Submission to the Health Committee on the Health Practitioners Competence Assurance Amendment Bill 2018

5 April 2018

Introduction

The Association of Salaried Medical Specialists is the 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 nearly 5,000 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 DHB permanently employed 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 and growing number work in primary care and outside DHBs. These members, many of whom are general practitioners, 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.

A just [health service] culture is one in which frontline personnel are comfortable disclosing errors, including their own, while maintaining professional accountability. It recognises individual practitioners should not be held accountable for system failings over which they have no control, yet does not tolerate conscious disregard of clear risks to patients or gross misconduct.

Center for Patient Safety (United States), published in the New Zealand Health Quality and Safety Commission's National Adverse Events Policy Reporting 2017[1]

General comment

We regard this Amendment Bill as a legislative red-herring tinkering around the margins of an Act to fix things that don't need fixing while the real risk of harm to the public – ongoing system failure – is ignored.

The specific focus of the Health Practitioners Competency Assurance (HPCA) Act, to ensure "health practitioners are competent and fit to practise their professions", is statistically an area of minimal risk to patients. In the year to June 2016, of 15,270 practising doctors, just six were under suspension or interim suspension (0.04%) and one (0.007%) was struck off the register through a discipline order under the Act (S101(1)(a).[2] In 2017 there were sufficient concerns about the practice of just two doctors (both general practitioners) for them to be brought before the Health Practitioners' Disciplinary Tribunal (for professional misconduct charges). One was found not guilty; the other was found guilty, fined and ordered to practise under supervision for 18 months.

This reflects not only the stringent training, registration, recertification and ongoing education requirements of doctors but also doctors' high level of professionalism and commitment to providing good quality patient centred and honouring their obligation to embrace life-long learning, self-reflection and self-criticism, peer review and the principle of 'first, do no harm'. It also reflects the reasons why doctors working in New Zealand are one of the most respected and trusted groups in New Zealand.[3] It also reflects that the current checks and balances on doctors' performance under the HPCA Act are working well.

The far greater risk of harm to the public in the health sector are systemic failures, including failures to provide safe conditions within which practitioners have to practise.

After increasingly disturbing reports from our members about workload pressures, the ASMS conducted national surveys of senior doctors employed in DHBs to assess their levels of fatigue and burnout, and the prevalence of 'presenteeism' (going to work while sick). The results of these peer reviewed studies showed 50% of the 1487 respondents reported symptoms of burnout (published in the *British Medical Journal in 2016)* and 88% of 1806 respondents reported presenteeism (published in the *New Zealand Medical Journal* in 2017). To be clear, the literature describes burnout as a state of 'vital exhaustion' which is strongly associated with higher risk of medical error. The extent of workload stress is further demonstrated in the presenteeism findings, with respondents citing the negative effects on patients and the additional burden on already-stretched colleagues as the main reasons why they did not take sick-leave.[4] [5]

Any reasonable person might have expected such results to set alarm bells ringing among our policy-makers, but there has been no response and no action to address unsafe workloads.

It has been widely recognised for many years that improving quality and safety in health care requires a systems approach. Errors in complex systems are nearly always multi-dimensional, as is service performance, whether it is considered good or poor.[6] [7] The then Minister of Health Hon Annette King acknowledged this in a policy document in 2003 which states a system approach is necessary "because the health and disability system is complex, with decision-making and actions occurring across a range of people, individuals, teams, organisations and subsystems". [8]

The Medical Council of New Zealand (MCNZ) explains it further:

> *A useful concept is to look at error as a failing of processes and systems. An individual may be at the sharp end of this failure but should not be blamed for its defects. Reason[1] describes the "Swiss cheese" concept of error. High technology systems such as medicine have many defensive layers. Well trained professionals, procedures, guidelines and computerisation all can be considered defensive layers against error and can be likened to individual slices of Swiss cheese; mostly intact but with some holes. The presence of a hole in one slice doesn't necessarily cause an error, as it is probable that the next slice in the series will prevent the error. When holes in successive slices line up momentarily, error occurs….*
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> *Developing a culture of safety in medicine requires effective communication and trust between team members and acknowledgement of the failure of processes rather than individuals as the cause of the majority of errors in medicine.*
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> Coles Medical Practice in New Zealand, 2013

Evidently much of the 'Action Plan'[9] emanating from the 2003 policy document does not appear to have gained much traction in establishing a genuine systems approach to safety.

A critical part of that Action Plan, was that service providers (including public and private hospitals, rest homes and residential services) are compliant with all standards under the Health and Disability Services (Safety) Act 2001, including requirements to establish both risk management and quality improvement strategies. Ensuring service organisations such as district health boards (DHBs) are fit to practise and are accountable for any shortcomings depends on the effectiveness of the standards regime through which organisations can be certified for periods of up to five years.

However, we have serious questions about the validity of the current outcomes-based standards regime as it applies to safe and effective staffing levels and, in turn, patient safety. Outcomes-based health care standards depend on extensive data and analytics capabilities that DHBs do not possess. Further, one of the lessons from the Mid-Staffordshire failings in the UK was that safety management in health care needed to move from a 'reactive mindset' to become more proactive about reducing patient safety risks. [10]

There are numerous examples showing New Zealand's outcomes-based standards regime is failing to produce a safe system. Mental health and addiction services, for instance, are subject to meeting such standards, yet that has not prevented the well-documented and widely reported service failures, largely due to staffing shortages, which have been deemed serious enough to prompt a government inquiry.

At the time of writing, a media investigation into the state of New Zealand's maternity services found: "In 2015, the most recent year for which data is available, there were 578 perinatal deaths…This is the lowest number on record. But in a quarter of these deaths, issues around care – including its organisation and management, barriers to access, and staffing – contributed to the death. One in seven deaths could have been avoided."[11]

The ASMS's own research indicating high levels of 'presenteeism' and burnout among senior doctors, discussed above, is significantly at odds with the summarised DHB certification audit reports which generally suggest senior doctor staffing levels are adequate.

Surveys of clinical head of departments in six randomly selected DHBs, seeking their assessment of senior doctor staffing levels, raise further questions as to the reliability of certification audits, with HoDs indicating significant staffing shortfalls in all DHBs surveyed.[12] For example, more than half of the HoD respondents in one DHB (Hawke's Bay, with a 92% response rate) assessed there was

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[1] British psychologist James Reason, who pioneered the modern field of systems analysis of industrial accidents.

inadequate internal senior doctor cover for short-term sick leave, annual leave or continuing medical education leave. Nearly three-quarters of respondents believed their staff had inadequate time to spend with patients and their families to provide good quality patient centred care. Overall, they estimated they needed a 22% increase in full-time-equivalent senior doctors to provide safe, quality and timely health care. The summarised certification audit report of the same DHB reports, however, reports that "staffing is effectively managed to meet demand".[13]

The lack of robust and regularly collected data on the safety and quality of health service workplace environments, and the consequent lack of transparency, diminishes the importance of the effects of poor working conditions when the quality or safety of a clinician's practice is under investigation.

Learning from mistakes

The recent case of a doctor being struck off in England after a child died while under her care is an example of how things can go badly wrong in a number of ways when doctors are expected to work in unsafe working conditions. The case, which has rocked the medical profession in the United Kingdom (UK), involved a paediatric registrar, Hadiza Bawa-Garba, who had been described by colleagues as an 'excellent doctor' but who made mistakes amid multiple system failures. The systemic faults included both nursing and medical staffing failures which among other things led to her having to cover for several colleagues, including a specialist who was away on training duties. She had been put in a situation of looking after six wards, spanning four floors, undertaking paediatric input to two surgical wards, giving advice to midwives and taking GP calls. She also had to cope with a major IT failure in the hospital.

While the death of the child is an unacceptable tragedy, the treatment meted out to Dr Bawa-Garba by the General Medical Council (GMC) was widely condemned by doctors, who consider Dr Bawa-Garba was scapegoated for hospital system failures. Nick Ross, the president of the organisation Healthwatch, the public's 'champion for health and social care', added his voice to the protests, calling the case 'chilling'. Mr Ross, who is also a director of a major acute hospital trust and a lay member of the Royal College of Physicians' committee on medical ethics, wrote in the *British Medical Journal*: "[The case] indicates that we can blame trainees for lack of training and supervision, whether they are senior or junior, whether their units are under pressure or understaffed, and whether there are contributory failings by nursing or other colleagues. Had this happened in our trust, I hope the board would have accepted much of the responsibility." The fact that Dr Bawa-Garba's acknowledgement of mistakes was used as evidence against her fuelled further criticism.[14] [15]

Referring to efforts in the UK to promote a speak-up culture in the National Health Services (similar to New Zealand's adverse events reporting policy encouraging staff to report adverse events or 'near misses' to improve patient safety), Mr Ross said the outcome of the case "undermined patient care by endorsing and promoting a blame culture that was inimical to safety". He called on the GMC to produce a clear statement that "puts patient safety first, medical candour second, adversarial procedures last, and retribution nowhere".

The potential for such a case to arise in New Zealand is high.

The invidious position that doctors are put in when trying to do their best for patients in poor or unsafe working conditions is underscored in the MCNZ's statement on dealing with acute patients, including that: "Every effort should be made to avoid withdrawing or not providing treatment when this would involve significant risk for the patient and the only justification for doing so is resource limitation." This message is reinforced in the comments of an 'expert witness' published in the findings of a Health and Disability Commission (HDC) report that "busy-ness of doctors in practice is no defence for an error".[16]

The policy and legislative emphasis on ensuring practitioner competency without a similar or even greater emphasis on ensuring system-level competency is a clear and present health and safety risk for patients and doctors alike. While doctors are called upon to report mistakes so lessons can be learned for the betterment of good patient care, for the same ends we call on New Zealand policy-makers to learn from the mistakes illustrated in this case.

First and foremost, policies supported by appropriate resources must be in places to ensure the conditions within which doctors work are 'fit for practice'. Events that led to an investigation of a health practitioner's competency must also take into account, as a legal requirement, any systemic failures associated with the event. Where systemic safety risks are identified, the organisation concerned must be required to rectify the deficiencies. While such measures are included in the current standards regime, they are not achieving their intent.

Not least, patient safety must be the paramount consideration in any policies aimed at naming practitioners where a responsible authority publishes a notice of an order in respect of that practitioner. This must include a requirement to weigh any evidence that naming the practitioner may enhance patient safety against the evidence that naming the practitioner will risk patient safety. This issue is discussed further below.

Our responses to specific matters raised in the HPCA Act Amendment Bill are given below, though we regard these matters as marginal against a much greater health sector safety issue that requires a broader review of the relevant policies, legislation and processes.

Naming policy

The stated purpose of the naming policy in the Amendment Bill is threefold:

> *First, to enhance public confidence in the health professions for which the authority is responsible and their disciplinary procedures by providing transparency about their decision-making processes.*

Comment:

We are not aware of evidence suggesting public confidence in the health professions needs to be 'enhanced'. On the contrary, with regards to the medical profession, the available evidence shows a high level of public confidence as noted above.

We recognise, however, that patients or family members affected by a health practitioner's error can be unforgiving, and some may perceive that justice can only be achieved by punishing the practitioner. But, as the *Healthwatch* president in the UK, points out, "resentment and vengeance do not make for good public policy, let alone safe clinical practice".

The Cabinet paper putting the case for the amendments to the Act argues that: "On the whole, the New Zealand public cannot make judgements, based on the information available, about the appropriateness of responsible authority decisions on practitioner practice…".[17]

But with regards to the decision-making processes relating to disciplinary procedures, the HPCA Act (S95) requires the Health Practitioners' Disciplinary Tribunal to conduct hearings in public unless the tribunal considers there are good reasons not to, including the public's interest. The same applies to the publication of names. These decisions are explained to all affected parties and are open to appeal. Even where hearings are heard in private, the tribunal may allow any particular person to attend it if satisfied that he or she has a particular interest in the matter to be heard.

In line with its policy of openness and transparency, all decisions and orders of the tribunal are published on the website. The website also provides statistical information on the decisions and orders and an 'events calendar' listing forthcoming disciplinary hearings.

As discussed above, however, there is an urgent need to review the way disciplinary decision are arrived at, which should take into account explicitly the conditions within which the practitioner is expected to work and would require amendments to the HPCA Act. To enable such a measure, robust and nationally consistent key performance indicators for health care organisations must include adherence to an agreed set of patient safety criteria, including safe staffing levels. This may require amendments to other legislation, including the Health and Disability Services (Safety) Act 2001 and tightening risk management and remedial action provisions in the Health and Safety at Work Act 2015.

In order for the New Zealand public to be able to make informed judgements about the appropriateness of responsible authority decisions concerning individual practitioners, it would be necessary to have much greater transparency about the conditions within which the practitioner was working. This cannot occur until adequate information is available on systems safety.

> *Second, to ensure that health practitioners whose conduct has not met expected standards may be named where it is in the public interest to do so.*

Comment:

As discussed above, there is already provision in the current Act to name practitioners who are brought before the Health Practitioners' Disciplinary Tribunal. Indeed, it is standard practice to do so unless the tribunal, which is appointed by the Minister of Health, determines there are overriding reasons to withhold naming the practitioner.

Further, we note that current legislation does not restrict the Health and Disability Commissioner (HDC) from naming practitioners in HDC reports. The HDC Act gives the Commissioner a broad discretion to determine his or her procedures. The HDC established a 'naming policy' in 2008 whereby individual practitioners will be named only if:

- the conduct of the provider demonstrates a flagrant disregard for the rights of the consumer or a severe departure from an acceptable standard of care, such that the provider poses a risk of harm to the public; or
- the provider has refused to comply with the Commissioner's recommendations; or
- the provider has been found in breach of the Code in relation to three episodes of care within the past five years where each breach involved an (at least) moderate departure from appropriate standards.

Consequently: "In practice, registered health practitioners are only likely to be named for public safety reasons in rare cases."

> *Third, to improve the safety and quality of health care.*

Comment:

The two principal questions to be weighed up in a naming policy are: Are there reasonable grounds indicating the naming of a practitioner will make patients safer? And are there reasonable grounds indicating that naming a practitioner will make patients *less* safe?

The response to the first question is covered above in the HDC's assessment of when, on rare occasions, practitioners should be named as a matter of public safety.

To address the second question, the ASMS supports the current policy, overseen by the Health Quality and Safety Commission (HQSC), of developing a speak-up culture in the health service by enabling health professionals to disclose mistakes they had made, confident that the information would not be used to publicly blame or humiliate them, so that lessons could be learnt to enhance

patient safety. Similar incident reporting policies to improve safety are common overseas in health systems and other services and industries.

The promotion of a just culture that supports those who report adverse events and does not pursue public shaming was an approach taken by one of New Zealand's top companies in a high-profile case in 2013.

The Medical Protection Society's online publication *Casebook reported:* "An Air New Zealand pilot fell asleep for a minute twice while cruising between London and LA. Both the airline and the Civil Aviation Authority of New Zealand strenuously rejected pressure to identify the pilot. The pilot remains unnamed and no charges were pressed because Air New Zealand considers reporting incidents of fatigue a part of increasing their safety culture." [18]

Any changes from current practices with regard to naming practitioners which inhibit reporting of mistakes will have a negative impact on patient care.

> *Reporting must be safe. Consumers, whānau and staff must be empowered to report adverse events and near misses without fear of retribution. Reported events must be investigated with a focus on determining the underlying system failures and not blaming or punishing individuals. Health and disability service providers must ensure a just culture prevails so individuals are not held accountable for system failures.*[19]
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> HQSC: National Adverse Events Reporting Policy 2017

For the reasons discussed above, amendments to the Act requiring authorities to develop and regularly review 'naming policies' are not only unnecessary but, depending on the policies adopted, potentially a backward step for patient safety.

In particular we are strongly opposed to the amendment (157I) which protects a responsible authority from defamation in relation to the naming of a health practitioner in accordance with a naming policy. A responsible authority must never be allowed to defame a health practitioner without being accountable for it, especially given the serious consequences for the practitioner's reputation and livelihood.

Information about health practitioners

We agree that accurate workforce data is essential for workforce analysis and planning. We recognise that good quality workforce planning can contribute to improving patient safety by helping to ensure the future health workforce has the capacity and capability to meet increasing service needs.

We also recognise that a number of responsible authorities, including the MCNZ, already collect detailed workforce data from health practitioners when their annual practising certificates are renewed and provide this, anonymised in accordance with privacy requirements, to the Ministry of Health for workforce planning purposes.

We therefore support the amendment enabling more robust data to be collected by responsible authorities being made available to the Ministry for this purpose, consistent with the principles of the Privacy Act 1993.

We note specifically the information may be used only for the purpose of supporting the Ministry's responsibilities for workplace planning and development and is not published in such a way as to identify any health practitioner.

Improved data collection and reporting will, however, incur additional costs for responsible authorities which may increase fees if not directly funded.

Amalgamation of authorities

To fulfil their roles and functions effectively, it is important that registration bodies are responsive to registrants' needs and circumstances. Services are best delivered by those with good knowledge of the profession they are working with and who can relate to practitioners' particular needs in that professional group.

We note that the bill provides for authorities to be amalgamated by Order in Council made on the recommendation of the Minister of Health. The Minister of Health must consult the authorities that are subject to amalgamation and be satisfied that amalgamation is in the public interest.

Given the critical role that these authorities play for their respective professions, and the public, in maintaining the required standards of patient safety and quality of care, the risks of diluting their expertise and their effectiveness must be thoroughly examined before any such amalgamation is recommended. This would require the consultation process to be particularly robust, and must include professional associations and colleges, as well as the responsible authorities concerned.

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