College News

Nurse prescribing gathers steam

Momentum is gathering in the ill-considered drive to institute independent nurse prescribing. Initiated by enthusiasts within the Ministry of Health, and perpetuated by uncritical enthusiasm from two successive Ministers of Health, the proposal is fraught with problems. Wyatt Creech concedes he is dependent on expert advice on "technical matters", but only accepts that advice from a narrow and partisan source.

The College continues to lobby at the political level (including individual politicians and the Select Committee considering the Medicines Amendment Bill) and will be seeking a more active media presence, highlighting issues of patient safety.

The release of the final report of the UK Review Of Prescribing, Supply & Administration Of Medicines provides interesting contrasts to the proposals for New Zealand. The UK report consistently draws a distinction between professionals who initiate prescribing and devise the broad treatment plan (independent prescribers) and those who prescribe certain medicines for patients whose condition has been diagnosed or assessed by an independent prescriber, within an agreed assessment and treatment plan (dependent prescribers).

Although the initial New Zealand Ministry of Health working group on nurse prescribing acknowledged this distinction, it has become lost in the wilderness of political posturing and the subsequent report of the Ministerial Taskforce on Nursing. As far as we can tell, the advocates of nurse prescribing in this country favour the independent model.

Pilot scheme vetoed

The NZ Ministry of Health working group grudgingly admitted in November 1997 that there is no clear evidence of benefit from nurse prescribing, and recommended a pilot study as the best way forward. The RNZCGP has consistently promoted this option, but the Ministry ignored the advice of its own working group and elected to proceed (under political direction) with the introduction of prescribing for the young and the old. The current proposals are for nurses to prescribe medicines ranging from antibiotics and inhaled steroids through to narcotics for groups which comprise a significant proportion of the population of New Zealand.

They also constitute the most difficult and vulnerable groups to prescribe for with safety. There is no commitment to analysis of the benefits, safety and cost – even if this were possible with such enormous scope of practice. Similarly, there is no suggestion that continuation of this initiative is contingent on demonstrating that is

worthwhile. It is a fait accompli.

The contrast with the UK situation is acute. The Department of Health in the UK has conducted an extensive series of thoroughly evaluated pilot schemes on extended nurse prescribing prior to the release of their current policy. Also in marked contrast to the local proposals, the UK report identifies controlled drugs and antibiotics as unsuitable for new prescribers. No such restrictions have been suggested here.

Interestingly, the UK report identifies only two nursing specialties (family planning nurses and tissue viability nurses) as potential independent prescribers. Dependent prescribing is envisaged for specialist nurses in the areas of asthma, diabetes and palliative care.

The College is greatly concerned not only about patient safety and cost implications of independent nurse prescribing, but also about the divisive effects on teamwork in primary care.

At a time when collaboration between providers is signalled as the only way forward, it appears particularly bizarre for legislators and the Ministry to spend so much effort on facilitating one provider group to act autonomously

Back to the Top

Consumer Liaison Committee. Council voted to establish a consumer committee with four consumer representatives, including one Maori, for a one-year trial period.

The chair of the consumer committee will be invited to attend Council as an observer with speaking rights.

New constitution on its way. The College Council met on 26 and 27 March. A sizeable portion of the first day was spent examining the revised draft constitution.

The existing constitution has been repeatedly modified over the years in an ad hoc manner to accommodate changes to College structures and processes. Some of the changes have been minor, but have required complicated changes to multiple clauses in the constitution with ratification at the AGM. This has resulted in a clumsy and difficult document.

The new version has been separated into two parts: the rules, which describe core structures and goals of the College, and the regulations, which contain the detail. Changes to the rules will require ratification at the AGM, whereas the regulations can be changed by Council. The new constitution will be circulated to members and put before the AGM in Wellington in July for approval.

Working with the universities. The history of the College's relationship with the universities is complex. However, a new liaison committee (the Joint Advisory Board) has been approved, with representation from both organisations.

A signal of the new commitment to an improved working relationship was the attendance of two university representatives at a recent strategic planning day for the GPVTP. The expectation is of greater GP input into diploma courses, and more use of the universities' educational expertise for development of the GPVTP.

Back to the Top

Pharmaceutical changes cause concern

The RNZCGP frequently responds to Pharmac's proposed pharmaceutical changes. The following article briefly outlines our concerns about the changes recently introduced by Pharmac.

Availability Pharmac contracting significantly impacts on general practice: the variety of available pharmaceuticals is reduced.

Some low volume/low cost pharmaceuticals which have application principally in general practice have disappeared from pharmacy shelves. The result is either that GPs have to use more expensive substitutes, or the substitutes (if available) are less suitable.

It appears that this concern regarding practice quality has not been taken into consideration by Pharmac.

Quality Pharmac's contracting process has significantly impacted on pharmaceutical quality.

Substitute pharmaceuticals do not always meet the packaging quality of the brands they are replacing, eg, Global's atenolol is presented in free form and not the calendar pack of other brands.

These inadequacies have obvious implications in the area of patient compliance. We have recommended that Pharmac set quality standards for pharmaceutical packaging and ensure that these are audited with the intention of improving the standards. Such audits should be transparent and available to consumers and health professionals in order to improve the effects of market forces in the pharmaceutical arena.

Subsidy changes The large number and the frequency of changes to pharmaceutical subsidies is impossible for the average GP to keep up to date with, even when limiting themselves to their own areas of typical pharmaceutical utilisation.

Many of the changes are poorly publicised and are buried in the lists of changes to the Pharmaceutical schedule. The result is a greatly increased workload for GPs, with a negative impact on the quality of patient care. An example being the removal of the subsidy on combination thiazide/betablockers which led to significant cost increases for many patients. These changes are often seen to be "sprung" on both GPs and patients.

Funding It is not clear how IPA pharmaceutical budgets will be impacted, if at all, by many of Pharmac's suggested changes.

Although the College is not privy to the contracting between IPAs and Pharmac, we hope that IPA pharmaceutical budgets will reflect the same projected cost increases as are allowed for in RHA agreements for funding.

Specialist & Special Authority criteria We are not aware of Pharmac's criteria for deciding whether a pharmaceutical will be Hospital Pharmacy-Specialist prescription (or Special Authority or Specialist only), and how often it is reviewed. Transparency in this process is vital. If the cost of these agents is the principal reason for specialist restriction, Pharmac should make this clear.

The development of the criteria should take into account the fact that Special Authorities affect more than one type of vocationally registered medical

practitioner.

Summary The RNZCGP focuses on improving GP performance. Pharmac's approach to "consulting" GPs concerning proposed pharmaceutical changes (and the resulting decisions), may seriously impact on quality patient health care in the future. We have urged Pharmac to consider the "buy in" of GPs in order to improve the process and consequently GP performance.

Consultation with limited timeframes (frequently only seven days) does not enhance cooperation with the Pharmac process.

Back to the Top

Early vocational education

Ian St George is a Wellington GP

Introduction

The realisation that GPs need special vocational education in the workplace dawned only slowly on a profession that had always regarded the undergraduate programme as sufficient. In 1964 Ashley Aitken presented a memorandum to the New Zealand Council of the Royal College. He and Ken Williams recommended a four-year programme of hospital training with, during the second two years, a one-month course of lectures and annual three-month release periods to approved general practices.

In November 1970 the College Council agreed to the selection of appropriate practices and in 1972 Eric Elder of Tuatapere and John Hiddlestone, the medical superintendent of Kew Hospital, introduced a registrar training scheme in Invercargill.[1]

These activities built on even earlier ones: Hiddlestone would later write: "It is impossible to attribute origins or initiatives as though there were some unique creative impulse. For many years and in many places concerned and dedicated family physicians had helped each other both as contemporaries or in a senior/junior relationship." [2]

William F Shirer

While researching the history of John Street Doctors in Newtown Wellington,[3] I was shown an account of what may be the first vocational education scheme for general practice in New Zealand.

Dr William Francis Shirer worked here from 1924 to 1969. He was born in the old manse in Adelaide Road in 1899, the son of the Reverend William Shirer who had begun 41 years of Presbyterian ministry there in 1888. WF (Bill) Shirer graduated from Otago Medical School in 1923 and worked as a house surgeon at Wellington Hospital until he took over this practice from Dr (later Sir) Fred Bowerbank. The Shirers lived above the surgery from 1924 and Dr Shirer ran a large solo practice.

In 1946 he was attending 250 deliveries a year and seeing 60-70 people a day. The constant intrusion on the Shirers' private lives and the desire to experiment with what was then a new concept – a group practice – led them to move house. The upstairs was turned into a flat and the downstairs became John Street Doctors, Wellington's first group practice. His son, WC (also Bill) Shirer, now a prominent

Wellington surgeon, studied the practice for his medical school thesis.

The thesis

For many years students in public health at the University of Otago were required to submit a thesis describing some original work, and presented as part of the requirement for the third professional examination. William C Shirer presented his thesis in 1951. It was entitled "A general practice" and was an account of his father's practice at John Street Doctors.[4]

WC Shirer analysed the practice work retrospectively over randomly selected days in 1948. On an average day WF Shirer saw 40 patients at the surgery and visited 14 at home. His assistants each saw 18 at the surgery and visited 16 to 20 at home. On an unusually busy day in August 1951, Dr Shirer saw 50 patients in six hours at the surgery and visited a further 25 at home to complete a 12-hour day.

Group practice was a new idea. Robb had written that postgraduate courses were essential for the maintenance and improvement of the standard of general practice[4], p24 and a few years later, Porritt had remarked on how difficult it was to find a practitioner at nights or weekends in New Zealand.[4], p37 It may seem obvious to us now, but the concept of cover by partners in a group for nights, weekends, postgraduate education and short holidays was new and exciting.

"It is important in any medical services that the patient should be able to obtain a doctor at any time that is necessary. A group practice certainly is one way of dealing with this problem. It is really only a matter of efficient organisation among interested doctors, if such can always be found." [4], p23

Once new assistants had become accustomed to the practice, each doctor would take at least two or three continuous weeks off during the year. In addition, postgraduate courses might be attended.

The group practice as a teaching one

A number of "assistants" worked with Dr Shirer in the late 1940s and early 1950s. They generally joined the practice after a house surgeon year and worked there for one or two years before moving to other parts of the country. The idea that a period of vocational education with a senior practitioner might be useful was revolutionary, even subversive, at a time when medical education in hospitals was regarded as quite sufficient for practice in the community. It was a two-way process.

A leading article in the *British Medical Journal* had stated in 1950:

"The experienced general practitioner will be of the greatest help in introducing general practice to novices but the initiates in their own turn can contribute towards the postgraduate training of their principal." [4], p38

WC Shirer quotes his father's words:

"In the brief luncheon interludes, consultations about cases and clinical discussions are normal. Many of the patients are known to the team, with benefit to the patient. It must also be of benefit to each of the doctors concerned. Here then, is an organisation where an important part of postgraduate education can be undertaken with benefit to all parties, including the patient. In fact a total scheme of postgraduate education can be incorporated. Should one doctor be away at a course, there are still two to carry on. In the practice itself new treatments and older experience are continually being exchanged." [4], p38

Delegation

There were (then, as now) some difficulties in delegation. WC Shirer wrote:

"It is noteworthy that there is not nearly the demand to obtain consultation with the junior doctors, varying with the time they have been in the practice. One feature of this type of group practice is the advantage of the younger doctor to be able to consult a more senior man on small details of practice, and even on a more unusual type of case, eg, one of the assistants was consulted by a patient with a red rash with a collar distribution round the neck. The patient was taken across to the senior practitioner in the other consulting room who diagnosed the case as one of *Pityriasis rubra* (rosea) with an unusual distribution. The assistant being shown one case, diagnosed another in the same week."[4], p21

He added: "It is difficult in a practice such as this to obtain a balance of patients for each of the doctors. It is obvious in looking at some of the numbers of patients seen in a day by the various doctors that the assistants do more visits in proportion to consultations. This is due to (1) the patients wishing to see the senior practitioner in consultation, and (2) the policy of sending the assistants to all new calls where they are acceptable. In the words of the senior practitioner 'it is difficult to hand consultations over to assistants'. The rules are that all new messages are diverted to the assistants where possible, and that casual consultations and others without appointments are again, where possible, transferred (this is not easy)." [4], p21

Discussion

This thesis is a time capsule, containing not only valuable historical material on vocational education, but also fascinating information on general practice ideas of the time. The Otago Medical School library must have many other public health theses of similar historical importance.

Acknowledgements

I thank Bill Shirer for showing me his thesis, and for providing other helpful information.

References

1. St George IM. *Stepping out from yesterday – a brief history of vocational education for general practice in New Zealand.* RNZCGP, 1997.

2. Wright-St Clair R. A history of the RNZCGP. Wellington, 1989.

3. St George IM. *A special general practice – the story of John Street Doctors.* Wellington, 1998.

4. Shirer WC. A general practice. Thesis submitted to Otago Medical School, 1951.

Back to the Top

Report on the Annual Conference of the RNZCGP Environmental Working Party

Focus on Food Safety and Human Health

Nelum Soysa was the Chairperson of the Environmental Working Party 1995-99

In attendance

Drs Bernard Conlon, Britta Conlon, Rae West, Paul Butler, Tim Fletcher, Andy O'Grady, Sarah Bruce, Nelum Soysa (Chair), Cornelius van Dorp, John Almond, Will Patterson, David Pemberton, Mike Godfrey and Brendan Hoare (President NZ Soil and Health), Chris Wheeler (Past President NZ Soil and Health), Alison White (pesticide expert), Bob Anderson (Physicians and Scientists for Responsible Application of Science and Technology), Lynne Dempsey, Li-Chen Hoare, Noeline Almond, Mich Lavelle, Jean Anderson and Brian Wood were the lively participants.

Dr Will Patterson was one of the public health specialists at the centre of the BSE/ CJD epidemic in the UK and gave an excellent keynote address. Brendan Hoare presented the importance of organic agriculture, Bernard Conlon spoke on genetic engineering, Chris Wheeler on the association of cancer with food additives, and aspartame in particular, and Alison White on the use of pesticides.

Precautionary principle

The Wingspread Statement on the Precautionary Principle was made at Wingspread, Wisconsin.

1. People have a duty to take anticipatory action to prevent harm.

2. The burden of proof of harmlessness of a new technology, process, activity or chemical lies with the proponents, not with the general public.

3. Before using a new technology, process or chemical, or starting a new activity, people have an obligation to examine "a full range of alternatives" including the alternative of doing nothing.

Decisions applying the precautionary principle must be "open, informed and democratic" and "must include affected parties". The health risk from unsafe food is a prime concern of the RNZCGP Environmental Working Party (EWP).

We identify safe food to be:

- grown/farmed in accordance with nature
- able to nourish and sustain those who eat it
- neither be a tool for economic subjugation nor be controlled by economics
- the integrity of organically grown food must be supported
- genetically engineered food (GEF) is not safe till proven otherwise, according to the precautionary principle
- GEF must be called engineered.

Risks unknown

The risk of GEF is unknown because:

- it involves transpecies insertion of genetic material
- the secrecy of the experimental process and the integrity of the data

presented by corporates who own the patent rights makes the validity suspect

- the absence of community involvement in release of these food substances
- the risk to infants and to immuno-compromised patients
- absence of long term surveillance and environmental impact reports of transgenic crops, animals and organisms.

Recommendations

The EWP believes:

1. Full food labelling should be mandatory and be enforced by statute. This should include all components produced by GE processes and organisms.
2. There should be a ban on crop and animal experimentation in New Zealand until they are certified according to the precautionary principle.

Back to the Top