NEW ZEALAND MEDICAL ASSOCIATION

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By email: Kathryn_Baker@moh.govt.nz

Dear Kathryn

Credentialling Framework for New Zealand Health and Disability Service Providers

Thank you for the opportunity to comment on this draft document. Our comments on the proposed credentialling framework are made in respect of the medical profession only. While it may be that other health professions have implemented credentialling differently in respect of other health practitioners we have not addressed their issues.

General Comments

We understand that the background to this document is the Ministry of Health credentialling guidelines *"Toward Clinical Excellence: A Framework for the Credentialling of Senior Medical Officers in New Zealand".* These guidelines are still fairly sound although there is merit in reviewing and expanding them. We understand that the main issue that has arisen in regard to those guidelines is in respect of a lack of consistency in implementing the guidelines by DHBs.

We believe that there is a serious lack of clarity around the purpose of credentialling and the relationship to professional regulatory processes; regrettably, this document does not clarify the situation. In our view these fundamental issues need to be resolved to ensure that current credentialling practices are appropriate, as well as to allow for the potential expansion of credentialling to other professions.

Our understanding is that the credentialling of a doctor should relate specifically to the DHB or other institution's decision as to what tasks or functions the doctor can undertake given the environmental context. While the doctor's scope of practice has been determined by the relevant college and recognised by the Responsible Authority (in this case the MCNZ) through registration, the facility then credentials the doctor

for the tasks s/he is authorised to do within a specific work environment. Sometimes limitations are created by the fact that there are limited resources available. The example given in the document of an orthopaedic surgeon with experience in spinal surgery who is credentialed to perform all orthopaedic surgery excluding spinal procedures because the hospital does not have the required facilities and back up support necessary, is precisely what we understand credentialling to be used for. In our view credentialling used in this way is entirely appropriate.

We understand that credentialling has also been used at other times for those situations where a doctor has over time specialised within his/her scope of practice to such an extent that s/he does not feel competent to practice to the full breadth of his/her scope and requests the facility credentialling a more limited set of functions within the doctor's scope. While we accept that this is happening we query whether this is appropriate as we believe that this is a situation which falls within the authority and responsibility of the MCNZ as detailed in the Health Practitioners Competence Assurance Act 2003 (HPCA Act). This is critical for reasons of professional autonomy, but also because of patient safety, and continuity of process. We believe that the Medical Council as the ultimate arbiter of competence must retain control of the process. It is critical that in circumstances where a doctor's scope of practice is limited or restricted for reasons of competence, that the situation is fully transparent to the Medical Council. Using credentialling in this way may result in a lack of clarity in respect of individual competence.

The document goes further than this and proposes that this framework should be widened to allow the credentialling process to include matters outside the doctor's scope of practice. This however is precisely what is intended to be covered by the MCNZ's registration process.

In our view the proposed extension of a doctor's scope of practice is - and should remain - entirely within the province of the MCNZ and the relevant college, as should matters in respect of clinical competence. This proposal to extend a scope of practice in this way is in our view in conflict with both the spirit and substance of the HPCA Act which provides:

> **"20 Authority must inform applicant that it proposes to depart from indicated scope of practice or to decline application**
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> (1) In assessing an application under section 17, an authority must consider whether the applicant is qualified and competent to practise within the indicated scope of practice submitted by the applicant under section 17(2)(b)(i).
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> (2) If the scope of practice that an authority proposes to authorise for an applicant differs from that indicated by the applicant under section 17(2)(b)(i), whether in respect of conditions to be stated or otherwise, the authority must inform the applicant in writing why it proposes to authorise a different scope of practice.

(3) If, in assessing an application under section 17, the authority proposes to decline the application, the authority must inform the applicant in writing why the authority proposes to decline the application.

(4) When the authority informs an applicant under subsection 2(2) or subsection (3), the authority must also give the applicant—

(a) a copy of any information on which the authority relies in proposing to authorise a different scope of practice or to decline the application; and

(b) a reasonable opportunity to make written submissions and be heard, either personally or by his or her representative, in respect of the matter.

(5) Subsection (4)(a) is subject to section 154.

21 Authority may authorise scope of practice or changed scope of practice

(1) The responsible authority may authorise a scope of practice for an applicant who applies to be registered as a health practitioner.

(2) The responsible authority may authorise any changes to the existing scope of practice of a health practitioner who applies for a change in the authorisation of his or her scope of practice.

(3) A change determined under subsection (2) may consist of any 1 or more of the matters described in section 22(2).

(4) If an applicant is, under section 20(4)(b), entitled to an opportunity to make written submissions and be heard, an authorisation under subsection (1) or subsection (2) may be determined only after the applicant has had that opportunity.

22 Contents of authorisation of scope of practice

(1) An authorisation, under section 21, of a scope of practice must state the scope of practice by describing the health services that the applicant is, subject to any conditions included in the authorisation, permitted to perform.

(2) An authorisation, under section 21, of a change to a scope of practice must state the change involved by reference to 1 or more of the following matters:

(a) the health services that the applicant is permitted to perform:

(b) the cancellation or variation of any condition that forms part of the applicant's scope of practice:

(c) the inclusion in the applicant's scope of practice of any new conditions.

(3) Any conditions included in a scope of practice under subsection (1) must be of a kind that the authority considers are required to ensure the competent practice of the applicant, and, without limitation, may include any of the following:

(a) a condition that the applicant practise subject to the supervision of 1 or more nominated health practitioners or health practitioners of a stated class:

(b) a condition that the applicant practise subject to the oversight of 1 or more nominated health practitioners or health practitioners of a stated class:

(c) a condition that the applicant not perform any task of a stated kind or that he or she perform those tasks only in stated circumstances:

(d) a condition that the applicant practise only in a stated capacity, for example, as an employee of a nominated person or a person of a stated class:

(e) a condition that the applicant practise in association with 1 or more nominated persons or persons of a stated class:

(f) a condition that the applicant practise only for a specified period:

(g) a condition that the applicant attain 1 or more further stated qualifications or attain further experience of a stated kind:

(h) any condition that the authority believes on reasonable grounds to be necessary to protect the safety of the public."

It is worth noting that credentialling is not mentioned in the statute at all suggesting that the legislators did not intend credentialling to be a prime *"competence assurance activity"* in respect of individual health practitioners.

Further, by allowing a scope of practice to be extended through the credentialling process we are concerned that the facility will be impinging on the role of the MCNZ and the Colleges. There is an inherent conflict of interest in its doing so given that the facility's focus is necessarily about output rather than maintenance of individual professional competence. We therefore oppose any proposal to extend scopes of practice through credentialling.

Having said that, we appreciate that there are situations where it may be appropriate for a doctor's scope of practice to be extended and/or a doctor's performance assessed. However, such decisions must be made by the MCNZ in conjunction with the relevant college as the HPCA Act anticipates. The facility's role in determining a doctor's duties and functions should be limited to issues around context, including

available facilities and resources which determine how much of their scope of practice the doctor can fulfil in the particular environment.

Having provided the above comments we now comment on specific matters in the proposed framework.

Definitions

We believe that definitions in the document in regard to credentialling are confusing and seem to be contradicted at various points throughout the document. We believe however that the definition of Organisational Credentialling *"identify[ying] the specific clinical responsibilities the health professional is considered competent to undertake and appropriate to perform within a specific context, which includes clinical support and available resources*" and found on page 5, is an appropriate definition. We would however change the term *"health professional"* to *"health practitioner"* so that it is consistent with the HPCA Act.

Another area of confusion is in the use of the term "scope of practice" which is a term defined in and well understood in terms of the HPCA Act, and the reference to "organisational scope of practice" which is something entirely different. We suggest that different wording is used in respect of the latter to avoid this confusion.

Application to General Practice.

We understand that this framework is intended to cover general practitioners who work for DHBs but are less certain that it is to be applied to general practitioners who are self employed in small businesses. While the former may be acceptable extending the framework to encompass the small business model is problematic and needs to be the basis of further consultation.

Application to Private Practice

As with general practice we also believe that the credentialling framework is unsuited to small private practices where the owner of the business is the one who needs to be credentialed. Again key stakeholders need to be consulted before the credentialing framework is applied to small private practices. Note however that in referring to private practice we do not include private hospitals which we believe would benefit from the application of a credentialing framework.

Credentialling Status and Disciplinary Action

The document states that a *"credentialling review must not proceed where the practitioner has an unresolved disciplinary matter, to ensure that the non punitive nature of credentialling is not compromised".* While we understand the concern that the process of credentialling could be used in a punitive way where there are disciplinary issues, it may be equally punitive for a practitioner to be unable to be credentialled in a situation where there are outstanding alleged disciplinary issues. Our system has always been based on the premise that a person is presumed to be innocent until proven guilty. Moreover disciplinary matters can lie over a practitioner for a considerable time and it would be unfair for the practitioner's ability to be credentialled to be held up while the matter winds its way through internal – and

sometimes external legal - processes. If a person has not been found to be largely incompetent, or where a performance issue is not safety related then credentialling should occur although it may be appropriate in situations where safety issues are raised for the disciplinary situation to be considered as part of the credentialling process.

Practice Visits for Assessment of Performance

The document presupposes that practice visits for performance will occur and asks what information from these visits should be used for credentialling. It should be noted however that this matter is still at a consultation stage and a final decision has not been made. It does however raise another issue however, namely the duplication of processes.

Duplication of Processes

The proposed framework involves various combinations of peer review, 360 degree reviews and performance assessment, all of which are already in place in other guises (e.g. RANZCOG currently runs practice visits and peer reviews are already generally required by the MCNZ). We are concerned that this proposed credentialling framework will duplicate activities and functions already undertaken and add to the confusion between credentialling and regulatory processes. The framework needs to be aligned with current processes so that duplication does not occur.

Audit

While as noted above we have reservations about this proposed credentialling framework as drafted, we do believe that should a final framework be developed and implemented then it must set a standard that all DHBs are required to meet and performance against those standards audited regularly.

Consumer roles in credentialling

We accept the requirement of DHBs to have community input into as many parts of the DHB's activities as possible and believe that in most cases this is appropriate. We are not sure however that in respect of credentialling the involvement of consumers would add value to the process.

Consumer access to credentialling information

While we support consumers having access to the credentialled status of providers and organisations and access to credentialling processes in general we would not want consumers to have access to the specific detail of an individual practitioner's credentialling status (e.g. the reasons for a particular status). In our view this is an individual employment or contract issue and therefore private to that individual and facility.

Locums

There are also issues concerning the credentialling of locums. While we agree that locums should be credentialed, the fact that locums may work for very short periods of time for a number of different facilities may mean that for practical purposes the framework will need to be modified to accommodate their situation.

Locum Database

The framework contemplates the establishment of a locum database that records the locum's employer history, employment timeframe, service level and clinical responsibility which could be provided to the new employing organisation. We are not convinced that this measure is necessary or appropriate, and would seek further discussion on the rationale behind the proposal.

Doctors Undertaking Training

We understand that it is not intended that this framework cover doctors undertaking training. In our view it should not as

a) trainees are supervised and

b) trainees are often required to move between facilities to gain training experience; not only at the end of a three or six month rotation, but also during a rotation and credentialling may unreasonably fetter such training.

Summary

In summary we

- Support the credentialling of a doctor where it limits a scope of practice as a result of environmental issues that limit the doctor from working to his or her full scope of practice.

- **Do not** accept that credentialling should be used as a tool in respect of determining individual competence.

- **Do not** support credentialling being used to extend a scope of practice. This is a matter entirely for the MCNZ and colleges and appears to be in conflict with the HPCA Act 2003.

- Believe that there is a lack of clarity regarding the purpose of credentialing.

- Consider that there are significant difficulties in applying this credentialling framework to small businesses in private practice and recommend that significant consultation occur with key stakeholders before being applied to this group.

- Believe that credentialling should not be curtailed because of outstanding disciplinary issues.

- Note that the presumption that practice visits for performance will occur is premature.

- Are concerned that the proposed framework will unnecessarily duplicate existing processes.

- Believe that once a framework is finalised, an audited standard should apply to all DHBs and institutions that undertake credentialling activities.

- Question whether a consumer role in credentialling will add any value.

- Oppose consumers having access to specific detail about the credentialling of a particular doctor.

- Believe that the framework may need to be modified to cover the very different environment locums work in.

- Believe that this credentialling framework should not apply to doctors undertaking specific training.

We are happy to discuss any of the above matters further with you should you wish.

Yours faithfully

Dr Peter Foley
Chair