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## New Zealand Medical Association

17 December 2007

Ryan McLean  
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Ministry of Health  
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**Wellington**

Dear Ryan

### **Review of the Health Practitioners Competence Assurance Act (HPCA) – Key Issues**

Thank you for providing us with the opportunity to give respond on this matter.

Please find **enclosed** a copy of our submission in regard to what we believe are likely to be the issues. Note that the list is not definitive and we reserve the right to raise other issues relating to the HPCA in the future should we become aware of them.

Yours faithfully

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# **NEW ZEALAND MEDICAL ASSOCIATION**

## **Review of the Health Practitioners Competence Assurance Act (HPCA) – Key Issues**

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## **Review of the Health Practitioners Competence Assurance Act (HPCA) – Key Issues**

The NZMA is New Zealand's largest pan-professional medical organisation. We have around 4000 members who come from all areas of medicine including medical students, resident medical officers, general practitioners, and other specialists.

The key roles of the NZMA are to:

- provide advocacy on behalf of doctors and their patients;
- provide support and services to members and their practices;
- publish and maintain the Code of Ethics for the profession; and
- publish the New Zealand Medical Journal.

Set out below are the matters that are of importance or concern to the NZMA. Please note that the list is not definitive and we reserve the right to raise other issues relating to the HPCA in the future should we become aware of them.

### **Scopes of Practice**

You may recall that when the HPCA Bill was first introduced it considered creating fairly narrow scopes of practice. While scopes of practice were not new to the medical profession they had not previously been legislated for and were established by the respective branches of medicine and were fairly broad in nature. NZMA advocated retaining the right to broad scopes of practice which are necessary for the flexibility inherent in the practise of medicine. While in recent times we have seen other Authorities developing – or considering developing - quite narrow scopes of practice, we consider that in regard to medicine broad based scopes of practice continue to be essential.

Over the years we have seen the increasing development of overlapping scopes of practice. For example, there are a number of medical practitioners who also practice the modalities of psychotherapy or acupuncture. We are firmly of the view that the appropriate regulator for these practitioners is the Medical Council of New Zealand and we would be very concerned if as a result of this review there was a requirement for medical practitioners to have dual registration with accountability under both Authorities.

### **Restricted Activities**

The Act currently defines a number of restricted activities. Section 9(4) of the HPCA provides:

No person may perform, or state or imply that he or she is willing to perform, an activity that, by an Order in Council made under this section, is declared to be a restricted activity unless the person is a health practitioner who is permitted by his or her scope of practice to perform that activity.

We believe the public have a right also to be protected against certain potentially dangerous activities being carried out by registered health practitioners who do not have the full range of skills to do so.

### **Quality Assurance Provisions**

As you will be aware, under the previous Medical Practitioners Act there were very effective provisions governing protected quality assurance activities that operated well. The introduction of the HPCA lead to a new regime governing these that is very bureaucratic in nature and we were concerned that this might impact on their establishment. Although we are not aware of any quantifiable research on the establishment of protected quality assurance activities, it is our understanding that uptake has been quite low. We would like to see research undertaken in regard to implementation and if, as we believe few protected quality assurance programmes have been established, then we believe there is a need for the current provisions to be reconsidered.

### **Mandatory Reporting**

NZMA has always been opposed to mandatory reporting in respect of competence issues. We are aware however that there may be some organisations who may be interested in re-litigating this issue. Our concern is that mandatory reporting of competence issues is likely to result in the issue being avoided, thus having the opposite effect to what is intended.

### **Regulatory Authorities**

Perhaps the most complex issue this review will have to deal with is the regulation and function of Regulatory Authorities. There are a number of issues relating to this, namely function, regulating the regulator, the establishment of new Authorities, composition of Authorities (elected representatives and lay people). We deal with each in turn.

### ***Function***

The primary function of the Regulatory Authority is to register and oversee the practitioners of a particular health profession (Section 5 (1)). Section 118 of the Act goes on to set out the functions of the Authorities in detail. A perusal of these shows that the Authorities are there to ensure that health practitioners working under the particular Authority meet the requisite competency requirements. Overall the intention appears to be that the Authority is there to protect the interests of the consumer.

Recently however there have been instances where some authorities have gone beyond their statutory role. For example the Pharmacy Council of New Zealand has recently been involved in directly and publicly advocating for a position on behalf of the profession it is supposed to be regulating. We feel that there is a clear conflict of interest in their doing so as it may not necessarily be in the best interests of the consumer. While this was clearly outside the Authority's function, there seems to be no mechanism in the Act – apart from the broad discretion of the Minister to intervene (which in turn poses its own set of problems) to prevent this from happening.

Similarly when creating a new scope of practice, while there is an obligation on the Authority to consult with all organisations “*that the authority considers will be affected by the proposal*” (Section 14 (2) (b)), this seems to be interpreted fairly narrowly by some Authorities with the result that proper consultation doesn’t always occur. For example, when the Midwifery Council proposed a new scope of practice of midwifery assistant who would report solely to the midwife, it did not consult with NZMA notwithstanding that we have a longstanding interest in, and experience of, maternity issues, and many of our members are involved in providing maternity services.

### ***Ministerial Intervention in the Activities of the Authority***

We voiced our concern when the Bill was first introduced at the wide powers given to the Minister to intervene in the actions of an Authority. We continue to have these concerns as the wide discretion allows potential political interference should the Government of the day wish to influence the Authority’s decision or direction.

### ***Composition of Medical Council of New Zealand (MCNZ)***

We have three concerns in relation to the composition of the MCNZ. These relate to membership, elections to the medical council and the criteria regarding who can be appointed as a lay person.

#### **a) *Membership***

The current wording of the Act provides that the Authority must include “*a majority of members who are health practitioners*”. We believe the wording should be more specific to say “*a majority of members who are health practitioners regulated by that Authority.*” Under the current wording it is entirely possible for a future government to decide to appoint health practitioners who are not medically qualified and may not have the requisite knowledge of medicine to participate effectively. This is potentially harmful to public safety.

NB: Although we stated the above in regard to the MCNZ specifically we note that our comment is applicable to membership of Authorities in general.

In addition we believe the criteria for appointment, should require those appointed as health (we say medical) practitioners to be currently in practice (or teaching) so that they are in touch with current issues. Where the Minister of Health is responsible for appointing a person to the Council there should be clear and transparent guidelines for the Minister to follow in determining who should be appointed.

#### **b) *Elections by medical practitioners***

The Ministry of Health will be well aware of the NZMA’s wish for a proportion of the MCNZ to be comprised of people directly elected by the profession. While we accept that the overriding issue is public safety, we consider that such election is necessary if the Authority is to continue to hold the trust and confidence of the medical profession it

regulates. While there may be other professions that do not wish to have elections to their respective Authority, we do not see the issue of elections to the MCNZ as being a matter of interest to them as it does not affect them.

**c) Definition of lay person**

We continue to have concerns about the definition of lay persons under the Act. The Act defines lay person as “a person who is neither registered nor qualified to be registered as a health practitioner” This definition is in our view too wide as it allows for people employed by or having interests in the sector, which in turn may lead to partisan views or conflicts of interest. It is also in conflict with the definition set by the National Ethics Committee and published by the Ministry of Health in 2002. That definition says:

“A lay person is a person who is not:

- currently, nor has recently been, a registered health practitioner (for example, a doctor, nurse, midwife, dentist, pharmacist);
- an officer of, or someone otherwise employed by, any health board, health authority, the Ministry of Health, or medical school;
- involved in conducting health or disability research or who is employed by a health research agency and who is in a sector of that agency which undertakes health research; or
- construed by virtue of employment, profession or relationship to have a potential conflict or professional bias in a majority of protocols reviewed.”

In our view the above definition should be used in place of the one currently in the HPCA.

**Ethical Standards**

The HPCA provides for the MCNZ to “set standards of clinical competence, cultural competence and ethical conduct to be observed by health practitioners of the profession”. (Section 118 (i)) As you are aware the NZMA Code of Ethics has for many years been accepted as the Code of Ethics for the profession and has been well recognised in common law. We believe that it is appropriate for an ethical code to be drafted by the profession rather than the MCNZ, especially when there is considerable potential for political influence or intervention. While a Code of Ethics endeavours where possible to conform to the law it may not always do so. We have seen extreme examples of this historically when Germany authorised Doctors to conduct experiments on Jews. This may have been “legal” but clearly was unethical and it is appropriate that the profession should be its own watchdog in regard to ethical standards. To give a more contemporary example, were Parliament to pass legislation to make euthanasia legal, it would still be regarded as

unethical in terms of the Code. So, in our view, it is critical that development of ethical standards be left separate from the functions of a statutory authority.