National Council of
Women of New Zealand
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Wahine O Aotearoa

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26 November 2002 S02.48

Submission to the Health Select Committee on the Health Practitioners Competence Assurance Bill

Introduction

The National Council of Women (NCWNZ) is the umbrella organisation representing 42 nationally organised societies. It has 34 branches throughout the country attended by representatives of those societies and some 150 other societies as well as individual members. The Council also operates an electronic discussion group for younger women, inviting comment from them on various topical issues. The purpose of the Council is to serve women, the family and the community at national and international level, through study, discussion and action. Ten Standing Committees undertake specialised work for the Council. The members of these Committees are drawn from Branches and the Nationally Organised Societies, and because they are from all over the country, work largely by correspondence and email. A Circular is prepared each month to provide members with up-to-date information on many matters, and to give an opportunity to contribute to current issues.

NCWNZ Policy

A review of the policies of NCWNZ indicates the background from which this submission is prepared emphasising in particular:

a) the importance of the need for the public to be assured of the competency of health practitioners, and
b) procedures by which health practitioners will be encouraged, and if necessary, forced, to maintain and/or increase their levels of competency.
c) procedures for complaints which allow the complainant to feel s/he has been heard.

Executive Summary

After due consideration, NCWNZ identified the following:

1. General support for the direction of the proposals of the Bill.
2. Concern that the time frames for hearing complaints will be excessive.
3. The need for much better resourcing for the Health and Disability Commission to prevent delays.
4. Greater representation of lay persons on the various hearing committees.
5 Clearer definitions and greater transparency on how the members of those committees are selected and appointed.

General

The provision of health services, the safety and well-being of patients, and the skills and competency of health professionals have been matters of concern for the National Council of Women of New Zealand since its inception in 1896, with a resolution recorded in 1897 on the working conditions of nurses. In more recent years submissions made, particularly on Medical Practice, Medical Practitioners, and the Health and Disability Commission, have emphasised the concerns of the Council regarding the issues of patient protection and safety, and their need to be able to trust that health professionals are competent to practise.

We strongly opposed the various proposals during the mid 1990s to deregulate a number of professions, seeing that as likely to be very confusing and highly detrimental to patients who would have had no way of knowing the level of competency of the person in whom they were placing trust for what is frequently a matter of life and death.

In 2000 the NCWNZ submission on the Discussion Paper which foreshadowed this Bill we reported "Opinions range from professionals feeling strongly that this Bill cannot cover all health professionals adequately to others thinking that the Bill is acceptable providing that the term 'health professional' is carefully defined and its meaning made explicit".

Another of our major concerns has been that complaints about medical practitioners are heard and judged by their peers, with only limited participation by lay persons. For women complainants in particular this could be intimidating and judgements were not always felt to be fair to the complainant. In response to the 2000 Discussion Paper we supported the separation of the registration of professionals from disciplinary functions, and are pleased to see this is provided for in the Bill. We therefore welcome the proposals in this Bill, and the consolidation of a number of Acts to provide a more specific framework which will apply to a large number of health professions.

We note too, that in a number of instances provisions have been tightened and conditions and expectations more clearly defined. These changes will simplify the whole process, and make it easier for a person to know how and to whom complaints can be made.

We also commend the realistic increases in maximum fines throughout the Bill to levels that recognise current values of money.

We are pleased that this Bill has finally been presented, and look forward to its passage in the near future.

Specific Comment
Part 1: Preliminary and key provisions
Clause 3: Purpose of Act
(1) We are pleased to note that the words used to describe the purpose of the Act are almost exactly those we sought to have included.

Clause 7: Unqualified person must not claim to be health practitioner
We welcome this clear statement that only persons properly qualified can use names, titles and descriptions that imply a person is a health practitioner of a particular kind.

Clause 8: Health practitioners must not practise outside scope of practice
(3) It is sensible that exceptions will be permitted for working outside the scope of practice in (a) emergencies and (b) as part of a course of training or instruction but we suggest that in (b) the words, " '**while under the supervision of a person authorised in that particular practice'** should be added.

Part 2: Registration of, and practising certificates for, health practitioners
Prescribed scopes of practice, qualifications, and experience
Clause 11 Qualifications must be prescribed
(4) It is good that an authority must monitor every New Zealand educational institution that it accredits, but we have some concern that monitoring of any overseas educational institution is not similarly mandatory. It is not uncommon for persons claiming to hold overseas qualifications to later be found to be incompetent. It seems clear that there needs to be better monitoring of

overseas institutions than has been the case, in even the recent past. In the submission on the Medical Practitioners (Foreign Qualified Medical Practitioners) Amendment Bill we proposed that the standards of overseas institutions should be reviewed, perhaps at five yearly intervals, to ensure that their level of training was still consistent with New Zealand requirements.

Clause 15: Fitness for registration
We are surprised that it is required that a person must be (a) able to communicate adequately **or** (b) have a reasonable ability to comprehend English. It would seem important that a person be able to do both. We therefore suggest that these two sub-clauses be rewritten as one to make it clear that a person must be able to speak, write and comprehend English for the purposes of practising at the level of desired registration. In our submission on Foreign Qualified Medical Practitioners we noted that concern was expressed about cultural norms and expectations that are different from those usually held by New Zealanders especially in relation to the status of women and to attitudes towards medical practitioners. Communication and comprehension involve more than skilful use of words.

Part 3: Competence, fitness to practise, and quality assurance
Clause 33: Notification that practice below required standard of competence
We support the requirement that the Health and Disability Commissioner (2) and the employer of a person dismissed for reasons relating to competency (3) must report the circumstances promptly to the Registrar of the responsible authority.

We note the use of the word “promptly” in a number of places in this clause and the following ones. We trust that this will be interpreted strictly, and that reviews, orders to undertake further training and so on, will happen quickly. It often seems to the public that such procedures drag on, and incompetent persons are permitted to continue to practise to the sometimes great disadvantage of their patients.

Clause 34: Authority must notify certain persons of risk of harm to the public
While a number of organisations are required to be informed that a person may pose a risk of harm to the public, these do not appear to have to take any action, nor is there any need to make such information public. We wonder what the situation will be if a member of the public is harmed after such information has been received. We trust, for instance that the harmed person would be entitled to receive compensation from the Accident Compensation Corporation, even if the normal criteria were not met.

Part 4: Complaints and discipline
Referral of complaints and interim suspensions
While we support the proposal to channel all complaints through one agency, it could also slow the process. Even at present, complaints investigated by the Health and Disability Commissioner can take 12 months and more for resolution. Far greater resources for the prompt processing of complaints at the Commission, and, where appropriate, referral to the responsible authority will be essential. Excessive delays in hearing of complaints simply exacerbate the distress of the complainant.

Clause 66: Interim suspension of practising certificate pending prosecution or investigation:
We are pleased that where the alleged conduct is considered to be serious, the authority will be able to suspend the practising certificate or to include conditions in the scope of practice, while awaiting a decision from the appropriate investigating bodies. But we are somewhat concerned that such a suspension cannot be ordered until the practitioner has been given ‘a reasonable opportunity’ to respond. This could be a considerable time. We would like to see a specific time be put on this, or to give the authority similar powers to those of the Tribunal (under clause 89) can make an interim suspension without giving the practitioner notice.

Clause 68: Complaints investigation committees.
Concern has been expressed about how committee members will be appointed, where they will be drawn from, and what experience they will have. We note that there is a Panel maintained for the Health Practitioners Disciplinary Tribunal to be drawn from, and suggest that this practice would be applicable for the complaints investigation committees, too. This Panel may not need to be Ministerial. It could be maintained by the Health and Disability Commission.

We query the possible composition of these committees as it appears they could be weighted in favour of the particular profession. The proposal continues the present situation where the public perceives a profession protects its own members.

Sub clause (1) states that a complaints investigation committee will consist of two health practitioners and one layperson, and in addition under sub clause (2) a further health practitioner or possibly a further lay person who is a member of the authority may be appointed. This means there could be three health practitioners and one lay person. We presume that a further health practitioner might be needed where the matter concerns a particular specialisation or scope of practice and that specific knowledge is required to make a reasonable decision.
We suggest that it would be better to word sub clause (1) as follows: **'two health practitioners who are registered with the authority; one of whom should, where necessary, hold specialist knowledge of the scope of practice of the matter under investigation'.**

Ideally we would like to see at least equal numbers of lay persons and health practitioners, but recognise that four persons could lead to a tied vote. There will be considerable benefit for both the complainant and the health practitioner involved, and for the system, if complaints can be satisfactorily dealt with at this early stage.

Another possibility for the composition of these committees would be to follow the pattern that has been used in the ACC committees investigating medical misadventure, i.e. three persons: one lay person, one medical practitioner specialising in the cases under investigation, with a legally qualified person as the chair. Such composition would remove the need for the appointment of a legal advisor as proposed under clause 70.

Clause 69: Committees may regulate own procedures.
We strongly recommend that these committees should meet in private. While a public hearing is appropriate at the stage of Tribunal investigations, committee investigations are at a preliminary stage. It is not appropriate for local media and people not involved with the investigation to have access to information that can be intimate, private, and sensitive. Meetings held in private would protect both the complainant/s and the practitioner.

Clause 70: Committees may appoint legal advisers and investigators.
Members who have been involved in similar complaints procedures speak of the importance of having legal advice available, but note our suggestion under clause 68

(4) We do not understand the rationale behind the prohibition of such a legal adviser acting for the committee if a charge is laid before the Tribunal. The briefing of a further counsel will increase both the duration and the cost of proceedings.

Clause 76: Complaints investigation committee may recommend suspension of practitioner's practising certificate if public at risk.
As in clause 66, NCWNZ supports the requirement for the committee to recommend to the responsible authority the suspension of a practising certificate where it considers the public may be at risk if that person continues to work. We note however that this is a recommendation, not an

order, and trust that the authority will take the appropriate action, which would, we presume, be similar to that described in clause 66. We would, however, prefer a committee to have the same power as that given to the Tribunal to suspend without notice (clause 89).

Clause 83: Panel
We take this opportunity to commend the work done on behalf of the Ministry of Consumer Affairs on choosing lay people for such tribunals, and also the lists of possible appointees that are available from it and a number of other Ministries. We also recommend the importance of seeking nominations from appropriate non-governmental organisations.

(4) (c) We recommend that not all the initial members be appointed for five years; that some should be removed, for example, after three years.

Clause 84: Constitution of Tribunal for hearings.
(b) The selection of lay persons should not be made by the chair or the deputy – to enhance independent, open-minded considerations. The proposal could result in the formation of an easy-to-manage group, leaving out independent thinkers.

Clause 91: Hearings to be public unless Tribunal orders otherwise
While this clause insists on the hearing of evidence in public, it allows for evidence to be given in private if appropriate. We support the concern for the claimant/s, and the likelihood of evidence of an intimate nature being presented, shown by this clause. We have frequently received comments from people appearing before the present disciplinary bodies that they feel they are on trial, especially as they can be cross-examined by legal counsel on behalf of the practitioner, while the complainant has no such legal advice, and is often alone in a formal and intimidating environment.

In the same way, **Clause 93** shows concern for witnesses. Claimants and witnesses are not on trial. Their trauma can be minimized by private hearings.

Clause 99: Funding of Tribunal and disciplinary proceedings
We expect that the requirement that each responsible authority must pay for a proceeding against a health practitioner for which it is responsible, will be a considerable incentive to ensure that its registration processes are robust, and that those it registers will make every effort to maintain their competency. However we have some concern that should an authority refuse or be unable to meet those costs, the complainant will be at great disadvantage. It is unclear whether the expenses of the complainant or of witnesses will be met from the funds of the Tribunal. Such persons should not be precluded from attendance because of the cost of doing so.

Clause 100: Recovery of fines and costs
It is unclear to us whether the costs referred to in this clause include those due to complainants in reimbursement of expenses, and if so, what the situation will be if the health practitioner is no longer employed or is bankrupted as an outcome of the hearing.

Part 6 - Structures and administration
Continuation and establishment of authorities
Although a number of professional bodies of health practitioners and individual practitioners are among the members of NCWNZ, we have concentrated this submission on the concerns and interests of clients of such practitioners, considering that those professions will be making submissions in their interests.

Part 7
Miscellaneous provisions, consequential amendments and repeals, and transitional provisions
Clause 153: Publication of orders
Provisions in this section are important for the protection of consumers. We note that (4) (a) upholds any issues of privacy allowed by **section 91.**

Part 8: Amendments to the Health and Disability Commissioner Act 1994
We reiterate our concern about the need for far greater funding to be available to the Commission to allow it to carry out the extra tasks expeditiously.

It appears to us that if a complainant is unsatisfied with the decision of a complaints investigation committee set up by an authority there will be the right to then take the complaint to the Tribunal, but cannot find a specific permission given. We trust this is so, but recommend that such a permissive statement be included.

Part 9: Amendments to the Medicines Act 1981
Clause 252: New sections 55A to 55G inserted
55D: Restriction on companies operating pharmacies
(2) (a) We welcome the provision that at all times at least 51% of the share capital must be owned by the pharmacist/s, but we do have concern that other persons or a company would be able to accumulate the remaining shares in a number of pharmacies, and thus exercise considerable, and perhaps undue, influence over a number of pharmacies.

Conclusion
NCWNZ thanks the committee for the opportunity to present this submission, which covers issues that vitally affect the continued well-being of all New Zealanders and the level of trust that should exist between health practitioners and clients. We look forward to its speedy enactment.

Beryl Anderson
National President

Janet Hesketh
Convener Parliamentary Watch Committee