26 July 2018

Kanny Ooi
Senior Policy Adviser and Researcher
Medical Council of New Zealand
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Dear Kanny

Re: MCNZ's draft revised statement on Safe Practice in an environment of resource limitation

The NZSA welcomes the opportunity to provide feedback on the proposed revised draft.

About the NZSA
The NZSA is a professional medical education society, which represents over 600 medical anesthetists in New Zealand. Our members include specialist anesthetists in public and private practice, and trainee anesthetists. We facilitate and promote education and research into anesthesia and advocate on behalf of our members, representing their professional interests and the safety of their patients. As an advocacy organisation, we develop submissions on government policy and legislation, work collaboratively with key stakeholders, and foster networks of anesthetists nationwide. The NZSA, established in 1948, also has strong global connections and is a Member Society of the World Federation of Societies of Anesthesiologists (WFSA).

Overview
The NZSA commends MCNZ for seeking to develop a statement which reflects a more patient centred approach. We are supportive of most of the key proposed changes, particularly the importance of medical practitioners considering factors of equity, cultural competence, and working in partnership with patients when making decisions of resource allocation. We also fully support the inclusion of Choosing Wisely principles. However, the NZSA does have concerns about aspects of some proposed changes, which are outlined in our submission.

Specific comments and responses to questions

(A) Summary box at the outset
Are there any other key points that should be included or omitted from the summary box?

Bullet point four states: *Doctors must balance their duty of care to their patient with their duty of care to the wider population by making efforts to use resources efficiently and equitably,*

consistent with good patient care, and in accordance with guidelines and pathways where these apply. We believe that this is unworkable as it contains a conflict of interest. We would suggest that when treating the patient in front of you, your duty is to do the best by that individual regardless of the resource it may take. The duty to the wider population needs to be determined by policy and not when also juggling the plight of an individual. This is also in direct conflict with principle number 10 in MCNZ's statement: *Doctors have a responsibility, as advocates for their patients, to seek the provision of appropriate resources for their patients' care and report any deficiencies to the appropriate authorities. Where these deficiencies are serious, the report should be made in writing.*

We believe that it is the responsibility of the Ministry of Health and PHARMAC to make the public aware of resource constraints, as the focus of medical practitioners needs to be on providing the best care to each of our patients. An article that looked at equity in health within a country found that the decisions made by medical practitioners are based on providing equity in healthcare. The principle of not leaving any patient untreated was very dominant. This article backs the view that health providers cannot be the ones who decide where resources are to be allocated as this is subjective and the individual patient will come first.[1]

(B) Expanded 'background'
The proposal to add the sentence stating that health rationing requires clinical input and leadership is supported.

Our health sector needs increased clinical governance to best meet the needs of patients.

(C) Proposed changes to the section 'Ethical principles'
We fully support the inclusion of a footnote reference to the global initiative Choosing Wisely, now being implemented in New Zealand, which has been endorsed by the medical colleges including the Australian and New Zealand College of Anaesthetists (ANZCA). This patient-centred initiative is to be applauded as it aims to avoid low-value care and inappropriate clinical interventions and provides a sound platform for clinicians to help their patients make informed decisions about treatment and health outcomes.

(6) More emphasis on working in partnership is strongly supported as it reflects the major shift which has taken place in the doctor-patient relationship, and correlates to patients have more say in their healthcare and informed consent. Many studies have identified this shift of the patient's involvement in their own care.[2]

(D) Incorporating Choosing Wisely principles
We fully support paragraph 10 being expanded to include the principles of Choosing Wisely, for the reasons we have outlined under C above. We would also draw your attention to ANZCA's Choosing Wisely Principle 4 'Avoid initiating anaesthesia for patients with limited life expectancy, at high risk of death or severely impaired functional recovery, without

[1] Allocating health care resources: a questionnaire experiment on the predictive success of rules, International Journal for Equity in Health 16(1): 112, 2017 June 26.

[2] Status report from Norway: Implementation of patient involvement in Norwegian health care, http://dx.doi.org/10.1016/j.zefq.2017.05.015

discussing expected outcomes and goals of care.' Patients over 70 years of age who undergo major surgery in Australia and New Zealand healthcare facilities are at high risk of postoperative events, with 20% experiencing complications within 5 days, 10% requiring critical care admission and 5% dying within 30 days. Conversations in which the medical practitioner may have to discuss the high risk of postoperative morbidity and mortality with patients deemed at risk, are difficult and medical practitioners need more training in having these conversations. There will be times, particularly for patients deemed to be fragile, (that is the state of increased vulnerability to stressors such as surgery and hospitalisation which increase the risk of adverse outcomes) where it will not be in their best interest to have an operation or other surgical services.

There is currently considerable research into implementing frailty assessment as part of clinical practice and assessing whether preoperative measures and postoperative management can improve outcomes. Discussion with the patient and their family about the risks and benefits of hospitalisation and surgery in this context are hugely important, but as stated more training is needed for doctors in how to raise these issues and discuss them with patients. As ANZCA states under principle 4: "For patients at highest risk, and where time allows, the discussions should be led by a multidisciplinary, consultant level team, particularly where there is a risk of futile surgery and/or futile intensive care. It is important to ensure that alternative care, focused predominantly on comfort and dignity, is offered to patients and their families."

This of course requires a well-resourced palliative care service for these patients.

We are happy to provide further information on the issues raised or to answer any questions the panel may have in relation to our submission. I can be contacted on: president@anaesthesia.nz

Yours sincerely

David Kibblewhite
NZSA President