Regulation of New Zealand Physiotherapists over the past 100 years

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ABSTRACT

Over the 100 years of physiotherapy in New Zealand there have been three pieces of legislation that have regulated physiotherapists. The first two acts, the Masseurs' Registration Act 1920 and the Physiotherapy Act 1949 focussed largely on registration requirements and supported self-regulation in relation to the quality of clinical practice. The most significant changes in regulation of physiotherapists have occurred over the last 10 years following the introduction of the Health Practitioners Competence Assurance Act 2003. This generic piece of legislation, affecting all registered health professionals, places emphasis on: disciplinary processes, defining scopes of practice, and the need for continuing competence assurance. It also provides an enabling regulatory framework that could be used to develop a changing health workforce that adapts to the communities changing needs.

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INTRODUCTION

Regulation of the profession of physiotherapy in New Zealand commenced in 1920 with the introduction of the Masseurs Registration act 1920. The regulation component was small with most of the focus of this act being on registering appropriately trained professionals. These registration requirements continued in successive acts affecting the physiotherapy profession. The 1920 Act was replaced in 1949 by the Physiotherapy Act and this was replaced in 2003 by legislation that regulated 19 professional groups under the Health Practitioners Competency Assurance Act (HPCA Act).

HISTORY OF PHYSIOTHERAPY REGULATION

Nearly 100 years ago the first practitioners of our profession in New Zealand were invited, by a newspaper advertisement, to apply for registration under the Masseurs Registration Act of 1920. The framework for this first piece of legislation was based on the Medical Practitioners Act of 1867. The document had been to parliament several times since 1912 but it was reported in Kai Tiaki (1921) to have been 'set aside due to more urgent legislation related to the war'. This new act required masseurs working in public health environments: to be registered, to be competent either from experience, by virtue of training, or by passing an examination that followed 12 month training, and to 'be of good character and repute'(section 6 (1) Masseurs Registration Act 1920) . Applicants were not eligible for registration if they had been convicted of an offence punishable by imprisonment. The legislation deemed it an offence to wrongfully procure registration and to mislead the public if not registered as a masseuse. These legislative requirements are still reflected in our current legislation. In 1921 the newly formed Masseurs Board had the authority to approve training institutes and the Otago School of Massage was the preferred qualification (Masseurs Board 1920). The Masseurs Board considered approaches from other institutes wishing to provide training, amongst these were requests from Auckland Hospital; however this request was not supported by the Medical Superintendent of the hospital (Masseurs Board 1921). Another unsuccessful request to provide masseur training came from the Blind Institution (Masseurs Board 1924).

In 1935 an amendment to the Act extended the minimum training requirements from 12 months to 21 months and permitted nurses, who had completed a relevant training additional to their nursing qualification, to practise actinotherapy. The amended Act defined actinotherapy as the external application of infrared and ultraviolet irradiation.

The Masseurs Registration Act 1920 was replaced by The Physiotherapy Act in 1949 and administration of the Act was delegated to the Physiotherapy Board. Changes in this Act required physiotherapists to: hold an annual practising certificate (they could be fined for practising without one) and to notify a change of address within 3 months. This is a requirement of our current legislation. In 1953 the requirement to be licensed to use ultrasound was added. Registrants under the 1949 Act received a badge as well as their registration certificate and were required to be 21 years of age before being eligible to practise.

The 1949 Act also introduced a fitness to practise clause relevant to physiotherapists who had been admitted to a mental institution. These physiotherapists were required to obtain Board approval before returning to practise. The 1949 Act also increased the Boards authority from approving the training institutes to prescribing the subject matter for exams and regulating the number of persons that might be trained at any time. The Board was able to remove people from the register (as in the previous Act) suspend registration and fine practitioners up to 50 pounds.

The Board's role in approving qualifications and training institutes continued to be utilised as changes to physiotherapy education took place. These included the abolition of the state exam, the introduction of a new training school at Auckland Institute of Technology, the diploma qualification, and then the extension from a three year degree course to a four year degree programme. The completion of the entry level competencies for physiotherapists in 1999 was a significant piece of work that provided the profession, curriculum developers, and employers, with a benchmark for knowledge skills and attributes of a safe and effective entry level physiotherapist. It also mandated a science base to physiotherapy as a core principle and as such

Figure: A Masseur's Registration Act 1920 certificate (Acknowledgements: The Thompson family)

NEW ZEALAND

The Masseurs Registration Act. 1920.

This is to Certify that Edith Jane Thompson

other branches of physio therapy

In Witness whereof this Certificate has been awarded

Section 6 (1) of the Masseurs Registration Act 1920

Registered No 257.

Signature of Holder

added to the assurance the public might have in practitioners. Similarly, the introduction of the four year course required curricula and students to manifest an understanding of research methodology.

CURRENT LEGISLATION

The HPCA Act 2003 introduced additional requirements for physiotherapists and delegated greater authority to the responsible authorities enforcing the legislation, in our case the Physiotherapy Board. The HPCA Act replaced all profession specific acts and brought 19 professional groups under one piece of legislation. This move was aimed at getting consistent accountability across professions. The new Act introduced the need to assure the public of continuing competence and fitness to practise, the need for health practitioners to be registered under a scope of practice, the ability for a professional group to have more than one scope of practice, and provided an updated discipline and complaints procedure. The one piece of legislation for all health professionals provides a pathway for new professional groups to be brought under the Act in the interest of public safety. The principle at the core of the Act was to protect the health and safety of members of the public.

The HPCA Act defined a more prescriptive complaints process for all the professions regulated under the Act. The role of the Health and Disability Commissioner (HDC) was expanded to provide a single point of contact for all complaints related to a practitioner's practice (Godbold 2008). Under the Act there was a single charge of professional misconduct. Cases that did not fall within the HDC jurisdiction and cases of criminal conviction were managed by a Board appointed Professional Conduct Committee (PCC). A single disciplinary tribunal was introduced, the Health Practitioner Disciplinary Tribunal. This tribunal heard cases referred by the HDC or a PCC. The aim of this tribunal was to get greater consistency of processes, a common threshold for triggering complaints and consistent penalties across the professions. The Board now had the authority to cancel, suspend or add conditions to a practitioner's registration and scope of practice, and also to censure, counsel, fine, and charge costs.

When the HPCA Act was first introduced, there were rumblings of concern from health professionals about their legal obligation under section 34(1) of the Act. This required health practitioners to report a colleague if they believed they might pose a risk of harm to the public by practising below the required standard. This expectation was interpreted by some health professionals as 'dobbing in' a colleague. Prior to this, the culture of professionalism deemed it unethical to disparage another health professionals practice. As Paterson (2012) points out in his book *The Good Doctor,* it is often colleagues that recognise questionable health professional performance and so they have a duty of care to the public to report the practice rather than a loyalty to a colleague. The new Act broadened the scope of how a Board could respond to clinician concerns. This included the ability to review practice, seek information from any source, and provide support to a clinician if appropriate.

The ability to prescribe scopes of practice has given the responsible authority the opportunity to develop different aspects of physiotherapy practice such as the newly prescribed physiotherapy specialist. The Physiotherapy Board is now in a position to explore the possibilities of extended scope practitioners. In the past, the Acts had defined what a physiotherapist did by their training content (Masseurs Act 1920) and a description of techniques that were part of a physiotherapist's practice (Physiotherapy Act 1949). The definition of physiotherapy developed under the new HPCA Act has been kept broad to allow for an evolving scope of physiotherapy practice.

The Physiotherapy Board (PB) welcomed the inclusion of competence assurance in the legislation and felt this was critical to its public protection role (PB 2002).The board had previously petitioned successive governments on the lack of direction for regulators in relation to on-going competence (PB 2003). Prior to the HPCA Act, the Board could only apply the competencies to practitioners seeking registration. The Board introduced a recertification programme around activities that supported the principle of lifelong learning. This programme was based on the findings from a survey of New Zealand physiotherapists about their current levels of continuing professional development (PB 2004). The challenge was to design a system that was not too demanding on the clinician but still able to give reassurance to the public. This new programme was met with concerns from some of the profession who felt the requirements could have a negative effect on the workforce; particularly the part time and older clinicians who may choose to exit the profession rather than meet these additional requirements (Armour 2006). The recertification programme aimed to show that practitioners: kept up to date with developments in their field of practice, did not isolate themselves in their practice, continued increasing their knowledge throughout their career, and that the programme would be relevant to the individual's practice (PB 2004). Peer review was more recently included in the recertification programme.

THE FUTURE

In 1921, one hundred clinicians were registered in the first year of registration. At the turn of the century 2,491 annual

practising certificates were granted in that year and now in January 2013 there are currently 4,199 physiotherapists with Annual Practising Certificates. The Physiotherapy Board is charged with the responsibility of public assurance that the public are not at risk of harm from practising physiotherapists. Ron Paterson (2012) the former Health and Disability Commissioner, states that despite the HPCA Act the continuing competence of doctors is not assured. The question needs to also be asked of physiotherapists. Do the mechanisms the Physiotherapy Board now has in place provide reassurance of continuing competence? There is a need to balance the demands on health professionals with the risks of harm and the challenge of measuring on going competence. While continuing professional development programmes have been introduced by some international regulatory authorities and many New Zealand responsible authorities, there is little agreement as to how to determine on going competence in a cost effective but meaningful way that relates to the level of risk of harm. This continues to be an aspect of regulation that is widely debated in the literature (Health Professionals Council 2008). There are 40 countries where physiotherapists are regulated in some manner (Grant 2008). There is an International Network of Physiotherapy Regulators Authorities (INPTRA) who meet, discuss, and compare programmes. There is a growing body of literature related to regulation from the Council for Healthcare Regulatory excellence, Health and Care Professions Council and Australian Health Practitioner Regulation Agency as well as the opportunities to benchmark programmes and outcomes with health Boards under the HPCA Act. The Physiotherapy Board of New Zealand has already contributed to the growing international shared experiences of regulation at INPTRA forums and will this year add the formal evaluation of its recertification programme to that body of knowledge. The Board needs to continue to monitor the level of harm caused by physiotherapists to determine the answer to public reassurance. Evidence of harm is provided by Accident Corporation Commission (ACC) treatment injury data when there has been a claim made by a patient. The board is notified of adverse outcomes that are reported to the HDC and the profession expects Physiotherapists to declare any adverse outcomes to their professional body. Treatment injuries accepted by ACC and attributed to physiotherapists have averaged 55 per year over the past 6 years. Five of these cases caused serious harm and a further nine required treatment by secondary services. The most common injuries caused by Physiotherapy interventions were skin reactions and exercise injuries (Taylor 2012).

The focus on public protection is linked with the responsibility towards the health of the public and this aspect is particularly linked to development of a physiotherapy workforce that meets the public's needs. The Board holds workforce data necessary to assist with planning workforce needs of the future. There are some limitations in these data as the holding of a current APC does not always correlate with the number of Physiotherapists actually practising in New Zealand as practitioners may leave the country during that APC year. The Board will continue to develop useful data that supports workforce planning and looks forward to working collaboratively with all responsible authorities to develop a workforce that keeps pace with the communities changing needs. As our profession is evolving so are other professions and their growth may be into aspects of practice traditionally associated with physiotherapy. While this will have some perceived benefit to the public, it raises some concerns as to how physiotherapy regulators ensure a standard of practice in non-physiotherapy health professionals. Are the skills being picked up by other health professionals appropriate to their base skills and understanding or should the Physiotherapy Board have oversight of these activities? This same concept needs to be applied to physiotherapists as they develop further skills that may have been the domain of another profession. At present registered physiotherapists are guided by the position statement *Physiotherapists Practising in a defined field of interest* (PB 2011) and the expectation that they will attain competence in a reputable manner. This position gives physiotherapists the responsibility of self-monitoring their training with the introduction of a new skill into practice, but only within the general scope of practice of a physiotherapist. The need for on-going work here should be a collaborative task for the collective responsible authorities of the health professions under the act.

CONCLUSION

Statutory regulation provides a framework for the Board to develop processes to keep the public safe. It limits the practice of physiotherapy to those with appropriate qualifications who are fit to practise and who have maintained their on-going competence. It is not a replacement for personal responsibility of all health practitioners to maintain competence as part of their professionalism. In this dual responsibility of health professionals and regulators to ensure the public are free from harm, there is also the responsibility for the health and wellbeing of the public. The future focus needs to continue to use the regulatory framework to develop a workforce that meets the health needs of the public by developing new scopes of practice, enabling an easy flow of like trained physiotherapist from countries with similar health systems, ensure that learning from any adverse outcome or near miss are disseminated to all physiotherapists/ health professionals and ensuring clinicians do maintain their competence and wellbeing, and reduce the incidence of adverse outcomes for the public.

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