



How to manage a media call: to help ensure what you want to say (or your organisation's position on an issue) is what gets reported.

Driving to the airport after our August breakfast seminar I listened to a cabinet minister using the opportunity presented by a Linda Clark interview to put out a positive message about the foreshore/seabed issue. His response was a classical case study of the ABC technique advocated by Sally Haysom in her seminar presentation.

Sally is the Managing Director of Professional Public Relations, one of New Zealand's largest public relations consultancies, which offers a full range of services, including media training, to a diverse range of clients including health organisations, corporates and businesses in a cross-section of industries.

In addressing her topic, "The reporter's phone call - a well-managed outcome or your worst nightmare?" Sally provided seminar attendees with a 40-minute value packed summary of PPR's six hour media training course. She pointed out that while PR can't "fix" a problem, it can help significantly, for instance showing that you care and what you are doing to make it better.

Noting the symbiotic relationship between reporters and interviewees (they need a story, we need to get our story heard) Sally emphasised the need for preparation and practice. Anticipate the questions. Reporters, like policemen, are interested in who did what to whom, when, where, how and why.

How do you get a chance to practice before you face a live interview? Look for training, either in house or outsourced. Listen to people being interviewed and note what does and does not work. Follow the ABC technique. What's that? Talk to someone who attended the seminar or contact Sally for media training.



Sally Haysom



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Voluntary Dehydration: does it lead to a 'good death'?

Increased debate on the ethical, moral and legal issues around measures of assisted death is a phenomenon of our time. In the last month, three events have raised the issue even higher.

First, at the end of July the New Zealand Medical Association called on all MPs to vote against the private member 'Death with Dignity' Bill then being given a first reading in Parliament.

'The NZMA and medical organisations throughout the world, including the World Medical Association, consider that it is unethical for doctors to participate in or assist euthanasia. Doctors consider it their duty to save lives, not end them,' said NZMA chairman Dr Tricia Briscoe. 'Our position is based on a longstanding and careful consideration of the issues involved and access by the terminally and chronically ill to high-quality palliative care.'

Dr Briscoe continued, 'Doctor-assisted suicide and euthanasia involve taking people who are at their weakest and most vulnerable and placing them in a situation where they believe their only alternative is to kill themselves. How a society treats its weakest, most in need and most vulnerable members tests its moral and ethical tone.' 'The 'Death with Dignity' Bill relies heavily on doctor involvement in the euthanasia process. Members of Parliament need to be aware that even if the Bill were passed, it would continue to be unethical for doctors to be involved, so at a practical level a key premise of the Bill is untenable.'

Whether our parliamentarians took notice of the NZMA submission is not known. However, by a small majority they did vote against the Bill being given a second reading. Public debate around the Bill clearly shows that, in this country, there are sizeable constituencies both for and against any form of assisted death.

While this debate was in full swing, media world wide picked up a report in the July 24 edition of the New England Journal of Medicine. Oregon researchers reported in the NEJM on the first study to document hospice nurse experiences with terminally ill patients who deliberately refuse food and water to hasten their deaths. On the basis of reports by hospice nurses, the researchers found that elderly patients in hospice care who no longer found meaning in living, stopped eating and drinking and usually died a "good" death within two weeks after stopping food and fluids.

"Voluntary refusal of food and fluids occurs often enough that it must become part of our dialogue on end-of-life issues facing care providers, terminally ill patients and their families," said Linda Ganzini, M.D., M.P.H., director of the Palliative Care Fellowship at the Portland Veterans Affairs Medical Centre and professor of psychiatry in the Oregon Health & Science University (OHSU) School of Medicine.

As they interviewed physicians about their experiences with patients who request assisted suicide under the Oregon Death With Dignity Act, the researchers had become aware that some patients were choosing to hasten death by refusing food and water. "The idea to stop eating and drinking was not coming from the physicians," Ganzini said. "In fact, physicians worried about the choice and were surprised when patients had a very peaceful death and didn't suffer from hunger and thirst."

Ganzini, Ann Jackson, M.B.A., Director of the Oregon Hospice Association (OHA), and their research colleagues subsequently sent a questionnaire to all nurses employed by hospice programs in Oregon and analysed the results. Of 429 eligible nurses, 307 (72 percent) returned the survey and 102 of these reported that in the previous four years they had cared for a patient who deliberately hastened death by refusing food and fluids. This number may be inflated if more than one nurse reported on the death circumstances of the same patient.

Nurses reported that patients who were ready to die, saw continued existence as pointless, and considered their quality of life poor. The survey showed that 85 percent of patients died within 15 days after stopping food and fluids. On a scale from 0 (a very bad death) to 9 (a very good death), the median score for the quality of these deaths was 8, as rated by the nurses.

"We were surprised that patients who chose this means to hasten death were, according to their nurses, more peaceful and suffered less in the last two weeks before death than patients who choose assisted suicide," Ganzini said.

With a Death with Dignity Act, Oregon is the only U.S. State where there is no legal sanction on assisting the suicide of terminally ill patients.

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Several other findings were surprising, she added. In a state where assisted suicide is legal, there were almost twice as many reports of terminally ill patients who pursued voluntary refusal of food and drink, compared with those who chose assisted suicide. Also, the majority of patients who started down this road never turned back. Only a few patients abandoned their plan because of thirst or family pressure.

Compared with 55 patients who died by physician-assisted suicide, the reported 102 patients choosing to hasten death by refusing food and fluid were, on average, a full decade older (74 vs. 64 years of age) and were less likely to be evaluated by a mental health professional (9 percent vs. 45 percent). They were more likely to have a terminal neurological condition, although most people in both groups had cancer. Both groups expressed similar overall reasons for hastening death, but patients refusing food were less likely to want to control the circumstances of their death. Of note, Oregon researchers had recently reported that controlling circumstances of death was a major motivation for patients who sought assisted suicide (*Journal of Palliative Medicine*, June 2003).

Ganzini said more research is needed to answer questions such as whether the Oregon experience can be generalized to other states and how best to care for patients who want to hasten death by refusing food and fluids. "The important message to take away from our study is that a number of hospice patients are making this choice," she stressed, "and that this simply must be part of the discussion as we seek to improve palliative care and better understand the needs of patients approaching the end of life."

In an accompanying perspective, Sandra Jacobs discussed physicians' reactions to this increasingly common practice. "Some may feel uncomfortable and 'complicit' at hastening death, while others feel that continued involvement in their patient's care is preferable to turning away", she said. "Setting the standard for physicians to 'give permission' for this practice may create an ethical conundrum".

Some caregivers expressed the belief that voluntary refusal of food and fluids was preferable to committing suicide by overdose or other means. Although most of the deaths in the study were rated by the nurses as being of "good" quality, follow-up interviews with a subgroup of nurses revealed poor quality of death in some patients, such as prolonged survival and body odour after fasting in an obese patient.

Report co-author Theresa A. Harvath, RN, PhD, has suggested to Dr. Jacobs that refusing sustenance might not be a good option for patients who do not have a malignant process or organ failure, because death may take too long and involve increased suffering.

Ganzini, has expressed concern that publication of the report could lead to "thousands of elderly, depressed people going on hunger strikes" and to some physicians offering this option to their patients before enough is known about it. She noted that there is a great deal of tension at the end of life between the doctor's roles to prolong life and to relieve suffering. Patients enter hospice care at a time when prolonging life is no longer a major goal. We didn't assess physicians' level of comfort with this issue, although we would like to study it. Some doctors may think this is another form of suicide but we didn't survey the doctors. The patient's decision to refuse food and fluids to hasten death was reviewed by their physician in 60% of cases, but we don't know the physician's reaction to that decision.

There have been many questions about the validity of the report because nurses' reports in the study were based on memories of patients that they might have cared for up to four years earlier. Ganzini responded, "in the larger area of palliative care, how to assess pain and suffering in dying patients hasn't been fully understood. Hospice nurses have extraordinary experience in caring for terminally ill patients, though, so they're probably in the best position to determine whether patients are experiencing pain and suffering. We outlined in the article that there are many potential threats to validity, including the length of time elapsed between the experience of caring for a patient who refuses sustenance to hasten death and the reporting of that experience. But the important point of our study is that it broadens the experience."

The final of this trilogy of events has been the deposition hearing and committal to trial of Lesley Martin, a Wanganui nurse charged with the attempted murder of her terminally ill mother three years ago. Martin's case has caused wide debate, much of it generated by Martin and her supporters, who advocate assisted death. As part of their argument they claim that the assisted

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death of terminally ill patients is a covertly common activity of healthcare workers. Some would agree and others disagree with that statement.

As the debate continues the public and media will look to healthcare workers and managers for informed comment. Questions around your response to the findings of the Oregon study are quite likely. Now would seem to be the best time to consider what you would say when you are approached.

NZIHM AGM

Our AGM was held on the first day of our conference and it was pleasing to see the number of members unable to attend the conference who took the time to attend the AGM. Associate Professor John Rasa from the Australian College of Health Service Executives (ACHSE) was present, representing Mavis Smith, Federal President.

All members will have received copies of the annual reports and financial statements. Your Institute is in a sound position. Three new members were elected to the National Executive and three re-elected. We are fortunate to have so many capable people willing to offer their services. Particularly noteworthy is the commitment of Trisha Ross who is currently, National Vice President, National Treasurer, Auckland Branch Chair and national conference and branch seminar programme co-ordinator.

The highlight of our AGM was the awarding of Fellowship certificates to new Fellows of the College. Fellowship is the highest level of College membership. While in Auckland, John Rasa with Ian Wolstencroft (National Counsellor) conducted New Zealand's first Fellowship Exam. Leading the way, Trisha Ross successfully passed her minor oral examination and with the acceptance of her Thesis was awarded her Fellowship. The pathway to Fellowship is now established. Take the opportunity to reach for this worthwhile qualification.



AGM Top Table: John Rasa, Trisha Ross and Fiona Ritsma



John Rasa, and our President Fiona Ritsma, presented Fellowship awards to these Auckland members: (From the left)

Dr Rod Perkins	(New Zealand's first PhD in Health Management)
Lesley McTurk	(NZIHM President 1997-99)
Anthea Penny	(NZIHM President 1993-94)
Trisha Ross	(by examination – thesis and minor oral)
David Rees	(original Fellow of NZIHM)

Fundamental changes to the supply side of the market needed to contain health-care costs.

A U.S Senate Appropriations Committee conducted hearings this June on healthcare access and affordability, and cost containment strategies. The Commonwealth Fund was invited to give testimony. Although the American healthcare system is quite different to ours, the basic premise of the Commonwealth Fund testimony covers measures advocated and sometimes adopted here in New Zealand. No innovative or radical solutions were offered.

The Fund advocated that the key to containing costs – as well as getting higher value for what is spent – may well lie in fundamental changes in the supply side of the market. “We need to shift our attention to reducing errors, eliminating waste and duplication in clinical care, modernising and streamlining administration, promoting transparency and accountability for performance, and aligning financial incentives for physicians, hospitals and other healthcare providers to reward high quality and efficient care.”

“Accessing a high performance healthcare system – high quality, safe, efficient, and accessible to all – will require a major change in the U.S. system of delivering health services,” said Fund witnesses. Steps recommended by the Fund include;

- Public reporting of cost and quality data on physicians, hospitals, nursing homes and other health care providers.
- Broad-scale demonstrations of new approaches to health insurance coverage, science based benefits, use of modern information technology and high quality care.
- Investment in health information technology.
- Development and promulgation of clinical guidelines and quality standards.
- Paying for high performance in the delivery of health services under Medicare, Medicaid and private insurance.
- Investment in research to gain evidence on what works to improve care, eliminate waste and ineffective care, and promote greater efficiency, including use of modern information technology, team work, and improved access to care.

Fund witnesses claimed that these steps would take the U.S. a long way to ensuring that they have a high performing health system worthy of the 21st century

During its testimony the Fund noted that the U.S. has relied on a mixed public-private system of insurance, managed care, and market competition to shape the health care system. Yet the U.S. has the highest health care spending per capita in the world, and during the 1990s health spending in the U.S. rose faster than in other industrialised nations.

- Health insurance premiums are rising 10 to 15 percent a year. Insurance companies are increasing profits and reserves and recouping losses incurred in the mid 1990s. The underlying rate of increase in health care costs is slower, but nonetheless troubling.
- In 2001 the U.S. spent 14.1% of GDP on healthcare – a major jump from the 13.3% of GDP in 2000
- In 2001 health care costs per capita increased 8.7% - considerably faster than inflation in the economy as a whole. While projected to slow somewhat, the U.S. can expect 7% annual increases for the next decade.
- Prescription drugs remain the fastest growing health care item, but acceleration in hospital costs is a troubling development.
- Utilisation of health care services, after being relatively flat in the mid 1990s, is rising – more use of hospital outpatient services, more prescription drugs, more physicians visits, more emergency room use.
- The rapid increase in specialised physician services under Medicare – specialist consultations, ambulatory surgeries, brain MRIs, pacemaker insertions, heart echography – raise the possibility of “physician induced” demand.
- Administrative expenses are increasing 11.2% per year. Administrative expenses for private insurance are two and one half times as high as public programmes.

Administrative expenses are increasing 11.2% per year



**New Zealand
Institute of Health
Management
A Branch of the
Australian College of
Health Service
Executives**

For all inquiries re Branch activities or membership contact nzihm@extra.co.nz or (09) 577 5477 Phone/Fax



Up coming Seminars

October 16th
@ Gillies Hospital
160 Gillies Ave, Epsom
5.30m. for 6 p.m.

Attracting and retaining health workforce into the future

Graeme Ewing, Principal, EQI Global

Non Members Welcome

Cost

Members \$20

Non Members \$30

Light refreshments supplied

Nov 5th

Ann Hall, Principal ITLaw Contracting with IT Vendors

2003 Conference

Working with IT is always an adventurous journey to an uncertain destination. And so it was for the over 200 delegates and IT industry representatives who attended our joint IT – Management conference at Auckland's Hyatt Regency Hotel. During the three day conference and workshop a wide range of presentations were offered. Not all hit the mark with everyone but there was sufficient diversity to inform and stimulate the thinking of all attendees.

The conference followed the Australian Health Informatics Conference and was able to draw on international speakers from that conference. It was both intriguing and thoughtful to listen to "overseas experts" agreeing to disagree on the process and software one should use for developing clinical guidelines. Not all presentations were abstract. Theory was matched with practical examples germane to new initiatives many organisations are undertaking.

As is always the case, opportunities to network and catch up with colleagues from other disciplines and other areas was an important part of the conference.

A group, chaired by Trisha Ross, is already hard at work planning for both our 2004 conference and our 2004 Branch Seminar programme. Feedback from members is always welcome. Tell us what subjects you would like covered and we will find an interesting speaker to present. Alternatively, tell us about an interesting speaker you have heard or would like to hear.

A fair suck of the sav

This Australasian colloquialism came to mind as we set about managing the SUCC (Sudden Unexplained Collapse in the Community) cluster in Dunedin. The lessons from SARS have been understood. Communicating quickly and accurately to both the public and healthcare workers in a time of uncertainty must involve working with the media.

For all parties to get "a fair suck of the sav" media messages must be carefully prepared, media spokespersons identified and briefed and a consistent message conveyed.

On this occasion, communication managers at both the Ministry and DHB level led the communication management. Media and public interest was satisfied and the right message was communicated.

Not all DHBs and health providers have the luxury of a communication manager. Where that is the case, seeking expert help is strongly advised

Graham Ewing, our October Seminar speaker, has been involved in high profile executive search and recruitment for more than 18 years. Assignments have involved appointments of Company Directors, Executive Directors, Chief Executives, Senior and Executive Management. In the public health sector Graham has been involved in the appointment of Chief Executives to most of the District Health Boards nationally.

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at nzihm@extra.co.nz