TE PUAWAI

The Blossoming

The Professional Update for Registered Nurses

April 2015

TE PUAWAI

The Blossoming

Whakatauki

Kia tiaho kia puawai te maramatanga

"The illumination and blossoming of enlightenment"

This whakatauki highlights the endeavours of the College of Nurses as an Organisation which professionally seeks enlightenment and advancement.

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College of Nurses Aotearoa (NZ) Inc

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Editorial

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I have just finished another 4 days of class with a group of primary health care nurses doing postgraduate education. As always I am left somewhat overwhelmed by the palpable frustration expressed about their inability to deliver care in the way they can see is needed to meet patient need.

I have long been aware of the tension between the rhetoric espousing the need to respond to the rising demand for PHC services and the seeming reluctance to change the policy and operational drivers, which largely enable the service delivery models to continue unchanged. To a large extent nurses are caught in the crossfire of this tension. They are clearly able to see what they need to do differently and they are continually fobbed off with variations of "you cannot do that as it will not generate any money for the business".

Many of them, prior to postgraduate study, are unaware of the large volumes of tax-payer money which come through the DHB via the PHO to purchase a range of services for patients. This is roughly 70% of the income provided to General Practice. It has always been clear to me from listening to PHC nurses that there is considerable variation in how the money is used in different settings. Different practices utilising the same funding sources demonstrate significant variation in services to patients. Largely this is at the discretion of practice owners and it appears that there is no mechanism for requiring that Government funding be spent in particular ways.

It may be considered that targets are one accountability mechanism. I have, however, heard far too much about the way in which target reporting is handled to feel that there is any genuine, useful or consistent accountability associated with reporting on targets.

The Ministry has made clear that the private business model of General Practice is here to stay from a policy perspective. I have come to wonder if nursing needs to be disconnected from direct employment in that model and that a large proportion of the funding for patient services should in some way be able to support nurses to provide a continuum of care regardless of where patients are receiving services. This would enable nurses to have full autonomy over their practice, allow alignment with community need and foster genuine collaboration and team work between nurses, General Practitioners and other practitioners.

It feels rather extraordinary to be still arguing for this outcome in 2015. The launch of the PHC strategy provided such hope to nursing and our document Investing in Health (MoH, 2003) showed that we knew exactly what needed to happen to deliver on the goals of the strategy. Somewhat daunted by lack of progress in 2007 we came together as a profession and revised the recommendations to the Ministry of Health, PHOs and DHBS in order to release the potential of nursing to meet community and patient need.

After prolonged consultation and deliberation in 2007 we agreed that our pressing goals remained as follows

- The need to address disparities in health and health service delivery
- The need to provide better prevention and management of long term conditions
- The need to deliver effective care and services to children and young people

In order to meet those goals we made the following recommendations

Recommendations

To PHOs

- That all nurses regardless of practice location have access to a nursing leadership structure
- That mechanisms are created to further enable all nurses to have input into policy development and operational management of issues related to quality of care, safety, continuity of care, patient-staff ratios and clinical outcomes
- That processes ensure that nurses are held directly accountable for high quality practice
- That there are differentiated practice levels or roles and differentiated pay scales for nursing congruent with differences in educational preparation, certification, and other advanced nursing preparation
- That organizations utilize clinical nurse specialists, nurse practitioners, nurse researchers and/or educators to support and enhance the work of primary health care nurses in clinical care and to further improve health outcomes
- That nurses have equal participation in clinical decision-making and the organization of clinical care systems.

To Ministry of Health

- That the Ministry of Health expert nursing advisory group on primary health care be urgently reconvened
- That the resource devoted to nursing in the MoH be increased
- That in order to ensure succession planning, a senior nurse advisor position is created to support the Chief Advisor (Nursing)
- That nurse sensitive patient outcome indicators are created, tested and utilised as a basis for funding mechanisms
- That the contract between DHBs and PHOs is carefully reviewed to ensure that nursing services are enabled

and able to be directly and fairly funded.

- That the enrolment process is urgently reviewed to ensure primary health care services are accessible for all.
- That the recent hasty funding formula review is revisited to specifically assess the degree to which the funding formulae support appropriate deployment of nurse services.
- That alternative models of employment of primary health care nurses be actively developed in partnership with the sector

To District Health Boards

- That all DHBs are required to have a Director of Nursing with direct primary health care responsibilities
- That all DHBs are required to support a primary health care nurse development team structure designed to build capacity and guide developments across primary health care nursing services.
- That focused investment in post-graduate education occurs well beyond the current inadequate amount of money moved from the CTA to DHBs for post graduate and post registration nursing education. This will require DHBs to lobby on behalf of nursing.
- That formal funding of graduate places in PHC settings must be made available as a matter of urgency. This will require DHBs to lobby on behalf of nurses in order to achieve DHB goals for a sustainable PHC workforce.
- That the development and implementation of nurse practitioner roles in boundary spanning roles: family nurse practitioners, older person's health and child health are implemented as a priority
- That alternative models of employment of primary health care nurses be actively developed in partnership with the sector

Readers can see that there are some “achieved's” that can be awarded. But if we were to conduct a further revision we might well produce virtually identical recommendations in 2015 and then again in 2020 and probably beyond… Personally this begins to feel pointless and tedious and a gross abrogation of our responsibility to those who are clearly not having their needs for primary health care met.

It has been exciting in the last few weeks to see a growing chorus of disquiet amongst some PHC nurse leaders who recognize the stagnation that is occurring despite no reduction in the rhetoric, the meetings, the earnest documents, and the investment in the status quo. What will we do with this energy and impetus? What are the mechanisms by which we can say clearly that serious change is required? and that it is long overdue and the huge potential inherent in nursing continues to be squandered.

In 1998 we produced a document entitled *Releasing the Potential of Nursing* Ministerial Task Force, (MoH 1998). We saw it as being a long slow evolution towards a better alignment of nursing services with community need. I have now come to the view that evolution has not and will not solve anything. A revolution is needed towards the goal of *investing in health* rather than *investing in the status quo.*

Industry Influence In Health Care & Research: Does It Matter?

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On 24th November 2014 a ground-breaking Cochrane symposium took place at the Faculty of Medical and Health Sciences at the University of Auckland. The symposium was free and was open to the public. The topic was the influence of industry on research agendas' methods and healthcare.

Seven speakers, including Professor Lisa Bero, a world renowned expert on pharmaceutical industry inter-action and influence in medical research, described the impact of the pharmaceutical industry in their various fields.

Professor Bero is a pharmacologist who studies how science is translated into clinical practice and health policy, including the study of how a variety of biases influence the integrity of the research. She described how wide-spread the problems associated with the conflicts of interest in research have become due to industry funding for research and education as well as the growing number of researchers who also have personal financial ties to their sponsors.

Numerous studies over the past decade have provided empirical evidence of bias in research, the effect this has on the subsequent development of guidelines and recommendations, and on purchasing and prescribing decisions. (1) (2) This is compounded by the multiple effects in the research literature.

There are many different ways to bias a clinical trial and the pharmaceutical industry has used and continues to use all of them. They include the research question itself, the population enrolled in the research, the research methods used, how the research is conducted and how it is published. Selective reporting of the studies' results is rife, and negative results are usually buried.

There is however growing interest and investment in changing the system. A Drug Industry Document Archive (DIDA) has been established. (3) It contains internal corporate documents from large pharmaceutical companies including Merck, Parke-Davis, Wyeth, and Pfizer. These documents reveal questionable drug industry practices concerning clinical trials, publication of study results, pricing, marketing, relations with doctors and involvement in continuing medical education.

Industry-independent experts

Two journalists, Shannon Brownlee and Jeanne Lenzer, are also doing their bit for the campaign to restore ethical practices to the research industry. They have compiled a list of more than a hundred independent health care experts to whom reporters can turn. Those on the list state that they do not have financial ties to drug or medical device manufacturers. (4)

Professor Bero ended her presentation with a discussion on the various ways of attempting to manage conflicts of interest – ban them, manage them or disclose them – and provided examples of how effective or ineffective they are. It is obvious that disclosing conflicts of interest is not working that well, and that there is a need to seriously manage them at the very least. As other presenters repeatedly pointed out New Zealand is lagging behind in acknowledging that we have a problem, and putting in place a robust system of dealing with what has become an increasing large can of worms.

Peter Griffin & *ProPublica*

The next speaker was Peter Griffin, founding manager of the *Science Media Centre* and the founder and editor of Sciblogs.co.nz. He also writes about technology for the *NZ Listener.* He talked about *ProPublica*, an independent non-profit newsroom based in New York City that produces investigative journalism in the public interest, and described aspects of the Physician Payment Sunshine Act.

Peter Griffin began by pointing out that in last five years pharmaceutical companies have agreed to pay over $US13 billion in fines to resolve US Department of Justice allegations of fraudulent marketing practices, including the promotion of medicines for uses that were not approved by the FDA. They include:

- Pfizer – $US2.3 billion
- Merck – $US950 million
- GlaxoSmithKline – $US3 billion
- Sanofi-Aventis – $US109 million
- Johnson & Johnson $US2.2 billion
- Eli Lilly – $US1.42 billion
- AstraZeneca – $US520 million
- Abbott – $US1.5 billion
- Boehringer Ingelheim – $US95 million
- Amgen – $US762 million
- Endo – $US192.7 million. (5)

Obamacare

He then outlined the situation in the USA where one of the provisions of the Patient Protection and Affordable Care Act, known as Obamacare, is a mandatory open disclosure system. The Open Payments database by the Centers for Medicare & Medicaid Services (CMS) is a federal public database that was launched on 30 September 2014 with the intention of bringing transparency to financial relationships between doctors and the pharmaceutical industry. It requires all manufacturers of drugs, devices, and biological and medical supplies covered by federal health care programmes to collect and track all financial relationships with doctors and teaching hospitals. The database includes payments for research, gifts, meals, travel, or speaker fees.

The Physician Payment Sunshine Act was first introduced in 2007. It was initially introduced independently and failed, but it then became part of the Patient Protection and Affordable Care Act and was enacted along with that Act. Although there have been some initial technical glitches, and the predictable expressions of outrage from doctors and researchers, the database is now up and running. (6)

Dollars for Docs

ProPublica has also launched another initiative called “Dollars for Docs” in which patients can log in their doctor’s name and get information on the money she or he has received from drug companies. (7) Peter Griffin pointed out the top 300 doctors getting the most industry money were all men.

Then there is PharmaShine, which claims to be the largest data source of its type with information on over six million individual payment trans-actions to more than 700,000 health care professionals. (8)

Why NZ needs a Sunshine Act

Professor Cindy Farquhar, co-chair of the

Cochrane Steering Group, began her presentation with an insightful account of her own history of how she became "pharma-free." She started a trend as subsequent speakers then revealed where they were on the spectrum of being on the take from drug companies, and the reaction from some of their colleagues when they decided to come clean and refuse industry money.

PharmFree Scorecard

Professor Farquhar described how the American Medical Student Association (AMSA) became concerned about how medical students and trainees become indoctrinated into thinking that industry funding, gifts and handouts are the norm. In 2007 AMSA launched the first PharmFree Scorecard for students which evaluated conflict of interest policies and curricula at Academic Medical Centers in the USA and Puerto Rico.

The Scorecard is an evolving tool that "offers a comprehensive look at the changing landscape of conflict of interest policies across US medical education, as well as in-depth assessments of individual policies that govern industry interaction between students, faculty, and the pharmaceutical and medical device industries." (9)

AMSA's PharmFree Campaign is now called *Just Medicine* – "no kick backs, no speakers bureaus, no free samples, Just Medicine." The AMSA website states: "Our vision for the practice of medicine is that it is simply based on evidence, not marketing, personal gain, or any interest other than that of the patient. (10)

Professor Farquhar then drew attention to just how far behind New Zealand is in addressing these issues. Many NZ doctors and others are on the receiving end of gifts, fees, travel and sponsorship, and New Zealand has only what she described as "soft options" for dealing with conflicts of interest. This country is desperately in need of its own Sunshine Act. When senior doctors are already getting around $17,000 to attend conferences and other important continuing education events there is really no excuse for them to be accepting drug company money.

Tamiflu – a nice little earner

Dr Vanessa Jordan is a NZ Cochrane Fellow and a methodologist who specialises in systematic reviews. Her presentation described how Roche's blockbuster antiviral drug, oseltamivir, (Tamiflu) became one of the most widely recognised medicines in the world as concern grew about a new flu pandemic – H1N1 or swine flu.

After over five years of struggling to access the drug trial data which was previously unpublished and hidden from view a Cochrane review was finally able to reveal the unpalatable truth about Tamiflu. (11)

Tamiflu is actually no more effective than an aspirin. It does not reduce flu symptoms to any significant degree and nor does it reduce complications of the flu or reduce hospital admissions. Its adverse effects – nausea, vomiting, diarrhoea as well as headaches, psychiatric disturbances and renal events – far outweigh any of its overhyped and very minor benefits. Yet nearly 100 countries stockpiled supplies of Tamiflu, spending $US18 billion worldwide. New Zealand bought 300,000 doses.

As Ben Goldacre wrote in *The Guardian* back in April 2014, Tamiflu has become the poster child for the missing-data story.

"And it is a great poster child. The battle over Tamiflu perfectly illustrates the need for full transparency around clinical trials, the importance of access to obscure documentation, and the failure of the regulatory system. Crucially, it is also an illustration of how science, at its best, is built on transparency and open-ness to criticism, because the saga of the Cochrane Tamiflu review began with a simple online comment." (12)

Dr Jordan also emphasised the need for all clinical trials results to be published to ensure that doctors have full information about the medicines they prescribe to their patients. She referred to the AllTrials campaign which is dedicated to making it mandatory to publish the results of all trials. Currently the results of half of all clinical trials are hidden. Even the FDA doesn't get all the data from the clinical trials of all the drugs and devices they approve for use. (13)

There were also excellent presentations from Professor Chris Bullen on clinical trials and industry, and Dr Sarah Hetrick on the 2014 Cochrane antidepressant review, "*Selective serotinon reuptake inhibitors (SSRIs) for depressive dis-orders in children and adolescents*" that she was the lead author of. (14)

Professor Shaun Hendy's presentation, "Can we trust our scientists?" focused on the role of scientists in today's world. He used two events that received worldwide media attention – the Fukushima Dai-ichi disaster in Japan and the Fonterra botulism scare in New Zealand – to illustrate the role of science in both disasters. Industry funding under-mines the trust that the general public has in scientists and limits their ability to talk to the public. There is a real need for independently-funded scientists who do not have conflict of interests to front the media when disasters occur.

The afternoon symposium finished with a panel of five blokes who were interviewed by the *Dominion Post's* Nikki Macdonald. Among them was the Ministry of Health's Dr Stewart Jessamine, who unfortunately never fails to sound like an apologist for the pharmaceutical industry.

The AWHC wishes to acknowledge that this informative and challenging symposium would not have eventuated without the determination and commitment of Professor Cindy Farquhar. Thank you Cindy!

Most of the presenters' slides from the symposium are now available at: http://nz.cochrane.org/symposium

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Prostate Screening

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A recent opinion piece in the *New York Times* by Richard Ablin, the man who discovered the prostate-specific antigen, or PSA, is surprisingly entitled "The Problem with Prostate Screening." (1)

The PSA test is now the most widely used tool in prostate screening and Professor Ablin is concerned at how it is being used. "There has been a growing concern about whether the use of the PSA test has led to over-diagnosis and overtreatment, with millions of unnecessary surgeries, complications and deaths," he writes.

His concerns are centred around the recent publication of the results of two studies which reported large reductions in prostate cancer deaths. One is the European Randomized Study of Screening for Prostate Cancer, and the other is the Swedish Goteborg study, the results of which provided a basis for the European Randomized Study.

Unfortunately there are big problems with both of these studies. Major concerns about the methodology and results of the studies were first raised earlier this year in the *Journal of the National Cancer Institute* by two Australian researchers. In March the Goteborg study's authors announced in the *British Medical Journal* that their data "are not available to outside investigators."

"That the researchers would block access to government- and charity-supported research is bad enough. Even worse, it calls into question why, if the data was strong, the researchers wouldn't open it up to independent scrutiny," Professor Ablin says. The public must be able to trust that scientific data from clinical trials is accurate and unbiased, and he is worried "that this trust, particularly when it comes to American men and their physicians and screening programs for prostate cancer, is now at risk."

The issues that prompted his opinion piece are unfortunately very familiar as the preceding report on the Cochrane symposium demonstrates. At their core is the impact of conflicts of interest on research and how it is reported, and these studies provide a fascinating case study.

The European Randomized Study reported results from seven countries, while Goteborg was a single-site study in Sweden. In both, men were divided into two groups: one group underwent regular PSA tests, while the other group was not screened. The results were published in *The New England Journal of Medicine* and the *Lancet Oncology Journal* respectively.

The Australian researchers noticed that there was something strange about the data sets – a large amount of the data in the European Randomized Study came from a separately reported Finnish study which showed no significant lifesaving benefits of PSA screening.

There were also issues around biased patient treatment. Many of the men who developed prostate cancer received excessive amounts of a treatment called hormonal mono-therapy which has been found to accelerate cancer.

"Further bias was highlighted by Otis Brawley, the chief medical and scientific officer of the American Cancer Society, and Paul Goldberg, the editor of the Cancer Letter. (2) They pointed out that the non-screened Swedish men who contributed to the two studies *were not even informed that they were in a clinical trial.*" [italics added]

Last but not least is the conflicts of interest issue. Several senior authors of the European trials as well as their American supporters, have conflicts of interest that relate to payments from companies involved in marketing PSA tests, or in holding patents in PSA and prostate cancer diagnostic space.

Professor Ablin concluded his opinion piece by stating "As a result, those physicians who have not examined the data in depth are now treating patients on the basis of deeply flawed data. How flawed? That's the real issue: because the authors won't release their data, we don't know."

It is imperative, he states, that "our regulatory bodies must insist that clinical trials, and especially taxpayer-funded ones, be open to scrutiny by independent investigators who have no ties to industry. Hoarding data, especially flawed data, is unacceptable when lives are at stake."

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1. http://www.nytimes.com/2014/11/26/opinion/the-problem-with-prostate-screening.html?_r=0
2. Otis Brawley & Paul Goldberg are the co-authors of "How We Do Harm." Chapter 20 has a graphic and disturbing account of what happened after Ralph DeAngelo went for a prostate cancer screening test.

Moving House or Changing Job

Please remember to update your contact details with the College office.

Email: admin@nurse.org.nz

National Rural Health Conference Rotorua March 2015

Report by Anna Reed NP

More than 440 people attended this year's National Rural Health Conference hosted by the New Zealand Rural General Practice Network and the Rural Health Alliance Aotearoa New Zealand in association with the New Zealand Rural Hospital Network (Dalton Kelly, 2015).

The College of Nurses Aotearoa (NZ) Inc generously offered me the opportunity to attend this conference when Diane Williams the incumbent (Nurse Practitioner) NP stood down as a Committee Member for the Rural Health Alliance New Zealand (RHANZ).

I had put up my hand to be considered as a Committee Member for the RHANZ because the College of Nurses believe it is strategically important for an NP to be on the RHANZ. The Masterton Medical Centre is one of the rural areas hosting the Rural Medical Immersion Project for Trainee Doctors; therefore was I not in essence a rural practitioner? However it soon became apparent that this injudicious belief was far from the real coal-face of Rural Health Care Practitioners. The Conference was attended by very experienced Rural Primary Health Care NPs and NP interns who throughout the 3 days explored and debated the roles of nurses within rural health care including Nurse Practitioners, Rural Nurse Specialists, and Practice Nurses. Discussion about impending legislation including the proposed RN prescribing and working collegially across the Rural Sector to provide collective support, education and confidence made me feel I was in the presence of NP pioneers. It seemed appropriate that on Friday night at the awards ceremony Nurse Practitioners working in rural areas were recognised as being invaluable and dynamically linked to sooner, better more convenient rural health delivery.

As a Delegate there is always a need to find a take-home message; for me one of the most powerful was from a key-note speaker Ernesto Sirolli a consultant in the field of Economic Development; amusing, polished and motivating he gave a snap-shot into his work on a person centred approach to local

economic development. It was possible to apply this theorem to the rural issues found in any of New Zealand's more disadvantaged areas such as described by Dr Lance O'Sullivan, Dr Rawiri Jensen and Dr Ryes Jones. Given the theme of the conference, the subject of health inequality was, as expected, a foremost topic, GPs and nurses maintaining the belief that average New Zealanders continue to 'normalise' inequalities, assume they are fully understood and that there remains a general indifference supporting shallow explanations for health disparities in NZ. In his presentation Dr Jones believes that as health professionals, 'we hold a privileged position in society, we have access to knowledge and resources, are trusted by the public and have credibility in the media, therefore now is the time to stop tolerating inequities and the systems that create and maintain them; advocacy is an integral part of health professional'. As Ernest Sirolli says "stop trying, just do it"

Anna Reed
Nurse Practitioner (Scope Older Adult)
Masterton Medical Centre

Time To Come Clean On Breast Screening

Reprinted with the kind permission of the Auckland Women's Health Council Newsletter

The February 2015 issue of the National Screening Unit's newsletter *Screening Matters* features an article announcing that "BreastScreen Aotearoa (BSA) is reviewing its health education resources to ensure they are meeting the needs of women and effectively communicate the latest information on the harms and benefits of population breast screening." (1)

This review is long overdue as New Zealand women are still not being given evidence-based information on the lack of effectiveness of breast cancer screening programmes. However it is extremely unlikely that a health agency whose role is to promote screening can be entrusted with the task of providing good information on the risks of breast cancer screening and lack of evidence that it saves lives.

In February 2015 Lynda Williams travelled to Sydney for the weekend to hear presentations by Don Benjamin, Convenor and Research Director of the Cancer Information & Support Society in Sydney, and Professor Peter Gotzsche, Director of the Nordic Cochrane Centre in Denmark, on cancer screening.

Don Benjamin

In his presentation Don Benjamin outlined the principles of running and interpreting results from randomised controlled trials, summarised the results of breast, bowel, prostate, lung, and ovarian cancer screening trials, and summarised the levels of overdiagnosis resulting from cancer screening.

He began with a brief history of cancer treatment and then described the old cancer paradigm – cancer is a systemic disease, so identify and treat causes, and then examined the new paradigm – cancer starts locally and later spreads so "get it all, and get it early."

Before it can be assumed that cancer interventions, particularly surgery or screening, are effective it is necessary to provide reliable evidence of benefit. Of course, the gold standard of evidence is the randomised controlled trial (RCT) which Don Benjamin went on to talk about in some detail.

And this is where it gets tricky and somewhat confusing, especially when it comes to measuring efficacy. In answer to the question what do the results of a well-run randomised controlled trial evaluating treatment look like, Don said:

- After a trial is completed the number of deaths **from all causes** in the treated group is compared with the number of deaths **from all causes** in the control (untreated) group.
- All causes include cancer mortality and non-cancer mortality.
- Non-cancer mortality should not be affected by screening or treatment.

After showing that RCTs revealed that "getting it all" has no proven effect on survival or mortality, Don then went to show that early surgery was equally ineffective.

"In 1996 I analysed the results of the seven RCTs evaluating breast cancer screening and concluded that screening does more harm than good:

- Screening does not reduce overall (all cause) mortality
- Radiotherapy was used differently in the screened and control groups (in breach of the RCT rules)
- This meant that many women who would have died from breast cancer instead died from heart failure making it appear that there had been a reduction in breast cancer deaths (confounding factors).

This lack of proof of overall benefit was subsequently confirmed in 2001 by Peter Gotzsche and by William Black et al in 2002."

Don then described how RCTs have also revealed the lack of efficacy of early surgery – as a result of screening – for lung cancer, prostate cancer, ovarian cancer and bowel cancer. He ended his presentation by discussing the harms of screening in terms of both overdiagnosis and the resulting overtreatment.

In summary:

"There are significant benefits from screening for breast, bowel, lung, prostate or ovarian cancers.

There is significant harm resulting from overdiagnosis of breast and prostate cancers.

There is harmful overtreatment for breast, lung, prostate and ovarian cancer.

So there is not only no survival benefits from 'getting it all' or 'getting it early,' but attempts to do so result in significant overdiagnosis and harmful overtreatment."

Peter Gotzsche

Peter Gotzsche's lecture was based on his 2012 ground-breaking book "Mammography Screening" Truth, Lies and Controversy" which takes an evidence-based, critical look at the scientific disputes and the information provided to women by governments and cancer charities. It also explains why mammography screening is unlikely to be effective today. (2)

A copy of the Nordic Cochrane Centre's booklet on Mammography Screening is available in a variety of languages including English at:

http://www.cochrane.dk/

The discussion that followed the presentations from both men revealed that many of the women in the audience were unaware of the risks of mammography screening and were shocked and dismayed at what they had just heard.

Alexandra Barratt

On 3 March 2015 *the British Medical Journal* published Alexandra Barratt's paper "Overdiagnosis in mammography screening: a 45 year journey from shadowy idea to acknowledged reality." (3) Alexandra Barratt is a professor of public health at the University of Sydney and was one of the speakers at the Preventing Overdiagnosis conference held at Oxford University in September 2015.

In the "How to do better" section of her paper Professor Barratt referred to the need for quality information for patients:

"Many women continue to be prescribed or encouraged to undergo screening rather than being supported to make an informed choice. Women should be given information that has been carefully developed and tested, because information is an intervention that may have both positive and detrimental effects.

Screening targets for screening services should be questioned, and consideration should be given to ensuring the provision of balanced information – for example, using the "consider an offer" approach outlined by Entwistle and colleagues in 2008. Practitioners should not be incentivised to achieve participation, nor should high participation in screening be regarded as a marker of health service quality." (3)

In conclusion the AWHC hopes that BreastScreen Aotearoa will rise to the challenge in Professor Barratt's paper and revise their nine pamphlets, two booklets, three posters and five information sheets to present women with the balanced information they need to make an informed choice about screening.

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Professor Jenny Carryer RN PhD FCNA(NZ) MNZM
Kim Carter RN FCNA(NZ) NZCPHCN (NZNO)
Taima Campbell RN, MHSc (Nsg) PG Dip Bus (Māori Dev)
Dr Mark Jones FCNA(NZ) FACN

Location	Date/Venue	Time	Earlybird Discounted Fee If Paid By
Auckland	20 & 21 July 2015 Ko Awatea Centre Middlemore Hospital	9.00am – 4.30pm	24 June 2015
Wellington	October 2015 (Date & Venue to be advised)	9.00am – 4.30pm	

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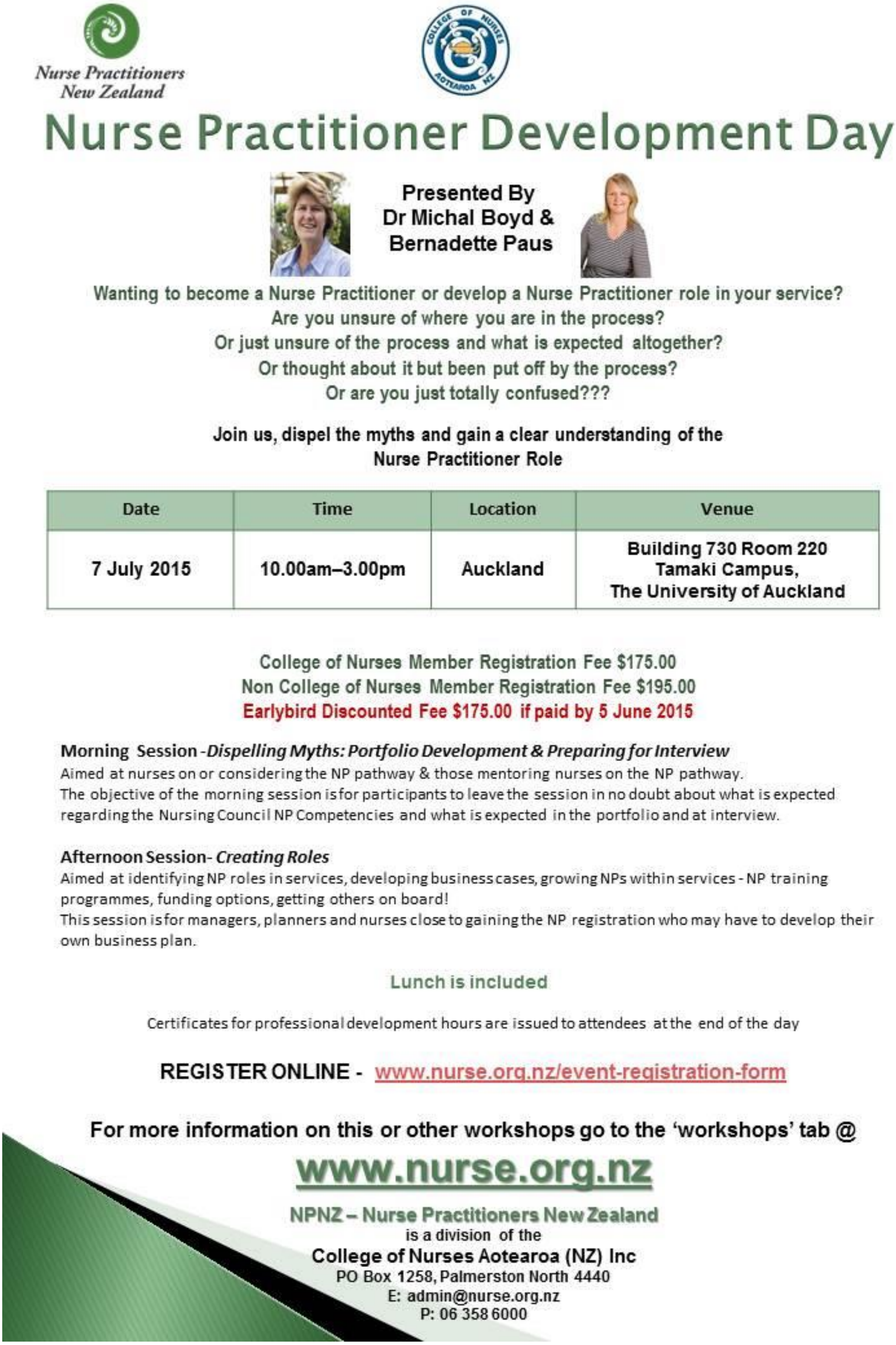

Nurse Practitioners New Zealand

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Presented By
Dr Michal Boyd &
Bernadette Paus

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Join us, dispel the myths and gain a clear understanding of the Nurse Practitioner Role

Date	Time	Location	Venue
7 July 2015	**10.00am–3.00pm**	**Auckland**	**Building 730 Room 220 Tamaki Campus, The University of Auckland**

College of Nurses Member Registration Fee $175.00
Non College of Nurses Member Registration Fee $195.00
Earlybird Discounted Fee $175.00 if paid by 5 June 2015

Morning Session - ***Dispelling Myths: Portfolio Development & Preparing for Interview***
Aimed at nurses on or considering the NP pathway & those mentoring nurses on the NP pathway.
The objective of the morning session is for participants to leave the session in no doubt about what is expected regarding the Nursing Council NP Competencies and what is expected in the portfolio and at interview.

Afternoon Session - ***Creating Roles***
Aimed at identifying NP roles in services, developing business cases, growing NPs within services - NP training programmes, funding options, getting others on board!
This session is for managers, planners and nurses close to gaining the NP registration who may have to develop their own business plan.

Lunch is included

Certificates for professional development hours are issued to attendees at the end of the day

REGISTER ONLINE - www.nurse.org.nz/event-registration-form

For more information on this or other workshops go to the 'workshops' tab @

www.nurse.org.nz

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Life Members

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Name	Date Awarded
Judy Yarwood	October 2014