ASMS

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

TOI MATA HAUORA

Submission to the Health Select Committee on the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill

7 OCTOBER 2015

Background

The Association of Salaried Medical Specialists (ASMS) is a union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members and we now represent more than 4,000 members, most of whom are employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. Over 90% of all public hospital senior doctors and dentists eligible to join the ASMS are in fact members.

Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, Iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

General comments

The ASMS supports moves to improve the efficiency and effectiveness of health services and any developments that enhance patient-centred care. We recognise that to achieve high-quality patient-centred care stronger collaboration and coordination of services is required at every level. That means viewing the health system not so much in terms such as 'primary care' and 'secondary care' etc, but as single continuum, with care provided by integrated multidisciplinary teams. We also recognise that in complex dynamic systems such as health services, the roles and responsibilities of clinical team members will change over time, in part due to changes in clinical training, the use of new technologies, and advances in research-based knowledge that guide the development of best practice standards.

Not least, the ASMS recognises New Zealand's public health services are operating in the face of entrenched medical specialist shortages, increasingly tighter budgets, and increasing health needs, with accumulating anecdotal evidence of a growing unmet health need. We have noted, as a result, that policy-makers often tend to pursue quick-fix answers to complex challenges without due regard for supporting evidence – an issue raised by the Prime Minister's Chief Science Adviser, Peter Gluckman, in his 2013 report on *The role of evidence in policy formation and implementation.* This can lead to unintended consequences and, with regard to health policy in general, can present increased risk to the patient and the provider of health care.

This submission reflects what Professor Gluckman calls a "growing recognition of the need to be more rigorous both in the employment of evidence for the development of policy, and in the assessment of its implementation". It is also in keeping with the New Zealand Medical Association's *Principles of Health Workforce Redesign*. For example, any proposed changes to workforce design should:

- Maintain or improve patient-centred access to the healthcare system, quality of patient care (including safety) and the patient experience.
- Ensure all reform is based on an assessment of the best available evidence/and or practice.

- Ensure that if role substitution or task delegation occurs, the delivery of healthcare is 'fit for purpose' with all appropriate training, legislated authority and accountability for work delivery in-built.

The full list of principles is designed to ensure changes such as those proposed in this Bill are safe, ethical and shown to be beneficial to the patient. All of the proposed changes in the Bill should therefore abide by those principles. There are several, such as those discussed below, which do not.

Specific comments

Proposed amendments to the Burial and Cremation Act 1964

The ASMS has concerns about the proposal to introduce a 'certificate of cause of death' in place of a 'doctor's death certificate' and allow such certificates to be given by a nurse practitioner as well as a doctor. We note that, according to the Ministry of Health, an underlying reason for this proposal is poor access to general practitioners, "particularly in remote places and outside normal working hours":

> *Often the MCCD [Medical Certificate of Cause of Death] is not signed for several days after the death, often due to high doctor workloads or difficulty contacting the attending doctor. In some cases the nurse is the health practitioner who is most knowledgeable about the patient's health status. In some cases doctors can be pressured to sign an MCCD in situations where they do not necessarily have the information to properly assess the cause of death.*[i]

Our assessment of the available information is that the proposal would not solve the identified problem but would introduce a risk of certificates being signed off with inaccuracies.

The proposal raises a number of questions:

- Determining the correct 'cause of death' can be a highly complex diagnostic task for a medical practitioner. Where is the evidence that determining the cause of death can now be undertaken safely by a practitioner with lesser diagnostic skills and knowledge?
- The Nursing Council reports there were just 107 nurse practitioners in March 2013. Of these, 70% were aged 50 or over, and only six reported working in a 'rural' area.[ii] How could such a small number of practitioners have any meaningful effect on the identified problem?
- If doctors are sometimes pressured to sign an MCCD when they are not ready to (another sign of an over-stretched medical workforce), would a nurse practitioner not be put under the same pressure?
- Perhaps the most significant question is that if 'high doctor workloads' are preventing doctors from dealing with MCCDs in a timely way, how many other health needs in the community are also being adversely affected for the same reason?

We note that a Cabinet paper says registered nurses have been signing death certificates in the United States since 2004. This is misleading. Currently, many states still do not authorise nurses to sign death certificates and we are not aware of any robust study to indicate nurses' accuracy in assessing cause of death, compared with that of doctors.[iii]

The ASMS does not support this proposal. However, we note that in the United Kingdom and Australia, where only doctors can sign death certificates, nurses can *verify* death, which is a prior step and allows the body to be prepared for the funeral. This would be a more appropriate alternative. In the meantime, the general practitioner workforce shortages identified by the Ministry of Health requires urgent measures to address, with a much greater effort than has been evident to date.

Proposed amendments to the Children, Young Persons, and Their Families Act 1989

The proposed amendments to this Act include proposals which would allow non-medical practitioners to conduct 'medical examinations'. Good law requires clear definitions. The Act does not include a definition of 'medical examination'. However, the adjective 'medical' is commonly defined by dictionaries as 'relating to the science or practice of medicine'. Our first point here is that if a non-medical person is to conduct an examination, it is not a medical examination, it is something else – for example, a physical examination, or a nursing examination. Any changes to the legislation must be consistent and clear in its use of the term 'medical'.

The proposal to change Section 49, allows the court to order a 'medical' examination by a health practitioner whom the court considers qualified for the purpose. In this case the Act specifies the purpose of such an examination is to determine whether there are reasonable grounds for suspecting a child or young person 'is suffering ill-treatment, abuse, neglect, deprivation, or serious harm'. If such examinations were analysed retrospectively, it may well be that some would theoretically fall within the scope of some non-medical practitioners. However, diagnoses are not made retrospectively.

When a child or young person undergoes a medical examination, especially where they may have suffered physical and/or mental injury, they may present with a number of injuries and related symptoms. The challenge is not only to be able to determine the likely cause of the injuries (for the purpose stipulated in the Act), but also of course (for the immediate health care needs of the child, or young person) to diagnose any symptoms that may be related to those injuries and possible one or more conditions causing those symptoms. Some symptoms, such as a headache or abdominal pain, may turn out to have a benign cause unrelated to any injury, but it can take a lot of highly skilled diagnostic work to come to that assessment.

The proposal would enable the court and non-medical health practitioners to makes decisions for which they are not qualified and which could be to the detriment of children and young people's health. The ASMS therefore does not support this proposal, nor, for the same reasons, the proposals to change Section 53 (allowing a social worker to arrange for a 'medical' examination by a health practitioner whom the social worker considers qualified for the purpose), or the proposal to change Section 179 (relating to medical, psychiatric, and psychological examinations).

Proposed amendments to Mental Health (Compulsory Assessment and Treatment) Act 1992

Clause 51 of the Bill proposes an amendment that the Director of Mental Health may nominate any health practitioner, rather than just a medical practitioner, to accompany district inspectors and official visitors to hospitals and services under the Act. The context for this proposal is unclear. The ASMS therefore cannot support it.

Proposed amendments to the Misuse of Drugs Act 1975

This proposal would allow nurse practitioners and designated prescriber nurses to prescribe controlled drugs to patients that are dependent on those controlled drugs. The Ministry of Health's explanation is that: "The small number of registered doctors in addiction treatment means that access to OST [opioid substitution treatment] is difficult and often is delayed more than is medically and socially appropriate." Consequently, the Ministry says there is 'significant unmet need for OST', estimating that about 5000 people who are addicted to opiates are not accessing the programme.[iv] A Cabinet paper suggests this may amount to about half of the people in New Zealand who were opioid dependent, but only 60 people were on the OST waiting list as at December 2012.[v]

That such a large number of people are not accessing this service is alarming. While the lack of GPs appears to be a factor (and we ask again to what extent are other services inaccessible because of this shortage), the scale of unmet need in this case raises serious questions about the effectiveness –

or possibly unintended consequences – of the programme. The ASMS urges that this is urgently and thoroughly investigated. Until such an investigation is conducted, it would be highly unwise and potentially harmful to extend OST prescribing to nurse practitioners and designated prescriber nurses. The ASMS therefore does not support this proposal.

---

[i] Ministry of Health. *Regulatory Impact Statement: Overview of required information*. Available: http://www.health.govt.nz/about-ministry/legislation-and-regulation/regulatory-impact-statements/health-practitioners-replacement-statutory-references-medical-practitioners

[ii] Nursing Council of New Zealand. *The New Zealand Nursing Workforce*: A profile of nurse practitioners, registered nurses and enrolled nurses, 2012-13, NCNZ 2014. Available: http://www.nursingcouncil.org.nz/Publications/Reports

[iii] T Ryall. "Further policy to be included in the Health Practitioners (Replacement of Statutory references to Medical Practitioners) Bill," A Cabinet Social Policy Committee Paper, Office of the Minister of Health, 29 May 2013. Available: http://www.health.govt.nz/system/files/documents/pages/soc-further-policy-to-be-included-2013.pdf

[iv] Ministry of Health. *Regulatory Impact Statement: Overview of required information*. Available: http://www.health.govt.nz/about-ministry/legislation-and-regulation/regulatory-impact-statements/health-practitioners-replacement-statutory-references-medical-practitioners

[v] T Ryall. "Further policy to be included in the Health Practitioners (Replacement of Statutory references to Medical Practitioners) Bill," A Cabinet Social Policy Committee Paper, Office of the Minister of Health, 29 May 2013. Available: http://www.health.govt.nz/system/files/documents/pages/soc-further-policy-to-be-included-2013.pdf