President’s Blog April 2016

As always there are several (three) issues on the boil or hopefully simmer. Two are related and one is yet another compliance requirement that we will have to incorporate into our daily lives. So,

Workforce

Prescribing changes

Health and safety regulations. (I will however not address this further at present as I touched on H & S in my recent president’s column in our April 2016 magazine).

Workforce:

In 2014 there was discussion about whether we were training too many anaesthetists in New Zealand. To attain more detailed information the NZSA and NZNC ANZCA set up a joint working party to assess the issue. This resulted in a pilot study initiated by the group and carried out by the National Committee. The study is still a work in progress and the data collected hasn’t been collated for the public arena. It also doesn’t take into consideration all factors, however it highlighted a few themes:

- At the time of the census just under half of the departments were using locums.
- More than half reported that they had cancelled lists due to no anaesthetist being available over the previous 12 months. Cancellations ranged from 1 per year to 30 sessions per month.
- Alternatively, non-clinical time was sacrificed.
- Other departments increased output by paying penalty rates – i.e. overtime.

Jeremy Cooper and Nigel Robertson have written some thoughts in response, which I have had the privilege to read and agree with. This is particularly pertinent as these two were part of the Anaesthesia Resource Group, which published a workforce review document in 2010. This was interestingly initiated in response to concern about a projected deficiency in anaesthetic human resource, or the 100/40 problems. (Coined by Health Workforce New Zealand which anticipated that by 2020 there would be a 100% increase in health care required but only a 40% increase in resource).

In NZ and Australia there are still vacancies in less desirable locations, which is a problem that needs to be addressed. (In my opinion this is a major liability for us as an anaesthetic community, which I have addressed in a previous blog.)

- There is not a strong indication at present that NZ is training too many anesthetic specialists for NZ’s needs.
The variables, which feed into the job market for anesthesia specialist jobs, are many and only some can be influenced by organisations like ANZCA, or the NZMC, even if this was indicated.

There may well be a more competitive job market for new specialist anesthetists trained in Australia and NZ. However, compared to times in the last four decades it may be less competitive now than in the past. A competitive job market, if extreme, may well have disadvantages for many, but it must be noted that there are advantages of a competitive market for employers and patients.

Although not stated as such above, most people now accept that the major problem is maldistribution rather than over supply.

**Prescribing changes:**
To further complicate this stew we now add non-medical prescribing. This is an international trend and is also taking place here in NZ. The obvious change to us as anaesthetists was prescribing by nurse practitioners, and now nurse specialists and in the future potentially any nurse who has undergone required training. However, there are other groups that have or are in the process of obtaining prescribing rights; optometrists, pharmacists, podiatrists and dietitians. The drivers are complex and depend on which stakeholder group you belong to. The UK is further down this road then we and consequently there is more written comment so I will use the UK experience as an example: Prescribing rights were first granted to district nurses to enable them to obtain supplies, such as wound dressings and incontinence supplies, which had traditionally required a doctor’s prescription. Allowing prescribing addressed this inefficient and unsatisfactory anomaly. Nurses also often manage chronic conditions such as diabetes, asthma, heart failure and contraception, most commonly in conjunction with or under the supervision of a doctor.

In NZ there are a number of regions where access to a doctor is difficult and nurses manage a number of chronic conditions. So again the need to obtain the prescription from a second person- the doctor- is relatively inefficient and some would say degrading to both parties. Nurse prescribing in these situations is arguably a win for patients, the nurse and the doctor.

So the drivers:
- For the nurse, increased autonomy and professional satisfaction
- For the patient, better access
- For the doctor, reduced workload and ability to focus on more complex patients and problems
- For the government, a cheaper more accessible service, enabling all groups to work “at top of scope of practice.”
- Reducing medical monopoly and power.

The arguments against:
For the nurse, a biomedical focus rather than the traditional caring focus. Although interestingly, some would argue that offering a “cheaper” service is degrading.

For the patient, potential risk of exposure to inadequately trained prescribers. However, very little research available as yet.

For the doctor, boundary encroachment, loss of autonomy, dominance and the requirement to be “operating at top of scope” - potentially exhausting.

There are similar arguments for other groups. The most recent application is by the NZ Dieticians Board which is consulting to expand its scope of practice and prescribing, including the following: “Provision of evidence-based advice and recommendations on diet, nutrition and medicine-related health issues” and “For designated prescribers, the prescription of Special Foods and medicines.” This is somewhat vague and according to the new legislation it won’t be at all clear where their authority to prescribe would begin or end. But it seems these scopes and rights have significant approval momentum already.

Both the NZSA and NC have written submissions on the above issues. Our response on the whole has been to support non-medical prescribing provided the practitioners undergo appropriate training, are working in a team environment and only prescribe within their scope of practice.

Does this open the door for non-medical anaesthetists? Technically yes, and aspects of our role may be subject to “boundary encroachment.” However, with ever increasing standards and regulations I think it highly unlikely that the need for the package we provide – in terms of our competency base – will diminish. Lee Fleisher has written: “The temptation is strong to hunker down in the operating room and hope for the best...we would argue that clinical leaders can and should instead take a broad, proactive, and forward looking perspective and enhance the value of health care.”

Value is the new hot topic and I think this will determine what our future looks like. Yes, there will be non-medical prescribing but will the requirement for the medical anaesthetist disappear? I think this is unlikely. However, in light of the need for increase in value the expectation of our performance will change. Lee Fleisher has commented on this and I will explore this in my next blog.

Until then, may the force be with you.