Community responsibility and professionalism

Wayne Cunningham has written a very interesting article around professionalism, as it relates to community advocacy and advocacy on behalf of the medical profession.[1] I wish to offer the thoughts I have around the pitfalls of such advocacy.

I have spent many, many hours over the past few months involved in advocacy on behalf of the community, based upon what I see as the best interests of community care. I have discovered that there are very many pitfalls, it is not easy, and perhaps not at all rewarded.

My community has had a dedicated volunteer ambulance service for many years. I have been working with them for more than 10 years, attending emergencies with them or calling them to transport my patients to hospital. Due to our special geography I have been involved in many helicopter evacuations with them, often from bush or mountain. In 10 years we have been able to get a crew whenever it is required, and promptly. This is despite the fact that in the summer it is common to have two or more calls at once, and the volunteers often have to leave their paid work. Around two-thirds of our calls are for surface ambulance, one-third for helicopter.

We are very fortunate that we have always been able to provide crews, because there are no nearby crews able to back up. The closest neighbouring emergency services are 80–100km from us. Each member of these crews is a volunteer and they experience great difficulty covering their own volunteer services. The nearest paid crews are 180km from us, and to my knowledge have never been called here.

I believe we have a uniquely good record of rapid and effective response for a volunteer service. The medical staff work with the ambos as an integrated team. I have extreme admiration for the skills of the volunteers, particularly for those who have spent many hours honing their skills. Individuals among them have performed up to 700 helicopter evacuations and many more surface jobs. We are in perhaps a unique situation for New Zealand, relating to helicopter evacuations from wilderness areas. Due to the many walking tracks, the tourist destinations and the many fishermen off the coast and hunters in the hills, we are frequently involved in rescuing the sick and injured out of the wilderness. We go with the helicopters when required and we deal with 80% of the evacuated here in Te Anau. That is, only 20% end up going on to any hospital at all.

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We claim to be in a unique situation in New Zealand.

I have spent the last few months involved in what appears to be a vain attempt to hold the volunteer service together.

St Johns are attempting to force a single paid officer upon the ambulance service. I certainly do not see the logic in this, and neither do most of the volunteers. In particular the volunteers who carry the bulk of the work understand the problem. There will be a paid nine-to-five job for one person and no resourcing for the rest of the ambos who do the after-hours work. Do St Johns really expect this will not destabilise the service? It certainly appears to us that the volunteers are viewed as dispensable to the organisation.

My colleagues and I have spent the last few months talking, writing, arguing with St Johns, talking to politicians, and writing to politicians to explain the situation. The St Johns solution is opposed by the volunteers and the community, and it will lead to mass resignation of volunteers, particularly the most experienced ones. The result will be a greatly diminished ambulance service in our

area. We have a solution that we believe empowers the volunteers and acknowledges their value in a tangible way. It also helps mitigate the disruption of volunteering to their life and work. We have suggested paying all volunteers for 'road time'. We believe this is fair and equitable.

St Johns have said they will put in two paid officers as an interim solution (the long-term solution is one paid officer). This will give a double crew with single crew back-up. If we use a single crew, this will be the first time ever that it has been done, that I know of. Our local expertise will be greatly reduced.

Can I list some of the pitfalls of community advocacy?

1. It is very time consuming.
2. You will come under personal attack.
3. You will be distracted from your day job.
4. You will need to try to understand strategy and tactics and you will probably do this imperfectly.
5. You may find that the people you are supporting splinter and some may begin to criticise you.
6. You will discover that the organisations you disagree with don't care about or diminish your concerns. They will mislead or misinform you or others if it suits them.
7. If you fail, you will reassess your position. You will think about whether you want to walk away from your position, particularly if you have been left picking up the pieces!

Community advocacy is not an easy option. Don't go into it without realising the pitfalls.

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References

1. Cunningham W. Being a professional general practitioner and using principles of professionalism to consider workforce issues in general practice. NZ Fam Physician 2008; 35(3): 159-63.

Rural ambulance services

'Ambulance services in rural areas are part of a wider regional centre response service operating through the emergency 111 telephone call system at regional control rooms for the ambulance service provider. Currently there are eight regional control centres, but this number is being reduced to three as the system is upgraded and rationalised. These control centres are responsible for co-ordinating specialist emergency services at base hospital, road and air ambulance response and, in rural areas, local GPs through PRIME. Historically, the ambulance services in rural areas have relied on volunteers to maintain services. ... Ways of addressing this issue, such as paying trained people to undertake these duties on a part time basis, involve additional expenditure, but further progress could be made by closer communication and co-operation between the principal ambulance provider and local communities supporting volunteers.'

Rural Expert Advisory Group. Implementing the Primary Health Care Strategy in Rural New Zealand: A report from the Rural Expert Advisory Group to the Ministry of Health. 2002, Ministry of Health: Wellington.

Barriers to workforce innovation

'...the Taskforce has identified a range of barriers to change in the way the workforce delivers primary health care services. Some reflect historical practice, some result from prevailing attitudes and misconceptions, and others have arisen as unintended consequences of the implementation of the [Primary Health Care] Strategy. The following five key areas emerged as containing barriers to workforce change: the funding model; organisational structure and function; leadership at different levels of the sector; training of primary health care clinicians and management; quality improvement and assessment.'

Cook L, Horsburgh M, Hughes F, Logan R, et al., Working Together for Better Primary Health Care: Overcoming barriers to workforce change and innovation. Report to the Minister of Health from the Workforce Taskforce. 2008, Ministry of Health: Wellington.

Swedish view of New Zealand's medical errors

'Davis et al. analysed hospital records and compensation claims for medical injury for the same year and region of New Zealand. Slightly more than 2% of hospital admissions were associated with potentially compensable adverse events. Although the claims process was well targeted, few claims were filed, and even fewer were actually compensated. The ratio of successful claims to events potentially eligible for compensation was approximately 1:30. In a more recent study, only 1 in 25 patients who experienced injuries that were both serious and preventable in New Zealand's "no blame" system filed a complaint.'

Pukk-Harenstam K, Ask J, Brommels M, Thor J, et al. Analysis of 23 364 patient-generated, physician-reviewed malpractice claims from a non-tort, blame-free, national patient insurance system: lessons learned from Sweden. 2008; 17(4): 259-63.