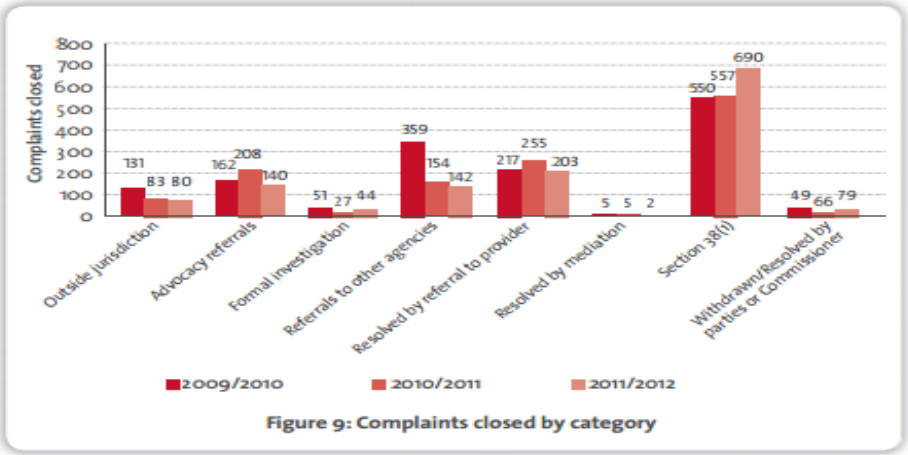

Figure 9: Complaints closed by category

In the context of an exploration of conciliation under the HPCA Act, it is notable that the HDC Act was amended in 2003 – to coincide with introduction of the HPCA Act – to enable the Commissioner to refer complaints to mediation without the need to commence an investigation.[53] Theoretically, this provided greater flexibility to utilise mediation at an early stage, although in reality it had little impact on the use of ADR in resolving patient complaints. On the face of it, the Commissioner does not consider many (or, more recently, any) complaints to be 'appropriate' for mediation.

B Referral to a Responsible Authority

The Commissioner also has discretion to refer a complaint to a responsible authority if the complaint appears to raise concerns about competence or fitness to practise, or if the appropriateness of the practitioner's conduct may be in doubt.[54] In the year ended 30 June 2016, the Commissioner investigated 80 complaints and referred 45 matters to (or back to) a responsible authority.[55]

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* The figures relating to s 38(1) are reference to the Commissioner's power to take no further action in response to a complaint.

[53] Health and Disability Commissioner Amendment Act 2003. See also Ron Paterson "Mediation – an HDC perspective" (31 May 2006) Health and Disability Commissioner <www.hdc.org.nz/media/183420/mediation%20-%20an%20hdc%20perspective.pdf> (accessed 7 May 2017).

[54] HDC Act, s 34.

[55] Health and Disability Commissioner *Annual Report for the Year Ended 30 June 2016* (31 October 2016), at 12. Note that of the 2,007 'closed complaints' reported for that year, the vast majority (756) were closed with 'no further action'.

Exercising the discretion to refer a complaint to a responsible authority would require the Commissioner to form a reasonable view that the complaint is one which falls more appropriately within the regulatory ambit of a responsible authority. However, resolving patient complaints is *not* the principal purpose of the HPCA Act: its central focus is to ensure that only competent and fit individuals are registered and practising as health practitioners in New Zealand and, relatedly, to set standards of competence and professional conduct. The ability to review a practitioner's competence; to assess a practitioner's health; or to discipline practitioners who fail to comply with professional standards, is broadly consistent with this purpose. For this reason, it is arguable that the Commissioner will refer, or ought to refer, only those complaints that warrant just such a regulatory or disciplinary response.

On this basis, the HPCA Act's provision for settlement of complaints by conciliation may indicate a lack of understanding about the role of responsible authorities, and PCCs, as compared with the Commissioner's core function of resolving patient complaints. Criticism of (then) similar conciliation provisions in Australia noted that:[56]

> The introduction of greater powers…to resolve less serious matters after the investigatory stage by conciliation is aimed at promoting flexibility and a timely resolution of negotiable complaints. However, this reform indicates "a substantial misunderstanding of the Board's role, which is to maintain standards, not to resolve patient complaints."* Dispute resolution is more properly the role of the Health Services Commissioner and, within this context, complaints about professional conduct are usually not deemed suitable for conciliation.

This criticism raises two relevant issues for conciliation under the HPCA Act. First, because the HPCA Act is not strictly intended to resolve patient complaints, PCC processes are not focused on the needs (or rights) of patients, nor the hopes or expectations that may have motivated a complaint. As their name suggests, PCCs are principally concerned with inquiring into professional (mis)conduct, and it is very likely that PCCs may approach their task with a view to upholding professional standards through disciplinary processes, except perhaps where conduct may be explained (or excused) by competence or health issues.[57]

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[56] Sarah L Middleton, Thomas D Pearce and Michael D Buist "The Rights and Interests of Doctors and Patients: Does the New Victorian *Health Professions Registration Act 2005* Strike a Fair Balance?" (2007) 186 MJA 192, at 193 (*This citation comes from Parliamentary Debates: VicHansard, 15 November 2005: 2096-2100). The authors were commenting on the then conciliation provisions in the Health Professions Registration Act 2005 (Vic), and the Australian equivalent of the Health and Disability Commissioner.

[57] HPCA Act, s 80(2).

Secondly, the availability – and non-use – of ADR by the Commissioner, the statutory agency with responsibility for the efficient resolution of patient complaints, may 'speak volumes' about the suitability of conciliation for the same complaint under consideration by a PCC.

That said, it is appropriate to acknowledge that in many cases a PCC may not be aware that a complaint has been referred by the Commissioner, nor that the Commissioner has the option of mediation to attempt to resolve a complaint. Further, PCCs are expressly required to give a complainant an opportunity to make submissions and be heard on a complaint.[58] This provides an opportunity for a PCC to explore a complainant's concerns and to understand what they sought to achieve by making the complaint. However, it remains that conciliation is not utilised by PCCs. To try to understand why this is, this paper now turns to consider whether conciliation can be regarded as a suitable option for resolving patient complaints, before going on to identify (and address) some perceived issues with the statutory model itself.

V Is Conciliation a Suitable Option?

The Commissioner has previously sought to explain the lack of use of ADR by pointing to criticism that mediation, and confidential settlement, is inconsistent with promoting and protecting patient rights.[59] It is possible that PCCs may hold similar views: while the HPCA Act is not strictly intended for resolving patient complaints, its principal purpose is to protect the health and safety of the public. Thus, a PCC may view the settlement of a complaint by conciliation as undermining their ability to protect the public (and, in turn, the public interest). But, research into patient complaints suggests that "patients can be powerful allies in the quest for safer care if they are given appropriate channels through which to voice their concerns."[60] The question, therefore, is whether conciliation is an appropriate channel for this purpose.

[58] HPCA Act, s 80(4).

[59] Ron Paterson "Mediation – an HDC perspective" (31 May 2006) Health and Disability Commissioner <www.hdc.org.nz/media/183420/mediation%20-%20an%20hdc%20perspective.pdf> (accessed 7 May 2017).

[60] Marie Bismark, Edward Dauer, Ron Paterson, David Studdert "Accountability Sought by Patients Following Adverse Events from Medical Care: The New Zealand Experience" (2006) 175(8) CMAJ 889, at 892.

A Arguments against Conciliation

There has long been concern that the private settlement of patient complaints is inconsistent with the public interest in safe and accountable health services.[61] The Commissioner has (apparently successfully) relied on its role as the "public watchdog" of patient interests to argue that serious failures should not be dealt with behind closed doors.[62]

Unquestionably, the confidential resolution of concerns about a practitioner's conduct or practice has the potential to "perpetuate the public perception of "secret deals" and non-disclosure",[63] and to raise fears that possibly serious errors, or even misconduct, is being concealed. The confidentiality afforded to conciliation and its outcome is, arguably, inconsistent with the accountability that had been sought with the patient-centred reforms to the health sector. In contrast, a formal disciplinary proceeding can be regarded as a transparent and publicly accessible process for addressing patient and public interests in the delivery of safe and appropriate healthcare.[64] In this respect, it is notable that a key purpose of disciplinary proceedings is to set standards of professional conduct and, therefore, to ensure that professional standards do not "lag behind or frustrate community expectations or interests."[65]

In addition, while a focus on the needs of the participants is lauded as a benefit of facilitated dispute resolution, it is equally arguable that, in healthcare disputes, that focus detracts from the 'bigger picture' – namely: that health practitioners operate within a broader health system, which may learn from other's mistakes or misconduct; the interests of other patients, who often have little or no choice about their health provider; and the value of precedents in setting accepted standards in the provision of health services. In short, these public interest factors could be said to be overlooked in conciliation, as illustrated by the following statement (albeit made with respect to mediation):[66]

> Society operates best within a certainty framework. By and large this societal dimension is missing from mediation. In focusing on the needs and interests of the parties it gives less heed to the public interest.

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[61] See for example Sharon Kirkey "Justice for Doctors; Patients' rights groups say private mediation may be concealing serious medical errors" (27 April 1994) The Ottawa Citizen.

[62] Paterson, above n 59.

[63] Wendy Brandon "Complaints Against Medical Practitioners" [2001] NZLJ 249, at 250.

[64] Tribunal hearings are held in public, unless the Tribunal orders otherwise (HPCA Act, s 95).

[65] *Dr M*, above n 34, at [14].

[66] Boulle, above n 11, at 94-95.

The lack of transparency about a complaint and its outcome, and indeed the lack of any information that may be relevant to the 'bigger picture' referred to above, is a powerful argument against the use of any form of ADR in response to patient complaints. Given the matters potentially at stake, there is some merit in an argument that the parties interests may need to yield to the public interest.

Furthermore, the nature of the relationship between a health practitioner and his or her patient, and the inherent power imbalance evident in such a relationship, has also formed the basis of arguments against facilitated outcomes in healthcare disputes. One author has commented (as to mediation under the HDC Act) that it:[67]

> …should be used sparingly in the context of relationships which, by their very nature, are not equal…This is especially the case in circumstances where the party who must entrust its well-being to the other may be weakened by illness, disability, pain, grief or lack of knowledge.

Unequal relationships and underlying 'weaknesses' are also likely to exist in patient complaints investigated by PCCs. In light of these factors, it could be contended that self-determination and autonomy, which are essential components in any facilitated process, may become the "victim[s] of exploitation"[68] when seeking settlement by conciliation. Compounding this, while a conciliator may advise on process and outcomes he or she cannot advocate for the interests of the patient, regardless of any disparity in the parties' relationship. For a conciliator to do so would be contrary to the essence of ADR, in which parties are encouraged to determine their own solutions. However, against this, a lack of patient support in the face of unequal power could mean that an objectively 'participatory' process results in patient misgivings and distrust, even if settlement is reached.

These are strong arguments. The public interest in transparent complaint resolution cannot be lightly dismissed. Similarly, the unequal relationship between the parties cannot simply be disregarded, particularly when one party's knowledge and influence could be perceived to override the concerns of the other. However, these factors must be weighed against the potential advantages of facilitated complaint resolution.

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[67] Brandon, above n 63.

[68] Brandon, above n 63, citing Richard Crouch "The Dark Side of Mediation: Still Unexplored" in *Alternative Means of Family Dispute Resolution* (Washington DC, American Bar Association, 1982) 339-357, at 343.

B The Case for Conciliation

Unlike other regulatory processes or disciplinary action, conciliation can allow for an emphasis on the relationship between the parties. This is an especially valuable consideration where there is the need to preserve an ongoing therapeutic relationship:[69]

> Conciliation offers a significant opportunity. It can re-establish stalled dialogue. It can help participants to understand that there are other valid points of view, and narrow the gap between differing expectations…

Importantly, conciliation involves dialogue that is encouraged and informed by a skilled facilitator. A conciliator with experience in healthcare complaints can be expected to be aware of possible power imbalances, and to ensure that *both* parties are given safe boundaries within which to be heard, and to respond to concerns. As such, conciliation offers an opportunity for patients to "feel that their voice has been heeded and their understanding improved."[70] Equally, conciliation could be said to give health practitioners a forum in which to improve their own understanding of the circumstances relating to the complaint. One UK doctor described her experience of conciliation as being one in which "[m]uch was learned on both sides…by realising their separate inner misunderstandings."[71] It has also been noted that "brief, but very acute, observations" by a conciliator about the manner in which the parties have approached the complaint (and the positions they may bring to conciliation) can serve to bring about "congruence and real communication."[72]

The advantages of direct and facilitated communication cannot be underestimated, particularly if the patient's motivation for making a complaint is to seek an explanation for what went wrong and to attempt to rebuild trust in a health provider. It is relevant, therefore, that nearly half of complainants make a complaint in order to seek an explanation.[73] The desire to find out what happened, and why, is "particularly strong where [there are] perceptions of being misled or of a lack of candour."[74] These feelings may be influenced by a belief (or indeed the reality) that a health practitioner is seeking to minimise

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[69] Sir Liam Donaldson, Foreword in Anne Ward Platt *Conciliation in Healthcare. Managing and Resolving Complaints and Conflict* (Radcliffe Publishing Ltd, Oxon, 2008), at x.

[70] Above n 69.

[71] Lesley Morrison and Mary Gillies "Consultation, Collaboration, Communication…and Conciliation" (2004) 54 Br J Gen Pract. 636, at 637.

[72] Above n 71.

[73] Bismark, above n 60, at 891.

[74] Joanna Manning "Access to Justice for New Zealand Health Consumers" (Health and Disability Commissioner Medico-Legal Conference: A Decade of Change, Wellington, 24 March 2010), at 2.

their legal risk, and to protect their reputation, in the face of a complaint. In those circumstances, a confidential conciliation is more likely than any other process to result in a candid – and therefore satisfactory – explanation. Relatedly, "provider explanation improves the likelihood a complaint will be resolved quickly,"[75] with the consequent benefit of avoiding entrenched positions and adversarial processes.

Similarly, because conciliation focuses on the interests of the parties it has a greater likelihood of being conducive to an apology. Apologies are a key "interest-based remedy"[76] that may not be achieved with a regulatory or disciplinary response. An apology can also be a significant part of addressing a patient's complaint:[77]

> …sincere apologies can have profound healing effects for all parties. They can bring comfort to the patient, forgiveness to the health practitioner, and restore trust to the relationship.

The potential benefits of a confidential apology may be wider than the complaint that is settled. It is arguable that the freedom to acknowledge mistakes, to express regret, and to take responsibility without fear of reprisal, may in fact lead to a practitioner having (and endorsing to others) improved understanding, improved practice, and safer and more accountable healthcare. That is, it may address public interest considerations, albeit without publicising them.

Finally, conciliation also allows for the possibility of financial recompense as part of any agreed settlement. In this respect, it is noted that payment of compensation to a complainant is not an available remedy following a disciplinary process under the HPCA Act.[78] Although compensation for personal injury is available under Accident Compensation legislation, that regime does not compensate for hurt feelings or distress. In any event, not all complaints will arise in the context of an injury, but they may nevertheless give rise to financial loss or other grounds for seeking compensation. The ability to settle out-of-pocket expenses relating to the circumstances of the complaint, or to offer a sum of

[75] Christian Behrenbruch and Grant Davies "The Power of Explanation in Healthcare Mediation" (2013) 24 ADRJ 54, at 59.

[76] Catherine Regis and Jean Poitras "Healthcare Mediation and the Need for Apologies" (2010) 18 Health Law Journal 31, at 40.

[77] Marie Bismark "The Power of Apology" (2009) 122 NZMJ 96, at 104.

[78] HPCA Act, s 101 sets out the penalties available to the Tribunal when a disciplinary charge has been proven.

money to underscore an apology or to recognise distress, could provide a patient with tangible evidence that their complaint has been taken seriously.

C Striking a Balance

It is clear that a balance needs to be struck between the possible benefits of conciliation and the public interest arguments that weigh against its use. The clearest way to achieve this sense of balance is to recognise that not all complaints will be suitable for conciliation. For example, it must be accepted that complaints involving serious patient safety issues, sexual misconduct or that otherwise indicate a significant departure from expected standards of professional behaviour would not be appropriate for settlement by conciliation.[79] It is also suggested that multiple complaints that can, collectively, be regarded as posing a risk of harm to patients would not be suitable for conciliation. In addition, it needs to be recognised that financial compensation and disciplinary processes serve quite different purposes. While compensation might meet the needs of the individual, discipline serves the interests of the community. This distinction highlights the importance of assessing the suitability of complaints for conciliation. It would be inappropriate for conciliation (and compensation offered at conciliation) to be used deliberately to avoid scrutiny of serious misconduct.

Excluding these serious matters, the arguments against conciliation more generally do not necessarily undermine its value in 'low-level' complaints that are capable of achieving a negotiated outcome. To illustrate, it is reasonable to contend that instances of poor communication, or misunderstandings relating to emotional responses, might be addressed through conciliation without undermining the public interest in safe and accountable health practitioners. The nature of such complaints is unlikely to justify fears that serious safety issues are being resolved in private. In any event, the ability of the conciliator to advise on outcomes offers some protection against settlements that are inconsistent with the public interest, or which are weighted in favour of the practitioner (due to any intrinsic inequality).

Even with those parameters in mind, there can be little doubt that since the HPCA Act's introduction PCCs will have investigated complaints that could have been suitable for conciliation. Nevertheless, conciliation has been so underutilised that it risks being entirely redundant. There is no empirical data about PCC's decision-making processes to determine a reason for this, and it is speculative to suggest that PCCs will always consider the types of arguments set out above if or when they turn their mind to conciliation. Instead,

[79] See for example Moira Ransom "The Role of Mediation in Health Disputes" New Zealand GP (13 December 2000).

any decision as to conciliation is more likely to be driven by a PCCs understanding – and the 'workability' – of the statutory model itself.

VI Issues with the Conciliation Model

Although conciliation might be suitable for resolving low-level patient complaints, it is suggested that there are a number of problematic features with the HPCA Act's conciliation model that may be responsible for its lack of use. This section critically examines the statutory model to identify, and address, these perceived issues.

A Definition

Anecdotally, PCCs simply do not know what is meant by 'conciliation.' Section 82 is the extent of the HPCA Act's (brief) guidance on conciliation. The term is not defined by the HPCA Act, and there is no indication as to the role of the conciliator.

In order for PCCs to appreciate the possible value of conciliation, it is fundamental that they are given information to begin to understand it. While guidelines could be developed to assist PCCs,[80] an obvious solution is to include a definition of conciliation within the statutory model. It would be essential for any definition to identify both the facilitative and advisory role of a conciliator, but also – it is suggested – their (protective) function of guiding parties to accept normative outcomes, consistent with the purpose of the HPCA Act. While the precise definition will inevitably be subject to debate, it does need to be sufficiently clear to assist PCCs, responsible authorities, practitioners and complainants to understand the intention behind it. Parliament must, therefore, belatedly turn its mind to the purpose of conciliation in the HPCA Act.

B Consent and Suitability

The current process for getting to conciliation fails to take into account two important factors. First, conciliation is ostensibly consensual yet the HPCA Act gives no indication whether the parties have any say in a complaint being submitted to conciliation. Compelling parties to participate in conciliation is inconsistent with the "voluntariness and

[80] Health Regulatory Authorities New Zealand (HRANZ), a collaborative network of responsible authorities, has published guidelines on other aspects of the HPCA Act. See for example "HRANZ/DHB Agreed Guidelines for Competency Referrals" < file:///H:/Downloads/HRANZ.DHB%20Guidelines%20comp%20referals%20July10.pdf> (accessed 3 June 2017).

empowerment" central to facilitated dispute resolution.[81] Relatedly, as noted above, some cases may not be suitable for conciliation, yet it is available for any complaint where there is a complainant.

The HPCA Act ought to expressly require PCC's to form an opinion as to the appropriateness of conciliation in each case. Requiring PCCs to assess the suitability of conciliation is much more likely to invite careful consideration of the nature of the complaint; the seriousness of the issues under consideration; the interests of the complainant; and any wider public interest in the issue that may properly rule out conciliation. If a PCC forms a view that conciliation is appropriate, it should have the discretion to offer conciliation to the parties. This would allow the parties to express their position on a facilitated process and, if they agree to it, to voluntarily participate in conciliation. Including provisions to this effect would provide greater clarity about when (suitable), and how (voluntary), conciliation might take place. Guidance about whether parties may be represented at conciliation should also be considered, as this might be relevant to their willingness to participate.[82]

C Confidentiality

Another area of uncertainty is confidentiality. The conciliator is required to report to the PCC about whether the complaint has been resolved, but the nature and extent of the information that may be disclosed is not specified. With this in mind, it is relevant that a PCC is required to disclose the conciliator's report to the Tribunal if it decides to lay a disciplinary charge following unsuccessful conciliation.[83]

The use of the conciliator's report in those circumstances raises a number of questions about confidentiality, and about how the Tribunal should treat that report. Ultimately, this would be an evidential issue for the Tribunal. However, a decision of the MPDT, dealing with an application to withdraw a charge laid after unsuccessful conciliation, indicates that it was clearly prepared to take into account the fact that conciliation had taken place, noting that it was "significant" (in the context of an application to withdraw) that the complaint was initially considered to be one which could be resolved between the parties.[84]

[81] Baylis, above n 7, at 287.

[82] See, for example, HDC Act s 61.

[83] HPCA Act, s 82(4).

[84] *Dr M*, above n 34, at [21].

This decision suggests that the Tribunal could have some interest in (and could even draw inferences from) an unsuccessful conciliation. Thus, any uncertainty as to the scope of the disclosure by the conciliator may be relevant to the parties' preparedness to participate in conciliation, and is also directly relevant to the importance of confidentiality to all ADR processes. For these reasons, the statutory model should provide some parameters as to the content of a conciliator's report.

But, any constraints on disclosure also need to take into account a PCC's responsibility to decide (based on the conciliator's report) whether or not the complaint has been successfully resolved.[85] In this regard, it is contended that it is reasonable for a PCC to be made aware of the terms of settlement to carry out this assessment. At present, the HPCA Act is silent about whether a PCC can know the details of an agreed outcome. However, a statutory scheme can properly, and transparently, set the requirements for the sharing of information following conciliation. It is certainly arguable that a PCC's review (and possibly even its approval) of an agreed outcome is a necessary safeguard against 'inappropriate' settlements. Relatedly, a PCC (and the responsible authority) having some knowledge of the terms of settlement is relevant to the enforcement of agreements reached at conciliation.

D Enforcement

The HPCA Act currently has no process in place for upholding a settlement that is achieved with conciliation. To regard conciliation as an effective alternative to other regulatory responses, it is suggested that PCCs, and the parties involved in the dispute, need some confidence that an agreed outcome will be enforceable.

Significantly, if a complaint is settled by conciliation – and a PCC is satisfied with that outcome – then, on the face of it, a PCC's role and its statutory powers come to an end. It has no ability to re-open its consideration of the complaint if the settlement comes undone. While a responsible authority might have discretion to refer the failure to comply with a settlement agreement (achieved as part of a PCC process) to a PCC for investigation,[86] it is possible that the referral would be limited to the breach of the settlement agreement, and may not allow for re-opening of the original complaint.[87] Further, while a patient may

[85] HPCA Act, s 82(3).

[86] Section 68(3).

[87] That said, if the facts establish it, a flagrant disregard of the terms agreed upon to settle a patient's complaint could be grounds for professional discipline. See in particular s 100(1)(b): professional misconduct because of an act or omission that has brought or was likely to bring discredit to the profession

choose to take private legal action to enforce the agreement, it is somewhat unpalatable for complainants to meet the cost of filling this gap in the statutory process.

It is appropriate for there to be an express provision relating to enforcement of settlement agreements achieved following conciliation. For example, it may be necessary to allow a complaint to be referred back to the PCC if agreed outcomes are not achieved within agreed timeframes. Without this, settlement by conciliation is largely ineffectual if its terms are not respected.

E Timing

A more fundamental issue with the statutory model is the fact that conciliation is available only *after* the completion of an investigation, and in circumstances where disciplinary action or other recommendations may still follow. This is problematic because a PCC must ensure that it has gathered sufficient evidence either to support a disciplinary charge or to justify any other decision *before* concluding its investigation.

It is suggested that it is the timing of any possible conciliation process that is most likely to be fatal to its use. It is unlikely that a PCC would consider conciliation to be appropriate in circumstances where its investigation led to a view that no further action was justified. In this respect, the cost of conciliation[88] and fairness to the practitioner, would be likely to override the needs or interests of the patient concerned. Equally, if a PCC believed that it had evidence to prove a disciplinary charge (even for a 'low-level' complaint), that factor could be highly influential in a decision to lay a disciplinary charge.[89] In those circumstances, conciliation has the potential to become an irrelevant consideration for a PCC.

The current timing of the availability of conciliation does not reflect the potential benefit of early intervention and early resolution of (suitable) complaints. A fundamental shift is required: decisions about conciliation need to be made sooner. One option is to allow PCCs the discretion to refer complaints to conciliation *before* they have completed an investigation (and perhaps without the need first to commence an investigation), with the express ability to resume an investigation if conciliation is unsuccessful.

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[88] Responsible authorities fund PCC investigations, and must also fund any conciliation process. See HPCA Act, s 82(5).

[89] It is significant that 94% of all disciplinary charges laid before the Tribunal are proven. See Lois J Surgenor, Kate Diesfeld, Michael Ip and Kate Kersey "New Zealand's Health Practitioners Disciplinary Tribunal: An Analysis of Decisions 2004-2014" (2016) 24 JLM 239, at 247.

Alternatively, responsible authorities could have the first opportunity to refer suitable complaints to conciliation. That is, if the Commissioner refers a complaint to a responsible authority, one of the available options should be the ability to offer the parties an opportunity to resolve the complaint by conciliation. While the HPCA Act is not intended to provide a mechanism for resolving patient complaints, such a change would recognise that patients may view regulators as having some responsibility for assisting with concerns that broadly relate to professional practice.

It is notable that two responsible authorities are currently working towards a 'Facilitated Resolution Policy', which is intended to "allow suitable complaints and concerns…to be addressed by a facilitated resolution process involving the complainant, the health practitioner and other relevant stakeholders."[90] It appears to be envisaged that ADR (described as including negotiation, mediation and "restorative resolution") would be pursued before, or perhaps in place of, referral to a PCC. The fact that policy decisions are being made to bring ADR into the realm of the responsible authorities, rather than being in the hands of an investigative body, suggests that there is appetite for change.

VII A Future for Conciliation?

While it has been suggested that there is a role for conciliation in resolving 'low-level' patient complaints, a lack of understanding about its meaning, arguments against (and fears about) its use, and a number of issues with the statutory model may dissuade PCCs from considering it. What, then, does the above analysis say about the future of the statutory model for conciliation?

On one hand, its lack of use is indicative of a regulatory failure: put simply, conciliation under the HPCA Act has not worked. A radical response to this failure is to remove conciliation from the HPCA Act, and to focus instead on the clear responsibility of the Commissioner to ensure that patient complaints are appropriately dealt with. In this way, only those complaints that justify a regulatory or disciplinary response (as opposed to a complaints resolution process) would be referred to a PCC. In turn, significant steps would be required to ensure that the Commissioner utilises mediation in appropriate cases, and

[90] Osteopathic Council and Occupational Therapy Board. See the Annual report of the Occupational Therapy Board 2016 <www.otboard.org.nz/wp-content/uploads/2016/10/OTB-AOG-16831-Annual-Report-2016-v7-WEB.pdf> (accessed 21 March 2017).

that this "fair, simple, speedy and efficient"[91] tool is appropriately prioritised and funded. The Commissioner may also need (legislatively endorsed) confidence that mediation can achieve the public watchdog role, by allowing for "a repository of "best practice" notes on commonly recurring healthcare complaints."[92] On the other hand, consideration of the suggested legislative amendments referred to above, perhaps coupled with other practical guidance for PCCs about the use of facilitated resolution processes, could improve the prospects of conciliation being used in appropriate cases, without the need for radical upheaval.

Whatever the future for conciliation might be, it should be informed by robust scrutiny, backed by empirical data and theoretical analysis. Indeed, it is timely for conciliation to be given the "theoretical rigour"[93] it deserves. Substantive empirical research beyond the scope of this paper is needed. A survey of PCC members, responsible authorities, patients, patient interest groups and professional associations could inquire into the current level of understanding about conciliation, any perceived impediments to conciliation, the circumstances in which conciliation is considered suitable, and the extent to which patient interests and the public interest might inform decisions about conciliation. Such research must include consideration of the Commissioner's role, and seek the Commissioner's input into the use of ADR in resolving patient complaints. In addition, the term 'conciliation' needs to be subjected to closer investigation to enable it to be defined, and to provide a clear justification for its use. This should include an examination of how this term is being used in practice, and consideration of its declining use in statutory models. This information could usefully guide a more thorough assessment of the statutory model and its place in resolving patient complaints. Put another way, comprehensive and careful reassessment is necessary to properly determine the future of conciliation under the HPCA Act.

VIII Conclusion

Conciliation under the HPCA Act offers an opportunity to resolve 'low-level' patient complaints without recourse to (expensive) formal disciplinary or regulatory processes. Theoretically, the confidential and facilitated dialogue at the heart of conciliation more readily allows for satisfactory explanations that can serve to maintain or re-establish trust in a therapeutic relationship. The conciliator's advisory role, and in particular their ability

[91] HDC Act, s 6.

[92] Behrenbruch, above n 73, at 59.

[93] Morris, above n 6.

to advise on normative outcomes, provides a safeguard against inappropriate settlements. Yet, despite its potential benefits, the conciliation model is essentially redundant. The reasons for this are multifactorial, although it is relevant that the HPCA Act places the protection of the public ahead of the interests of any individual complainant. Indeed, the HPCA Act is not strictly intended for resolving patient complaints, and even if a PCC was minded to consider conciliation, the statutory model offers little guidance, and therefore little incentive, for its use.

Consideration of the reasons for its inclusion in the HPCA Act, and the model itself, suggests that conciliation was adopted without careful analysis as to its meaning, form or purpose, and with little regard to the interface between 'settlement of complaints by conciliation' and the role of the Commissioner in resolving patient complaints. However, the fact that conciliation has been so significantly underutilised points to the need for a comprehensive reassessment of the statutory model and, possibly, legislative amendment. While some ideas for legislative change have been suggested, it is recommended that robust theoretical analysis of 'conciliation' as a dispute resolution tool, together with research into current levels of understanding about conciliation and its role in patient complaints, is necessary to inform any possible amendments. This analysis is long overdue, but without careful examination – and proper justification – for its inclusion in the HPCA Act, the future for conciliation is bleak.

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X Appendix

Health Practitioners Competence Assurance Act 2003

80 Recommendations and determinations of professional conduct committee

(1) Within 14 working days after completing its investigation into a matter concerning a health practitioner, the committee must make—
  (a) 1 or more of the recommendations specified in subsection (2); or
  (b) one of the determinations specified in subsection (3); or
  (c) both.

(2) The recommendations referred to in subsection (1)(a) are—
  (a) that the authority review the competence of the health practitioner to practise his or her profession:
  (b) that the authority review the fitness of the health practitioner to practise his or her profession:
  (c) that the authority review the practitioner's scope of practice:
  (d) that the authority refer the subject matter of the investigation to the Police:
  (e) that the authority counsel the practitioner.

(3) The determinations referred to in subsection (1)(b) are—
  (a) that no further steps be taken under this Act in relation to the subject matter of the investigation:
  (b) that a charge be brought against the health practitioner before the Tribunal:
  (c) in the case of a complaint, that the complaint be submitted to conciliation.

(4) The committee may not make a recommendation or determination unless the health practitioner concerned and any complainant has each been given a reasonable opportunity to make written submissions and be heard on the matter under investigation, either personally or by a representative; and for that purpose the committee must give the health practitioner and the complainant written notice of—
  (a) the latest date by which the committee will receive written submissions from the health practitioner and the complainant; and
  (b) the date on which the committee will hear persons who are entitled to be heard and wish to be heard.

82 Settlement of complaint by conciliation

(1) If a professional conduct committee has decided to submit a complaint to conciliation, it must appoint an independent person (the **conciliator**) to assist the health practitioner and complainant concerned to resolve the complaint by agreement.

(2) The conciliator must, within a reasonable time after his or her appointment, provide the professional conduct committee and the responsible authority with a written

report as to whether or not the complaint has been successfully resolved by agreement.

(3) If, after consideration of the conciliator's report, the professional conduct committee thinks that the complaint has not been successfully resolved by agreement, it must promptly decide whether—
  (a) the committee should lay a charge against the practitioner before the Tribunal; or
  (b) the committee should make 1 or more of the recommendations specified in section 80(2) about the practitioner; or
  (c) no further steps be taken under this Act in relation to the complaint.

(4) If the professional conduct committee decides to lay a charge before the Tribunal, it must—
  (a) formulate an appropriate charge; and
  (b) lay it before the Tribunal, together with a copy of the conciliator's report; and
  (c) give a copy of the charge and the report to the practitioner, the responsible authority, and the complainant.

(5) The costs of conciliation must be paid by the responsible authority.

(6) If the committee makes a determination that no further steps be taken under this Act in relation to the complaint,—
  (a) no further steps may be taken under this Act in relation to the complaint; and
  (b) the committee must give the practitioner, the responsible authority, and complainant written notice of—
    (i) the determination; and
    (ii) the committee's reasons.