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Ian Powell  
Executive Director

Dear Stephen

### REVIEW OF THE HEALTH PRACTITIONERS COMPETENCE ASSURANCE ACT

Thank you for the opportunity to make a submission on the statutory review of the Health Practitioners Competence Assurance Act (HPCAA).

The Association of Salaried Medical Specialists (the Association) represents salaried senior doctors and dentists. The Association was formed in April 1989 to advocate and promote the common industrial and professional interests of our members. The Association has nearly 3,000 members, the majority of whom are employed by District Health Boards (DHBs). About 92% of senior doctors and dentists employed by public hospitals run by DHBs are members of the Association. While most of our membership works in secondary and tertiary care in the public sector, a number work in primary care and outside DHBs. We have members at hospices, community trusts, iwi health authorities, union health centres, the New Zealand Family Planning Association and the New Zealand Blood Service.

As we understand the process, the Ministry is seeking information from organisations as to the operation of the Act at this stage but we will also have the opportunity to make a submission once the discussion paper is produced next year. I understand the current exercise to be focussed on issue identification and information gathering on the operation of the Act. On the basis of this understanding the Association is not putting forward our views on all the issues involved but simply highlighting issues that have actively come to our notice. As many participants in the sector have observed the level of awareness of health practitioners of the governing legislation is low. However all will be aware of their own regulatory authority and its requirements. Our own members' interaction with legislation will be focussed on their interactions with the Medical and Dental Councils, real or feared interactions on competence issues and increasingly, the operation of the protected quality assurance provisions.

You may be aware that when the legislation was being passed the Association participated in a group of professional associations and unions which identified some common concerns. This group is now meeting again and we are hopeful that this will again lead to the identification of issues of common concern which we will put to the Ministry next year.

The questionnaire provided for this purpose does not fit very well the Association's concerns as we wish to comment on only a few areas at this point. For the convenience of your analysis I will refer to the questions as they apply.

## **1. The Purpose of the Act (Question 1)**

Our overall concerns with the Act remain the increase in political and bureaucratic control that it makes possible. This has only been actualised to a limited degree in the few years since the Act came into force but once the trust of the public in the health professions has been lost or the trust of the health professionals in the system has been lost it will be extremely difficult to restore. Either eventuality will lead to harm to the health and safety of the public. In the period since the Act was passed the failure of the previous Minister to appoint the top polling candidates elected by their peers to the Medical Council and the increasing awareness of the potential that the Minister may lift the protection of the protected quality assurance activities provisions are the examples that come immediately to mind.

When the Act was being mooted it was referred to as ground breaking legislation partly because it extended the system of recertification that had been in force for doctors since the passage of the Medical Practitioners Act 1995 to a further 20 professions and partly because some commentators believed that it would lead to the breaking down of the barriers that professions and professionalism offered to the most economical operation of the health system. Often the discourse in the sector refers to the professions as among "the silos" preventing the logical and efficient operation of the system. Fortunately, in the Associations view, the Act at least so far, has not blurred or broken the professions. The purpose of the Act is to protect the health and safety of the public by providing that health practitioners are competent and fit to practice their profession. This provides the necessary tension between "the health and safety of the public" or quality of care and the efficiency demanded by constrained resources.

There has been some discussion (including among our own membership) as to the extra costs of groups outside of the traditional professions being brought under the Act. When the legislation was being passed we commented that it was extraordinary that the explanatory notes to the Bill stated that the Bill had no financial implications for the Crown.

## **2. Protected Quality Assurance Activities (Question 26)**

The Association had mixed views about this provision when it was promulgated. On the one hand we were pleased that protection had been extended to the other professions as well as medicine. On the other hand we were concerned that the protections under the Medical Practitioners Act were watered down largely as a reaction to the Waitemata DHB using the protection under that Act where there had been a high profile public scare.

Until recently the operation of the provisions has not come to our attention as a cause for concern. As we understand it the Minister has never used his power under section 61 to authorise disclosure. However recent efforts by the Police and the Children's Commissioner to obtain information from a Mortality and Morbidity Review Committees suggest at least a poor understanding of the provision.

We also still have concerns that the removal of the right not to disclose could too easily become a political one. The Ministers role in government is inevitably to some degree political. Some of the issues involved are very political. It may well be that the powers under section 61 are more properly wielded elsewhere.

At most DHBs sentinel event investigations have not been declared to be protected activities and the recent press interest in reporting of these investigations suggests that maybe they should be. New Zealand is small, many specialities have only a small number of doctors working in them and even completely anonymised publication will serve to make full investigation of sentinel events less likely and thus damage our ability to learn from our mistakes and further ensure the health and safety of the public.

It is also anomalous that social workers who are frequently members of multi-disciplinary teams are not covered by these provisions.

The Association cannot stress enough the importance of these provisions. It seems likely that over the next decade improvements in quality will be the area in which a small country like New Zealand will be able to make the most substantive advances in patient care.

We believe that the issues at stake in this section are so important that they should be discussed separately and should be the subject of a separate inquiry as part of the review of the Act.

### **3. Reporting of health practitioners (questions 20,21,24)**

The extension of mandatory reporting of health practitioners for competence was initially the most contentious area when the Act went through. We believe that this provision is working well as an enabling provision. We would be very concerned at the suggestion that it become mandatory for other practitioners to report health practitioners because of competence concerns. Even with compulsory reporting of practitioners for illness absurd results have sometimes occurred. One DHB had embarked on a process of reporting doctors to the Medical Council each time they took sick leave before the absurdity of their position was pointed out to them.

The current position where reporting is optional is sometimes used unnecessarily simply over disputes between clinicians over best practice. Should it become compulsory this would become considerably more frequent.

Section 34(3) requires employers to notify a regulatory authority where a health practitioner resigns or has been dismissed for reasons relating to competence. This provision has caused some difficulties in respect of resignations, in particular where the resignation has followed a period of tension or acrimony in the employment relationship. In such situations we have sometimes felt that the employer or Clinical Director may have displayed a degree of vindictiveness in reporting the doctor to the Medical Council when the threshold for their concern as to "competence" was really quite low, or arguably non-existent.

We accept of course that in those situations where a health practitioner has resigned to avoid an investigation or a review of a particular case, it is appropriate for the employer to make a referral under s.34(3). However, in our experience we believe that some referrals have been vindictive or lacked a reasonable basis. Indeed the referral (or the threat to refer) has then become a further source of tension between the parties. We are aware of a number of cases in which the Medical Council, after a preliminary assessment, has concluded that the referral did not in fact raise issues of competence, requiring further investigation.

### **4. Elections to regulatory bodies (question 37)**

The Association was deeply opposed to the removal of the right to elect representatives to the regulatory authorities. We have campaigned to have the Minister promulgate regulations so that there can be elections to the Medical Council. Our submission from May 2007 on the issue is enclosed.

### **5. Restricted activities provision,(question 6)**

From the outset the restricted activities provisions sat strangely with the approach of the rest of the Act. The current list exhibits no coherence and appears to be based on no clear principle.

**6. Single profession regulatory bodies (question 35 and 36)**

One of the difficulties that the smaller professions have experienced has been setting up a regulatory authority. The Medical Council represents one model with one regulatory authority representing one profession, the Dental Council another with one authority representing four professions. We understand that the Medical Council has already been approached to extend its brief to other professions. This is unlikely to be supported by the medical profession.

**7. Scopes of Practice (questions 8.9.10)**

The Medical Council has pursued a consistent policy of continuing the broad and consistent scopes of practice that have been the practice of the profession including (in the main) the traditional vocational scopes. We remain concerned that increasing workforce pressures may lead to variation of these scopes and this will remain one among many pressures for such potentially politicised legislation. It is important for the formation of functional teams that the skills and competencies of health professionals do not become opaque to members of other health professions.

Yours sincerely



Angela Belich  
**ASSISTANT EXECUTIVE DIRECTOR**

Encl Association of Salaried Medical Specialists' submission dated 22 May 2007.

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22 May 2007

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Ian Powell  
Executive Director

Dear Kathy

### **ELECTION TO MEDICAL COUNCIL: CONSULTATION ON REGULATIONS**

Thank you for giving the Association the opportunity to comment on this proposal.

1. The Association of Salaried Medical Specialists (the Association) represents salaried senior doctors and dentists. The Association was formed in April 1989 to advocate and promote the common industrial and professional interests of our members. The Association has almost 2,800 members, the majority of whom are employed by District Health Boards (DHBs). About 92% of senior doctors and dentists employed by public hospitals run by DHBs are members of the Association. While most of our membership is in secondary/tertiary care in the public sector, a number work in primary care and outside DHBs.
2. The Association is part of the Pan Professional Medical Forum that asked the Minister to promulgate these regulations. Both as part of the forum and on our own behalf the Association has been keen to ensure that doctors elected by doctors form part of the Medical Council. One of the concerns the Association had with the Health Practitioners Competence Assurance Act (HPCAA) was the loss of the right of doctors to elect doctors to the Council. It was to address that concern, widely held within the medical profession, that the HPCAA, when passed, gave the Minister the option of promulgating regulations to allow for elections. The Association urged the previous Minister to promulgate regulations to allow elections. We are very pleased that the Minister has agreed to proceed with this proposal and hope the consultation process will support proceeding with promulgating regulations that will allow election of doctors by doctors to the Council. We do however have a few concerns with the detail of the proposal which are set out later in this letter.
3. The principal purpose of the HPCAA is to protect the health and safety of members of the public. The Medical Council's role, in this respect, is two fold: first it must set standards (either directly or by ensuring that educational institutions conform to standards) and then ensure (by registering and reregistering doctors, dealing with information about competence and notifying of risk of harm) that doctors meet the standards on a continuous basis. The mechanisms that are available to them to do this are set out in section 118 of the Act. The Council can thus fail in its duty to protect the health and safety of the public in two ways: by a failure to set adequate standards as well as a failure to ensure that doctors meet those standards.
4. The "elephant in the room" when we discuss medical workforce issues is that issues of supply could be addressed by eroding standards. Poorly trained or less skilled doctors are less likely to be attractive in overseas markets. New Zealand could retain them if we dropped our standards of training and recruit them if we dropped our standards for registration. They would probably cost less than skilled doctors and may therefore present an attractive option to future governments hard pressed by acute shortages of doctors. Protecting the health and safety of the public requires that the Medical Council can resist such pressures.

5. A credible Medical Council ensures that the public can have confidence that doctors that achieve registration in New Zealand do so because their skills and qualifications meet the standard expected by New Zealanders. The continued functioning of the public health system which is staffed increasingly by overseas trained doctors requires the profession to answer to the public on this issue. A wholly politically appointed Council risks eroding that credibility. It would be easy to contend that cost pressures had lead to an erosion of standards. At present the Council answers those questions with authority (though questions were raised in the media during the recent media examination of a HDC report into an overseas doctor at Wanganui DHB as to a difference between College and Council standards). With a wholly politically appointed Council this authority will erode over time.
6. Public confidence in the Council is enhanced when the public can be sure that Council members have the mana bestowed on them through the mandate of their peers. Public safety is considerably enhanced when the public has recourse to scientific medicine.
7. Election of half the Council by the profession would go further to provide that assurance. A three way split between lay appointees, medical practitioner appointees and elected medical practitioners, as is proposed, would not go as far to providing that assurance as a Council equally divided between elected and appointed (both lay and professional) members.
8. The Council is completely funded by the profession. A profession by definition should have an element of self-regulation. Our members were puzzled when the HPCA Bill which mirrored the Medical Practitioners Act in so many ways appeared to take the right to elect members of Council away from them, were somewhat placated when the Act included the possibility of elections and then disappointed when the regulations failed to eventuate.
9. The Council has held one election in order to forward nominees to the Minister. The process was not an unmitigated success when the Minister failed to appoint the top candidates causing a great deal of probably baseless speculation as to why one of the candidates had offended the Minister and/or the Ministry and/or the Government and as to why the appointee had pleased the Minister, Ministry and Government. A straight forward election minimises the potential for this sort of contretemps. The credibility of the Council is not a given and can be damaged: advertently and inadvertently.
10. We note the lack of consistency in the wording of the proposal. Apart from lay appointees both elected and appointed members should be medical practitioners and the regulation should make that clear.
11. We also take issue with excluding doctors who have at any time been the subject of a professional conduct enquiry, an enquiry by the HDC or by the police. This is a contravention of the principles of natural justice. The issue is surely whether the practitioner has been found to have been guilty of serious wrongdoing by the Courts or the Health Practitioners Disciplinary Tribunal (HPDT). It might be reasonable to exclude such practitioners from eligibility. It is not fair or just to do so simply on the basis that an investigation has taken or is taking place. The process may find them to be totally without fault or only at fault in a minor way.

I hope that the proposed regulations are changed to exclude from eligibility for election only those doctors who have been found guilty of serious wrongdoing by the Courts or the HPDT and to embrace a 50/50 split between appointed (including lay people) and elected members of the Council and are speedily promulgated.

Yours sincerely



Angela Belich

**ASSISTANT EXECUTIVE DIRECTOR**