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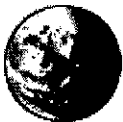
Ryan McLean/MOH  
08/01/08 09:42 am

To HPCA/MOH@MOH  
cc  
bcc  
Subject Fw: responses (late) to HPCA review questions

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----- Forwarded by Ryan McLean/MOH on 08/01/08 09:42 am -----



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08/01/08 09:23 am

To <Ryan\_McLean@moh.govt.nz>  
cc "Alan Shirley" <Alan.Shirley@wairarapa.dhb.org.nz>  
Subject FW: responses (late) to HPCA review questions

Hi Ryan

Firstly my apologies – Alan Shirley at Wairarapa Hospital did not have my admin support when this was due back – I am just back from my break.

Here are Alan Shirley's responses on behalf of the Wairarapa Hospital's Clinical Board.

I will provide just the numbers for the questions – I am sure you don't need me to rewrite them for you?

1 & 2 Yes, yet it is more bureaucratic and time consuming to ensure compliance with the act. The 'scopes' of practice are becoming narrow and boundaries are crossed with difficulty. Clinicians may find working within certain areas too restrictive. There is a growing need to depend on colleagues for registration support. Employees must understand the implications and restrictions of the requirements.

3. "Reporting requirements' may just add further bureaucratic work. They may not 'ensure' anything. Reporting 'demands' are passed down to the employers – compliance should not be made more demanding.

4. Yes. No further comment.

5. Scopes of practice can become too narrow. There is a balance between the benefits of being broad and being specific. There is a danger that 'general' care will not be provided because it is made up of components of specific care. The Medical Practising certificates appear to be working.

6. no comment

7. It would seem so. No other comment.
8. They may be removing the 'generality' from clinical care. This may make the provision of care more 'specialised' - therefore more 'centralised' and therefore less accessible. Quality may be compromised because of lack of access.
9. The 'instructions' given to registration authorities must not result in fragmentation on inaccessible care. The narrower the 'scopes' the less able clinicians will be to provide general care.
10. There may be a tendency to 'empire build'. With 4.5 million people scattered reasonably widely we need to decide how society will access care
11. We are aware of the responsibilities and difficulties – sometimes there may appear to be some unnecessary restriction. There may be instances where the level of qualification may be too high.
12. These regimes appear reasonable – yet can put more pressure on the individuals. Employers must provide time and support – this is not always done – and is a high expectation of employees. "Back filling" duties and maintaining service is difficult.
13. This all puts increased expectation on the individual practitioner. The implications of charging and increasing requirements should be 'carefully' considered. Individuals may be discouraged from remaining in the workforce.
14. Full discussion with the registering bodies and those being registered - what this actually means. We must ensure that people are able to provide a service and that overregulation does not occur. Rosters, clinical care, cost, time, women in the workforce, part-timers- compliance may become an insurmountable hurdle. We must remain practical.
15. I am sure there are. Each authority should consider this. Ivory towers should be avoided.
16. Cost, time, desire, practicality, inability to perform, loss of generalisation, loss of access to care, removing people from the workforce. A supported programme may be essential.
17. Difficult. We must protect the public, yet not destroy or proscribe the practitioner. I suggest it is working effectively. We would caution administrators about a desire to over notify.
18. The repercussions of this, ethical, moral, societal and personal need to be carefully thought through.
19. We cannot think of any – most – all will involve risk of harm.
20. We believe voluntary reporting is appropriate. Why does the 'law' or the registration authorities wish to legislate for the responsibility?
21. In theory, yes. In practice, the levels of 'possibly' need to be considered. The registration authorities need to be understanding of the 'possibility' not the certainty.
22. Probably. The implications for both parties are serious. Patients must be protected. Clinicians must be supported. Is practical support really available? ? Is supportive training really available?? We use the correct concepts in theory – what about actual practice?
23. The O/G college has on site observations as part of its recertification programme which confirms competence. They may be made one and the same. If

competency programmes become the 'norm' the practicalities need careful consideration.

24. What other parties?? Patients, relatives, the public have access to the registration bodies and are, and should be, encouraged to 'report'. How would the 'obligation' work??

25. Hopefully there would be insight by the practitioner. A lack of insight in itself may be cause for concern. If there is medical concern about 'fitness to practice' this cannot be ignored. Those making the examination have a professional, ethical and moral responsibility to both the public and the practitioner who is now a patient.

26. The 'real' and 'perceived' values of the QAAs differ. The 'perceived' protection encourages many clinicians to partake in frank discussion. Clinical and organisational improvements can/do result. Without the protection the level of involvement and discussion may reach a point where its value would be questionable. "Real" improvements result from detailed and frank analysis about what individuals actually did. This discussion, forum, environment must be encouraged. Is the 'protection' real? Is not 'everything' discoverable? If this is the view how do we encourage the sceptics to participate? If we believe 'protection' is necessary we need to show that it is meaningful and 'real'. There is 'suspicion' around the meaning of a 'protection'. What is the purpose of the reporting process? What is the value? Will the QIC initiatives question the need for the reporting process? QAA must continue with activities that prove the support for the necessary discussion. QIC may be the vehicle to allay suspicion.

27. No comment

28. If a practitioner cannot practise – then the public must be protected.

29. No comment

30. No comment

31. It appears appropriate.

32. No comment. Has this been an issue? Has 'team' behaviour been questioned? Has not the 'system' usually identified individual professionals?

33. Current arrangements probably OK. Any increase in costs will be passed on and those advocating for increased expense should understand where the money may come from. It may need to be an employer responsibility – part of the cost of having a health care 'licence'.

34. No comment

35. We understand the danger of a proliferation of authorities. Access to services may be 'priced out of the market'.

36. What feedback do you require? You produce significant demands in requesting opinions. The cost of 'small' professions will be prohibitive. Why is 'psychotherapy' not a subset of psychiatry and therefore allocated as a subgroup to the Medical Council?

37. An enormous question. For professions to elect their representatives – provided it is overseen - can only be a good process. By virtue of the time commitment only certain individuals will be interested. Is it financially worthwhile? If 'trained' - people should remain on the authority for 3-5 years. We are a small country and the increase in the numbers of authorities has to be questioned? With a minimum of '5' people in a registration authority how many professional members are required as a base for membership?

38. None. There is a 'slowness' to 'recognise' qualifications and 'authorise' qualifications. This can probably only be speeded up with more resource and therefore

more expense. Health care will become much more expensive because of 'regulation' – but so be it.

39. The larger ones – well. We would question the value of the smaller ones – but have no evidence.

40. No comment

41. The intricacies and implications of this needs careful consideration. It may be that the authorities require some government 'protection'. Governments like to devolve their responsibility and accountability and this may not always be useful.

42. We feel it is reasonable. We have no suggestions.

43. no comment

44. No comment

45. The potential for narrow 'scopes' will limit access to care.

The 'registration' process may deny access to overseas clinical staff and thereby access to care for the population of NZ.

The desire for recognition by registration of some groups may be inappropriate.

The cost of regulation will end up as an expense to those requiring care.

With workforce planning, most 'specialised' personnel evolve from 'generalised' personnel. For example, the provision of basic, bedside essential nursing care may be at risk.

Please contact me if any answer does not seem clear.

Kind regards

**Mary Anne Ashford**  
**Personal Assistant to Medical Advisor**  
**& Surgical Services Secretary**

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