

TE PUAWAI

- The Blossoming -



***The Professional
update for
registered nurses***

March 99

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.

College of Nurses Aotearoa

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EDITORIAL



At last we have made the move into glossy print and we are celebrating this with the launch of our new name "*Te Puawai*" which so appropriately speaks of blossoming and enlightenment.

More and more I am aware of the need for nurses to ensure that they are really well informed about the many professional, political and educational changes which impact on our professional lives. The process, as I have noted before, is very much a two-way one. As Executive Director of the

College I am very aware of our responsibility to provide as much information as possible to members through this and other fora. But there is of course the individual responsibility to actually read the newsletter, actively request the documents and to set up local meetings to discuss and provide active engagement with the issues.

All of us are guilty at certain times of proclaiming that we were not consulted. Sometimes we have genuinely been left out (these things do happen!) but more often we have buried papers or newsletters in the "must read ... sometime" pile and the inevitable happens.

I think it is crucially important that we make every effort to engage in the professional concerns of nursing. But it is even more important that we accept that we cannot all "be there", all the time and sometimes we need to accept the decisions of others with grace and trust in order to affirm and support their leadership.

Having said that - please read and enjoy this first edition of *Te Puawai* and please do become actively involved. Letters can be printed, comments and constructive criticisms will be graciously received. More than any of that, we especially want to print pieces about clinical practice excellence and innovations (and will cheerfully provide editorial help). Clinical excellence is, after all, the true indication of our "blossoming".

Jenny Carryer
Executive Director

MARCH 1999

GENERAL BUSINESS

COLLEGE BOARD

Following the postal ballot in December to fill the two non-Maori Board vacancies, we are pleased to welcome Denise Dignam and Annette Milligan to the College Board. Thank you to Mary Sylvester for being prepared to give her time and energy to the College. The photo below was taken at the first meeting of the new Board which was held in Palmerston North prior to the Advanced Nursing Practice Workshop in March.



Back Row (L-R): Annette Milligan, Mere Brooks, Denise Dignam, Denise Wilson
Front Row (L-R): Jenny Carryer, Stephen Neville (Chair), Mereana Roberts

GOOD NEWS

The College Board are delighted to announce that as from later this year we will be offering four \$500 scholarships for nurses to undertake postgraduate or post registration education. We would like input from members as to any particular focus you would like these scholarships to have, and suggested titles or names (ie, named after College members or Patrons as an example). It is proposed that the academic committee of the College will oversee the application and decision making process. We would like to announce the availability of these grants in the July newsletter so please provide early feedback.

WEBSITE UPDATE

The college website is up and running and can be located at www.nurse.org.nz. This means that if anyone in the world types in the words nurse.org.nz on any web browser they will find themselves at the College of Nurses Aotearoa (NZ) home page. Please visit the site and send any comments that you may have to s.neville@csc.canterbury.ac.nz. Over the next few months we intend to develop the site even further by including profiles of all Board members and information on how to contact the Regional Co-ordinators.

Stephen Neville
Chairperson for College Board

ACC ALERT

All nurses intending to register as ACC providers must apply now to ACC to register an interest. Registration forms can be obtained from your local ACC branch, or contact the ACC Registration Unit at ACC Corporate office - telephone (04) 918 7408.



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Where: Wellington School of Medicine
- Registrations:**
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Due to limited space, priority will be given to Full time enrolments (single and/or shared basis)

Enquires to: Anne Brinkman

Fax: 04 386 2975

email: anne.brink@xtra.co.nz

Address: C/- Chief Nurse Executive Office

Wellington Hospital

Private Bag 7902, Wellington

MAORI PATRON

Putiputi O'Brien, RGON, QSO, Dip Public Health, Plunket Diploma

The College of Nurses, Aotearoa (NZ) is privileged to have a toanga (treasure) such as Putiputi O'Brien as one of its Patrons. Putiputi is in high demand – supporting local health developments, supporting nursing (particularly Maori nursing) development nationally and internationally, and attending a wide variety of activities (such as speaking at Massey University) where she shares her knowledge and wisdom.



Putiputi's waka is Mataatua and is of Ngati Awa descent. She resides in the small eastern Bay of Plenty town of Te Teko.

Putiputi registered as a General and Obstetric Nurse after completing her nurse education at Waikato Hospital in 1945. From there she embarked on a nursing career in Public Health with the Health Department. On retiring from the Health Department, Putiputi worked in the area of Community health with Midland Health as a district Health Co-ordinator and the Manager of the Ngati Awa ki Rangitaiki health initiative.

Professionally, Putiputi has been a role model for nurses and has long held a passion for nurses and nursing with a special interest in Maori nurses, often being a bridge between the two worlds of Maori and tauiwi. She has been the Patron of the National Council of Maori Nurses since its inception, a result of her commitment to working with Maori nurses. Putiputi has travelled with Maori nurses nationally and internationally and has been a participant in, and supporter of the annual National Maori Student Nurse Hui, accompanying students and staff from Waiariki Polytechnic. Putiputi has also been a member of the Waiariki Polytechnic Nursing Advisory Committee. Recently, Putiputi opened the Advanced Nursing Practice Conference held in Palmerston North.

On becoming the Patron of the College of Nurses, Putiputi has gifted a whakatauki (proverb), from which the College newsletter has been named - this edition bearing the name *Te Puawai*, The Blossoming for the first time.

Kia taha, kia puawai, te maramatanga
The illumination and blossoming of enlightenment

The Board of Directors take this opportunity to welcome Putiputi as our Patron and toanga. We also thank her for the special gift she has kindly bestowed.

ADVANCED PRACTICE

As advertised in the last newsletter the College hosted a conference/workshop on 1/3 March in Palmerston North.

The aim of the workshop was a facilitated decision making process in order to agree on guidelines to support the development of advanced nursing practice in New Zealand.

Two keynote addresses were provided by Professor Sarah Sheets Cook, Professor of Clinical Nursing and Vice Dean at Columbia University, New York.

In her first address Sarah noted that the lack of a common language of nursing was a significant difficulty. She said that we tend to define ourselves by tasks or procedures or the site where we practice, rather than a set of specific, levelled competencies.

She spoke of the need for an extensive empowering process of socialisation for nursing students from the very first day of the educational programme and running all the way through to practice of the professional role. Socialisation "needs to recognise a separate and true professional role for nurses : one that is autonomous, collaborative, evidence based, requires authority for actions, responsible for outcomes, is self-actualising as a recognised expert in area of responsibility and encompasses both didactic and affiliative/intuitive interventions."

Professor Cook advocated an ongoing and highly visible campaign to increase public awareness and understanding of the service nursing provides and the issues it holds dear.

In her second address, Sarah strongly advocated the establishment of a consortium of major nursing organisations to speak with a common voice and purpose to promulgate nursing concerns, to carry out public relations initiatives and to lobby as needed.

Her most challenging suggestion was that nursing needs to raise its own funds beyond what may be allocated to it by Government or institutions. Sarah quoted Donna Diers who has noted that 'the only reason patients need to be actually admitted to hospital is for nursing care'.

Professor Cook closed her second address with "Some general rules of comportment ...

- all stakeholders, especially among nursing, have a valuable point of view
- can hold differing opinions about the operationalization of the same vision - and can still like each other even if disagree
- need to risk to 'actualise the vision'- can't wait for someone else to make decisions and take actions
- be proactive, not reactive
- always easier to say you're sorry than ask permission
- be honest, open and above-board, even if difficult or generates a negative response
- need to 'tell' people things at least 5-10 times before the message is 'heard'
- believe in yourself and in each other
- health care is a business, no matter who pays for it - learn to act like a business person."

On the third day the new Minister of Health, the Hon. Wyatt Creech addressed the conference. In his address the Minister noted that

"Currently we tend to look at the health system as if it were a pyramid. It has at its apex the very high-tech tertiary and quaternary services with secondary services the next layer down and at the base a very wide group of mixed and hard to specify primary care services.

It would be nice to turn that pyramid upside down. Because when it comes to benefits for people, it is the health dollar spent on those primary services in the community, those public health services, those information campaigns, those public education programmes, that provide so much benefit to so many.

Ideally we should aim to improve those primary services so those at the bottom are caught before they fall through the primary sieve into the secondary and tertiary services. We need to put the effort in so it that it really does work like a sieve which limits the number of people who end up flowing down through to the secondary health services.

What I want to see at the top of the health shopping list is how to keep New Zealanders fit and healthy. The best health system we can hope for is one where we keep New Zealanders out of hospital. We need to keep people healthy, and stop their health problems getting out of hand."

The Minister gave his full assurance that the recommendations of the Ministerial Taskforce on Nursing would be vigorously pursued. He said that he has now taken ownership of the report and assured us of his commitment to seeing it work. He noted that

"A project team to keep an eye on what is being done to make the Nursing Taskforce decisions happen in a way that is real, practical and will work has been set up. I expect the Health Funding Authority to be supporting nursing led initiatives. I would like to see nurses skills and expertise used more effectively. I would like them involved in the governance and management of primary care organisations. The Health Funding Authority should also be making sure the Clinical Training Agency makes advances. If we are to keep moving forward the health workforce needs to keep developing, training and extending itself."

The Process

The decision making processes occurred through a series of workshops at which groups of varying sizes debated different aspects of the core topic. As it stands at the moment, there was considerable agreement that:

- Advanced nurse practitioners should be educated at Masters degree level
- National strategic group should be formed to progress nursing issues
- Advanced nursing is in practice locations
- Education should be clinically focused and based
- ANP is competent in practice plus extra skills
 - ⇒ baseline competence
 - ⇒ meets complex health needs
 - ⇒ always based in nursing philosophy

- ⇒ research based
- ⇒ flexible approach for diverse needs of client groups
- Title protected by enabling legislation
- Need to market the role of the advanced practitioner
- Role is underpinned by the Nurses Act and the Medicines Act
- People who prescribe need to do so within advanced preparation framework
- National standards needed
- Nursing Council to co-ordinate consult and manage credentialling

The group discussed and identified the need for further dialogue on the following:

- National strategic group - who? how formed? exact role?
- Transition process needed from now to full implementation - details not clear yet
- There is dissension about whether ANPs must prescribe
- Education for prescribing to be a requirement in ANP programmes
- Credentialling - details of process and what it means need much more work
- Work required to define the competencies of ANP
- Funding/reimbursement issues are very unclear

At the closing session:

1. Group agreed that the workshop process/themes/decisions would be produced as a "work in progress" document and posted to all conference participants. Participants to review and comment on content.
2. Group nominated a working group to progress these issues following completion of the feedback period.
(Note: This group is NOT the National Strategic Group whose formation was suggested by conference)

<u>Members</u>	Annette Milligan
	Diana Gunn
	Jenny Carryer
	Judith Christensen
	Judy Kilpatrick

The conference closed with all participants reflecting and commenting on the process and outcomes.



ACC REFORM: HEALTH PROVIDERS' REFERENCE GROUP

This group is a Ministry of Health initiative to consider the impact of the ACC reforms on health providers. Its role is to provide feedback to the Government on what will happen for health providers as the changes are implemented.

The changes to ACC will be implemented in July 1, 1999. From that time, ACC will no longer cover accidents in the workplace – all other ACC cover will be unaffected. However the distinction between the sites of an accident will have to be clarified as the funding streams are entirely different – workplaces injuries will be covered by a private or state owned company, while all other claims will be funded by ACC.

This clearly has implications for nurses working in the occupational health field. The insurance companies will have very powerful incentives to keep premiums down to a minimum, and workplaces will be expected to be proactive in keeping costs down. Other nurses who will be affected include practice nurses, emergency nurses, nurses in rehabilitation work and nurses in independent community based clinics. Of course, all nurses who are employed will have to be aware of the changes in terms of their own employment, but that is not the focus of this group.

At this stage, the processes are being worked out in fine detail –

- What happens when someone makes a claim?
- How will that be processed?
- How will claims be tracked – with the NHI system, or another internal and unique insurance claim number?
- Who will have to locate that identifying number – the health professional first seen, or the insurance company?
- What will the forms look like?
- Will they be practical to use in the clinical setting?

At this stage of finalisation, what remains for all of us is to stay informed – have you read the yellow and green booklet *ACC Freedom to Choose* which was sent out in early March?

If you want to stay informed, check out the website <http://www.tochoose.govt.nz> or phone the Department of Labour on 0800 862 466.

I am a member of the Health Providers' Reference Group and invite College members to send comment to me:

Phone 03-546-8155

Fax 03-546-8154

E-mail to: amilligan@clear.net.nz

Annette Milligan

PRESCRIBING RIGHTS

The amendment to the Medicines Act which will see the extension of prescribing rights to a wider range of health professionals is approaching the select committee level of the legislative process in New Zealand. As members will be aware, the Ministry of Health and the Nursing Council have already done considerable work considering the outcomes of this legislative change for nurses in particular.

In participating in working groups and in the submission process the College works from the perspective that the health benefit to New Zealanders must be the defining principle for change. Recent review indicated that the nursing impact to the New Zealand health scene is restrained by numerous mechanisms, not the least the lack of prescriptive authority (Ministerial Taskforce Report, 1998). The College holds the position that independent nurse prescribing is a viable and legitimate aspect of Advanced Nursing Practice which can offer increased health benefit to the New Zealand public.

International health care delivery has recognised that nurses can contribute to increased patient health outcomes by offering prescriptive interventions as a part of a range of nursing treatment modalities and therapeutic interventions. Indeed nurses are more likely to offer a range of therapeutic interventions before they offer pharmacological interventions (Crall-Taylor, 1995; Mahoney, 1995; Mayes, 1996). When comparative cases are managed by nurses and medical practitioners the nurses have demonstrated more conservative prescribing practices. This is consistent with nursing as the central focus of care. The literature from

international contexts also indicates that prescribing practice increases collegial collaboration between multi-disciplinary health professionals (Crown et al., 1998). The College strongly supports any increase in professional collaboration for clinical decision making as do other professional bodies (Pharmaceutical Society, Irvine, 1997).

We stress that currently nurses who will be capable of prescriptive practice within the proposed scopes of practice are not educationally prepared to do so. Clearly, considerable attention to advanced education including advanced assessment and clinical diagnostic skills is required. It would seem that the inclusion of these skills in a nursing curriculum is somewhat problematic to the medical fraternity but we believe there is sufficient evidence that health care delivery will be improved by this process and it is therefore worth pursuing. Comprehensive review of existing education programs for nursing curricula indicates that these skills are not outside of nursing parameters (AACN, 1996; Woods, 1997). Indeed the essential process of assessment, nursing diagnosis and clinical judgement, based on best practice, for therapeutic intervention, is common to all nursing curricula both undergraduate and post graduate. While the College recognises the knowledge base required is indeed more comprehensive than is currently available, indication from within nursing education is that such curricula are under design and will be available **given that sufficient resources are forthcoming.** The College acknowledges the imperative for contribution from other health disciplines to the preparation for advanced practice roles.

A list of the foregoing and further references is provided for members who may wish to review some of this literature for themselves.

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PRIMARY HEALTH CARE POLICY GROUP

UPDATE

The Primary Health Care Policy Group continues to meet and develop the Position statement and policy direction for the College. Constructive comment has been provided for the first draft resulting in a second draft that we have included in this newsletter for your interest and comment.

The group has also proposed a consultation process with groups such as the Royal College of GPs and the HFA. Feedback from these consultations will inform the development of the strategies as outlined below.

We are keen to hear from any other College member who would like to contribute to this. Please contact Julie Martin, e-mail julie.martin@hfa.govt.nz.

In addition we would like to hear from nurses who would be interested in working with the College in the development and implementation of a primary health care nursing initiative.

Scope of Practice for Primary Health Care Nursing Draft No. 2 March 1999

The following scope of practice for primary health care nursing reflects the College's aspiration for nurses in this role.

Primary Health Care nurses will be registered nurses who are advanced practitioners with specialist knowledge and expertise in primary health care. They are committed to professional development demonstrated through postgraduate study and research. Their practice is undertaken both in collaboration with the client/patient and with a variety of health professionals. As professionals, primary health care nurses are directed by evidence based practice and assume responsibility and accountability for maximising client/patient benefit.

These nurses will draw on an extensive knowledge base including physiology, application of nursing interventions, health promotion, disease prevention, life span development and pharmacology. This knowledge base supports nurses to make clinical decisions about clinical management, co-ordination and referral. Primary care nursing practice occurs in a variety of urban and rural health care settings. The client may be an individual, family or population.

The current context and delivery of primary nursing care

Primary health care nursing currently encompasses a range of nurses working in the community, in private business, independent practice, district nurses, public health nurses, Plunket nurses, occupational health nurses and other specialist community health nurses. This proliferation of roles is confused by the proliferation of titles and as yet the concept of a generic title of primary health care nurse has not been embraced. This confusion is further perpetuated by titles associated with practice status, i.e., nurse practitioner, nurse

consultant, nurse specialist, etc. Use of these titles is not yet supported by credentialling or acknowledge by the nursing registration body.

In addition the current ranges of specialist primary health care practice role impact on resource allocation and tend to fragment service provision. In keeping with the health reforms, numerous employers each have a particular emphasis and philosophy that has the tendency to shape and define nurses' work. To date the nursing profession has failed to provide a clear direction for primary health care nursing. This lack of definition has contributed to a subsumed nursing role in primary health care. Resources for primary health care have also not been accessed by nurses due, in part, to existing service structures and funding mechanisms. As recognised in the Nursing Taskforce report, nurses have been slow to utilise the presumed benefits of competitive service provision heralded by the health reforms. Primary health care nurses often lack the skill and resources to maximise the theoretical potential offered by the reforms and are hampered by an employee mentality. While nursing leadership, initiative and vision for primary health care has been evidenced, the impact has been limited. Postgraduate Nursing education has largely delivered a social science offering, which has provided more generic curricula and failed to locate or advance the development of speciality practice. In-service and staff development within primary health care is either entirely absent or fragmented and lacks cohesive curriculum.

In the next stage the group will start to develop a strategy to support the planned scope. This will include addressing the following:

- Collaboration with the College of GPs
- Advancing nurse prescribing
- Defining nurse practitioner role
- Enabling practice skills
- Enabling College based postgraduate study/scholarships
- Review of existing barriers to scholarships, eg, NERF
- Identify research opportunities
- Contribute to the planned review of the CTA
- Investigate funding streams for supporting primary care postgraduate nursing education



PUBLICITY MATERIAL

It is still obvious that a lot of nurses do not know of the College's existence. Could members intensify their efforts to discuss and share information about the College. If you know of a place to put up one of the College's posters or place publicity brochures, please contact the College office.

SUBSCRIPTION RENEWALS

Please note that members who retire, become redundant, are full-time students, or who work less than 10 hours per week, may request the right to pay a half subscription. This is a service to members and does not mean any reduction in benefits.

RESEARCH ABSTRACT

TITLE: "Well-being in the older male: An investigation of mental, social and physical well-being indicators in Wanganui men".

AUTHOR: Stephen Neville, RCpN, BA, MA(Hons), MCNA(NZ)

THESIS HELD: Massey University Library, Palmerston North and Albany.
Christchurch Polytechnic Library.

There is no doubt that New Zealand's older adult population is increasing. This trend is in line with a global increase in numbers of older people. Increases in older populations mean numbers of people with problems related to psychological and general well-being also rise due to the incidence of long term illness and disability in this age group. This has the potential to increase the utilisation of currently shrinking health resources. While many health and well-being factors influence both men and women there appears to be an increase in research related to women's health and a corresponding decrease related to men's health issues. There is a paucity of research relating to the older male population even though men are more likely to die from intentional injury and use primary health services less than women. Because nurses work closely with people across primary, secondary and tertiary care settings they are well placed to undertake research and utilise research findings from studies relating to the older adult to promote health and well-being. The intention of this quantitative study was to gain a greater understanding of the relationships between mental, social and physical well-being indicators in older men. The data for the present study were collected by cross-sectional survey method. Survey materials and information were accessed from a number of sources including the health, psychology and nursing literature. Participants were obtained via a non-probability convenience sample drawn from several support networks associated with Age Concern Wanganui. Two hundred and seventeen men over the age of 65 years, residing in the Wanganui area, consented to participate in the study. Analysis of the data was undertaken in two stages. Stage one examined the bivariate relationships between study variables and stage two involved multiple regression analyses to assess the contribution of independent variables to outcome variables. A description of biographical information was also completed. Results showed that the issues most consistently related to well-being were those related to health. The number of visits to the doctor, number of medications taken and the number of illnesses/disabilities were all significantly related to well-being. A further factor related to well-being identified in the study was satisfaction with social supports. There is an inevitable loss of family and friends as one ages and this can affect one's social interaction with society. However this reduction in numbers of social supports can be offset by the quality of those supports one retains, particularly for men who have fewer support resources available to them.

This study has the potential to advance nursing knowledge by examining the relationships between mental, social and physical well-being indicators on psychological and physical well-being in older men. The outcomes can be utilised to inform and transform nursing practice in the area of health care of the older male as nursing realises the need for specialised knowledge in order to improve health outcomes in this population.

PAPERS AVAILABLE

The following papers are available from the College office:

- Advanced Nursing Practice Workshop held in Palmerston North 1/3 March - copy of pre-readings made available to delegates and a synopsis of the conference findings. Available from May 1998. **\$10 per set**
- Nursing Council of New Zealand Consultation Document *Competence-based Practising Certificates for Registered Nurses* September 1998. **\$5 per copy**
- Nursing Council of New Zealand *Framework, Guidelines and Competencies for Post-Registration Nursing Education* May 1998. **\$5 per copy**
- Ministry of Health Consultation Document *Nurse Prescribing in Aged Care and Child Family Health* December 1998. **\$5 per copy**

Please forward your request for papers and cheque to: P O Box 1258
PALMERSTON NORTH

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The following article and the one entitled *A Matter of Principles* are reproduced from *Like Minds*, the newsletter for the movement against stigma and discrimination associated with mental illness. The movement is an initiative of the Health Funding Authority.

Code of FAMILY rights

People with serious mental illness are not ill in isolation: their families and whānau are almost always involved. For this reason, families have worked with the Schizophrenia Fellowship to produce a new Code of Family Rights.

The Code has 16 provisions and includes a family's right to:

- be treated with understanding and respect;
- receive information on the range of relevant services and supports available in the community;
- have access to culturally accepted treatment options which include family;
- information about a family member's illness, the diagnosis, treatment and possible side effects of treatment; and
- inclusion in care planning, implementation and review.

The idea of a Code was mooted by families three years ago, when the Mason Inquiry was performing its review of mental health services. Heather says a common feature of all submissions made by families to Ken Mason and his team was that families were rarely regarded as a valuable source of information during assessment, planning, review and discharge stages of a family member.

'Many families feel after the Mason Inquiry that the family point of view is still being disregarded, hence the development of the Code.'

Heather says the aim is to have the Code of Rights recognised and implemented by all mental health services.

'It is clear that if families are educated and informed about mental illness, they are better able to support their relatives,' says Heather Simpson, National Director of the Schizophrenia Fellowship.

Copies of the Code of Family Rights are available from SF Offices. ➤

A Matter of Principles

- Legislation for Rights, Equality and Respect

One of the biggest barriers to recovery for people with experience of mental illness is discrimination. That is why stopping discrimination and championing respect, rights and equality for people with mental illness is so important.

Peter O'Connor, project manager with the Mental Health Foundation, says that in New Zealand there is a growing awareness that people with mental illness have the same individual rights as everyone else, although these rights are interpreted within a particular legal framework.

He says United Nations conventions have had a profound impact on our legislation. 'Although not always adopted by New Zealand, this international law has underpinned the drafting of our human rights legislation and its interpretation by the Court. It has also offered guidelines about appropriate standards for health care and services to mental health consumers.'

Of particular relevance is the UN International Covenant on Civil and Political Rights 1966, which sets out fundamental rights such as:

- the right to be free of cruel, inhumane or degrading treatment or punishment;
- the right to be treated with respect and dignity and with humanity if deprived of liberty;
- the right to freedom of movement and choice of residence; and
- equality before the law and equal protection of the law.

The principles in this covenant were incorporated into the New Zealand Bill of Rights Act 1990 which outlines criteria to be taken into account when interpreting other legislation, including the right not to be discriminated against. The Bill of Rights also protects the rights of consumers who appear as offenders in the criminal justice system.

Another equally important international law is the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991, which specifies the rights of mental health consumers.

'The Principles provide a benchmark for the protection of, and treatment of,

people with mental illness and reiterate a number of fundamental freedoms and basic rights, as well as outlining the standards for treatment that can be expected from a mental health system,' says Peter.

In New Zealand, we have laws that specifically prohibit discrimination on certain grounds. The New Zealand Human Rights Act 1993 defines 'disability' as one of the prohibited grounds of discrimination. This includes psychiatric illness or psychological disability or impairment. The Act also recognises that not all rights are absolute and allows specific exclusions, which the person seeking to discriminate must demonstrate.

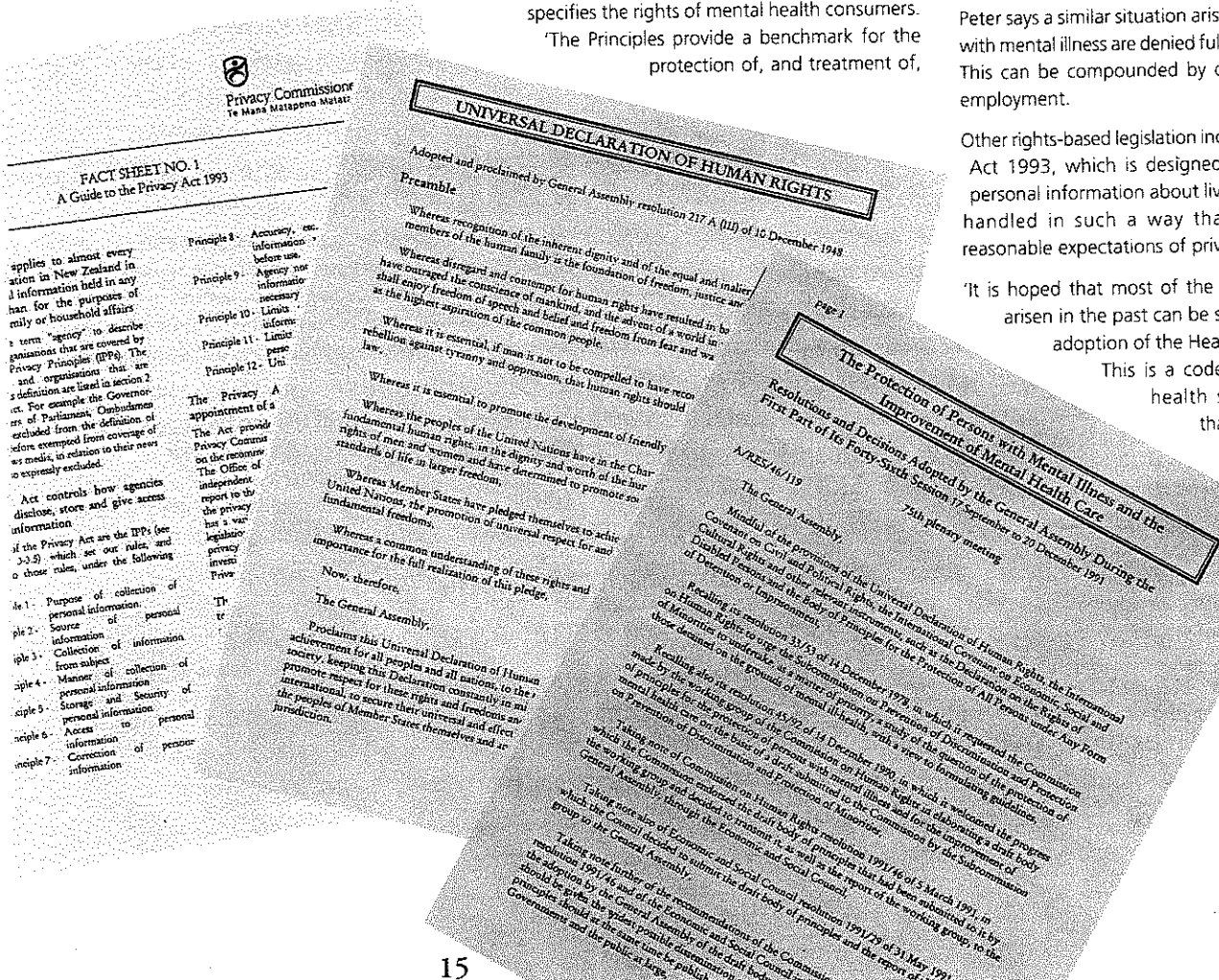
Employment, says Peter, is an area where discrimination against people with mental illness or a history of mental illness frequently occurs. 'An employer does not have to employ someone with a disability if the person can only do the job with the aid of special services or facilities, and it is not reasonable for the employer to employ them, or if the person's disability could result in harm to others.'

Peter says a similar situation arises where people with mental illness are denied full access to credit. This can be compounded by discrimination in employment.

Other rights-based legislation includes the Privacy Act 1993, which is designed to ensure that personal information about living individuals is handled in such a way that it meets the reasonable expectations of privacy.

'It is hoped that most of the issues that have arisen in the past can be sorted out by the adoption of the Health Privacy Code.

This is a code of practice for health sector agencies that should ensure



that consumers' rights to privacy are protected but balanced by health promotion needs, such as support from family and friends.'

The Health and Disability Commissioner Act 1994 established a complaints system similar to that of the Human Rights Commission, but with a national tier of independent advocates who provide support and advice for consumers who believe their rights have been infringed. The Health and Disability Code, which is derived from the Act, ensures that clinicians and mental health workers act in a professional manner to ensure the human rights of patients. The code has 10 broad categories of rights and obliges providers to inform consumers of their rights and how these rights can be enforced.

The Mental Health (Compulsory Assessment and Treatment) Act 1992 is part of a universal move towards mental health legislation that emphasises patients' autonomy. The Act defines patients' entitlements to information, consultation and legal representation and enables consumers to pursue grievances. It includes the appointment of District Inspectors with powers to conduct inquiries. Consumers can take complaints of breaches of their rights to the District Inspector. Consumers also have specific rights in relation to review of their clinical condition and on appeal to a Review Tribunal.

'This is only a brief look at the legal framework in New Zealand, which defines the rights and responsibilities of people in the mental health area and the wider community,' Peter says.

'It is a complex issue involving a whole raft of different pieces of legislation. Perhaps it is timely to begin looking at how discrimination is dealt with, through a coordinated presentation of rights provided in current legislation, to uncover any gaps, overlaps and conflicts between laws or regulations.'

'As identified by the Mental Health Commission, there is also a need to explicitly fit the legislation together and to identify clearly the rights and entitlements of mental health consumers.' >

The following articles:

Maori health statistics speak volumes Old and Worth Less? Hikoi of Hope

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New Zealand Health Review
The Journal of the New Zealand
Coalition for Public Health**

Maori health statistics speak volumes

THE RELEASE of the Ministry of Maori Development's report detailing social and economic gaps between Maori and non-Maori in July was over-shadowed by events surrounding the Minister, Tau Henare, at the time. For the record, here are some of the report's key findings concerning health:

- ❑ Measured in terms of life expectancy at birth, Maori health has improved substantially over the past 40 years. During this time, life expectancy for Maori females increased by 17 years and Maori males by 14 years. At the same time the disparity between Maori and non-Maori life expectancy narrowed considerably. The sharp decline in infant mortality, particularly during the 1950s and 1960s, has been the single largest contributing factor to the improvement in Maori life expectancy. Nonetheless, Maori life expectancy is still five to six years less than non-Maori. And Maori continue to lag behind non-Maori on almost all other indicators of health status.
- ❑ In 1997 hospitalisation rates for Maori were 133% higher than for non-Maori.
- ❑ In 1994, the rate of sudden infant death syndrome (SIDS) among Maori (6.9 per 1000 live births) was five times higher than the non-Maori rate (1.4 per 1000).

- ❑ In 1997 Maori children, aged 0-4 years, were hospitalised for glue ear at more than twice the rate of non-Maori.
- ❑ In 1997 Maori aged 5-34 years were hospitalised for asthma about three times the rate of non-Maori.
- ❑ New Zealand's youth suicide rate is one of the highest among OECD countries. In 1996 the rate of suicide among Maori males (15-24 years) was 70% higher than non-Maori males. The rate among Maori females was 34% higher than non-Maori females.
- ❑ The prevalence of cancer among Maori has increased over recent years, while it has decreased among non-Maori. The prevalence rate is about 40% higher in Maori.
- ❑ In 1997, Maori hospitalisation rates for diabetes was four to five times those of non-Maori.
- ❑ Since the early 1980s, non-Maori rates of hospitalisation for stroke have remained relatively stable, while rates for Maori have fluctuated upwards.
- ❑ Between 1981 and 1997, Maori hospitalisation rates for pneumonia and influenza increased, particularly during the most recent five years. In 1997, Maori were three to four times more likely to be hospitalised for these illnesses than non-Maori.
- ❑ Admissions to psychiatric hospitals in 1993 were almost twice those of non-Maori.

OLD AND WORTH LESS?

First superannuation, then assets testing, now health care rationing... The elderly may yet again be the prime targets for cuts in social spending if the Government's Health Funding Authority has its way in rationing health services. Lyndon Keene reports.

THE ELDERLY may find themselves pushed back further in the queue for some health treatments if proposals by the Government's Health Funding Authority are implemented. The HFA, which has begun plans to further ration health care services, wants to establish a pecking order for patients based on a measure of the likely quality of a person's life over time if they receive treatment.

Broadly, the fewer the number of years that a patient is likely to benefit from treatment, the fewer points they will get on the "life-years" scale. This will place them low on proposed clinical priority lists. (See box)

The proposed method of rationing, using a controversial measure called "quality-adjusted life years" (QALYs), may also disadvantage some people with disabilities because limitations of their activities would give them lower points on the quality-of-life scale.

One QALY, explains the HFA, is equivalent to living one year with "normal/good health-related quality of life (HRQOL), or two years with one-half normal/good HRQOL, four years at one-quarter normal/good HRQOL, and so forth".

An HFA document, "How shall we prioritise health and disability services?",¹ acknowledges "perceived devaluation of the lives of patients with disabilities implied by reduced scores for such patients". The document argues that treatment decisions are based on the potential to benefit - "people who start off with poorer levels of health...are likely to be capable of obtaining greater degrees of benefit" and therefore might expect to be scored favourably. It adds, however: "This

assumes...that residual health problems do not preclude a return to (or close to) normal/good health."

A practice called "discounting" is also being suggested, which places more value on immediate, rather than delayed outcomes. According to the HFA, this takes account of the fact that "people prefer to gain benefits sooner rather than later, due in large part to greater uncertainty attending delayed outcomes".

Ways of evaluating the effects of these measures have yet to be determined.

"Can we, should we, reduce things to numbers? ... How can such a model ensure that humanitarian concerns predominate?"

- HFA workshop participant

The main ideas behind the proposals were "tested" with service "stakeholders" at a series of invitation-only workshops in July.

The HFA's document, used as the basis for workshop discussions, states: "The HFA starts from the belief that however much money is put into the health and disability support system, there would still be a need to make choices between competing demands and needs."

It describes the HFA's aims to prioritise treatments as "a process of assessing the value of health and disability support services against agreed principles".

These principles, which are "derived from public values elicited through public consultation over a number of

years", are about providing effective, cost-efficient services equitably, which are consistent "with the values of communities" and with particular attention to be paid to Maori health.

Feedback documents from the workshops, obtained under the Official Information Act, show that while there is general agreement in principle on the need for prioritisation of services to be more explicit and equitable, and based on the most effective services, many concerns were raised among participants (who appear to have been selected mainly from among health service providers). Typical comments were:

- ❑ "There is an incorrect assumption that people who have 'something wrong with them' will experience a lower quality of life as a result ... Disability does not need to be assessed, treated and rehabilitated."
- ❑ "Effectiveness is biased towards services where outcomes are well defined. This works against concepts such as caring, or outcomes that are ill defined, or outcomes that don't fit."
- ❑ "There is an age bias - investment in youth versus 'burden' of age."
- ❑ "Where is the budget for research and development? If this is not increased, and the effectiveness information base has not improved, the process could remain 'a lot of fluff' and yet masquerade as science... It was advised the HFA does not take away existing services until they have robust data to support their decision."
- ❑ "The HFA appears unable to grasp that the Maori concepts of health outcome are fundamentally different from that which is offered

in this prioritisation process. The group therefore see the effort to fit Maori concepts of effectiveness into this framework as impossible and inappropriate."

- ❑ "There is a need for transparency in the process. Consult in an open public forum - with a submission-driven process."
- ❑ "Can we, should we, reduce things to numbers? What is intrinsically so valuable about such a reductionist approach? How can such a model ensure that humanitarian concerns predominate?"
- ❑ "The language used is not appropriate to public health. Public health is about shaping people's environment; community capacity; populations, not individuals; support and care, not 'quick fix'; working across agencies ... people being well. These are difficult to measure. There must be value for what we cannot count."
- ❑ "A fundamental approach should be meeting needs - starting from needs assessment. How do 'needs' inform the prioritisation process?"
- ❑ "The principle of safety is to do no harm. Is there potential for any of these principles or the prioritisation process to do harm...?"

THE HFA's workshop background paper acknowledges that "ideally" broader societal cost factors "should" be taken into account when considering the costs of health care (or the costs of not providing health care). It recommends against this, however, because: "Indirect costs such as patient travelling times and productivity losses are not easily measured."

In Canada, a comprehensive government report² estimates the total cost of illness to Canadian society, including indirect costs such as lost productivity, is roughly 22% of the gross domestic product (GDP).

The Canadian Minister of Health, Allan Rock, called this a "key document" for ensuring health dollars are well spent.

(Government funding of public hospitals in New Zealand is currently about 3% of GDP; total government health funding is about 6% of GDP.)

The HFA also acknowledges it is difficult to measure the extent to which

"Young v Old"

Excerpt from the Health Funding Authority's discussion paper on rationing health care, "How shall we prioritise health and disability services?":

“

5. Bias against elderly. The QALY [quality-adjusted life years] approach is often held to discriminate against the elderly by virtue of their shorter life-expectancies. Thus, a person aged 70 can only hope to be restored to a normal life-expectancy of another 10 years or so, whereas young people often gain several decades of life from treatments. This discrepancy will be reflected in the QALY's gained from treatment.

Many would hold that this "bias" is in fact appropriate in light of the concept of intergenerational equity. On this view, the health system should primarily help people live out their normal life-expectancy, and to the extent one has approached (or indeed exceeded) that life expectancy one's claim on health care resources is reduced. On the other hand, retired people often feel that they have "paid their due" in terms of taxes and other contributions to society and that it is "only fair" that they now reap the rewards associated with those dues.

What empirical evidence exists concerning the public's view on the question of "young vs old" would seem to support the kind of favouring of younger people, particularly children, entailed by the QALY approach. This can be seen both from the selection of child health as a priority area by the National Health Committee and subsequently by Government, as well as from the relative lack of protest at the Government's "under-six" policy (free GP visits and other benefits for children under age 6), which probably cannot be justified on grounds of effectiveness alone.

As such, we do not believe the concern about age bias is unduly troublesome. ”

suffering, disability and length of life are affected by treatments - which is required in the QALY approach. However, unlike the position it takes regarding the measuring of total costs of illness, it argues "the prioritisation process will encourage more attention to the need to obtain whatever information is available ... while encouraging the creation of new sources of information...".

THE PUBLIC is due to be consulted on these proposals early next year, but not, it appears, until decisions have been made as to which rationing process is adopted.

1. "How shall we prioritise health and disability services?", Prioritisation Team, Health Funding Authority, May 1998.

2. Economic Burden of Illness in Canada, 1993, Health Canada, 1997

Hikoi of Hope

The Anglican Church-led "Hikoi of Hope" which converged on Parliament on October 1, called for, among other things, a public health system that New Zealanders can trust. The Hikoi listed 10 reasons why New Zealanders have lost that trust.

1. Waiting lists - how does New Zealand compare with other countries?

New Zealand's hospital waiting lists and waiting times are among the longest among developed countries - they may even be the longest. Based on the latest official figures, an estimated 2500 in every 100,000 New Zealanders are on surgical waiting lists. That's nearly five times the rate of Australia's and about three times the rate of Holland's and Canada's, for example. England also has long waiting lists, though New Zealand's rates per population are about 8% higher. Furthermore, latest figures show there are no English patients waiting longer than 18 months for an operation and there are only about four percent waiting longer than a year. In New Zealand in 1997 there were more than 38,600 people (42% of the official waiting lists) waiting longer than a year, and more than 20,000 (22%) waiting longer than two years. In Holland a six-month wait for an operation is considered unacceptable.

Sources: *Purchasing for Your Health*, Ministry of Health, NZ, 1998; Federal Minister of Health of Health, Australia, media release 17 March 1998; *British Medical Journal*, 11 January 1997, 21 March 1998; Department of Health, England, media releases, 16 June 1998, 30 June 1998.

2. Poor accountability to the public

A decade ago the public was represented on elected area health boards. The Area Health Boards Act also established Community Health Committees and there were service development groups which were required to involve the public in areas such as mental health and maternity care. Today there is no elected public



Small beginnings... One branch of the Hikoi begins the long trek to Wellington on September 1 from Half Moon Bay on Stewart Island, led by Bishops Penny Jamieson and George Connor.

representation on any health organisation. A few individuals in one or two areas have been nominated by local body councils to sit on CHE boards. In June of this year, the few surviving community health groups had their small state funding allowances abolished.

Source: Minister of Health media statement, 28 May 1998; Otaki Community Health Group, media release, 8 June 1998

3. Rural hospitals doing less

Rural hospitals procedures have been reduced by about a fifth since 1993. In 1992 there were 1000 surgical discharges from Dargaville Hospital. Last year there were 45. Balclutha Hospital's discharge rates fell from 1716 to 71. Meanwhile rural general practitioners are becoming overworked and are leaving their practices. Provincial New Zealanders are having to travel to main centres for basic health treatment. A British study of international research into the safety and cost effectiveness of small hospitals which provide acute services suggests centralisation of services may not achieve the benefits that are often claimed.

Source: Opposition spokesperson on Health, media release 15 June 1998, 9 July 1998; *Concentration and Choice in the Provision of Hospitals Services*, NHS Centre for Reviews & Dissemination, Report 8, 1997; *Morning Report*, 22 June 1998

4. Larger hospitals are struggling to cope

Total public hospital discharges per 10,000 population increased by only 1.3% between 1994 and 1997, despite advances in technology which enable patients to recover more rapidly and enable more surgery to be performed on a day-treatment basis. Between

1990 and 1993, under the previous area health board system, hospital discharges per 10,000 population increased by 19.6%.

Sources: Minister of Health, media release (based on data from the New Zealand Information Service), 21 May 1998; New Zealand Health Review, Winter 1998.

5. More health dollars spent on bureaucracy

In 1991/92 the cost of administering the public health system through the Department of Health totalled \$52 million. The amount budgeted to administer the health system for this financial year is more than \$120 million, shared between the Ministry of Health and the Health Funding Authority. (A relatively small portion of this increase would be due to the administration of disability support services which were previously administered by Social Welfare.) Our public hospital companies employ one manager for every five medical staff (compared with one manager for every 14 medical staff under the previous Area Health Board system). Hospital companies are now spending an estimated \$330 million on managers and administration, due

largely to the work involved in contracting. Between 1993 and 1996 CHEs collectively spent more than \$50 million on independent management and financial consultants, in addition to their internal administration costs. Earlier this year it was reported that the Health Funding Authority was spending \$19,000 a month for public relations consultants, despite having a communications staff of 15.

Sources: Department of Health Annual Report, 1991/92; Budget 1998; *Health Expenditure Trends in New Zealand*, Ministry of Health 1998; *Health Statistics*, Association of Salaried Medical Specialists, 1996; Alliance health spokesperson, media release (based on response to a question in Parliament), 10 March 1998; *Morning Report*, 24 June 1998.

6. Hospitals lack funds to operate effectively

While total government health funding has increased in real terms in recent years, the extra money is not finding its way to hospital services. Total government health spending increased by 3.6% between 1988/89 and 1996/97 in real per capita terms. However, in the same period real per capita hospital funding decreased by 6.3%, even when taking into account CHE deficit financing and adjustments for different funding arrangements when area health boards changed to CHEs. CHE/public hospitals are \$1.3 billion in debt; they pay about \$60 million in interest payments annually. The Controller and Auditor-General, David Macdonald, said in July that preoccupation with financial measures is distracting hospitals from pursuing better services. In an Audit Office report he says hospitals are sometimes not paid a fair price for what they do.

Sources: *Health Expenditure Trends in New Zealand*, Ministry of Health 1998; *Statistic New Zealand: Trends in Area Health Board/CHE Performance*, Deloitte, Touche Tohmatsu, May 1996; *Report of the Controller and Auditor-General*, second report for 1998.

7. Mediocre funding levels by international standards

In 1980 New Zealand government spending on health was 6.2% of gross

domestic product (GDP), which placed us in 4th position among OECD countries. Since then New Zealand has been one of only five countries which have reduced health spending per GDP. By 1996 New Zealand government spending (including GST and CHE deficit financing) totalled 5.8% of GDP, placing us in 14th position among

"In 1960, New Zealand's infant mortality rate (IMR) ranked 6th out of 21 OECD countries; by 1995 we were in 15th place."

OECD countries. Over that same period private health spending increased from 12.0% to 23.3% of New Zealand's total health spending.

Source: *Health Expenditure Trends in New Zealand*, Ministry of Health 1998.

8. User charges prevent access to treatment

About 200,000 New Zealanders had not seen a doctor when they needed to during 1996/97 because of user charges, according to a Statistics New Zealand survey. The survey of more than 8800 adults and children shows 405,000 people had not seen a doctor when they needed to, with almost half citing costs as the reason they or their children had not sought treatment. Nearly 80 percent of the people surveyed had visited a GP at least once in the previous year. A survey of GPs published in the *GP Weekly* in November 1995 showed 71 percent of respondents believed their patients were delaying seeing their GP because of the cost.

Source: 1996/97 *New Zealand Health Survey*, *Statistic New Zealand*, July 1998

9. Crisis in mental health services continues unabated

The Mental Health Commission estimates staff numbers for children's

mental health services must increase eight-fold to meet the country's needs, and the number of staff working in adults services needs to double. Despite these signals, mental health services are being reduced in some areas. In July, for example, Wellington mental health services were facing cuts of up to 20 staff, and the general manager of mental health services at Waitemata Health said severely disturbed mental health patients are dangerously overcrowded and people are being discharged too early because of the demand for beds.

Sources: *Blueprint for Mental Health Services*, Mental Health Commission, 1998; *Evening Post*, 27 July 1998; *NZ Herald*, 10 July 1998.

10. Declining health status

Compared to other OECD countries, New Zealand has high rates of cardiovascular disease, respiratory disease, breast and bowel cancer, motor vehicle injuries and suicide.

Many cases are preventable. In 1960, New Zealand's infant mortality rate (IMR) ranked 6th out of 21 OECD countries; by 1995 we were in 15th place. Life expectancy in New Zealand has not increased as fast as in many other OECD countries. Since 1990, Maori life expectancy has not increased. Generally, Maori experience an excess burden of mortality and morbidity throughout life, starting with a higher infant mortality rate (mainly due to sudden infant death syndrome), high death and hospitalisation rates in infancy, childhood and youth (predominantly from injuries, asthma and respiratory infections), and higher mortality and hospitalisation rates in adulthood and older age (especially from injuries, cardiovascular disease, diabetes, respiratory disease and most cancers). Maori are more than twice as likely to be admitted to hospital than non-Maori.

Sources: *The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health*, National Health Committee, 1998; *Progress Towards Closing Social and Economic Gaps Between Maori and Non-Maori*, Te Puni Kokiri, Ministry of Maori Development, 1998.



Second National Guidelines Conference

New Zealand Guidelines Group

Date: 27-28 May 1999
Venue: Parkroyal Hotel, Wellington
Theme: Guidelines in Practice

For general information including registration contact:

Joy Mehlhop	Ph:	03-379 0390
Conference Innovators Ltd	Fax:	03-379 0460
PO Box 1370	E-mail	joy@conference.co.nz
Christchurch		

Further information on the conference and on-line registration will be available on the NZGG's website (www.nzgg.org.nz/) from March 1999.

For programme information please contact:

Ashley Bloomfield	Ph:	04-496 2312
National Health Committee	Fax:	04-496 2341
PO Box 5013	E-mail	ashley_bloomfield@moh.govt.nz
Wellington		

Confirmed keynote speakers:

Associate Professor Cindy Farquhar, Department of Obstetrics and Gynaecology, National Women's Hospital and Co-ordinating Editor, Cochrane Menstrual Disorders Group.

Professor George Rubin, Department of Public Health And Community Medicine, University of Sydney and Westmead and Director, Australian Centre for Effective Health Care

Associate Professor Rod Jackson, Head of Department and Director, Effective Practice Institute, Department of Community Health, University of Auckland

Professor Norman Sharpe, Head of Department of Medicine, University of Auckland and Chairman, New Zealand Guidelines Group

Professor Chris Silagy, Director of Public Health, Institute of Public Health Research, Monash University, Melbourne and Head of the Australasian Cochrane Collaboration

Confirmed Workshop Topics:

- Guidelines and the internet
- Use of guidelines in electronic form in general practice

- Consumer involvement in guidelines
- Finding the evidence: how to search the literature
- Evidence-based nursing and the role of guidelines
- Guidelines for the Disability Support Sector
- Selecting and running the guidelines development team
- Guidelines evaluation
- Critical appraisal of evidence for effectiveness
- Guidelines, evidence and the prioritisation of health care purchasing
- Ethical issues in guidelines development
- The role of guidelines in the funding of health and disability support services
- Selecting topics and formulating answerable questions: the suitability screen
- Adapting national guidelines for use at a local level
- Guidelines in Mental Health: Peculiar Issues
- Economic evaluation in guidelines development

Systematic Reviews of Nursing Research.

New Zealand Guidelines Group 1999 Conference: Pre-conference workshop by David Evans, Co-ordinator of Systematic Reviews, Joanna Briggs Institute for Evidence Based Nursing & Midwifery in association with the New Zealand Centre for Evidence Based Nursing.

Date: 26 May 1999
Time: 9.00am - 12.30pm
Venue: Parkroyal Hotel, Wellington

There is no charge for this workshop.
 Numbers are limited to 20 persons.

The aim of this workshop is to provide an overview of systematic reviews and their role in summarising nursing related research. Workshop sessions will focus on the different components of systematic reviews. Specific issues related to reviewing nursing research will also be addressed.

For further information, please contact:

John McArthur
 Director
 NZCEBN
 Auckland Hospital
 Private Bag 92024
 Auckland 1
 E-mail: johnmc@ahsl.co.nz

RECENT MEDICO - LEGAL DEVELOPMENTS FROM THE COURTS

Legal intervention in decisions to withdraw life support: *Auckland Healthcare Services Limited v L & L ("Baby L")* and other cases

In recent "withdrawal of life support" cases, the Courts have considered the "best interests" of the patient in conferring responsibility on the medical profession to make the decision as to whether or not to withdraw life support. In "Baby L" the High Court considered the best interests of a severely deformed baby when it granted an application to place the baby under Court guardianship, and conferred on a Court-appointed doctor the responsibility of deciding if and when to withdraw the baby's life support.

Baby L was born in July 1998 with severe neurological abnormalities and respiratory failure that would inevitably be fatal. According to the medical evidence, Baby L's outlook was hopeless and her treatment was futile and inhumane.

Auckland Healthcare Services ("AHS") made an application to the High Court pursuant to the Guardianship Act 1968 ("the Act") seeking leave to apply for her guardianship. It also sought an order that, if leave were granted, L would be placed under the guardianship of the High Court.

The Court considered that the fundamental principle is that contained in section 23 of the Act which places L's welfare as the first and paramount consideration. It noted that no resource question entered into the clinical assessment of L's medical condition.

Justices Cartwright and Paterson considered that L's medical condition meant that she was an "extreme case". They stated that, in such a case, consultation amongst appropriately qualified medical personnel is essential. This had taken place in respect of L. L's parents also expressed their views to the Court. Their Honours stated that the parents' views were of great relevance to the consideration of L's best interests, but that "the views of parents cannot act as a veto to an application". The Court agreed with counsel for the Attorney General that the approach to take was a "best interests" test which involved balancing the relevant rights, the therapeutic or medical benefit of the treatment, the chance of recovery, the impact of the treatment on the child and the parents' views. All but the last factor favoured AHS's application.

The Court concluded that this was one of the "extreme instances" in which the Court must take responsibility for L in its wardship jurisdiction. It considered L's right to life and her parents' wish for her life to be prolonged, contrasted with her right to be free from pain, and concluded that L's best interests would be promoted by granting the application. The Court granted orders :

- (i) to place L under Court guardianship;
- (ii) to appoint a doctor as the agent of the Court for the purposes of L's medical treatment; and
- (iii) that treatment may include a decision not to intervene actively to resuscitate L and/or to withdraw ventilatory support.

Auckland Area Health Board v Attorney-General [1993] 1 NZLR 235 ("Re L")

New Zealand Courts in other "withdrawal of life support" cases have also applied a "best interests" test. The Court in *Re L* applied this test and, as in *Baby L*, gave a wide discretion to the medical profession to make the decision to withdraw life support.

Re L involved an application by doctors for a declaratory judgment that they would not be liable for prosecution under the Crimes Act for withdrawing a patient's life support. Mr L was, like Baby L, in a "persistent vegetative state". His Honour Justice Thomas indicated that he would be reluctant to make the order sought if the Crimes Act were not potentially applicable in this case. He did not consider that courts should intervene in clinical decisions. However, he held that the Court did have the jurisdiction to make the order and he made it in order to protect the doctors involved.

Justice Thomas concluded that a doctor acting in good faith and in accordance with good medical practice is not under a duty to render life support necessary to prolong life if that is, in his or her judgment, contrary to the best interests of the patient. His Honour stated that doctors acting in accordance with the following guidelines will be deemed to have acted with a lawful excuse and so will not be liable to any criminal sanction:

- (i) they have made a bona fide consultative decision as to what, in their judgment, is in the best interests of the patient;
- (ii) the decision was made in accordance with the prevailing medical standards, practices, procedures and traditions which command general approval within the medical profession; and
- (iii) the appropriate ethics committee has been consulted, and the proposed course of action was arrived at with informed agreement (though not necessarily consent) of the patient's family or guardian.

Re G [1996] FLR 362

This case extended the reasoning about withdrawal of life support decisions to include a patient with severe brain damage who was not in a persistent vegetative state. However, the patient's prospect of recovery was negligible.

Mr G's family applied to the Court for consent to withdraw his life support. It also applied for a declaration that the discontinuance of treatment would not be unlawful.

The Court held that, if persons are incompetent to consent medical treatment, a Court may consent on their behalf. The proper approach is to adopt a "best interests" test, but to give weight to the likely wishes of the patient, and the views of the family and medical carers.

Brider and Hughes (Unreported, High Court, AP 120/98, 3 December 1998, Doogue & Durie JJ)

The recent High Court judgment in *Brider & Hughes v ACC* has received wide media attention.

The case is an emotive one. Ms Brider's husband, Mr Hughes was infected with HIV as a result of a blood transfusion required after he suffered a motorcycle accident in 1984. Mr Hughes claim for ACC was accepted on the basis that he had suffered medical misadventure. However, Ms Brider and her son also contracted HIV from Mr Brider. Ms Brider lodged a claim for both herself and her son with ACC. These claims were declined on the basis that the Accident Rehabilitation and Compensation Insurance Act 1992 ("the ARCI Act") only allowed cover for medical misadventure for the person who underwent the medical treatment.

Ms Brider applied for a review of this decision under the ARCI Act and, when this review was declined, she appealed that decision to first the District Court and then the High Court.

The ARCI Act provides cover for personal injury which:

“(2) Cover under this Act shall extend to personal injury which--

- (a) Is caused by an accident to the person concerned; or
- (b) Is caused by gradual process, disease, or infection arising out of and in the course of employment as defined in section 7 or section 11 of this Act; or
- (c) Is medical misadventure as defined in section 5 of this Act; or
- (d) Is a consequence of treatment for personal injury covered by this Act.”

“Medical misadventure” is defined in section 5 as “personal injury resulting from medical error or medical mishap”.

A number of phrases in section 5 refer to the patient who has received the medical treatment in question. For example:

“(4) For the purposes of the definition of the term “medical mishap”, the adverse consequences of treatment are severe only if they result in death or--

- (a) **Hospitalisation as an in-patient** for more than 14 days; or
- (b) Significant disability lasting for more than 28 days in total; or
- (c) The person qualifying for an independence allowance under section 54 of this Act.”

In the District Court His Honour Middleton DCJ concluded that, given the phrases used in section 5, the ACC could not accept a claim for either Ms Bridger or her son. Middleton DCJ stated:

Examination of s5 appears to me to emphasise that it applies to the person who specifically undergoes the treatment and who thereafter suffers an adverse consequence of that treatment. If it is said that these appellants have suffered an outcome which is recognised as rare then it must also be established that at the time of treatment the possible outcome was known to that person. I agree with Mr Barnett’s submission that the section cannot possibly have contemplated that the reference in s5(3) to “the particular person injured” could possibly include a third party. That proposal raises the question of how would the third party have any knowledge of possible risk arising out of treatment to the patient who received the medical treatment.

The whole tenure of s5 relates to medical treatment to the particular person to whom the medical treatment is given and it is difficult to accept from the particular nature of the wording of the section that it is intended to extend beyond the person who receives the treatment.

The High Court judgment was delivered on 3 December 1998. The Court made the following findings:

- while the ARCI Act introduced the notion of an insurance based scheme and restricted the circumstances in which cover was given, the principles in which accident compensation was introduced in New Zealand in 1972 still apply;
- therefore in approaching the 1992 Act, one can properly start with the assumption that cover for a particular situation will be same as the 1972 and 1982 Acts unless the specific case in question has been expressly taken away;
- the fair, large and liberal interpretation required by s5(j) of the Acts Interpretation Act 1924 applies;

- by prescriber definition, cover for medical mishap is restricted to consequences that are rare and severe but this does not oust the cases that have applied a causative chain to admit secondary victims.

The High Court found that s8 was the key provision and that the central word was "resulting" with the claims of secondary victims depending on the meaning of that word. The Court then found that the "every day use" of "resulting" did not require an immediate nexus. It therefore concluded:

Accordingly it can be said, quite naturally, and within the terms of s8(2)(c) that Ms Brider and Master Casey contracted AIDS as the result of a blood transfusion that constituted a medical misadventure, namely that to Shannon Hughes.

The Court concluded that the word "consequence" in s8(2)(d) is little different from "results".

While the High Court's view is an arguable one, with respect, it simply does not reflect the intention behind s5 of the ARCI Act. The phrases used in s5 are directed at medical misadventure suffered by the person undergoing medical treatment.

However, the issue has now been resolved by the Accident Insurance Act 1998. This Act, which was passed only days after the High Court judgment in Brider & Hughes, includes a specific exception for medical misadventure suffered by third parties.

Section 357 states:

"Personal injury caused by medical misadventure": Addition to Section 35 - For all the purposes of this Act, "personal injury caused by medical misadventure" includes personal injury that is an infection suffered by the spouse, child, or other dependant of an insured in the following circumstances:

- (a) the insured suffers a personal injury caused by medical misadventure and the injury is an infection; and
- (b) the insured passed the infection on to his or her spouse, or child or other dependant directly or through his or her spouse."

This means that there now can be no question that a spouse, child or dependent who contracts an infection from a patient who suffers a medical misadventure has ACC cover.

To discuss the matters dealt with in this publication you should contact Jill Mallon (jill.mallon@bellgully.co.nz) or Helen Preston (helen.preston@bellgully.co.nz) at Bell Gully Buddle Weir, Barristers & Solicitors, Wellington.

Disclaimer: The information in this article is necessarily brief and general in nature. You should seek professional advice before taking any action in relation to the matters dealt with in this article.

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PROFESSIONAL LIABILITY INSURANCE PROGRAMME FOR MEMBERS OF COLLEGE OF NURSES AOTEAROA (NZ) INC

The Professional Liability Insurance Programme is available to all members of the College of Nurses Aotearoa (NZ) Inc. The cover can be summarised as follows:

WHAT ARE YOU COVERED FOR?

Any claims arising from your activities as a Nurse alleging any civil or statutory liability, including any claim arising from the ownership or use of any kind of equipment. The cover will pay for any legal costs and expenses incurred in the defence of any action or complaint made against you such as disciplinary hearings, committees of enquiry, ACC hearings, Privacy complaints and the like. The policy will pay for any costs or damages awarded against you in any medical malpractice/negligence claims, as well as paying for any legal and other defence costs, whether the case is successful or not.

HOW MUCH ARE YOU COVERED FOR?

The basic limit is \$2,000,000 per annum subject to a limit of \$1,000,000 per incident including costs.

HOW MUCH IS THE EXCESS?

\$250 each and every claim including costs and expenses.

WHAT ABOUT YOUR PAST ACTIVITIES?

Apart from any current or pending complaints or claims against you, or circumstances which you are aware of now which could lead to a claim or complaint, the policy will respond to any claim/complaints arising from past duties or functions performed by you while you were a member of the College.

WHAT DO YOU DO IN THE EVENT OF A COMPLAINT/CLAIM?

You should immediately contact John Martin at Aon Risk Services NZ Limited, Professional Indemnity Division on (04) 472.1699, who will provide you with the appropriate advice. It is extremely important that you should seek the advice of your Insurers immediately any complaint is made against you.

WHO PROVIDES THE INSURANCE?

The cover is provided by AMP General Insurance Limited, who are one of the largest and most experienced Medical Malpractice Insurers in Australasia.

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