AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

JULY 2012

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THE GOOD DOCTOR:
WHAT PATIENTS WANT

After 10 years of listening to thousands of stories from patients and doctors in his role as Health and Disability Commissioner (HDC), and countless hours of researching and lecturing in health law and policy in the UK, the USA, Canada and Australia, Ron Paterson reckons he knows not only what makes a good doctor, but also what patients want.

At the beginning of June, several members of the Auckland Women's Health Council attended the launch of *The Good Doctor*, the book written by Ron Paterson after further research and reflection during his time as the 2009 NZ Law Foundation International Research Fellow. (1)

The Good Doctor is surprisingly readable and entertaining – one AWHC member described it as a real page-turner – given the weighty medical and legal issues that the book deals with.

The book is divided into four parts. Part 1, "The good doctor: the ideal," describes what a good doctor is, based on the views of patients and doctors, explains what a 'good enough' doctor is, and contrasts this with the 'problem doctor.'

Part 2, "Problem doctors, part of the reality," describes in detail what constitutes a problem doctor, provides a case study from the HDC files, along with the scandals and inquiries that have brought this issue to public prominence, and examines "some of the ways in which such doctors fall short – by leaving patients in the dark; by exploiting patients; by harming patients; and by treating patients callously."

Part 3, "The Roadblocks: why is change so difficult?" looks at why achieving the ideal is so difficult. This section explains the players and the system, describes undemanding patients and overburdened doctors, reluctant regulators, medical culture, and legal restraints.

In Part 4, "Prescription for change: what can we improve?" Ron Paterson focuses on three main areas where he sees that improvements are needed – information for patients, recertification of doctors, and public trust in the medical profession. His prescription is evidence-based and a bit scary – for both patients and doctors.

The scary bit

For patients, Part 4 is rather scary as among other things it describes the recertification process for doctors, and introduces the concept of the doctor who is not vocationally registered. Few members of the general public will have heard of vocational registration, let alone knowing what it actually means, or whether their own GP is vocationally registered.

But as Ron Paterson explains the Medical Council and the Health and Disability Commissioner certainly do:

"Non-vocationally registered doctors are more likely to be subject to complaints and competence concerns, particularly in general practice. This is hardly surprising, since one would expect the attainment of a specialist qualification and admission as a Fellow of a college to signify a higher level of skills and knowledge. Vocational registration means that a doctor is qualified and

permitted to work in a specialist scope of practice."

He goes on to state that "general registrants working in the community, particularly in solo practices or alongside other non-vocationally trained doctors, may perform poorly without detection. New Zealand, while at the forefront of promoting primary care, lags behind other countries by tolerating general registrants working in general practice. It is unsatisfactory that around one quarter of doctors working in general practice are not vocationally registered, nor working towards vocational registration by participating in a training programme."

Having read and then reread Part 4, the AWHC's co-ordinator wondered whether her own GP was vocationally registered. Her response was not what you might expect in a woman's health advocate. She wondered what she would do if she found that he wasn't vocationally registered. He had been her GP for many years, and she was reluctant to set about finding another one.

For a couple of weeks she thought about what she would do with the information, whether she would raise the issue with her GP if she found out that he wasn't vocationally registered, or whether she would take the easy way out and find another GP who was vocationally registered.

Finally, having made her decision, she plucked up the courage to go to her computer, nervously googled his name and went to the Healthpoint website which provides information on whether doctors are vocationally registered – www.healthpoint.co.nz

She was relieved but not that surprised to find that he was. Her brief discussions with him on health issues over the years inclined her to believe that he was likely to be vocationally registered. And if he wasn't, then she would make an appointment to go and see him and ask him about it.

The medical profession's response

The medical profession has been reported as reacting coolly to Ron Paterson's prescription for improvements, especially his claim that there was an unhealthy closeness between the Medical Council and the medical profession.

Medical Association, Dr Paul Ockelford, said the doctors on the Medical Council provided high levels of professional insight. And the Medical Council's chairperson, Dr John Adams, said its systems for requiring doctors to demonstrate ongoing competence as the basis of renewing their annual practising certificates struck the right balance between external regulation and the culture of medical professionalism. (2)

Of course this just confirms that there is considerable truth to the claim.

The book ends with Ron Paterson's three recommendations for regulatory change which he says are consistent with patient and public expectations, are practical and achievable, and are designed to support, not undermine medical professionalism.

And he's quite right – they are.

References

1. Ron Paterson. *The Good Doctor*. Auckland University Press 2012.
2.www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10810212

PERINATAL & MATERNAL MORTALITY IN 2010

The Perinatal and Maternal Mortality Review Committee (PMMRC) has released its report on perinatal and maternal mortality in New Zealand for the year 2010. This is the committee's sixth PMMR report. This year the report was able to analyse and report on five years of data for the period 2006 – 2010.

Maternal mortality

There was one direct maternal death and seven indirect maternal deaths in 2010. A direct maternal death is one that is the result of obstetric complications during pregnancy, birth and up to 42 days postpartum, and from interventions, omissions or incorrect treatment. An indirect maternal death is one that is the result of a pre-existing disease or a disease that developed during pregnancy that was not due to obstetric causes, but was aggravated by the physiologic effects of pregnancy.

The cause of the one direct maternal death was amniotic fluid embolism.

The seven indirect deaths include three suicides, two pre-existing medical conditions, one case of non-obstetric sepsis, and one case of intracranial haemorrhage.

Five years of data

The 57 direct and indirect maternal deaths from 2006-2010 included:

- 21 antepartum and 36 postpartum
- 37 occurred in hospital and 20 in the community
- 40 births and 17 undelivered babies
- 18 with potentially avoidable factors present, 37 with none and 2 were unknown.

The factors relating to the potentially avoidable deaths involved 18 cases relating to organisation and/or management, 17 relating to personnel, one relating to technology and equipment, three relating to the environment (long transfer) and 21 relating to barriers to access/ engagement with care.

The report notes that in the five years from 2006-2010 the MMR working group believed that a third of maternal deaths were potentially avoidable.

The most frequent causes of maternal death in New Zealand in the years 2006-2010 were suicide (13 cases), maternal pre-existing medical condition (11 cases) and amniotic fluid embolism (9 cases). Of the 11 women with pre-existing medical conditions, eight were recorded as being overweight or obese, and four had pre-existing cardiac disease.

Maori and Pacific mothers are more likely than New Zealand European mothers to die during pregnancy or in the six weeks postpartum.

Amniotic fluid embolism

The report states that amniotic fluid embolism was the third most common cause of maternal deaths over the five-year period, responsible for nine deaths. All mothers who died of amniotic fluid embolism were multigravidae and non-smokers, and all died in hospital. Three mothers died intrapartum and six postpartum.

Amniotic fluid embolism is associated with induction of labour and with caesarean section. Among the nine

deaths reported in NZ, five mothers were induced – four with prostaglandins and one with artificial rupture of membranes only. Six of the nine births were by caesarean section.

Recommendations

The report includes a number of recommendations relating to maternal mortality concerning maternal illness and death. They are:

- Pregnant women who are identified with pre-existing medical disease during pregnancy should be referred appropriately.
- The committee recommends that mother and baby units be established in the North Island, and notes the importance of screening mothers for a history of mental health disorders.
- A comprehensive perinatal and infant mental health service includes screening and assessment, timely intervention, access to respite care and specialist inpatient care for mothers and babies, consultation and liaison services.
- Termination of pregnancy services should undertake holistic screening for maternal mental health and family violence and provide appropriate support and referral.

Maternal Mental Health

Previous reports have also recommended the integration of maternal mental health services into maternity services, and confirmed the need for mother and baby units in the North Island, two initiatives that the AWHC has supported and lobbied for since the mid 1990s.

Perinatal mortality

In 2010 the perinatal mortality rate was 10.1 per 1000 deaths – perinatal mortality being foetal or early neonatal deaths after 20 weeks gestation and up to 7 days after the birth. This is higher than the rate in Australia but similar to the UK in 2009.

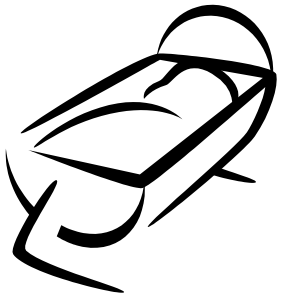
Some of the key points in the report:

- Maori & Pacific mothers are more likely to have stillbirths and neonatal deaths than NZ European and non-Indian Asian mothers. The reasons for these inequalities are unknown and require further investigation.
- There is an excess of perinatal-related death from spontaneous preterm birth among Maori and Pacific mothers.
- There is a significantly increased rate of stillbirth and neonatal death among mothers in the most deprived socio-economic quintile compared to all less deprived quintiles.
- Mothers under the age of 20 years are at higher risk of stillbirth and neonatal death compared to those aged 20–39.

Recommendations

The report has a number of recommendations regarding perinatal related illness and death, including the recommendations around babies that are small for gestation age, smoking cessation, maternal gestational weight gain and neonatal encephalopathy.

The PMMRC report can be found at:
www.hqsc.govt.nz/assets/PMMRC/Publications/PMMRC-6th-Report-2010-Lkd.pdf



NEW ETHICS COMMITTEES SYSTEM START WORK

On 13 June 2012 the Ministry of Health's seven ethics committees were formally disestablished and the new stream-lined, clinical trials-focused, pharmaceutical industry-friendly system with its four new ethics committees was established. It even came with a brand new website: http://www.ethics.health.govt.nz/

The four new ethics committees have only eight members instead of 12, resulting in a loss of expertise and a significant reduction in lay representation. Like their predecessors, the four committees are "ministerial committees" whose members are appointed by the Minister of Health. The new committees are called Northern A (Ryall's Folly), Northern B (Ryall's Foolery), Central (Ryall's Flunky) and Southern (Ryall's Fault).

At the same time the new "*Standard Operating Procedures*" for the new ethics committees took effect, thus completing the gradual dismantling of the world-class ethics committee system established in the wake of the Cartwright Inquiry to protect the interests of the patients, now known as research participants.

Protests

There was opposition to the proposed changes. Women's health groups protested, wrote letters, submissions and articles in an effort to draw attention to what was happening. We weren't the only ones. As described in an article in the February 2012 issue of the AWHC newsletter, five professors published an open letter to Minister of Health Tony Ryall regarding the proposed changes. They were the head of Otago University's bioethics centre, Professor Gareth Jones, Professors Donald Evans, Charlotte Paul, John McCall and Auckland University's Professor Tim Dare.

Their letter stated there were major concerns about the processes around the creation and implementation of the new policy and referred to major flaws in the quality of information received by the Select Committee that led to these changes.

It all fell on deaf ears as those in charge of the final unravelling of the ethics committee system of patient protection had dollars in their sights.

Ryall's Folly

Northern A has its first meeting at 1pm Wednesday 25 July 2012 at Novotel at 72-112 Greenlane Road East, Auckland.

Ryall's Foolery

Northern B will meet at 12 noon on Wednesday 1 August at Novotel, 7 Alma Street, Hamilton.

Ryall's Flunky

Central is due to meet at 12 noon on Tuesday 24 July at the Terrace Conference Centre, 114 The Terrace, Wellington.

Ryall's Fault

Southern is scheduled to meet at 12 noon on Tuesday 7 August at Copthorne Hotel at 449 Memorial Drive, Christchurch.

These meetings are open to the public so do go along and check out how the new committees are coping with their new stream-lined work loads.

http://www.ethics.health.govt.nz/

NORTH SHORE WOMEN'S CENTRE COURSES

The North Shore Women's Centre offers a variety of services for women, including information, referral and counselling as well as a number of courses and clinics.

The courses and groups include:
A creative art group

"Re-Defining Me" women's group

Bellydancing for beginners

Healthy Eating on a Budget

Tai Chai

The health clinics include:
A massage clinic held on the 2nd Friday of each month.

Mobile Breastscreening

A legal clinic held every Tuesday and Wednesday between 10am – 12 noon. Half-hour sessions.

A massage clinic held on 2nd Friday of each month.

Mobile cervical screening with a free smear for Maori, Pacific or Asian women, of women over 30 who have not had a smear test for 5 years or more.

Bookings essential.

For further information contact the North Women's Centre on phone (09) 444-4618, or visit their website: www.womyn-ctr.co.nz/

AWHC GENERAL MEETING 31 May 2012

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Medical devices
- Breast cancer screening
- Cervical screening committee
- DHB meetings
- Conferences

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.

AWHC NEWSLETTER SUBSCRIPTION

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Send your cheque to the Auckland Women's health Council, PO Box 99-614, Newmarket, Auckland 1149.

UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for July/August 2012:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
At the beginning of the year the Waitemata DHB has now moved to a 6-weekly meeting cycle.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 18 July 2012.

Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 8 August 2012 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 1 August 2012 followed by the Full Board meeting at 2pm. Both meetings will be held in the A+ Room, Clinical Education Centre, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Hospital Advisory Committee meeting will be held at 9am on Tuesday 24 July 2012 and will be followed by the Community & Public Health Advisory Committee meeting at 12.30pm at the Board Room at 19 Lambie Drive, Manukau City.

The Counties Manukau DHB Full Board meeting will be held at 1pm on Wednesday 1 August 2012 at 19 Lambie Drive, Manukau City.

BIOETHICS & HEALTH LAW CONFERENCE

The Australian Association of Bioethics & Health Law conference ***Harm, Health and Responsibility*** will be held on12-14 July 2012 at the Viaduct Centre Auckland.

Speakers include Dr Nancy Berlinger, Professor Carl Elliott, Professor Ron Paterson, Professor Charlotte Paul, Professor Mason Durie, as well as sessions that will be chaired by Grant Gillett, Joanna Manning, Monique Jonas, Phillipa Malpas, etc.

For further information go to: www.cdesign.com.au/aabhl2012/program.html