7 October 2015

Health Committee
Select Committee Services
Parliament Buildings
Wellington 6160

By email: select.committees@parliament.govt.nz

Submission: Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill

The New Zealand Society Anaesthetists welcomes the opportunity to make a submission on the above Bill.

About NZSA

The New Zealand Society of Anaesthetists Inc. (NZSA), is a professional medical education society representing almost 500 medical anaesthetists in New Zealand. We work to foster education and research into anaesthesia, and support the professional interests of our members. Members include specialist anaesthetists in public and private practice, and trainee anaesthetists. NZSA is a member society of the World Federation of Societies of Anaesthesiologists (WFSA).

Introduction

Anaesthetists are peri-operative physicians - working in pre-operative, per-operative and post-operative care. Anaesthetists work in collaboration with surgeons, nurses, midwives, obstetricians, radiologists, dentists and others to provide analgesia, sedation, anaesthesia and intensive care services to patients. We acknowledge the vital role that all play in these teams.

The NZSA respects the professionalism and care that health practitioners bring to their patients and we are supportive of practitioners developing their roles further, provided they are adequately trained, there are no new risks to patient safety or care, and there is clear evidence of benefit to the change.

We acknowledge that some procedures or processes currently required to be carried out by doctors could be delegated to other health practitioners without impacting patient safety or care. However, as with medical practitioners, the training of health practitioners needs to be relevant to the tasks they perform in their job. We outline below those areas where we believe devolving tasks to health practitioners is not appropriate.

The introduction to the Bill supports the concept of “innovative and efficient practice”. We would caution that the decision-making to achieve these goals needs to be sound and considered taking into account some wider impacts which we cover under the heading General issues.
General issues

Scope of practice

Further to our introduction point that medicine is a collaborative activity by a multidisciplinary team, we make the following general points about scopes of practice.

We note a desire in recent years by health practitioners to increase their scopes of practice. While we support others developing their roles further, the unintended impacts of these changes need consideration. These would include:

- health practitioners being encouraged to work at the top of their scope - we argue that it is a better and safer system to have all health professionals working at the appropriate level of competency within their scope of practice, and that working at the limit of the scope should occur rarely in order to maintain patient safety
- an impression with increasing scopes of practice that some health roles are interchangeable. All health practitioners have specific skill sets based on their training and clinical experience but that doesn’t make them interchangeable, which this Bill seems to suggest. We contend that for patient safety, efficiency and quality, many skill sets should remain separate
- Lack of recognition that different training processes for practitioners in different areas of healthcare embody different thinking mechanisms, and the combination of these brings strength and safety to the health workforce.

Finally on scopes of practice, we note that other industries with a proven quality and safety focus, such as aviation, do not routinely have their staff work at the limits of their training or scopes of competence, resulting in an excellent safety record along with commercial viability. We support this approach.

Workforce

We would also be concerned if these and other changes relating to scopes of practice were driven by workforce pressures in particular areas, or proposed without the due consideration of the impacts on the workforce. We refer to point 4 of the New Zealand Medical Association submission which raises the issue of GP numbers and availability and the predicted nursing shortage for New Zealand. We encourage that the decision-making on these changes takes into account changing and estimated workforce patterns as well as improving the current provision of services.

Specific points

Part 2 - Burial and Cremation Act 1964

We agree with the change of the death certificate to a ‘cause of death certificate’, but would only agree with nurse practitioners being delegated to determine the cause of death in patients with chronic diseases that have been diagnosed by medical practitioners, and who are under the care of a multidisciplinary team.

In all other cases a medical practitioner should have sign off of the ‘cause of death certificate’. The education over a broad spectrum of medicine (in anatomy, physiology, pathology, diagnosis, and therapeutics) of the medical training is attained over many years. We acknowledge that specialist nurses working in specialized areas (e.g., diabetes, respiratory, neonatal medicine) achieve comprehensive and detailed knowledge in those areas, but not across the broad spectrum of medicine.

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1 Qantas named world’s safest airline, The Guardian, 6 January 2015
In addition to this, there are difficulties within the current system which could be exacerbated by allowing a wider group of practitioners to determine the cause of death. Currently we are seeing a problem in some public hospitals where Registered Medical Officers provide inaccurate information on death certificates, often then remedied by their seniors. Allowing another group of practitioners to determine and document the cause of death could increase the occurrence of inaccuracies.

**Part 3 - Amendments to Children, Young Persons, and Their Families Act 1989**

Even within medical practice, the examination of paediatric and psychiatric patients is highly specialised. We are concerned that patients under this Act may not have access to the appropriate medical practitioner to assess them, so we oppose the amendment which would allow a social worker (Section 49) or court (Section 179) to determine the type of practitioner to carry out a medical examination.

If a medical examination is required this should be done by a medical practitioner. At the least, it needs to be stipulated that both the referrers and those undertaking the examinations are required to have appropriate training and seniority.

**Part 6 – Amendments to Mental Health (Compulsory Assessment and Treatment) Act 1992**

Regarding Clause 51, we believe that a medical practitioner should continue to accompany district inspectors and official visitors to hospitals and services and be the person who receives documents relating the patient under the Act, rather than a health practitioner. This is a highly specialised area where potential infringement of a patient’s health and/or human rights can occur. We believe a medical practitioner is the appropriate person to take responsibility for these areas, rather than a health practitioner.

**Part 7 - Amendments to the Misuse of Drugs Act 1975**

The proposed amendments to this Act widen the existing exemptions relating to prescribing, administering or supplying controlled drugs to a person dependent on that drug, to nurse practitioners and designated prescriber nurses, in addition to medical practitioners.

The NZSA supports the Health Quality and Safety Commission Safe Opioid Use Collaborative\(^2\), which clearly shows a need for education regarding opioid prescribing amongst current medical prescribers.

Given the complexities around the diagnosis and treatment of opioid dependent patients, we have concerns that allowing nurse practitioners and designated nurse prescribers to prescribe to this patient population could result in harm.

In the palliative care and hospice situations, nurse practitioners work within multidisciplinary teams. At present there are a limited number of practitioners in this field, but in the future patients could benefit from allowing these practitioners to be exempt.

**Chronic pain**

The care and management of those with chronic pain issues is currently an interdisciplinary matter, involving a team of health practitioners across a wide range of scopes, e.g. physiotherapy, psychology as well as specialist pain medicine doctors. This intertwining of experts is required to treat the multifaceted nature of chronic pain. In this instance, we would oppose devolution of the physician role as the appropriate

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\(^2\) Health Quality and Safety Commission Safe Opioid Use Collaborative
prescriber of pain medicines, which often include opioids and multi-modal analgesia, and sometimes require physical intervention. An important principle when prescribing long-term opioids is an opioid contract, and additionally that the prescribing should be limited to a specific practitioner. For these reasons this prescribing should be undertaken by an appropriately trained medical doctor, not a health practitioner.

Conclusion

In general we support the submissions of the New Zealand Medical Association and the Australian and New Zealand College of Anaesthetists New Zealand National Committee.

Thank you for the opportunity to make a written submission on this Bill. I am happy to discuss this submission further. Please feel free to contact me at president@anaesthesia.org.nz to arrange a discussion.

Yours sincerely,

Dr David Kibblewhite
President