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The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

New Zealand Medical Specialist workforce hits international rock-bottom

The brittleness and vulnerability of the senior medical workforce in DHBs is well known to those close to the clinical frontline in New Zealand. Historically this has largely been due to the challenge of a small geographically isolated country seeking to recruit and retain in a highly competitive international market. But, since 2006, this has been made worse reaching the level of crisis with a series of major improvements to the salaries of salaried specialists in Australia.

With a recognised minimum 'pay gap' on base salaries of at least 35% having emerged, DHBs are highly vulnerable to Australian competition for

a) overseas trained specialists (New Zealand has the highest dependency on overseas trained doctors in the OECD with Australia having the second highest),

b) specialists currently working in New Zealand but prepared, for a range of 'push' and 'pull' factors to consider alternatives, and

c) the high quality and valued registrars we train with the aspiration of them becoming the future DHB specialist workforce. Unlike the rest of the world, New Zealand is not geographically isolate d from the much larger and more competitive Australia.

> New Zealand has had a low ratio of specialists for some time but we have now reached rock bottom.

What's good about 28th out of 28? Even Turkey is doing better!

We know all this. But now we know how we rank internationally and it is not a pretty picture. The Organisation of Economic Cooperation and Development (OECD) is a Paris based organisation whose membership is made up of several relatively economically developed countries. Part of their work is comparative analysis of health systems, including data collection.

Practising Specialists per 1000 population in OECD Countries 2007 (or latest year available)

Greece	(2006) 3.4	Portugal	1.7
Czech Republic	2.9	France	1.7
Switzerland	2.8	Poland	1.7
Sweden	(2006) 2.6	Finland	(2006) 1.6
Iceland	2.3	United States	1.5
Slovakia	(2004) 2.3	Australia	(2006) 1.4
Norway	2.2	Mexico	1.3
Austria	2.2	Denmark	(2006) 1.2
Germany	2.0	Canada	1.1
Belgium	2.0	Korea	1.1
Spain	(2006) 2.0	Ireland	1.1
Luxemburg	2.0	Netherlands	1.0
Hungary	2.0	Turkey	1.0
United Kingdom	1.8	New Zealand	0.8
OECD Average	**1.8**		

Source: Health at a Glance, OECD 2009

One of their surveys covered medical specialist workforces in 28 member countries. It provides a sober message about our high level of secondary and tertiary care specialist shortages in DHBs. The OECD survey revealed that of the 28 countries surveyed in 2007 (2006 data is used in some instances) New Zealand has the lowest ratio of specialists to population (see accompanying box). New Zealand has had a low ratio of specialists for some time but we have now reached rock bottom.

While the OECD average is 1.8 specialists per 1,000 people, New Zealand is a pathetic 0.8%. Our

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strongest competitor for specialists is Australia which is at a much better 1.4. Even a poor country like Turkey is doing better. Three years later it is unlikely that anything has changed particularly as there has been a levelling out of specialist numbers in New Zealand and Australia's improved competitiveness has made greater inroads. Our ranking may not have changed (impossible to drop lower) while we may have moved a greater distance from the statistical OECD average.

> The accessibility, range and quality of patient services are being held together by an overworked and over-stretched medical workforce.

There will be variations in how these statistics are collected in each of the 28 surveyed countries, the OECD is a sophisticated organisation able to ensure as much as possible that apples are being compared with apples. Variations do not explain 28th out of 28. The fact that New Zealand is a small country does not justify our rock bottom rating. For example, Switzerland is 3rd; Sweden is 4th; Iceland 5th; and Austria 8th.

Confirming what we already know; unsustainable situation!

These damming international statistics confirm what we already know from our own practical experience of the effects of serious senior doctor shortages.

The accessibility, range and quality of patient services are being held together by an overworked and over-stretched medical workforce.

Given this state of affairs it is extraordinary that New Zealand's public health system is performing so well (as recognised by the international Commonwealth Fund data). This is a tremendous complement to the high performance and productivity of senior doctors, nurses and other health professionals. But so much of this depends on the exploitation of our senior doctors. This is unsustainable. Without remedy the system may eventually collapse, the phenomenon that risks following an unaddressed protracted crisis.

There are a number of measures needed to address this. They include improving models of care, utilising the enormous potential benefits of clinical leadership at all levels in DHBs, defrocking the managerial priests and appendages of the culture of managerialism that still sadly influence DHB decision-making, and enhancing senior doctor job satisfaction.

But, as essential as these are, competitive salaries and other terms of employment are also critical. In fact, they are indispensable.

> Until we can compete with our closest neighbour on salaries we are going to remain rock bottom in comparisons with specialist workforces of similar countries

Until we can compete with our closest neighbour on salaries we are going to remain rock bottom in comparisons with specialist workforces of similar countries leaving these other measures ineffective on their own.

The ASMS is looking to the new MECA negotiations to provide a pathway to addressing this key issue and, in doing so, taking New Zealand to a position of international respectability rather than embarrassment.

Ian Powell
Executive Director

President's Column

Cognitive Fluency – not so simple truths

Did you attend the ASMS Conference last December? What did you bring back to share with your colleagues? What difference have you made to their working lives?

Did you cover for your colleagues when they went to the Conference? What did they bring back to share with you? What difference have they made to your working life?

Have your hospital corridors reverberated with challenging arguments for and against Don Matheson's thesis that the New Zealand health system is cheap and provides great value for the money invested? That compared with overseas systems, we achieve better health outcomes for our population with fewer doctors and for fewer dollars.

Does your staff common room (of course you have one, don't you) rattle with debate over Des Gorman's vision of the future shape of the health workforce? About how radically differently this workforce will need to be, and how radically differently it will need to be trained.

Do you engage your managerial collaborators in earnest conversations about ensuring integration and shared trust being the name of the game in EOIs? About avoiding cost shifting, contracting out, dumping, devolving by, to, at, from primary or secondary care. About distributing expertise and boundary-less care rather than building empires and fiefdoms.

Are you haggling about rationing while ducking for the cover of what your patient needs? Balancing the rewards of the fascinating, rare, front-page and expensive with advocacy for the common, unsexy, long-feedback endeavours? Owning leadership of the debate for the reformation of our health and funding priorities?

From conference unto clinic

Translating the energy and fervour of any gathering into the language of our everyday conversations will always be challenging. The messages get muddled, if not mashed. The themes get tangled, if not twisted. Especially for those not imbued with the imprinting of the interactions between speakers and audience. Cognitive fluency is challenged.

The messages we trust are the familiar and repeated. We accept more readily our prior beliefs, especially if told in clichés or rhyme. We expend less mental energy when the arguments sound like those we have heard before. We reserve our brain space for analysing the unfamiliar and weird, yet trust it less. Evolutionary common sense is to allow common experience to skate under the surface of intense concentration – if it is familiar it hasn't eaten us. Lobbyists and marketeers know this and construct messages of hope or despair in soundbites of superficial sensibility, in appeals to and uses of cognitive fluency.

But the really tough questions, the ones we really need to grapple with, require deep thought. And deep thought is prompted by cognitive disfluency. When the question or message is not couched in rhyme or easy reason. When we have to re-read it and struggle with its construction. Then we truly pause, even stop in our clinical tracks, and look with fresh eyes at the meaning of what we ask of ourselves and those around us.

Tough answers

Are we, as medical specialists, the proprietors of our craft groups? Proprietors of our institutions, of our regional networks, of our national health system, of our patients and populations?

Can we, as a union of senior doctors and dentists, claim primacy for our roles in our health system compared with RMOs and the RDA? Primacy compared with nurses and the NZNO, compared with allied health and the PSA, with managers and DHBNZ, with DHB Boards, with PHO Boards, with the Ministry, with the Minister, with patient advocacy groups, with the media, with the Colleges, with the Health and Disability Commissioner?

Should we, as mature health professionals, be the best proponents of virtuous rationing? Are we the best promoters and catalysts of innovation and change? Does our fight for improved pay and conditions set us up as the best protagonists for patient care or are our efforts labelling us as antagonists? Are we seen as professional and not profligate?

If the answers roll easily off your intellectual tongue, beware the trap of cognitive fluency. What is really difficult is the disfluency of the implications and the realisation of the answers. The unease and dis-ease of diverse responses. In what they imply for you as an individual and your Association as a collective in our actions and advocacy. Especially when many of you feel you have heard it all before. Feel you are suffering the fatigue of familiarity. Maybe asking how many sea changes can be flooded into in one clinical lifetime?

And just want to return to what you trained to do – the clinical stuff. Rather than struggle with leadership of our complex dynamic chaotic system. Or truly train yourself to train the future, and different, workforce.

So I leave you with one final question.

What am I doing in this corner of your universe?

Jeff Brown
President

Assistant Executive Director

Devolution or integration? Secondary services and primary care

The government is trying to deliver on its election promise to devolve services from secondary care to primary care ("at no charge") including establishing 'Integrated Family Health Centres' (IFHCs). The initial plan was to give $6.5 million to DHBs to advance this policy. In late 2009 that money was instead used for a process called 'expressions of interest' where primary care providers put forward proposals to establish IFHCs or to devolve secondary services from DHBs to primary care. There were around 70 applications. Nine of these 'expressions of interest' were successful and obtained funding to proceed on to the development of business cases. These business cases have now been received by the Ministry of Health and are going through an assessment process. A final decision on the business cases will be made by the Director-General of Health probably in April.

Nine successful applicants

The nine successful applicants were announced by Health Minister Tony Ryall on 4 November last year. He described them in the following words:

Canterbury Clinical Network – A consortium of PHC providers covering half a million people. The proposal focuses on evolving general practice into IFHCs, developing the wider team of primary health care professionals and improving cooperation between primary and secondary care.

Greater Auckland Integrated Health Network - A consortium of 274 general practice teams, 11 PHOs and 3 DHBs delivering primary health care to a million Aucklanders. The consortium is committed to working together to achieve better health outcomes, better patient experience and better use of money, establishing up to 12 IFHCs over the next three years.

Health+ Alliance PHO – Three Pacific PHOs providing primary care services at 17 clinics. The proposal highlights new opportunities for Pacific primary care to better coordinate its services and workforce regionally and to build critical mass for the Pacific sector, including three IFHCs.

Kawerau PHO – All three PHOs in the Eastern Bay of Plenty, merging into one PHO. They propose one Integrated Family Health Centre in Whakatane within the next three years and two smaller Whanau Ora Centres in Opotiki and Kawerau.

MidCentral PHOs – All four MidCentral PHOs (Otaki, Horowhenua, Manawatu and Tararua). They propose five Integrated Family Health Centres (IFHCs), collaboration across health and social organisations, mainstream and Iwi providers, more clinical leadership, management of long term conditions, focus on care of the elderly, care of the young and care of those with mental health issues.

Midland Network – 11 providers from Taranaki, Waikato, Tairawhiti and Lakes districts which cover an enrolled regional population of around half a million people. The proposal identifies consolidating $66 million worth of services that are currently purchased and managed by four of the Midland region's DHBs and their provider arms that could be devolved into the community. Also developing 9 IFHCs.

National Maori PHO Coalition – 11 PHOs from around the North Island. The proposal aims to devolve services and government-held resources to Maori communities. The Coalition aims to develop a national network of Whānau Ora models of care including IFHCs, new care pathways, health and social service integration.

Wairarapa Community PHO – A partnership of Wairarapa organisations, including the seven GP practices, the primary health care nurses group, Wairarapa Hospital clinicians and iwi providers. It is clinically led, and aims to establish the Wairarapa Integrated Family Health Model of care as an integrated health system for Wairarapa people.

West Coast PHO – The proposal is centred around Integrated Family Health Centres, workforce retention and devolution of suitable hospital based/DHB owned services. The proposal aims to build on existing initiatives including: nurse-led clinics; the PHO Long Term Conditions programme; rural/generalist and rural imersion programmes for Doctors; Clinical and Rural Nurse Specialists

The full 'expressions of interest' are now available on the Ministry of Health website **http://www.moh.govt.nz/moh.nsf/indexmh/phcs-bsmc.** On the whole the documents are highly aspirational and characterised by a marked lack of specificity probably inevitable given a very short time frame for development and the fact that most were developed without engagement with the affected DHBs.

Engaging with clinicians

Few if any secondary care clinicians appear to have been involved in the development of the original expressions of interest which were developed at a breakneck speed. The original time table, which was to develop the business cases (the next stage) by 14 February would not have allowed for any such engagement. Health Minister Tony Ryall was approached on this issue at the ASMS Annual Conference last year and agreed to some modification of the time table so that secondary

care clinicians could be involved. However, this small extension of a fortnight still meant the the amount of time available and the time of the yea ('summer shut-down') that genuine effective engagement was precluded except where it had occurred in the development of the original 'expression of interest'.

The guidelines for the development of the business cases were also very clear that a successful business case would be required to demonstrate engagement with secondary care clinicians. Some of the business cases assert such engagement. However unless these have built on an existing structure of engagement it is difficult to see how such engagement can have occurred in the time frame particularly in the more ambitious proposals.

Clearly some clinicians have been involved but in the main most were not with descriptions of presentations taking place without rescheduling of clinical work; engagement with clinical directors only; or the impossibility of getting a clear picture of what effect a proposal might have because it was so vague. As well there have been some proposals which should not have sign off from DHBs without them going through the MECA consultation process.

The approach taken by the ASMS in these and other discussions is that there should be three key thresholds – clinical appropriateness; fiscal sustainability; and the avoiding of fragmentation and disintegration and its consequences (for example on teaching).

The ASMS has also raised more general concerns in reference to:

- Confusion over what new developments in general practice can be charged to patients and what can't (things arising out of the evolving nature of general practice can be charged to patients but things arising out of this political initiative can't).
- Possible budget-holding thereby given more entrepreneur primary care business interests fiscal leverage over the DHB (including where DHBs lose funding but retain costs).

The business cases

Though the business cases are not publicly available ASMS has been able to obtain some information about them. Some of the business cases differ in their thrust from the original expressions of interest. In general they bear little resemblance to what one would normally expect of a business case lacking specificity and financial rigour. They are essentially scoping in nature.

Some specialists have been involved in the Canterbury, Wairarapa and MidCentral business case development. In Canterbury they report that the business case seems to be a continuation of the already well developed Canterbury initiative where primary and secondary care are becoming more integrated with a focus on making the patients experience better. The Wairarapa proposal also appears to have good buy in from secondary care clinicians as the continuation of an already existing programme of integration. The MidCentral initiative has been described as 'exciting'.

The Midland or Pinnacle 'expression of interest' affecting Lakes, Waikato, Tairawhiti and Taranaki DHBs has been viewed with some suspicion as it proposed the devolution of $66 million of present DHB secondary care budgets (largely mental health) to primary care. However, the business case, we are assured, does not continue down this path but, despite some very interesting (and costly) ideas, it does not appear to specify where the money is coming from. It is significant that the financial analysis justifying the business case was only about two pages, was only received by the four DHBs a few days before the business case had to be submitted to the Ministry of Health, and was regarded by experienced DHB managers as weak.

The Greater Auckland Integrated Health Network (GAIHN) affects the Waitemata, Auckland and Counties Manukau DHBs. It involves the largest numbers with over one million enrolled patients. This is bigger than any single DHB. It is almost impossible to conceive how there can have been genuine engagement with the hundreds of senior doctors in secondary care whose work may be affected by this proposal and who have ideas and proposals them selves for the better integration of primary and secondary care. Apparently this business case no longer includes setting up IFHCS. As with the Midland/Pinnacle business case the financial analysis behind the aspirations was only received by the three DHBs a few days before the business case had to be submitted. Again it meant there could not be the appropriate financial scrutiny one would normally expect of a business case.

The 'expression of interest' for the GAIHN proposal includes a proposal for the devolution of some diagnostic radiology to primary care. This proposal has very many fishhooks and has caused some disquiet among radiologists at the three DHBs. It would have considerable potential to de-stabilise both the DHBs' radiology services and the clinical services that they support.

The West Coast business case, despite assurances from the DHB Chief Executive that it would make clear that there had not been time for genuine engagement with secondary care clinicians, asserts engagement with SMOs, proposes the replacement of the DHB with the PHO or another trust as employers of GPs currently employed by the DHB and asserts presentations to primary care GPs (who are DHB employees) in between patients was engagement.

The concern for the ASMS must be where commissioning or devolution of secondary care away from the DHBs has the effect of providing poor or lesser quality care to the public, decreasing the standard of care for services remaining in the public hospital or leads to the privatisation of care. We also need to be concerned about potential effects on members' job descriptions and terms and conditions of employment.

Angela Bellich

Assistant Executive Director

Historic ASMS–IPAC agreement paves way for enhancing primary/secondary interface

The ASMS and IPAC (Independent Practitioners Association Council - the organisation of primary care networks and general practice teams) have since the 1990s had an uneasy and distant relationship characterised by wariness. IPAC's membership comprises of organisations rather than individuals and includes most IPAs (Waikato based Pinnacle being the main exception) and some Primary Health Organisations (PHOs). Subsequently IPAC has rebranded itself as 'General Practice New Zealand'.

"Independent, multidisciplinary and pluralist ethics committees should be established, promoted and supported at the appropriate level in order to provide advice on ethical problems

From the ASMS standpoint the 1990s was a time when, in an ideological commercial era, some more entrepreneurial IPAs were promoting primary care control of secondary care financial budgets (sometimes called fund-holding) taking the lead from GP fund-holding initiatives in England at that time. Although it never materialised in New Zealand (but was controversial in England) we were concerned about the de-stabilising and fragmentary effect this would have on secondary services along with the risk of patient needs being shaped by profit motives.

However, that was the 1990s, a decade in health policy that has little to recommend it. The subsequent nine years saw the emergence of Primary Health Organisations (PHOs), which had more of a community thrust and were not-for-profit, with much variation in size and activity. PHOs themselves proved to be a mixed picture of performance; some very good and innovative while others being little more than a new link in the paymaster chain between central government and GPs. But, regardless of the performance of PHOs, this post-commercial era inevitably encouraged IPAs (and IPAC) to rethink their role in the health system.

Much water has subsequently passed under the bridge between the ASMS and IPAC. For example, fund-holding of secondary care services is no longer seen as the panacea it once was in some ideological quarters (despite some moments of fantasy and the lure of a bit of 'dosh'). It is interesting to look abroad. In England, the original home of GP fund-holding, the so-called NHS Czar of primary-secondary integration has acknowledged that the much touted practice based commissioning is now dead because of lack of interest by general practice, largely on practicality grounds.

"Independent, multidisciplinary and pluralist ethics committees should be established, promoted and supported at the appropriate level in order to provide advice on ethical problems

Late last year the ASMS received an informal approach from IPAC for dialogue to which we responded with a mix of curiosity and enthusiasm. Direct discussions quickly led to the realisation that in fact we had much more in common than we previously thought and that there were powerful reasons to establish a close collaborative relationship. What we both thought the other was coming from proved to be either incorrect or at least not fully understood. We both learnt that the things that united us were far greater than those (whatever they were) that divided us.

As the starting point and scene setter the following joint statement from ASMS and IPAC was released in February (see box).

ASMS-IPAC joint statement

IPAC and ASMS jointly affirm:

a) The necessity for all professionals across the spectrum of patient care to work together in the interests of individual patients.

b) The necessity for all professionals across the spectrum of care to work together for groups of patients, to design systems and pathways that bridge home to health centre to hospital care.

c) The necessity for all organisations representing professionals working together to transform the system, to provide equitable access to health care, in the best place at the best time by the best individuals and teams.

In jointly affirming these necessities, IPAC and ASMS will work together to promote clinical leadership and governance throughout the New Zealand health system such as shared access and shared initiatives between primary and secondary care.

The essence of the statement is a commitment to promoting improved coordination and integration across the spectrum of care based on clinical leadership and clinical governance along with shared access and initiatives. The focus is on collaboration rather than power relationships and fiscal levers. Although it is only a small part of what the joint statement covers, both the ASMS and IPAC hope that it helped shape and guide approaches in the business case development in several DHBs of the 'expressions of interest' primary care providers process currently underway.

There are tremendous gains to be made in the accessibility, effectiveness and quality of care for patients by closer collaboration and coordination between primary and secondary care. The prevalent colour in the health system is grey, not black or white. Of necessity health systems are characterised by both simple values and organisational complexity. Integration and coordination are essential in working through grey complexity while adhering to the system's values. Both the ASMS and IPAC believe that the agreement reached between them will help shape and facilitate this, as well as being a foundation for further collaborative work.

Ian Powell
Exeecutive Director

New Administration Officer Terry Creighton joins the ASMS team

Terry Creighton has been appointed as Administration Officer following the resignation of Jo Jourdain who is soon to be married and settle in Christchurch. Terry has had a varied career working primarily in banking and finance roles and has an extensive background in office administration and customer service. For the past ten years he worked as a loan manager at Prometheus Finance, a small ethical finance company in Napier.

Colleges issue warning caution on physician assistants pilot

The Council of Medical Colleges has written to Professor Des Gorman, Chair of Health Workforce Board, a committee of the new National Health Board which in turn is a business unit of the Ministry of Health. The CMC's letter (4 March) follows a meeting with Professor Gorman on the physician assistants pilot in Counties Manukau, expected to be followed by other pilots in the northern region. The letter is reprinted below with the approval of the CMC

Dear Professor Gorman,

Thank you for your presentation to the Council of Medical Colleges (CMC) on Friday 19th February 2010.

The Colleges were particularly interested in the discussion around Physicians Assistants and the pilot being undertaken at Middlemore Hospital.

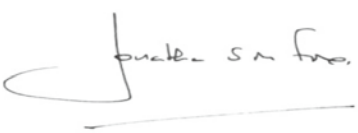
I use the word pilot because that is how it is described in the briefing papers the Colleges received. We note however that you referred to it not as a pilot but as a demonstration project. Calling it a demonstration project implies that this is the start of a national implementation programme.

All members of CMC recognise the need to enhance and support the current limited health workforce in New Zealand and are open to exploring new solutions.

The Council of Medical Colleges wish to express a major concern on behalf of all the Colleges. This is the potential flow on effect on the training and clinical experience for our medical students, junior doctors and their teachers - our senior doctors, if some of their current scope is removed.

There is a critical need for this pilot to be rigorously evaluated. The evaluation should incorporate an analysis of the impact on medical student training, experience and supervision. Patient safety should also be considered in evaluation. This evaluation should be subject to peer review and involve comment from all Colleges. CMC would welcome the opportunity to coordinate such comment. We look forward to being kept fully informed of the progress of this initiative.

Yours sincerely



Dr Jonathan E M Fox
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Chair

The case for ethical networks in DHBs

The article below is by Dr Al Macdonald, renal physician at Capital & Coast and former ASMS National Executive member. He also gave a presentation on this subject to the ASMS Annual Conference last December. Dr Macdonald has been thinking through how to improve the focus and effectiveness of ethics processes for some time including a recent sabbatical programme.

I was first paid to wield a stethoscope in 1968. Since then I've witnessed the evolution of decision making on ethical issues in the context of an individual patient from an authoritarian, albeit paternalistic, approach to one which is more inclusive and emphasises patient autonomy. In a similar fashion patient management is now as likely to reflect decisions made by multidisciplinary teams as those made by individuals.

Within the multidisciplinary team there may be divergent views upon various aspects of treatment and it is imperative for all members of the team to feel empowered to voice their opinions. Although it is preferable to be able to resolve issues within the context of the healthcare team, if such resolution is not easily achievable amongst the possible ways that resolution might occur is by referral to a Clinical Ethics Advisory Group (CEAG).

Overseas, the establishment of CEAGs has occurred in a wide variety of ways. In some countries the establishment has occurred as the result of legislation. In the United States, the accreditation process has reached the point where it is now a requirement for hospitals in many states to have a clinical ethics committee in order to be registered as a health facility. In other countries the formation of CEAGs has been on the basis of interested professionals forming ad hoc committees to address local ethical problems. In countries adopting the latter approach, the achievement of a critical mass of CEAGs leads to the development of shared expertise and in the case of the United Kingdom, the development of a national clinical ethics network in 2001. To date about 80 out of 260 NHS Trusts have CEAGs.

In New Zealand it is unclear how many clinical ethics committees there are. There is no formal network and in this sense we lag behind other countries. This should not be seen as a disadvantage however because it allows us to look overseas and see what we can learn and then see if the development of a New Zealand clinical ethics network has some merit.

In making a case for the development of a New Zealand national clinical ethics network it is worthwhile reflecting upon the UNESCO Universal Declaration on Bioethics and Human Rights 2005. Amongst the recommendations made were that:

"Independent, multidisciplinary and pluralist ethics committees should be established, promoted and supported at the appropriate level in order to provide advice on ethical problems in clinical settings…to foster debate, education and public awareness of, and engagement in, bioethics."

"Independent, multidisciplinary and pluralist ethics committees should be established, promoted and supported at the appropriate level in order to provide advice on ethical problems in clinical settings…to foster debate, education and public awareness of, and engagement in, bioethics."

Turning attention to local political influences which underpin the more clinical involvement in the running of our health services, in March 2009 the Minister of Health introduced the document In Good Hands. He indicated that the Government was "serious about re-engaging doctors and nurses in running the front line health services." In his preceding 'Letter of Expectations' to the DHBs, he encouraged the formation of clinical networks in the context of true clinical leadership. He also posed a challenge for us "to stay within the resources".

In April 2009 the Health and Disability Commissioner noted in one of his reports that "It is troubling that nurses, doctors and hospital management can predict problems and identify solutions, but that Chief Executives and Boards can be so slow to respond". He went on to say "this confirms the need to strengthen clinical governance in the New Zealand health system".

Involvement in the area of clinical ethics is a way of fulfilling many of the wishes that are contained in these statements. Having a national clinical ethics network can help the establishment of CEAGs around the country. Different DHBs will develop different CEAGs which will adapt to meet local clinical ethics needs.

In February 2009 I presented a case for a national clinical ethics network to the chief medical officers/advisers of all the DHBs. In December I presented the case in favour of a network to the Annual Conference of ASMS. Subsequent to this I have presented the case to the National Ethics Advisory Committee. In response there has been an expression to give financial support for the formation of a steering group to explore the possibilities of developing a network for New Zealand.

In the early phases of development of CEAGs, the emphasis is likely to be on the development of expertise in case consultation. Of equal importance however is the application of this increasing ethical expertise to examine policies

within DHBs which have a specific ethical component within their purview. Following on from this there should be a commitment for our DHBs to facilitate ethical education amongst all health professionals. Such commitment will enable us to move in a direction that is likely to lead to a more mature debate about the clinical ethics problems that we now face. How else will we address the increasingly complex ethical problems that are likely to face us in the future?

If we do not build this ethical platform now, then we may proceed along the road that leads to the low level, highly emotive and polarised invective that has characterised many recent discussions in the American health care "debate".

Evelyn Waugh said "America is the first society ever to pass from barbarism to decadence without an intervening phase of civilization". We would not want to be the second.

Al Macdonald

Dealing with Coroners

Unexpected deaths demand investigation by a coroner – but what part do doctors play in this? Dr Alan Doris Medical Protection Society explains:

The coronial system performs an important function in investigating the cause and circumstances of unexpected and unexplained deaths. Recognition of strains on the system led to a Law Commission review, published in 2000, and subsequently the Coroners Act 2006, which came into effect on 1 July 2007.

The Act allows for the creation of up to 20 full-time legally-qualified regional coroners, replacing 55 part-time coroners. The creation of the new office of chief coroner seeks to ensure the effectiveness and consistency of coronial services nationally. MPS has noted a significant increase in the number of calls by members seeking assistance in providing evidence to the coroner, which may reflect this changed environment.

In general, only deaths which are unexpected, are of unknown cause or of individuals in official care or custody, or that occur in relation to medical or surgical treatment or appear to be self-inflicted, must be reported to the coroner. The purpose of a coronial inquiry is to formally establish the causes and circumstances of such a death. Recommendations may be made by the coroner to reduce the chances of other deaths in similar circumstances, and to determine whether it is in the public interest for the death to be investigated by other authorities.

If it appears that charges will be laid in relation to a death it is likely that the coroner's inquiry will be postponed until any criminal proceedings have been finally concluded. This can lead to a considerable period of time between death and the coroner's inquiry. Investigations by other authorities, such as the Health and Disability Commissioner (HDC), may wait until a coroner's inquiry is concluded before carrying out their investigation, or alternatively may precede a coroner's inquiry.

The coroner will often seek evidence from health professionals involved with the deceased before death, in addition to information from a post-mortem examination. The coroner may also seek independent expert advice in areas requiring particular technical knowledge.

After notification of death, information is usually requested from a doctor by a police inquest officer, either verbally or written. As the police may also be investigating the death for other reasons, it is important to establish that the purpose of the officer's request is to provide evidence to the coroner. MPS recommends that members ask for requests from the police to be in writing, and that any statement given to the police is written and in a format appropriate for the coroner.

A report for the coroner must be clear, comprehensive, accurate and answer any specific questions asked. It is an offence – punishable by summary conviction and a fine of up to $1,000 – for a statement to contain false or misleading information, or to knowingly or recklessly omit information. Getting it right in the report is crucial to assist the investigative process and MPS can assist members in doing what, for most members, will be an unfamiliar task.

While a coroner has the power to make findings based on written information alone, an inquiry may progress to an inquest, which is an examination of the evidence held in public in the coroner's court. Most doctors prefer not to have to appear in person at an inquest and providing a good written report increases the chances of achieving this.

An inquest is an inquisitorial rather than adversarial process with the aim of establishing facts. Although the purpose of an inquest is not to determine liability for death, it can be a daunting, unfamiliar and stressful experience.

Parties at an inquest may include the bereaved family, hospital or other service providers, as well as individual clinicians. All may have legal representation and be cross-examined on

their evidence. This can be an opportunity for a family and the coroner, who will be cognisant of the family's concerns, to seek answers to questions directly from the deceased's healthcare providers, so it is important to be prepared for what can be a very challenging situation.

It is usually possible to anticipate questions or issues that will arise during cross-examination. Thinking about these in advance of the inquest and discussing them with a colleague is advisable. MPS can instruct a barrister to represent members at an inquest and to assist in preparing the member to give evidence and be cross-examined. An inquest is a thorough process and can last for a period of time ranging from hours to weeks, depending on the issues and number of witnesses involved.

During an inquiry, or at its conclusion, a coroner may make adverse comment on the conduct of a doctor involved in the care of a deceased patient. In all such cases, the doctor must be given an opportunity to respond to the proposed adverse comment before any final findings are made. Adverse comment can lead to adverse publicity and be picked up by other authorities investigating the circumstances of the death. For example, the HDC or the Medical Council may subsequently refer to evidence provided to a coroner, or the coroner's fwings.

This was the case for an MPS member recently, when a complaint was made to the HDC by a family several weeks after the coroner made critical comments regarding the care of the deceased.* The subsequent investigation considered evidence provided to the coroner at the inquest. Though the HDC investigation did not originally include the member's care, critical comments by an independent expert led to this, and the member was found to be in breach of the Code of Health and Disability Services Consumers' Rights.

For most doctors, the courtroom is an alien environment and giving evidence and being cross-examined on it can be intimidating. The matters under examination are very important for all concerned, and the outcome may have significant consequences for the doctor. At the same time, an inquest that enables a family to have their questions answered can lead to the satisfactory conclusion of a matter. MPS can advise and assist members asked to provide evidence and encourages members to call MPS when information is first sought.

**A report by the Health and Disability Commissioner*

ASMS services to members

As a professional association we promote:

- right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists

ASMS email Broadcast

In addition to *The Specialist* the ASMS also has an email news service, *ASMS Direct.* This is proving to be a very convenient and efficient method of communication with members.

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at *ke@asms.org.nz*

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for around 3000 doctors and dentists, over 90% of this workforce.
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

Other services - *www.asms.org.nz*

Have you visited our regularly updated website? It's an excellent source of collective agreement information and it also publishes the ASMS media statements. We welcome your feedback as it is vital in maintaining the site's professional standard.

Support Service for Doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members an important support service. The support service provides access to a free professional counselling service.

Doctors seeking help can call *0800 225 5677 (0800 Call MPS).* The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling or support The service is completely confidential.

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www.asms.org.nz/system/jobs/job_list.asp

We encourage you to recommend that your head of department and those responsible for advertising vacancies, seriously consider using the facility. Substantial discounts are offered for bulk and continued advertising.

How to contact the ASMS

Phone	04 499-1271
Fax	04 499-4500
Email	asms@asms.org.nz
Web	www.asms.org.nz
Post	PO Box 10763, Wellington
Location	The Bayleys Building Cnr Brandon St & Lambton Quay Wellington

Minister of Health's letter of expectations to District Health Boards

Every year the Minister of Health sends a letter to District health Board Chairs setting out the expectations they have of the Board for the year. This year's letter was sent out around 9 February.

'Future increases in Vote Health smaller than in previous years'

The initial issue that the Minister raises with the DHBs is financial. He states that 'future increases in Vote Health will be smaller than in previous years.' DHBs are expected (not unreasonably) to operate within their approved budgets. What may be unreasonable is pressure to provide services at certain level when it is very clear that budgets are insufficient to fund them. From a good governance point of view it may be better to have planned deficits rather than unplanned deficits consequent on pressure to produce unrealistic balanced budgets.

The letter states clearly that there should be no expectation of top ups. Quite what the consequences would be for a board which is heading for a greater deficit than agreed is unclear. Probably if a board overspends outside of a sanctioned deficit then it would be possible for the Minister to sack board members and bring in Commissioners (who would then embark on a programme of cuts). The simple change in governance may not be of huge consequence to clinicians in itself. What it does is enable successive governments to posit the problem as mismanagement by Boards and managers (failure to keep within budget) rather than rationing (we will not provide sufficient money to provide that service).

It is clear already that financial monitoring will be up close and personal with personal meetings with the Minister for financially misbehaving Chairs and Chief Executives. If these have any sense they will attempt to involve senior doctors in these meetings when cuts to services are on the table. Our members will need to advance their financial literacy to act as persuasive patient advocates.

Equity and debt are also to be constrained so the programme of rebuilding of decayed hospitals will, at least, slow. The letter ends with an exhortation to a 'strong focus on productivity and getting the best value for every health dollar.'

Targets: increased surgical volumes each year, reduced waiting times in EDs and cancer treatment

In secondary care the Minister expects elective surgery volumes (including FSAs) to increase every year. DHBs are expected to consider 'sustainable longer-term relationships (with the private sector)' rather than spot purchasing to maintain volumes. ED waiting times are to decrease in line with the 6 hour target. Intervals between cancer diagnosis and treatment are expected to decrease particularly for radiation treatment. This is all very much in line with previously notified targets.

'Services provided in community settings at no cost to patients': Primary Care

In primary care the Minister notes the business cases that resulted from the expressions of interest process but expects even those DHBs not involved to provide 'access to a wide range of services closer to home' which is interpreted as services provided in community settings at no cost to patients. DHBs are expected to work with community and hospital clinicians to provide these services and have to specify them in their District Annual Plans (DAP). The DAP will have already been drafted and should have gone to the Ministry by 9 March as a first draft presumably with this wider range of services in a community setting listed in them. The Minister also expects DHBs to facilitate the consolidation of Primary Health Organisations.

'From the governance level throughout the organisation': Clinical Leadership

The statement here is very strong saying that the expectation is a strengthening of clinical leadership 'from the governance level throughout the organisation'. The Minister also points out the different feedback he is getting from clinicians and management about the extent to which clinical leadership is in place. There appears to be a genuine intent to follow up forcefully with Boards until there is genuine clinical leadership in place.

'Not interested in process but in results'; a unifiedsystem

The Minister also expects accelerated progress on collaboration with 'neighbouring and close' DHBs and expects real gains identified in DAPs including clinical networks and regional service plans. He is 'not interested in process but in results'. Disputes between Boards are to go to the National Health Board. The support so far received from Boards for collective procurement and back office rationalisation is expected to move on to other improvements flowing on from the MRG (Horne) Report such as the work (presumably) of the new Health Quality and Safety Commission.

The letter continues the trajectory that the government has clearly signalled but which may yet be derailed if cuts in new funding make cuts in services inevitable and DHBs have been pressured into making unrealistic budget projections.It is likely that this letter has had additions made for specific DHBs.

Angela Belich
Assistant Executive Director

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