

# Asia Pacific Journal of Health Management

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*The Journal of the Australasian College of Health Service Management*

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*Cover picture:* Cover picture of a stethoscope is representation of clinical communication, management practice and its use as a tool clinically for healthworkers across the globe in all stages of clinical care right to end of life. This is a kaleidoscope of the articles on offer in this issue of the APJHM.



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## Localism: A way forward?

The implementation of the national health reforms has seen the introduction of the word 'local' into the reform agenda. It is used in the name of State jurisdictions acute care providers and in the national primary health care framework organisations currently described as Medicare Locals. Why is this so? Why has 'local' become central to the language of national health reform and of the organisational structures that deliver health services across Australia?

A review of the Final Report of the National Health and Hospital Reform Commission [1] and the subsequent National Health Reform Agreement [2] provides limited indicators as to why 'local'. Neither document includes an underlying philosophy or clear public policy that enshrines 'local' with a clear definition or implications about how the word might drive the reforms and the subsequent organisation and delivery of health services. The Final Report sets the word in the context of health system levels describing what might be done at 'national, regional and local levels'. [1, p.8] It also talks about 'connection' and 'integration' and the need to 'redesign health services around people', [1, p.6] 'foster community participation' [1, p.7] and to 'foster local implementation models'. [1, p.8]

The National Health Care Agreement is more specific in intent, describing objectives in terms of acute services to 'improve local accountability and responsiveness to the needs of communities...' and to 'decentralise public hospital management...' 'to shape local service delivery according to local needs...' 'to integrate services and improve the health of local communities'. [2, p 46] According to the Agreement the strategic objective of the newly created Medicare Locals is to identify health needs of 'local areas' and the 'development of locally focused and responsive services' and in achieving this objective they are to reflect their local communities and health services in their governance arrangements'. [2, p.50]

There is nothing further in the documents to provide us with guidance on how to understand this attempt at localism. Perhaps the introduction of 'local' heralds a move away from the highly centralised control of health services, in place prior to the reforms, towards greater decentralisation. It may just be an adjustment of the ever-present tensions between those who favour highly centralised control in favour of the proponents of decentralised organisational

and service delivery forms? It is a likely recognition that it was desirable to move away from the negativity of prior centralised systems as demonstrated in formal Inquiries of some State jurisdictions at the time. [3-5]

Bell and colleagues [6] draw our attention to the importance of language and its effect on practice in discussing health reform - this time in Scotland - focused on 'integration'. They suggest that the rhetoric in their example fails to connect with the practice of health professionals and managers and despite the language of reform, the 'dissonance between rhetoric and reality stubbornly seems to remain'. [6, p.41] So is this the case in the Australian reforms? Where did 'local' come from? Why is it important in the Australian context?

Localism is not just a feel good word to assuage community negativity about the state of its health services nor is it just an assumption that it is an intrinsic public good. [7] It is a form of governance that has recently been legislated as government policy in the United Kingdom public sector. The implication is that the NHS could be affected by a radical shift of power from the centre to local communities. [8] In the more devolved NHS, diversity has been allowed and four different devolvement models have evolved, termed as professionalism in Scotland, markets in England, Northern Ireland has permissive managerialism and Wales has adopted localism. [9] Sweden and its healthcare system is also held up as an exemplar of localism being effective as a local governance model. [10]

Localism is based on the principle of subsidiarity that states that 'government should only fulfil a subsidiary function for those tasks that cannot adequately be dealt with by lower tiers [11, p.11] In the British legislative initiative this is described as a shift from '...big government to big society...' [8, p.1; 12, p.1] Six 'essential actions' are described to bring about this transition:

- Lifting the burden of bureaucracy
- Empowering communities to do things their way
- Increasing local control of public finance
- Diversifying the supply of public services
- Opening the government to public scrutiny
- Strengthening accountability to local people [8, p.7; 12, p.2]

The logic of localism is said to be 'based on two uncontroversial statements...These are that services are often provided in quantities and ways that do not reflect or involve the local communities' and that they are essentially sickness services without much emphasis on reducing illness and improving health and wellbeing. [9, p.12] The Welsh devolution policy towards localism sees a health policy emphasis towards public health and greater engagement and towards the development of local solutions to population challenges. This approach has the potential to move to local participation, integration of effort and a change in emphasis from service provision to population health. [9]

Ewan Ferlie in his review of public management reform narratives [13] describes some of the prevailing preferred approaches as 'hierarchies', 'quasi markets' and networked-based approaches. He describes 'new localism' as a candidate narrative that is 'a reaction against the target led and top down nature of... the NHS'. [13, p.39] He goes on to suggest that for 'primary care this new localist idea suggests a greater role for non-profit organisations, more localised decision-making and resource allocation'. [13, p.79]

So what does this trend to localism as public policy reform mean in the Australian healthcare context? Well, if nothing else it might give us the opportunity to build on the initial enthusiasm engendered by the health reform for the local health districts or hospital authorities and the Medicare Locals to work together to do things better at the local community level. But it will require government(s) to provide generative space that will allow this and give permission for local governance structures and managers to respond to opportunity. This generative space at the moment is cluttered with the language of performance management, targets and indicators, a preoccupation that has limited value and diverts attention from achievement of more effective care; [14,15] an approach that should be replaced with discussion and debate about how to do things better, being effective ahead of efficient and how might we add value.

So in the context of health reform, the well intentioned language is about integration, collaboration, coordination, partnership, inter-agency, single system, whole system, fit for purpose, seamless patient journey, responsive to local need, resourced rigorous and resilient, evidence-based, best practice. [6,16] There is little published evaluative evidence that under our centralised hierarchies these practices have been substantially advanced or that the structures have been effective in the implementation of these well intentioned practices.

In the end we need to move away from the emphasis of governance on rules around form and structure (institutional power) to governance by rules around practice. [14] At the local service delivery level we need flexible opportunities to garner localism through strategic use of quasi markets, contestability, community and relational governance and the governance use of fit for purpose networks. It is likely that we will need to utilise a number of these approaches, flexibly. According to Morrell these are conceptual models for describing prevailing patterns of organising work and the allocation of resources. [14, p.57] This search for differing solutions suggests 'wider changes in society and the role of government'. [14, p.56] Others suggest this involves delivering solutions that are 'place-based', local strategic partnerships/plans, neighbourhood renewal strategies. How do we put this language into practice?

Perhaps in the spirit of localism and the concept of subsidiarity, Government should focus on what only it can do best. Firstly, work towards the removal of perversity in funding and payment systems, the impediments to workplace reform that all currently limit initiative and innovation. Secondly, allow generative space and incentives for providers to pool resources to meet common agendas through better use of existing resources. Thirdly, make all new program funding contestable, requiring collaborative partnerships or networks to be developed and governed locally. Fourthly, provide innovation funding for new models of governance and service delivery that substantially address identified local need. Fifthly, reduce the performance management reporting regime to manageable proportions.

It would be good to start the discussion and, perhaps debate about how we might make a real difference in the Australian healthcare system through localism by utilising a diversity of governance models at the local level that engage both communities and stakeholders.

**David S Briggs**

*Editor*

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In this issue, the first fully produced on our online submission system, we present a range of interesting research, management practice and viewpoint articles.

O'Brien and colleagues present a research article based on the authors' United Kingdom experiences with a clinical communication program that suggests it is an effective intervention for reducing future risk for high risk physicians; an important issue for all those involved in the delivery of clinical services. Next MacCarrick and colleagues provide a review article on preparing evidenced-based future medical leaders from the Australian perspective. This article is based around RACMA's initiative in preparing clinicians for medical administration careers.

Jessing presents a contemporary analysis of management practice and the experience of one local health district in New South Wales in meeting relatively new National Safety and Quality Health Service Standards established by the Australian Commission for Safety and Quality in Healthcare. This article describes how the health district established a system of audits, called MAXC, to meet the accreditation requirements.

Marcus and colleagues provide a further research article about the experience of Filipino nurses in their professional practice in one state-based health system in Australia. Described as hard workers, this article provides new evidence about the transition and employment outcomes of this group of health workers in their migration to Australia. Of interest to all of us given the multicultural and global nature of the health workforce.

The next article is a Research Note from Djurkovic and colleagues that explores the issue of workplace bullying of healthcare trainees. They suggest that it is a serious issue that requires further research to aid the development of appropriate policy.

Beattie and colleagues located in Singapore, New Zealand and Australia, provide a research article describing their observations of end-of-life care needs of people dying of stroke in those countries. This was a retrospective study of relevant medical records. The study suggests there is a place for both palliative care and symptom management in this group of patients.

Finally, Crocombe and colleagues provide us with viewpoint and commentary about the changing oral health situation and movement towards primary oral healthcare in Australia.

## The Clinical Communication Program: an effective intervention for reducing future risk for high-risk physicians

M O'Brien, M Dinwoodie, B Hartwig and D Blaney

### Abstract

**Objective:** To evaluate the effectiveness of the Clinical Communication Programme (CCP) as a remedial intervention for high-risk physicians.

**Design:** Physicians with a high-risk profile within the Medical Protection Society (MPS) were identified via a scoring system developed by its membership governance department. If communication issues were considered to have contributed to their risk the member was invited to attend an intensive communication skills training (CCP). Event data (claims, preclaims, disciplinary and regulatory episodes) was recorded and analysed pre and post CCP.

**Setting:** The intervention took place in the various centres in the United Kingdom and was attended by British Physicians who were members of MPS.

**Outcome Measures:** Change in incidence of event following communication skills training.

**Findings:** Post CCP incidence rate fell for all but four physicians. Post CCP these four physicians accounted for 75% of events.

**Conclusions:** The Clinical Communication Program is an effective remedial intervention for most physicians with a high-risk of future claims. There is a small group who did not benefit.

**Abbreviations:** CCP – Clinical Communication Program; CI – Cognitive Institute; MPS – Medical Protection Society.

**Key words:** remediation; high-risk doctors; disruptive doctors; communication skills training.

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### Introduction

Patient-initiated actions against physicians, such as litigation or complaint to a complaints body, healthcare organisation or regulatory authority, are a major issue in clinical medicine worldwide and are a significant cause of patient distress, physician concern and increasing cost. Consistently, international studies have identified that a small number (3-14%) of physicians account for approximately 50% of all complaints and claims. [1-6] Of these, a significant proportion is associated with a failure of doctor-patient communication. [7-12]

How to identify and engage with physicians who generate a high number of patient complaints and claims is a challenge for the institutions in which they work, indemnity organisations and the wider profession. A number of authors have studied the characteristics of physicians who have experienced a greater than average number of complaints or claims and have consistently documented a number of risk

factors. [12-15] The presence of a pre-existing complaint has been reliably found to be a predictor for future complaints. [1,16,17,18] Importantly in a recent work, Bismark found that the risk of subsequent complaint was directly related to the number of previous complaints. [6] However once high-risk doctors are identified it is not clear if it is possible to intervene to reduce future risk. A limited amount of work has been published demonstrating the effectiveness of educational interventions in students and physicians in training who are identified as 'in difficulty' [19] but there is little published evidence on the effectiveness of educational interventions for established physicians. Since 2005 the Medical Protection Society (MPS), in partnership with the Cognitive Institute (CI), has implemented a program for the identification and educational remediation of members who have a significantly adverse risk profile. We report on the outcome of one of these interventions, the Clinical Communication Programme (CCP) developed by CI.

## Methods

MPS is the leading provider of comprehensive professional indemnity and expert advice to doctors, dentists and health professionals around the world with over 280,000 members in more than 40 countries. MPS is a mutual, not-for-profit organisation offering members help with legal and ethical problems that arise from their professional

practice. Managing both individual and cohort risk is a major focus of activity. In 2005, in partnership with the CI, an Australian-based clinical communication skills and risk management organisation (and now a wholly owned subsidiary of MPS), MPS instituted a process of educational remediation for members who were identified as presenting a significantly increased future risk based on their accrued risk history. Members were identified through a membership governance system that applied a number of defined criteria to the risk profile of individual members and scored members' risk accordingly. Members identified through the governance system were required to comply with specific conditions related to their risk management if they wished to continue in membership. The top one per cent of high-risk members (ie, those with the high-risk score) were screened and if issues of patient communication or interprofessional interaction were identified as contributing to their risk they were offered the opportunity, as a condition of their continuing membership, to participate in the Clinical Communication Program (CCP).

The CCP was developed and piloted in Australia by CI. The CCP consists of three phases centering on a three-day residential workshop with pre and post workshop activities and is designed so that each phase complements the others. Details of the CCP are provided in Figure 1.

**Figure 1. Outline of core components of each phase of the CCP**

<p><b>Phase One</b></p> <p>Preparation and goal setting phase (assessment of communication skills via video-recordings of 'live' patient consultations, reflecting on a simulated consultation, reading of reference material relating to physician-patient communication, and participating in a discussion with an allocated facilitator to set personal goals for the program).</p>
<p><b>Phase Two</b></p> <p><b>Residential workshop</b></p> <p>During the residential workshop, activities focus on the following areas:</p> <ul style="list-style-type: none"> <li>• presentation of the research that confirms the fundamental importance of effective doctor-patient communication and its association with complaints and claims;</li> <li>• development of specific communication skills and techniques;</li> <li>• identification of factors that affect communication performance;</li> <li>• rehearsal of skills and techniques in simulated consultations using highly skilled actors;</li> <li>• personalised feedback and coaching from the facilitator; and</li> <li>• action plans and support for the 'real world'.</li> </ul> <p>There are also opportunities during the workshop to address issues specific to an individual participant's communication challenges.</p>

Figure 1. Outline of core components of each phase of the CCP *continued*

### Phase Three

Implementation and coaching phase (mentoring to assist in the application of newly learned communication skills, further video-recording of patient consultations, reflective survey and final discussion with facilitator following formal assessment of video recorded consultations).

The program is conducted over 24 weeks and involves 24 hours face-to-face contact as well as a minimum of five sessions of telephone mentoring (30 – 60 minutes each) and six hours of reflective activities. Participants' communication skills are assessed via recordings of 'live' patient consultations both initially and at the end of the program.

#### The residential workshop is conducted over three days

#### Key principles incorporated into the design of the program:

- Activities are tailored to meet the specific communication training needs of each participant.
- A trusting, supportive environment conducive to learning and self-reflection is created where participants are prepared to extend themselves.
- A workable action plan with concrete goals is developed to provide direction for delegates as they make their transition back to the 'real world'. Support from a facilitator is provided throughout the whole program (before, during and after residential workshop) to assist with the change process of implementing new skills.

All facilitators are experienced clinicians who are selected, trained and quality assured by the Cognitive Institute. All facilitators have additional qualifications and/or extensive experience in education, clinical psychology and/or counselling.

The MPS claims data for each of the CCP participants who were all United Kingdom-based was accessed before and after completion of the CCP. Claims, preclaims, disciplinary and regulatory episodes are referred to collectively as 'events' and the event frequency was recorded for each physician against the number of years they had been in membership. This was corrected for any period of suspension or time out of practice. The event date was recorded as the date on which the event occurred, not when it was notified to MPS. This provided a comparator of events per year of membership before CCP and events per year of membership after CCP. We did not record complaints or telephone advice calls. The reason for excluding complaints is that in the United Kingdom, complaint reporting at the time of the study was not mandatory and a significant number of complaints that are handled 'in house' either directly at the hospital or General Practice level are not routinely referred to MPS. We therefore considered that the reporting of complaints would be variable and would be a potential source of reporting bias. We assumed, reflecting the extensive experience of MPS in the notification behaviour of physicians who receive

patient-initiated action, that all claims, disciplinary and regulatory referrals would result in contact with MPS and a request for assistance.

The study reviewed those physicians who underwent CCP from June 2005 to January 2010. We did not continue to analyse beyond 2010 as there is a reporting lag with claims between the time of the incident and the time of the claim being logged and we estimated based on historical data that about 80% of claims would be reported within two years. We analysed the pre and post CCP event incidence for each participant using a Mood Median Test and a Mann-Whitney Test.

### Results

A total of 145 doctors underwent CCP from 2005-2012. We identified 58 with complete data sets who completed CCP between February 2005 and May 2010.

All 58 were practising in the United Kingdom in a range of specialties (Figure 2). Twenty-six were graduates of British medical schools. Due to incomplete event data we limited the number of years of membership pre CCP to 25 as a

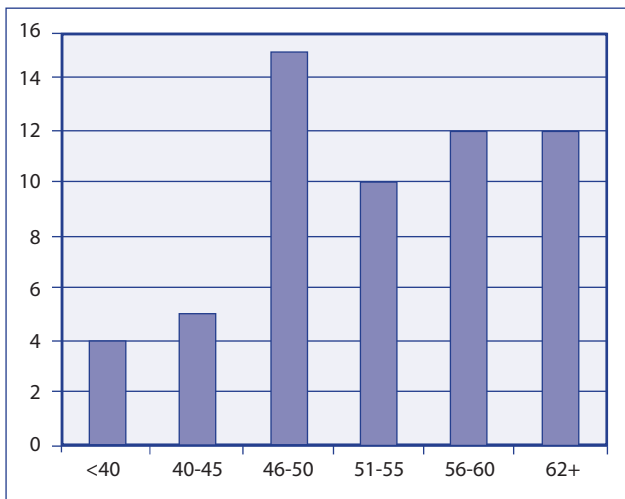


**Figure 2. Number of doctors by specialty**

SPECIALTY	
GP	28
Plastic surgery	9
Surgery	8
O & G	5
Psychiatry	5
Anaesthesia	2
Medicine	1

maximum. The duration of membership pre CCP ranged from 25 years to two years (median 16.6) and post CCP from two to seven years (median 3.6 years). The age range of the doctors was from 32-70 years old (Figure 3) with a median of 46.

**Figure 3. Number of doctors by age**



The most frequent factors identified in the patient initiated events of the doctors referred to the CCP are listed in Figure 4. The reasons were often multiple and rarely did only one apply. Most doctors had at least three identified factors.

**Figure 4. Most frequent issues identified from patient-initiated events**

• Concerns about team working
• Concerns about communication
• Concerns about professional behaviour
• Concerns about personal behaviour, manner and attitude
• Concerns about clinical performance

The 58 doctors had in total 1,038 membership years pre CCP and a total of 201 membership years post CCP when adjusted for suspension from practice, restrictions on practice and limited or reduced practice imposed by the regulator (The General Medical Council).

We aggregated all the events as described above (claims, pre-claims, disciplinary and regulator referrals) pre and post CCP. There were a total of 444 events pre CCP and 54 events post CCP. The event rate pre CCP was 0.42 or one event every 2.3 member years; the event rate post CCP was 0.26 or one event every 3.8 years ( $P < 0.0001$ ). The data for claims alone show a reduction from 215 claims or one every 4.7 member years pre CCP to 22 claims or one every ten member years post CCP ( $P < 0.0001$ ). In respect of claims, four doctors accounted for 75% of claims post CCP, which would imply that a small number of doctors did not benefit from the intervention.

An important sub group of members (34) held full membership and clinical practice throughout and were not subject to any restriction or suspension from practice. In this group the event rate fell from 0.46 events per member year to 0.23 post CCP ( $P < 0.0001$ ). Sixteen out of the 34 doctors had no events post CCP.

GPs are the main specialty group in the study (nearly half) and form a second subgroup. They demonstrated a similar decline in claim and event rate. Pre CCP there was 0.14 claim per member year and this fell to 0.09 claim per member year post CCP. For GPs, the total event rate fell from 0.34 per member year to 0.21 per member year ( $P < 0.0001$ ).

## Discussion

Our retrospective study demonstrates a significant reduction of total 'events' after the doctors underwent an intensive clinical communication skills training program.

It is clear from the literature that poor physician-patient communication is a significant cause of patient dissatisfaction and the resultant patient initiated complaints and claims. [6,8,11,20,21,22] Our findings confirm that the CCP is an intervention that is highly effective in reducing future claims and litigation risk of physicians who had been identified as posing a significantly higher risk than their peers. The study demonstrates a highly significant reduction in 'events' post CCP across a range of physicians from varying specialties indicating that CCP is a versatile intervention. The results are more surprising because the physicians included were all outliers in terms of their past risk profile and may have been considered irremediable. CCP is available in the

Asia-Pacific, South Africa, Ireland and the United Kingdom. It is time and resource intensive and costs on average in the range of (US)\$3-5000 per participant.

In this study we used peer referenced claim, disciplinary and regulatory referrals data which are indicative of physician relative performance or patient satisfaction and demonstrated that following CCP there was a reduction in incidence of events at a time when litigation rates in the United Kingdom and MPS claim incidence were increasing. MPS internal data and recent data from Australia indicate that the risk of a subsequent event is directly related to the number of previous events. [6] One would expect the physicians in this study to have had additional events post CCP if the intervention had been ineffective. However, CCP reduced this trend in future risk.

Events such as claims and complaints cause significant distress for the doctor involved, disruption and workload for the organisation in which they work and reflect adverse patient experience or outcome. It is recognised that a small percentage of doctors account for disproportionately large numbers of complaints and claims. The issue of how to manage these high-risk physicians has long been a concern for medical defence organisations, healthcare institutions, regulatory bodies and for patients. Most of the published literature on remediation refers to interventions with underperforming students or doctors in training and relates to knowledge or clinical skill deficiencies identified in their training. [19] There are few studies in the literature that demonstrate effective remediation in established physicians. Hickson et al have reported on their experience of a peer referenced system which includes an early messenger/alert stage that precedes active intervention and report good success with this early intervention. [23] In a thematic review Hauer et al found only four studies (all Canadian) that reported the outcome of educational interventions in established physicians. The outcomes Hauer et al described as being relatively 'soft' included chart reviews, self-reflection and physician interviews, which are arguably proxy measures of either performance or patient outcomes. In this study we used event data that are related to peer or patient initiated concern about the physician's performance. Interestingly 3.7% (four doctors) of the study group accounted for 75% of the post-CCP claims. This is consistent with the experience of others who suggest there are a small number of doctors who do not respond to attempts at remediation. [24]

There are a number of limitations in the present study that we acknowledge. The study population was relatively small; we did not control for other variables or use matched case controls and the data we used was not purpose specific. The physicians were required to undertake the CCP as part of their continuing membership of MPS and caution is therefore required before extrapolating the results to physicians taking the program voluntarily. It is possible that following the intervention the physicians involved reported fewer events to MPS. We think the latter is unlikely given the significant financial or professional implication of a claim or regulatory referral. While research has shown that simple strategies that raise awareness of being 'high-risk' compared to peers are effective for the majority of doctors in bringing about risk reduction behaviours, [24] the same research also identifies that 30% do not respond and require further intervention. The physicians in our present study are mostly likely to come from the 30% of 'non-responders' identified in Hickson's paper.

The findings of this study have important implications for the use of CCP as a potential prognostic indicator. Many indemnifiers, employers, regulators, complaints bodies, training programs and professional associations face difficult choices in working with and formulating management plans for doctors who are the cause of frequent complaint or claim because of interpersonal and communication performance issues. This study's finding of a clear demarcation between 'responders' and 'non-responders' raises the opportunity for such bodies to utilise the program as both a therapeutic intervention and prognostic guide. A poor response to the program (in contrast to the experience of others with similar initial risk) may be seen as valuable information to guide the formulation of further risk management strategies. Given that CCP is now available across most of the Asia-Pacific, South Africa, the United Kingdom and the Republic of Ireland, the authors believe these findings offer the potential for indemnifiers, regulators, employers and professional bodies to enact with confidence an enhanced approach to reduce the risk of complaint and claim across a large proportion of physicians.

### **Future research**

Further research using matched controls would help to confirm whether the results seen were attributable to the CCP. Further evaluation of the data at a future date would help determine whether the benefit of the CCP intervention was sustained.

## Conclusion

CCP is a highly effective intervention for use in high-risk physicians who have been identified through peer-referenced data to have significantly higher number of claims and/or regulatory referrals than their peers. Used in combination with an early alert system it provides in our view an effective way to manage physicians with an adverse risk profile.

## Ethical approval

Considering our research involved the use of existing collections of data that contain only non-identifiable data about human beings and that use of this data carries no foreseeable risk of harm or discomfort to the participants it was considered that this research was exempt from ethical review. (Guidelines for ethical review of the National Health and Medical Research Council.)

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## Preparing Evidence Based Future Medical Leaders: an Australasian perspective

G MacCarrick, K Owen and R Header

### Abstract

There is growing interest across the globe in how best to prepare future medical managers and leaders. Arguably such training needs to be embedded in all specialist medical curricula, as is the vision in the United Kingdom. One model is that offered by the Royal Australasian College of Medical Administrators (RACMA). The Australasian model entails a recognised postgraduate specialist training program leading to specialism and a formal career path for qualified doctors in the discipline referred to as 'Medical Administration'. A particular challenge currently facing RACMA is how best to embed the development of research skills into its specialist training program. This paper explores how

doctors are being prepared for their evolving roles and responsibilities in management and leadership in Australasia, including their important role as health services researchers.

*Abbreviations:* HSR – Health Services Research; HSRAANZ – Health Services Research Association of Australia and New Zealand; MLCF – Medical Leadership Competency Framework; NHS – National Health Services; PGY – Post Graduate Year; RACMA – Royal Australasian College of Medical Administrators; RPL – Recognition of Prior Learning; WFMM – World Federation of Medical Managers.

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### Background

Despite lack of formal training, doctors across the globe are increasingly assuming greater leadership and management roles in healthcare. Over the last four decades, a range of policy initiatives have been introduced in different jurisdictions to improve accountability of healthcare organisations, and in particular, to address concerns over patient safety. The need to reduce clinical error was highlighted in landmark studies such as the Australian Quality in Healthcare Study, [1] which associated 17%

of all hospital admissions with adverse events related to healthcare – the majority considered preventable. Global debate has since focused on the role of doctors in leading the required development and transformation of health services to address challenges such as quality and safety. [2,3]

The key is providing ongoing faculty development and support for doctors as they embrace their emerging management and leadership roles and responsibilities in increasingly complex healthcare systems. Such education and skills training is gradually being embedded in our undergraduate medical curricula. In addition, some centres offer specific tailored training for those who choose to make medical management and leadership a specialist career path.

In the United Kingdom, Lord Darzi's High Quality Care for All: NHS next stage review [4] recommended a mindset change viewing the clinical leader using a 'practitioner, partner, leader' model. Similarly other National Health Service (NHS) and General Medical Council publications, such as Tomorrow's Doctors [5] redefine 'doctor', reflecting an international trend to interpret the role more broadly and to include management and leadership as part of this.



In 2007, the NHS Institute for Innovation and Improvement was given responsibility for leadership development and building leadership capacity across the NHS. Key amongst the projects that followed was the Enhancing Engagement in Medical Leadership Project to develop and promote medical leadership engagement across the United Kingdom. In conjunction with the Academy of Medical Royal Colleges, a Medical Leadership Competency Framework (MLCF) was produced. [6] The MLCF provides a structure for the leadership development of medical students, trainees and qualified doctors.

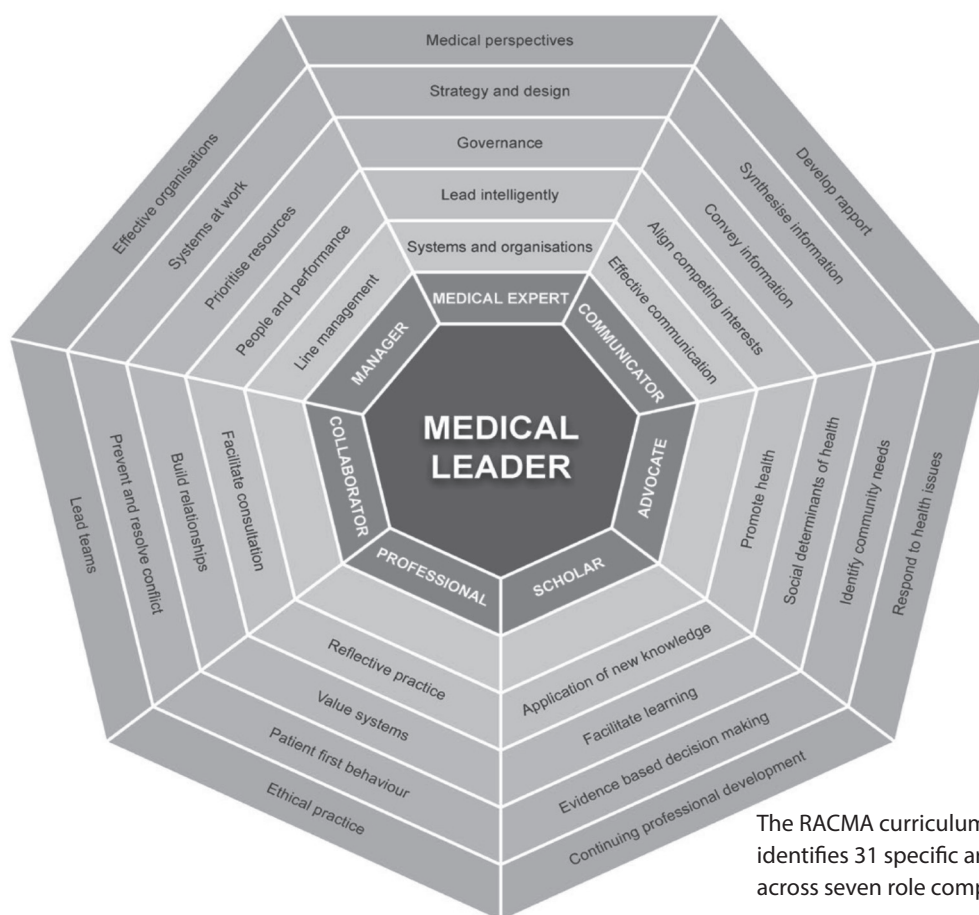
### The Australasian model

In Australia and New Zealand, the discipline of Medical Administration is recognised by the respective Medical Councils as a specialist branch of medicine. The Royal Australasian College of Medical Administrators (RACMA), founded in Australia in 1967, aims to promote and advance the study of the principles and the practice of health services management by medical practitioners. RACMA defines Medical Administration as follows:

Administration or management utilising the medical and clinical knowledge, skill and judgement of a registered

medical practitioner, and capable of affecting the health and safety of the public or any person. This may include administering or managing a hospital or other health service, or developing health operational policy, or planning or purchasing health services. [7]

In order to become a trainee of RACMA, a doctor must first complete a period of clinical practice (direct patient care). At a minimum, this is the postgraduate period (PGY 1-3). In fact, more than 60% of trainee commencements are senior doctors with much more experience ie, the majority have trained in another medical specialty, and having moved into medical supervision/management roles, they enrol with RACMA to formalise medical management qualifications. The program includes theoretical studies at university master's degree level, a period of supervised practice, and a national program of workshops, written work and examination by the College. The duration of this training program varies depending on demonstrated pre-existing competency (established using recognition of prior learning processes) and successful completion of the College's requirements.



The RACMA curriculum framework identifies 31 specific areas of competence across seven role competencies.

In 2010, RACMA hosted a meeting of invited medical leaders from around the world to discuss the possibility of establishing a global network of medical leaders and managers to promote medical leadership in advancing the quality of care and health services management. It was agreed to establish a World Federation of Medical Managers (WFMM) [8] to advance this goal. The WFMM has continued to meet annually with members coming from the United Kingdom, Italy, Norway, Holland, Sri Lanka, Hong Kong, Australia and New Zealand, Canada and the United States. Most recently, South Africa has joined the group and will attend the 2013 meeting in Vancouver. At the 2010 meeting, RACMA launched its own Medical Leadership and Management Curriculum. The Curriculum defines competencies for Specialist Medical Managers and the processes by which these are attained and maintained through continuing professional development. The RACMA Medical Leadership and Management Curriculum is an adaptation of the seven CanMEDS [9] roles, integrating these competencies in the expression of an additional medical leadership role competency. The College subscribes to the view that leadership and management are two distinct systems of action. [10]

### **Medical leader as scholar**

Amongst the framework's many statements of outcome, scholarship and evidence-based practice are key. Trainees are expected to demonstrate a lifelong commitment to learning as well as to the development and communication of new knowledge about medical leadership and management practice. In 2011, the College commenced planning for a revised training program to enhance research and investigation in the field of health services research. The Research Training Program established in 2013 is currently underway supported by a part-time senior fellow and a project officer.

### **Defining health services research**

Health Services Research (HSR) is a multi-disciplinary research activity that has been gathering momentum over the past four decades with an emphasis on improving health services. The Health Services Research Association of Australia and New Zealand (HSRAANZ) [11] makes the important distinction between HSR and single-discipline research in that it seeks to understand dimensions of health services from multiple perspectives. As such, RACMA trainees are expected to draw on theoretical frameworks from a variety of disciplines including medicine, nursing, allied health, psychology, sociology, political science, management science and health economics.

### **Challenges currently faced**

The articulation of the vision to embed research skills as a competency is not without challenge. One key weakness identified by early working groups was research capacity within the fellowship. A survey of Fellows undertaken to assess current academic research skills indicated that whilst many respondents had published papers in a range of journals, few had formal academic qualifications in research ie, at doctoral level. Establishing and supporting an appropriately skilled faculty to supervise and mentor trainees is key to the success of the RACMA research vision.

Although trainees have traditionally been required to undertake a recognised Masters level degree as part of their training, the content of each of the Masters Programs has varied slightly depending on the institution and the subject choices made by enrolled trainees. To overcome this, two additional core subject requirements have recently been added, namely 'research methods' and 'leadership'. Going forward, all trainees will now be introduced to a range of research topics including understanding and critically evaluating research; ethics policy and procedure; planning and managing research projects; information retrieval; as well as research approaches and processes used in the health and behavioural sciences. In addition, commencing 2013 trainees are now required to attend a webinar on HSR, submit a research proposal for assessment and complete a three-year, research-based case study.

Another unforeseen challenge, recently identified by trainees, has been the time taken to obtain ethics approval for the research-based case study. All candidates are encouraged to consider ethics and privacy issues as they embark on their research proposal. The time taken from submission to receipt of ethics approval can take weeks to months depending on the institution, contributing significant delays to an already tight timeframe. Nonetheless an understanding of the ethics approvals process is itself an important skill and trainees are strongly encouraged to embark on the ethics approval process as soon as they have identified a suitable research question.

A further concern raised by trainees is the impact of rotational training, in particular the challenge posed in terms of satisfying the College's requirements for submitting a research-based study. Trainees are currently encouraged to choose a research question that is transferrable, or if location specific, is capable of being explored from a distant site.

Since the research training program commenced, a small number of senior trainees have identified themselves as already possessing significant Health Services Research competence. This presents an additional challenge to the College in terms of extending the existing policy on Recognition of Prior Learning (RPL). Work is currently in progress to map the awarding of advanced standing to trainees with respect to research requirements, including the development of a blueprint that details the decision-making process leading to the award of RPL. Decisions relating to RPL and research will apply not only to those trainees who are enrolled in the standard pathway, but also to those enrolled on the recently established 'accelerated pathway'. Since the accelerated pathway was introduced in 2009, over seventy additional applications for fellowship training have been received, representing a 38% increase in total trainee numbers for the same period.

A further challenge for the College has been to ensure that teaching and assessment in the area of research is 'constructively aligned' with the stated learning objectives. [12] Key amongst the proposed competencies to be assessed are the ability to: pose a scholarly question within the context of health services research; conduct a systematic search for evidence; select and apply appropriate methods to address the question; and disseminate the findings. An important tenet of the proposed assessment strategy is the provision of quality formative assessment through regular feedback. This has proven to be a particularly important consideration with the first cohort of trainees, for whom the submission of a research proposal is an additional and new training requirement.

The final challenge relates to transition. Whilst the new research training requirements are being introduced, the College has previous cohorts of trainees (prior to 2013) with a slightly different set of training and assessment requirements. This places an additional administrative burden on the College, in terms of accurately tracking completion of training requirements.

## Summary

World-wide there is growing interest in, and need for, training and education for the role of medical manager and leader. This training needs to be embedded in our undergraduate medical curricula as well as postgraduate specialist training programs. The Australasian model offered by RACMA, entailing a recognised training program leading to specialism and a formal career path for qualified doctors

is one model, among others. Such training needs to prepare medical managers and leaders capable of contributing new knowledge, through robust research to all aspects of our health services that affect the quality, cost, availability and access to healthcare. Some of the preliminary challenges faced by RACMA as it seeks to establish its new research training program are described. Despite these challenges, the College remains committed to training which embeds systematic cognitive skills to be able to reflect critically on theory and practice and generate new knowledge in the context of health services management and leadership.

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## Measuring Aspects of eXcellent Care (MAXC): easing the burden of auditing for the National Safety and Quality Health Service Standards

M Jessing, K Brookes and G Rubin

### Abstract

From 1 January 2013, all public and private health services in Australia are required to be accredited against National Safety and Quality Health Service Standards promulgated by the Australian Commission for Safety and Quality in Healthcare (ACSQHC). [1] The new accreditation requirements specify the completion of forty-seven clinical audits. As it is anticipated that administering the audits will be time-consuming and this will reduce time spent delivering clinical care, South Eastern Sydney Local Health District (SESLHD) has developed a system of audits to meet the requirements. The Measuring Aspects of Excellent Care (MAXC) system of audits is based on the measurement

of process indicators. This paper describes the design process and implementation strategies used. The MAXC system of audits has been used by two facilities to achieve accreditation under the new standards.

*Abbreviations:* ASCQHC – Australian Commission for Safety and Quality in Healthcare; MAXC – Measuring Aspects of Excellent Care; NSQHS – National Safety and Quality Health Service; SESLHD – South Eastern Sydney Local Health District.

*Key words:* audit; National Safety and Quality Health Service Standards; process indicator; accreditation.

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### Introduction

Measurements of quality are an essential prerequisite to raising standards of care. Continuous monitoring of quality and standards of care is necessary for organisations to meet external accountabilities such as accreditation requirements and reporting to jurisdictional bodies. From 1 January 2013, all public and private health services in Australia are required to be accredited against National Safety and Quality Health Service Standards promulgated by the

Australian Commission for Safety and Quality in Healthcare (ACSQHC). [1] The new accreditation arrangements have as a mandate the completion of forty-seven clinical audits. Moreover, there are a number of additional data collection requirements to demonstrate evidence of compliance. This data collection is directed at improving performance in relation to clinical safety and quality. The literature supports the use of clinical audit as a way of measuring quality of care and services against agreed standards. [2,3,4] Most healthcare clinical audits fail to identify the factors contributing to poor outcomes. Rather, they tend to be:

- Outcome focused and a poor indicator of quality as there are many variables that contribute to outcomes, eg there are many contributing factors that lead to a high rate of medication incidents.
- Large paper-based reviews to observe drift from delivery of best practice.
- Intermittent with results /reports delayed.
- Data collecting exercises which are not specifically designed to drive change.

There are potentially many contributing factors that lead to poor outcomes. It has been suggested that process indicators are more valid when compared with outcome



measures. [5 p.475] Process indicators are direct measures of the quality of the healthcare provided as long as there is a demonstrated link between a given process and an outcome. [5 p.479] Griffiths, Jones and Murrells [6, p.2] indicate that occasionally the relationship between a particular process and an outcome measure is so strongly established that a measure of the process may suffice or even be preferable as a proxy indicator. For example an observational audit of two nurses checking a Schedule 8 drug at the bedside could be used as a measure in preference to the number of Schedule 8 administration errors. The ongoing monitoring and early identification of deficits in the processes that contribute to poor outcomes assist an organisation to identify and reduce those deficits. Hanskamp – Sebregts, Zegers, Boeijen, Westert, van Gorp and Wollersheim [2, p.2] highlight that a major advantage of this type of auditing is that it reveals the underlying cause of safety problems and reveals which improvement should be made to prevent adverse events.

#### Developing a model to meet the audit requirements of the National Standards

We developed a system of audits to meet the audit requirements of the National Safety and Quality Health Service (NSQHS) Standards. The Measuring Aspects of Excellent Care (MAXC) system of audits is based on the measurement of process indicators. The process indicators are directly aligned with the actions of the NSQHS Standards. In some instances up to four process indicators are measured to demonstrate compliance with an individual NSQHS Standard action.

The MAXC system of audits is a set of easily measurable process indicators of clinical care that is modelled on the NHS Heart of England Foundation Trust Nursing Care and Patient Experience Metrics that were introduced in 2008. [7] The NHS metrics were designed to measure process indicators in relation to clinical risks including patient observations, pain management and falls assessment. This program has been extensively reviewed with several adaptations made to the original model. [6, 7, 8, 9]

The MAXC system of audits was first trialled in a network of Sydney Metropolitan Hospitals incorporating the St George and Sutherland Hospitals. It was initially designed to support the organisational goal of delivering safe, effective, quality care. The model was developed around selected quality and safety domains such as skin integrity, medication safety, infection control, communication, service culture, emergency preparedness, patient flow, nutrition and catering, equipment, patient identification and cleaning and waste management. We used this model as a framework to develop a system of audits to meet the requirements of the NSQHS Standards.

The MAXC system of audits is designed to generate an organisational compliance rate against the actions of the NSQHS Standards with each ward/department participating in data collection. The system consists of ten spreadsheets, ie one for each NSQHS Standard (Tables 1 and 2). Each spreadsheet contains process indicators and guidelines for staff to audit compliance against the required actions on ten different occasions over a one month period.

**Table 1: Elements of MAXC audit spreadsheet**

ACTION	REFERENCE TO NSQHS ACTION BEING AUDITED
Domain	Safety and quality indicator
Process Indicator	Statement of the expected practice
Guideline	Statement for measuring the process which has been checked for reliability
Occasions	Each number represents one audit undertaken generating a yes/no answer
Average	Auto calculation of average rate of compliance with process indicator measured

**Table 2: MAXC Clinical handover audit tool – an excerpt**

WARD: 2 EAST				OCCASIONS										
ACTION	DOMAIN	PROCESS INDICATOR	GUIDELINES	1	2	3	4	5	6	7	8	9	10	AVERAGE
6.3.1	Clinical Handover	Nursing/Midwifery change of shift handover occurs at the bedside during evening to night shift handover	Observe 10 different evening to night shift handovers. Did the handover occur at the bedside? Y=1; N = 0	1	1	0	1	0	0	1	1	1	1	70%
6.3.1	Consumer Participation	Nursing Staff involve the patient in bedside clinical handover	Observe ten different bedside clinical handovers on different days over the month. Was the patient observed to be included in the discussions? Y=1; N = 0	1	1	1	0	0	0	0	0	1	1	50%

All guidelines for measurement were developed to generate a 'yes' or 'no' answer. They are written in a way that is readily measurable, clinically relevant and that ensures inter-rater reliability. Griffiths and Maben [4, p.63] support the need for the development of an indicator program that includes a definition with validation to ensure consistency across settings.

**Implementation of the MAXC system of audits**

Wards/departments complete all audits on one spreadsheet each month in accordance with the District Audit Schedule. The schedule has been developed to ensure that all wards complete audits for each NSQHS Standard on a quarterly basis allowing time for improvement strategies to be implemented and evaluated. Ward/department managers allocate one process indicator each to different staff members of the multidisciplinary team including administrative staff. Allocated staff members are provided with a print out of the spreadsheet, which they complete over the one-month period. Audits are rotated between staff over time to maintain the integrity of the data. The MAXC system of audits is designed to be completed by staff during the course of their every day work so that this does not impact on clinical care time, eg a falls risk screening audit

can be conducted while writing clinical notes. Foulkes [11, p.44) cautions that any indicator program should not impact on clinical care by increasing the amount of data entry.

Administrative staff enter the data onto the ward spreadsheet at the end of the month. Individual ward spreadsheets are located on a share drive and are grouped by clinical division, eg surgery, medicine. This enables benchmarking of results between individual wards on a monthly basis. The spreadsheet auto calculates a compliance rate per process indicator and generates a graph that compares performance across the wards/departments (Table 3). Monthly results are reviewed in ward and divisional meetings and action plans for improvement are developed as required. This regular review process allows for improvement to be actioned in close to real time. Ursprung, Gray, Edwards, Horbar, Nickerson, Plesk, Shiono, Suresh and Goldmann [4, p.284] conducted a pilot study to determine the feasibility and utility of real time safety auditing during routine clinical work in an Intensive Care Unit. They found that real time safety audits can detect a broad range of errors. Their study revealed that significant safety problems were detected promptly leading to rapid changes in policy and practice.

**Table 3: Report of Organisational Compliance an example**

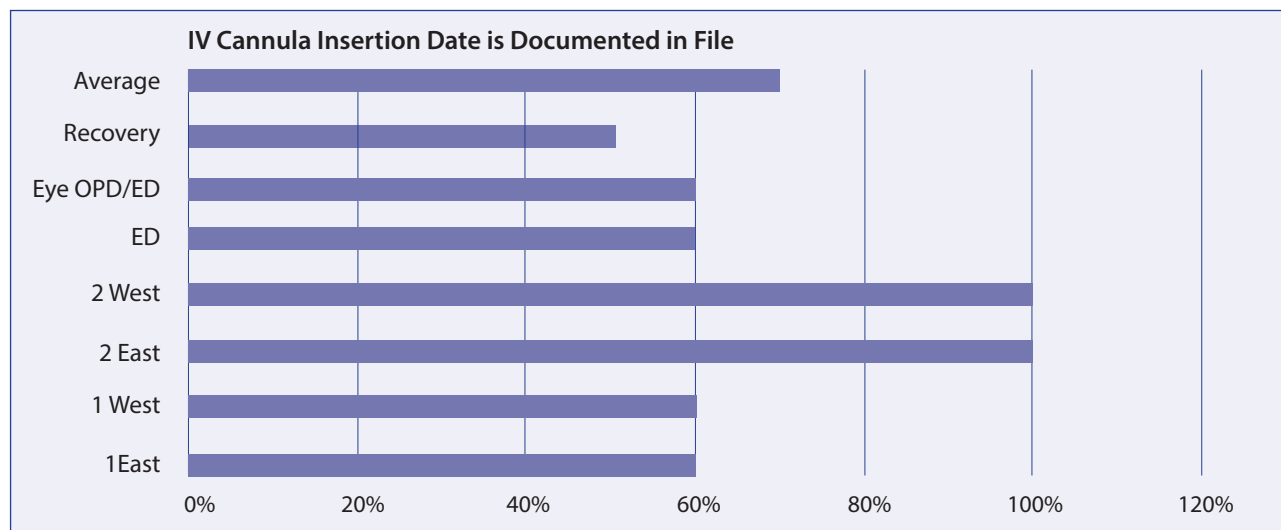
DOMAIN	PROCESS INDICATOR	SURGERY	MEDICINE	AGED CARE	MEDICAL IMAGING	FACILITY AVERAGE
Informed Consent	Patients whose first language is not English have a signed consent form with health interpreter reference	0%	10%	81%	100%	48%
Documentation of Informed Consent	The record contains a written consent for procedures that is complete and legible	92%	77%	97%	70%	84%
Documentation of Informed Consent	Only SESLHD accepted abbreviations are used on the consent form (as per District Abbreviations Policy)	98%	92%	95%	100%	96%
Consumer Participation	Patients fully understand the risks of procedures	90%	97%	100%	100%	97%
Management of Peripheral IV Cannulas	Intravenous cannula sites do not show signs of infection	98%	93%	99%	N/A	97%
Management of Peripheral IV Cannulas	Intravenous cannula insertion date is documented at the site	46%	61%	70%	N/A	59%
Management of Peripheral IV Cannulas	Intravenous cannula insertion date is documented in the Clinical Record	46%	59%	87%	N/A	64%
Management of Peripheral IV Cannulas	Intravenous cannulas are in site 72 hours or less as per PD256 Peripheral Venous Cannulation	86%	80%	97%	N/A	88%
Management of Urinary/ SP catheters	Urinary / SP catheter insertion date is documented in the Clinical Record	54%	80%	95%	N/A	76%
Management of Urinary/ SP catheters	Urinary / SP catheter insertion size and type is documented in the Clinical Record	38%	67%	69%	N/A	58%
Management of Urinary/ SP catheters	Urinary / SP catheter recommended date for change / removal documented	58%	40%	55%	N/A	51%
Compliance with Aseptic Technique	Hand Hygiene is performed prior to starting a procedure	83%	100%	100%	N/A	94%
Compliance with Aseptic Technique	Aseptic non touch technique is used to open dressing packs	94%	100%	100%	N/A	98%
Compliance with Aseptic Technique	Aseptic non touch technique is used to clean the wound	93%	100%	94%	N/A	96%
Compliance with Standard Precautions	Gloves are worn when handling bodily fluids	100%	100%	100%	N/A	100%
Compliance with Transmission Based Precautions	PPE is worn when managing patients with an infectious disease	98%	100%	92%	N/A	97%

- Compliance less than 70% (requires immediate attention),
- Compliance less than 90% (requires short-term attention),
- Compliance greater than 90%

As the MAXC system of audits requires staff to audit their own wards, questions have been raised about the integrity of the results. To address this concern, it is recommended that staff from another clinical area complete an audit to verify the scores on an ad hoc basis. This is particularly relevant if results are consistently 100% and are not reflective of outcome data. Hermida, Broughton and Miller Franco

[12, p.690] conducted an external review of the internal validity of twelve organisations participating in a quality indicator program using self assessment. They concluded that whilst self assessment teams err towards enhancing their performance, the degree to which this occurs does not adversely influence the results. Self assessment was therefore determined to be a sufficiently valid process

**Table 4: Comparison of ward performance at Divisional level an example**



for tracking performance. It has been suggested that the opportunity to complete internal audits empowers staff and enables them to regain control of quality of clinical care. [11, p.45]

**Reporting Results**

Each audit is conducted on ten occasions over the month by one staff member. This is not an onerous task as the audit process is integrated into routine clinical practice. Indeed, feedback suggests that staff feel empowered and it has encouraged local ownership through the development of action plans as previously discussed. Ward results are aggregated into a facility compliance rate, providing an overall indication of organisational risk (Table 4 provides a sample report). The presentation of data at clinical quality committee meetings has generated competition among clinical divisions leading to improved performance. In addition, the reporting of results to District committees related to the NSQHS Standards (eg falls prevention committee) facilitates the review of District level of risk. As this is a new system of audits, it is intended that compliance rates will be monitored and trended over time.

**Discussion**

All SESLHD facilities are currently using the MAXC model of audits. To date, two major teaching hospitals have been successfully accredited by the Australian Council for Healthcare Standards (ACHS) using the MAXC system of audits. Implementation required strong Executive Sponsorship as well as education and support for key staff. As the MAXC system of audits presents a different model, education was required about the concept of

process indicators as well as the utility of the system. To ensure sustainability, it was necessary to closely monitor compliance with completion of the audits. This enabled assertive follow up by managers and Executive Sponsors.

The District MAXC system of audits was initially developed using generic process indicators. In some instances the guidelines were re-worded to meet specific specialty area requirements. For example, some wards use a medication trolley and others put the medications in the patient’s beside locker. Both need to be locked at all times and checked as part of the medication safety audit. The MAXC guideline was written to reflect these local processes.

The successful implementation of MAXC requires a facility champion to assist staff with education, troubleshooting as well as providing general oversight of the program. This includes generation of reports for the peak quality committee, collation of action plans and management of permissions to the share drive. This staff member could be a Quality Manager or Senior Nurse Manager at Divisional level.

The MAXC system of audits has several limitations in its current format. The first is the use of a share drive as this prohibits multiple users at one time. Second, the use of a share drive presents the risk that data can be overwritten so it is important to protect spreadsheets to ensure the template is maintained. It is envisaged the MAXC system of audits will transition to an electronic system using hand held devices in the near future. Third, the MAXC system of audits has not been validated. It is therefore important to validate results by cross checking with other data sources, eg incidents and complaints data and clinical indicators. It

is also recommended that audits are conducted by different staff members on a rotational basis to improve the reliability of the results.

### Conclusion

The MAXC system of audits has been well received across SESLHD and has supported two facilities to achieve accreditation. It is a simple model of audits that measures process indicators in preference to outcome measures. Aggregated data from MAXC audits provides Executive Managers and Accrediting Agencies with ward, division, facility and District compliance rates.

Plans are underway to involve consumers in the development of relevant process indicators, completion of audits and the evaluation of results. It is anticipated that Consumer Advisory Committees will be involved in the development of action plans for improvement.

The strengths of the MAXC system of audits are that they are completed as part of everyday work activities. They do not remove front line staff from clinical care. In addition, the collection of audits is distributed amongst all ward staff and this tends to promote local ownership of results. This is not always the case when audits have been completed by external personnel with delayed reporting. Further, the MAXC system of audits improves the timeliness of reporting as the spreadsheets automatically generate results that can be actioned immediately. This simple model adopted across SESLHD facilities can be easily transferred to other organisations.

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## The workplace bullying of healthcare trainees and its effects

D McCormack, N Djurkovic and G Casimir

### Abstract

**Objectives:** This paper explores the workplace bullying of healthcare trainees and the resultant effects on the trainees.

**Design/Setting:** Semi-structured interviews are used with three healthcare trainees.

**Results:** The results indicate that the healthcare trainees are subjected to a range of work-related and person-related forms of bullying behaviours. The effects of these behaviours are substantial and are manifested in psychological, physiological and physical forms.

**Conclusions:** Workplace bullying is a significant issue impacting on healthcare trainees and needs to be addressed. Further research is needed to aid in the development of appropriate policy and intervention. Sustained efforts are required to curb the bullying of trainees.

**Key words:** healthcare; trainee; workplace; bullying; health; effects.

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### Introduction

Despite broad interest in workplace bullying, few studies have focused on the bullying of trainees/apprentices. The aim of this study is therefore to explore the workplace bullying experiences of healthcare trainees.

Imbalance of power has been highlighted as an important antecedent in workplace bullying. [1-2] Young staff members in general – who tend to hold relatively junior positions –

are ‘soft targets’ for bullying behaviours [3]. Trainees and apprentices are also a ‘risk group’ [4-5] with minimal ability to defend themselves. [6] Apprentices in the restaurant sector [4] and trainee teachers on placements [7] have reported being bullied by staff.

In the healthcare sector, it has been found that most psychiatry trainees have experienced bullying and that the perpetrator is most commonly the relevant consultant. [8] Similar findings were made for trainee doctors. [9-10] Another study found that student nurses on clinical placement reported their feelings of being exploited, unwanted and socially excluded. [11] In another study student nurses were found to have been the target of bullying perpetrated most commonly by other nurses. [12]

A direct relationship has been found between the workplace bullying of apprentices in restaurants and their intention to quit their jobs, with this relationship being mediated by variables including the apprentices’ exit costs. [4] Other studies have found that intention to leave evolves into actual turnover of trainees and apprentices in general as a result of bullying [7], with some quitting their training altogether. [13] It remains to be seen whether other consequences of bullying – both individual (e.g., diminished health [14] and organisational (e.g., decreased productivity [15] – apply also to trainees/apprentices. This study therefore examines the

workplace bullying experiences of healthcare trainees and its effects.

## Method

Semi-structured individual interviews were used for this study. Participants were informed that the voluntary interview would be about the bullying of trainees and that responses would be anonymous. Three healthcare trainees (all female) were interviewed in a private room at their technical college away from their worksite as part of a larger study of the workplace bullying of trainees/apprentices. Two note-takers recorded the interviews. Relevant ethics approval was first obtained.

## Findings

The following quotations from the interviewees provide examples of various bullying behaviours. To protect the identity of the participants, the term 'healthcare professional' refers to the primary service provider, while the term 'supervising nurse' refers to the participant's immediate supervisor. A code (i.e., T1, T2, T3) indicates which trainee provided the quotation.

Several person-related bullying behaviours [16] were reported, suggesting a general lack of respect for the trainee. For example:

*"It's just lots of little things repeated... She [supervising nurse] will say 'You should know that' or 'that's a stupid question'... She will 'shrug off' (ignore) my questions and then later be nasty to me for not knowing." (T1)*

The interviewees often felt that they were singled-out for the bullying behaviours, thereby influencing their perceptions of injustice:

*"I haven't seen him [healthcare professional] be negative to other staff... It's frustrating because he won't take me to surgeries because I don't know what I'm doing – I just feel like saying 'Of course I don't know what I'm doing because you won't teach me!'... One time we were overstaffed and he was taking another girl to the surgery and I asked if I could just come along and see how it's done but he said he didn't want too many nurses around – it was an opportunity to learn and he wouldn't let me." (T2)*

*"She [supervising nurse] was not rude to everyone, she treated certain people differently... I think she had issues with (people from) different nationalities... I heard that another girl – an Asian girl – had left because of how she was treated by the same supervisor... If I didn't understand a task straight away she said 'I've never seen anyone like you in all my life' or 'Everything about you – I don't know what's wrong with you.'" (T3)*

In some cases, the humiliation and belittling comments occurred in front of others, including patients – for example:

*"He [healthcare professional] screams at me in front of people. When he did that I wanted to cry but I couldn't do anything – what could I do?" (T3)*

*"He [healthcare professional] will ask me 'on-the-spot' questions and if I don't know the answer he'll say 'You're such an idiot'... He belittles me in front of other staff..." (T2)*

The interviewees also spoke of several work-related bullying behaviours [16] including an unreasonable workload, possibly jeopardising staff and patient safety – for example:

*"I get no break between 8:45 and 14:30... Often I don't finish until 19:45 even though I know my contract says I'm supposed to finish at 17:00." (T3)*

*"He [healthcare professional] doesn't give me time to do sterilisation or other tasks that I'm supposed to do and that puts a lot of stress and pressure on me... It makes it look to the other girls like I'm not pulling my weight..." (T2)*

Finally, it would be incorrect to attribute all of the bullying behaviours to the healthcare professional. The main perpetrator for one of the interviewees was the supervising nurse:

*"At first I thought [the healthcare professional] would back me up because he warned me about her [supervising nurse] and he could see what she was doing. In some ways he did back me up – like he agreed that stuff was happening – but he said 'that's just what she's like.'" (T1)*

The participants reported several effects that the bullying had on them – including not wanting to go to work, decreased motivation, and crying – for example:

*"You don't feel motivated, you don't want to be there, days drag out. It's sad because patient interaction was something I really enjoyed at the beginning but now I'm too scared to say anything... I dread waking up and having to go there – especially Fridays because then it's just me and him [healthcare professional]... He doesn't work on Tuesdays – Tuesday is my happy day!... I started crying in front of a patient one day after he [healthcare professional] had just 'kept at me'... He knows full well that it's making me upset... Sometimes I come home from work bawling (crying)." (T2)*

Furthermore, the effects of the bullying extended beyond psychological to physiological and physical manifestations – consistent with the psychosomatic theory of workplace bullying [3,17]:

*"I've been grinding and clenching my teeth – I never did that before. When I first started the placement a dentist gave me an oral exam and she said everything was fine... Six months later she noticed a huge difference: I'd worn through the enamel down to the dentine of the teeth – she said it happens due to stress... Another thing is that my psoriasis has been significantly worse since I started working there and that's associated with stress as well." (T2)*

The interviewees also indicated that the bullying made them question their own ability (i.e., diminished self-efficacy) and undermined their self-esteem:

*"It's made me second-guess myself. It's made me feel like I've got more weaknesses than strengths... My confidence has gone down a lot. It makes me feel like I'm shit at it, so should I be doing it?" (T1)*

*"After the way I've been treated, if something comes up, like we have to do an unexpected procedure at work, I feel like I can't wrap my mind around it as quickly as I should be able to." (T2)*

The 'ripple effect' of bullying is noted in the literature. [18] One participant reported that the effects extended to their families:

*"It has had a really serious effect on me personally and on my family... It affected my kids at school." (T3)*

The trainees also mentioned that they had considered quitting their traineeship due to the bullying:

*"I've considered leaving but it's purely financial – if I didn't have to pay back the money for the course... I would've been out of there months ago." (T2)*

The above quotation highlights the role played by continuance commitment [19] in hampering an individual's ability to remove themselves – in this case due to their financial situation – from the setting in which the bullying is occurring.

## Discussion

Some significant characteristics of trainees, including their lack of positional power and their young age, increase the risk of them being the targets of workplace bullying. The bullying experiences of trainees have not been the focus of many research studies.

The trainees in this study described being humiliated, not being provided with appropriate training, being made to work excessive hours, being screamed at, and generally being the target of abuse. The effects on the trainees included: diminished self-esteem, motivation and job satisfaction; crying (and in front of other staff and patients); and psychosomatic symptoms. There were also effects on the targets' families. The trainees also reported that their increased desire to leave their jobs was hampered by their financial dependence on their positions.

The results of this study have implications for the training of healthcare trainees. Traineeships require particular vigilance by all parties with respect to the possibility of bullying.[6] A proactive stance is required with all parties being made aware of the existence and efficacy of anti-bullying policies and available channels of redress. [6] It needs to be communicated to all parties that bullying will not be tolerated in the training environment.

## Limitations and future research

A limitation of this study is the small sample size. Nevertheless, the data gathered provide an insight to the experiences of healthcare trainees. Future studies, both qualitative and quantitative, have the potential to enhance our understanding of bullying by examining the observable signs of bullying, how trainees can report bullying, and what active steps observers and managers should take in prevention and intervention of the bullying of healthcare trainees.

## Concluding comments

The need for further research is highlighted by the following quotation from an interviewee:

*"I know I'm not the only one in this situation and I'm sure I won't be the last one either." (T2)*

The above quotation demonstrates the ubiquity of bullying and the need for sustained efforts to curb the bullying of healthcare trainees and other trainees/apprentices.

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## *Invitation to submit an article or write to the Editor*

The *Asia Pacific Journal of Health Management* invites researchers, policy makers and managers to submit original articles that increase understanding of issues confronting health leaders in countries throughout the region and strategies being used to address these issues. Articles from the private sector will be welcomed along with those addressing public sector issues.

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## 'Hardworkers': Filipino Nurses' professional practice in Queensland

K Marcus, S Short and B Nardi

### Abstract

**Objective:** The Philippines is one of the leading providers of nurses to the world with a Government policy supporting nurse export in exchange for remittances to the country. This paper assesses Filipino-qualified nurses who secured registered nursing status in Australia, on their sector of employment, their level of labour market integration and their level of theoretical knowledge, clinical and cross cultural communication skills.

**Design and Setting:** Directors of Nursing, Senior Managers, peers and Filipino qualified registered nurses who were employed in the public sector in Queensland [Australia] were interviewed. Questions included Filipino nurses and their communication skills, knowledge in theory, clinical and medication skills, and their migration and transition into the Australian culture. All interviews were recorded, transcribed and coded for thematic analysis.

**Findings:** Nineteen participants were interviewed with key themes emerging in migration, nursing theory and communication skills. 100% of participants described Filipino nurses as conscientious hard workers. The majority of Filipino nurses arrived in Australia after

working in the United Kingdom. While their clinical skills were considered good, their knowledge of nursing theory was considered to be lacking. There was concern that our sample was skewed towards highly educated Filipino nurses, which is atypical according to the literature. Problems with understanding the Australian language accent and slang was a common issue for Filipino nurses when arriving in Australia.

**Discussion:** This project was novel incorporating Queensland Health and key informants in the Philippines, providing new evidence about the transition and employment outcomes of Filipino registered nurses in Australia. This research contributes to health worker migration to Australia from source countries like the Philippines and encourages an ethical system for recruitment. The release of the WHO Code of Conduct for International Health Professional Recruitment in 2011, makes this study timely.

**Abbreviations:** NUM – Nurse Unit Manager; FN –Filipino Nurse; WHO-World Health Organization.

**Key words:** Filipino nurse migration; health workforce mobility.

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### Introduction

Health workforce mobility is a critical global phenomenon and Australia like other OECD countries, is likely to recruit nurses from abroad as a consequence of the aging population and maldistribution of nurses. The Philippines has become one of the largest providers of human export in the world while other Asian countries are now encouraging health worker migration or medical tourism; Indonesia too is overproducing nurses for export. [1,2] Concerns are raised when ethical policies conflict with the freedom of movement, especially when developing countries are faced with shortages of skilled health workers or an inability to expand their local health workforce due to financial or political constraints. An earlier publication from this project discusses Filipino nurse migration in Australia and ethical



considerations of nurse mobility. [3] Approximately 8.7 million Filipinos were living abroad in 2007, resulting in one of the highest emigration rates in the world. [4] Literature affirms that the Philippines purposely overproduces nurses for export in exchange for remittances and cannot absorb the number of nursing graduates in the country alone. [4] However, a high global demand for nurses has led to a mushrooming of schools in the Philippines, and has been associated with a decline in nursing education standards and registration pass rates. The global financial crisis pushed local nurses back into the workforce in developed countries, thus reducing the demand for Filipino nurses, which has added to the current oversupply of graduate nurses in the Philippines. Other issues also faced in the Philippines is the low retention of highly skilled health workers, including educators, as the best qualified tend to leave the Philippines for better opportunities abroad. Patient safety could also be jeopardised in Philippines' hospitals as junior nurses are likely to work unsupervised and once they gain two years' experience, they tend to leave the country. Competing at global levels, developing countries are unlikely to provide competitive salaries for individuals to remain in the country resulting in a draining of the supply of the best qualified. This remains a global ethical issue.

This paper assesses Filipino-qualified nurses who are employed as nurses in Queensland, Australia, on their sector of employment, their level of labour market integration and whether they experienced any marginalisation. Clinical skills, knowledge of nursing theory and cross-cultural communication skills were assessed in order to propose an ethical model for health professional recruitment to Australia. Results from this study will assist recruiters, government officials and policy makers in addressing an equitable allocation of resources in a sustainable and fair system for Australia, the Philippines and the individual nurses.

## Method

Qualitative content and thematic analysis was used to interpret meanings from the results. Data were collected through [i] semi-structured interviews in Australia in 2011 and 2012 and [ii] focus group interviews with key informants in the Philippines during 2012. For this paper, interviews in Queensland are discussed. Queensland Health purposively selected two Districts, based on the location of Filipino nurses.

In Queensland, semi-structured interviews were conducted face-to-face with 19 purposively selected participants; one Director of Nursing, five Nurse Unit Managers, five peers

and eight Filipino qualified nurses. An email with participant information forms, brochures and study protocols were distributed to the health facilities, who informed their nursing departments of the study. Interested participants contacted the researchers and were scheduled for interviews in June 2011 and February 2012. Interviews were conducted in a closed room at the designated hospital.

Two Filipino nurses were excluded from our analysis as they arrived in Australia as students who completed their Nursing degree at Griffith University. Our target group were Filipino nurses who qualified as registered nurses in the Philippines and were employed in Australia prior to the commencement of the National Registration and Accreditation Scheme in July 2010.

Qualitative thematic analysis was used for analysis of data and formal ethical approval was obtained from the Gold Coast Human Research Ethics Committee. All participants were informed about the study, questions and queries were answered and signed consent obtained. All interviews were digitally recorded and transcribed. Data are stored at the University of Sydney in a locked room for five years, as required by the ethics committee.

## Results

Key themes that emerged were migration, communications skills, theoretical knowledge and nursing skills, and the Australian lifestyle.

### Migration

The migration method to Australia varied for participants. Of the group interviewed, Queensland Health had recruited 50% Filipino qualified nurses through the United Kingdom, while roughly 12% arrived on a Family Migration Visa and 25% arrived under the Spouse Visa. One Filipino also entered via New Zealand, which shares reciprocal agreements with Australia. Approximately 38% of Filipino qualified nurses were required to undertake a so-called bridging course in Sydney or Queensland upon arrival. The bridging course was a compulsory requirement for these nurses to become registered in Australia. Another 50% of Filipino nurses had undergone an adaptation period in the United Kingdom which was an orientation program. Two Filipino nurses, and three senior nurse unit managers recommended the bridging course as fundamental for migrant nurses and their understanding of the Australian health system.

This study revealed that Filipinos were either migrating as students, spouses or arriving from other temporary countries like the United States or New Zealand before

settling in Australia. Direct migration pathways were limited from the Philippines to Australia. Filipino nurse experiences also varied depending on their method of arrival to Australia, but several exemplified stressful experiences during the migration and transition process.

*'Before you go with the bridging course you need all this English, English, English thing, so what I choose is I went [to] personally to the nursing council with [uh with uh for] that interview.....'my god' it's VERY stressful! ....., it's really stressful.....'* [FN from New Zealand]

*'...but during our times it was a bit of difficulty. The main issue is accommodation; you cannot get somebody to a foreign country who doesn't know the shopping mall, who wanted to immediately get out from that hotel and get a house but they need 100 points and points and points because there's so many trying to get the house that's the main big issues.'* [FN from the United Kingdom]

### **Theoretical knowledge and nursing skills**

A consensus view from senior managers, peers and Filipino nurses was that Filipino trained nurses had good technical and clinical skills but senior managers also felt that Filipino nurses lacked theoretical knowledge. All participants [100% ] identified Filipino nurses as hard-workers and were considered caring towards patients. However 80% of nursing managers, 12% peers and 12% of Filipino qualified nurses identified that Filipino nurses lacked depth of knowledge in nursing theory and did not understand the 'why' behind principles.

*'Local graduates seemed more knowledgeable about the principles and depth of reasoning in nursing'* [Senior Manager].

Fifty per cent of Filipino qualified nurses viewed nursing degrees in the Philippines as more intense with longer practicals, varied content and duration of degree; however our sample of Filipino nurses represented an 'elite' group. By 'elite' we refer to a skewed group who experienced education at a top private or top State nursing school in the Philippines, to which several participants obtained scholarships. This further indicates that a high standard of study was required at these top institutions. Only one Filipino qualified nurse felt their skills were being wasted while 50% recognised the significance of legal accountability and their scope of practice in Australia. A couple of peers assumed nursing theory was the same in the Philippines as that taught in Australia.

Assertive skills were found to be a challenge for Filipino nurses in general, as stated by almost 74% peers and nurse

managers. One quarter of Filipino nurses undertook assertive skills courses and challenged peers in the United Kingdom and thus felt they could do the same in Australia. But almost 60% of Filipino nurse participants were considered non-assertive. Twenty five per cent of Filipino nurses would not disrespect elders or seniors by challenging them and one Filipino nurse avoided direct confrontation. Culturally, respecting elders or those in superior roles adds to the lack of assertive skills of Filipino nurses. This is an area that will need more focus and training for Filipino nurses.

*'...Something you think is wrong, somehow you need to ask the doctors but the thing is – doctors are like Gods in our country you know, look like you don't have the right to question because they are doctors'* [Filipino Nurse].

Discrepancies in occupational language existed, as stated by all Filipino qualified nurses. Education in the Philippines is North American based, so the terminology is different to that used in Australia. For example, with hospital equipment in the United Kingdom and Australia, nurses refer to the 'bottle' but this is referred to as a 'urinal' in American textbooks. None of the participant groups felt occupational language was a problem, and was easily picked up in the hospital setting.

Medication safety [ie names and knowledge] was generally acceptable. Nurse Unit Managers agreed that the medication knowledge of Filipino nurses was much the same as other nurses which requires ongoing checking of calculations and research. However while 60% of nursing peers stated that medication names were a problem, 88% of Filipino nurses identified that medications were the same [generally], except branding and packaging was different.

### **Cross-cultural communication skills**

Understanding different accents and slang are common challenges upon arrival for most Filipino nurses. Irish, Scottish and Hungarian accents were considered to be the most difficult accents to understand as stated by 38% of Filipino nurses, whilst communicating with patients from America was considered the easiest. Thirty eight per cent of Filipino nurses stated Australian accents were not an issue. Approximately 88% of Filipino nurses and 40% of Nurse Unit Managers stated English language ability was not considered problematic as English was reported to be the mode of teaching in the Philippines. However in contrast, 60% of the Nurse Unit Managers, 40% of peers and 11% of Filipino nurses disagreed, stating English was either difficult to understand, especially under stressful circumstances and/or talking in a social setting was

considered daunting for a Filipino nurse. Conversely 25% of Filipino nurses expressed a comfort level when speaking with Asian nurses, especially Indian or Chinese nurses. Despite this, Australian slang was a common problem, so most avoided socialising or mingling with Australian nurses in fear of not understanding Australian idioms.

*'Oh LOVE it! It's just sometimes the way I feel and more comfortable talking to the Asians, having said that I have no problems talking to the Aussies and I think it's more for example again the slang – if they talk the Aussie language I have no idea'* [Filipino Nurse].

General terminology such as 'loo' or 'patient needs to go number 1 or number 2,' [Filipino nurse] created difficulties for Filipino nurses who were unaware of informal phrases. But the Filipino nurses stated they were not afraid to ask and learn. Australian slang was also considered one of the greatest challenges while comments from peers could add further confusion, like 'Are you from outer space?' [Filipino nurse]. One Filipino nurse utilised the Internet to understand Australian slang.

The impact of language issues at work varied. A senior manager encountered a Filipino nurse who misunderstood instructions during handover, however patient safety was not jeopardised. Two other Nurse Unit Managers experienced problems with Filipino nurses mixing words and genders but these minor issues did not cause harm to patients. Almost all participants considered written English skills of Filipino nurses as good and legible.

### Job satisfaction

Filipino nurses reported equal promotional opportunities as local Australian nurses. Two nursing peers discussed promotions of Filipino nurses and one Filipino nurse was recently appointed to clinical facilitator. Most Filipino nurses explicitly stated that they were working at their qualified skill level and were reluctant to take on higher roles in order to balance work and family life. All Filipino nurses were appreciative of the Australian lifestyle, the opportunities that were given to them and were generally very happy to live in Australia, especially once they were able to qualify for a mortgage. *'Oh I already have a mortgage, that's one of our satisfaction uh of our career!'* [Filipino nurse]. All participants described Filipino nurses as 'hard workers' and extremely caring towards their patients.

Filipino nurses and other Asian nurses tend to socialise in their own cultural groups during and outside of work through church or community groups. One nursing peer referred to the group of Filipinos in their ward as the 'Filipino

*Mafia'* [Nursing peer], which was referred to jokingly. The same peer also felt that Filipino nurses were treated differently, but could not elaborate how; *'it was just what I [peer] felt'*. One Filipino nurse 'LOVED' working when other Asian nurses were on the same shift as they felt there was a mutual understanding and felt more comfortable with Asian groups compared to English-Australian nurses. All Filipino nurses confirmed they had no problem with the 'Aussies' either.

### Principal findings

Filipino nurses are likely to have several migration pathways, with either the United Kingdom or the Middle East as the first migration step followed by a permanent location like Australia or USA. Experiences of Filipino nurses and the migration patterns to Australia varied, where the majority of nurses arriving via the United Kingdom found fewer difficulties as they were guided with accommodation, travel, registration and so on, unlike Filipino nurses arriving directly. Nurses who migrate directly from the Philippines found several obstacles to their transition, as one Filipino nurse from New Zealand described the stressful situation of English exams and the importance of passing, since they were unaware of the requirements prior to moving to New Zealand. Lorenzo et al [4] reported in 1998-2008 Filipino health workers permanently migrated to the United States, Canada or Australia, where they are likely to have relatives. Not many nurses from our study reported the move to Australia because they had relatives already residing here. Limited direct migration pathways mean nurses arrive as skilled migrants or under the family migration program. In 2009-2010, the Philippines was the fourth largest cohort of Family Stream migrants to Australia, behind China, the United Kingdom and India. [6] All Filipino nurses [except one who was recently employed and undergoing training] reported sending remittances to the Philippines to support their extended families. Remittances are a large contributor to the Philippines economy, receiving US\$21.3 billion in 2010, [4] which is why nursing is viewed as a highly attractive job in the Philippines. Unfortunately, budget figures indicate very little expenditure in the Philippines is expended in healthcare, with only 3.6% of GDP funds allocated to health. [7]

Literature confirms that Filipino nurses are well educated, [3,8] which is one of the reasons they are employed globally. Senior managers interviewed for this study, felt Filipino nurses had adequate clinical and medication skills but lacked depth of knowledge in theory. However, education standards are reported to vary distinctly from schools in the

Philippines. In 2005, 450 nursing schools offered Bachelor of Science in Nursing programs [3,9] which led to the reduction in the quality of nursing education. As a consequence, the number of Filipino nurses passing the licensure examination declined drastically. In 2002, 19,903 nurses applied to take the Graduates of Foreign Nursing Schools screening exam. While 17,496 took the exam, only 33% passed. [8] Another problem is that the most highly skilled Filipino nurses leave the Philippines, [3,4,10] resulting in gaps in hospitals and health professional education for the source country.

Filipino nurses are regimented in their care, according to senior managers and peers. Their disciplined manner of working is in accordance with research by Troy et al [8] whereby migrant nursing care was practised objectively with a lack of clinical autonomy for overseas-trained nurses in Ireland. This view was not negatively emphasised but rather stereotyped as Filipino nurses in general, with no significant difference in the nursing care provided to patients. Evidence also supports the lack of complaints about Filipino nurses where Winkelmann-Gleed [11] reaffirms that 80-90% of complaints in the National Health System in Britain were regarding staff attitudes and cultural differences but no complaint was made about Filipino nurses. Lorenzo et al [4] further affirms that Filipino nurses with speciality care experience in Emergency, Cardiac or Intensive Care Units were in greater demand overseas and so Filipino nurses' skills are highly valued.

With cultural diversity in Australia, language and assertiveness skills are fundamental for patient safety within a healthcare setting. Difficulties of Filipino nurses included accents, slang, terminology and typically a lack of assertive experience upon first arriving in the country. Peers also reported difficulties understanding Filipino nurses due to their American-Filipino accent. Results indicate that Filipino registered nurses found English language a challenge, especially slang terms commonly used in everyday language such as 'AM' or 'PM' when referring to time or phrases like 'lend me a hand.' Walters [12] substantiates that English language tests are difficult for a nurse that has never been exposed to an Australian accent before. This research is in accordance with our survey component of the study where just 11% of Filipino nurses passed the Occupational English Test in 2011, compared to the 17% average for migrant nurses. [13] There was also a consensus view that Filipino nurses felt well adjusted to communicate with different nationalities where 25% expressed a comfort level when speaking with other Asian nurses, especially Indian or Chinese nurses. Migrant nurses may find comfort from other minorities to

gain a sense of belonging. [14] Australian slang is an initial barrier, but is overcome with time, practice and experience in the Australian social setting. Additionally assertiveness was stated as an issue for 54% of senior managers and peers. The hierarchical nature of teaching in the Philippines discourages nurses to speak up to senior nurses or doctors and this is problematic in Australia where patient safety comes first. There were also substantial differences between Filipino nurses from the United Kingdom who were better equipped in assertiveness than Filipino-qualified nurses.

### **Australian lifestyle**

All Filipino nurses were appreciative of the Australian lifestyle. Most stated that they were unlikely to migrate to other countries. Family and work-life balance was seen as important factors for migration, as several mentioned having children in Australia and being 'happy to be here.' Filipinos contribute significantly to the Australian workforce; their labour force participation rate of 74 per cent was well above the national average of 65 per cent in 2011. [15] Interestingly, a lack of work opportunities and career progression offered to Filipino nurses is evident in several papers. [16,17] Kawi and Xu [14] found that overseas trained nurses were not given promotional opportunities but our interview results indicate the contrary to be true where career opportunities for Filipino nurses were the same as any other nurse.

Walters' [12] research states that migrant nurses from South Asia viewed the Australian lifestyle as a positive one, but also found that several participants could not fully integrate into the Australian culture and that most are still continuing to adjust. This could suggest Filipino nurses' adjustment to the Australian culture as a continuous process over a long period of time. *'It's really difficult especially maybe I don't have much adjustment when I was here but when I started in UK, I couldn't even taste the taste of water [laughs]. We have lots of anxieties, it's good the friends were there and they were very supportive.'* [Filipino Nurse]

With increasing multicultural diversity of the Australian workforce, ethnic groups are likely to integrate. Troy et al [8] confirms that Indian migrant nurses in Ireland were unable to integrate and adapt to the Irish culture due to a vast contrast to their own upbringing. Acculturation is tricky for migrant nurses, [8] consequently support groups are viewed as significant during transitioning processes. Working on the ward with other Filipino nurses was also viewed as a positive work environment.



## Limitations

Our results reveal a skewed, relatively elite sample of Filipino nurses, who obtained qualifications at a top tertiary institution and/or obtained expertise from other countries, like that of the United Kingdom. Therefore our sample provides somewhat limited insights that cannot be generalised too far to other Filipino nurses. An important factor to affirm is that the views of Filipino qualified nurses interviewed, stood in sharp contrast to the evidence on Filipino nurses' English language ability. Analysis of Occupational English Test outcomes from 2005 to 2011 demonstrates Filipino nurses secure exceptionally low pass rates compared to other groups. [13]

Additionally there was a substantial difficulty in finding the target group who were Filipino qualified nurses, meaning that they obtained their degree in the Philippines. However several Filipinos wishing to participate had actually obtained their degree from an Australian University.

Further research in other jurisdictions with a larger sample, including nurses in the private sector and enrolled nurses would be useful to identify potential Filipino nurses as a source for nurses in the future.

## Implications for nurse unit managers, recruiters and policy makers

Training of Filipino nurses is dependent on the individual institutions of employment. In the United Kingdom, an adaptation program is implemented to assist with the transition of migrant nurses while bridging courses are currently available in Sydney. Filipino nurses who arrive in Australia for work will need to obtain registration with the Nursing and Midwifery Board of Australia which requires their nursing education to be verified along with their English language test results. Introductory packages with resources and links to information on Australian slang and idioms as well as assertiveness courses would prove beneficial for migrant nurses. We note here that bilateral agreements between the Philippines and Australia do not exist yet, however the WHO code of conduct introduced guidelines on global health worker migration. Ethical recruitment is an important consideration for developing and developed countries.

## Conclusion and future research

The global movement of nurses is a complex ethical issue, which makes recruitment challenging for source and destination countries. Remittances contribute 10% to the Philippines economy, and almost all Filipino nurses reported financially supporting their family in the Philippines.

With limited migration pathways between Australia and the Philippines, Filipino nurses are likely to work in other developed countries before settling in a preferred destination like Australia. Filipino nurses were constantly referred as a hardworking group by all participants with proficient nursing knowledge. Although education standards in the Philippines vary between Universities, the relatively 'elite' group of Filipino nurses interviewed in our study deliver good clinical skills that would be valuable and provide an attractive option for nurse recruitment in the future.

This however drains the source country from experienced nurses and teachers which could jeopardise health care services in the Philippines. Several senior managers also quoted a lack of in-depth knowledge in nursing theory while communication skills were adequate. Another challenge for migrant Filipino nurses included Australian idioms, accents and slang. Creating a convivial environment in the workplace with the implementation of orientation and support courses will be essential for any migrant nurse. In addition family life is a considerable aspect in the lives of Filipino nurses and essential for a healthy transition to a new country. Further research is encouraged to gauge the potential for international recruitment of nurses in the future.

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## End-of-life Care Needs of People Dying from Stroke in Australia, New Zealand and Singapore: a space for palliative care

M O'Connor, J Beattie, E Wing Hong, R McKechnie and K Keow Lee

### Abstract

#### *Aims:*

1. Investigate the illness pathway of people dying of stroke in Singapore, New Zealand and Australia; and
2. Undertake a comparison of the needs of people dying of stroke between these countries.

*Methods:* A pilot retrospective medical record review was conducted with patients who died of stroke aged 18 years and over during 2008 to 2011 within acute care hospitals in Australia (n=10), New Zealand (n=10) and Singapore (n=7). This sample was designed to identify significant issues in the treatment and care of people who die of stroke, and will be used to inform a larger study. Sites chosen represented the key hospital for the treatment of people with stroke for a population of 200,000.

Medical record data were collected using an agreed template and concerns of patients, relatives and health professionals were also extracted. One researcher led the analysis, which included descriptive statistics and thematic analysis. Electronic and telephone discussions between researchers ensured consistency of data.

*Principal findings:* The majority of patients in Australia and New Zealand were transferred to stroke wards for care; those in Singapore were transferred to intensive

care and lived longer. A stroke care pathway was followed in all countries, with a palliation pathway identified in two records (Australia and New Zealand). Palliative care was documented in the majority of Australian and New Zealand records.

Concerns related to impaired consciousness and deterioration in patients' conditions. There was a lack of documented advance care plans and care directives; where present, staff had difficulty following them. Palliative care referral could make a difference to these patients and families.

*Conclusion:* Stroke happens suddenly. Time to death is often short. This pilot indicates there is space for palliative care in the management of stroke patients to assist in end-of-life decision-making and symptom management. A larger study on this issue is justified.

*Abbreviations:* DHB – District Health Board; ED – Emergency Department; EOL – End-of-Life; HP – Health Professional; ICU – Intensive Care Unit; MoH – Ministry of Health; NFR – Not-for-Resuscitation; PC – Palliative Care.

*Key words:* end-of-life care; stroke; care pathway; research; palliative care.

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## Introduction

Stroke is a leading cause of death in Australia, [1] New Zealand [2] and Singapore. [3] In the acute phase of stroke, accurately predicting prognosis can be difficult. [4] Australian figures show that greater than 20% of patients diagnosed with their first stroke will die within 28 days, [5] and that by five years, 60% have died. [6] It is predicted that these figures will worsen as the population ages. [4] Following the acute phase of hospitalised care, United Kingdom figures show that as many as 19% of patients who survive hospitalisation after stroke require transfer to nursing or residential homes to manage ongoing care needs. [7]

The World Health Organisation defines stroke as: 'rapidly developing clinical signs of focal (or global) disturbance of cerebral function, with symptoms lasting 24 hours or longer or leading to death, with no apparent cause other than of vascular origin'. [8]

While patients with cancer constitute the largest proportion of patients seen by Palliative Care (PC) services in most parts of the world, [9] the provision of End-of-Life (EOL) care services to patients who have had a stroke and their families remains challenging and unclear. [4, 10, 11] Some physicians regard stroke as a condition not appropriate for referral to PC, [12] leaving many patients and their families with unmet PC needs. [13]

In the three participating countries, there is little health policy connection between stroke and EOL care. However, the National Stroke Foundation in Australia has developed Clinical Guidelines for Stroke Rehabilitation and Recovery, which endorses that people with stroke who are dying, and their families, should receive care consistent with the principles of PC. [14, 15] Implementing these guidelines and determining the PC requirements for these patients can be a major challenge for managers of health services. [4, 16] Care delivery needs to be patient-centred, address stroke symptoms and immediate needs, ensuring that the patient's and family views on life and living are taken into account, with PC as a part of care planning offered to every patient. [17]

Compared to other diseases such as cancer, the onset of stroke and death can be short, with little time for family to adjust, often leaving them feeling unsupported. [18, 19] Communication, where families are invited to share in decision-making, is crucial. [17] Family meetings can have a positive effect on care for the dying patient with stroke as these ensure that clinicians and family are informed and in consensus, and better placed to make decisions about care. [19]

Research suggests that while medical and nursing staff have identified that patients with stroke might have PC needs, referral to PC services is not always considered appropriate in many countries. [20] However, this lack of referral is considered detrimental to the relationship between stroke and PC services, as working together would facilitate better understanding in both areas, resulting in improved patient care. [21] Incorporating a care pathway for the dying patient with stroke has been found to improve documentation of care delivered as well as ensuring appropriate care of dying patients. [16] In a United Kingdom stroke unit the care pathway for the dying patient provided guidance for aspects of EOL care such as comfort measures, medication prescribing, cessation of inappropriate interventions and psychological and spiritual care, including care of the family before and after death of their loved one. [16]

An Asia-Pacific regional workshop on PC research revealed that the provision of PC for people with non-malignant illnesses was problematic in many countries. As stroke is a major cause of death in most countries, agreement was reached to undertake a research project on people dying of stroke. The chosen sites were agreed to represent the key acute health services for the treatment of people with stroke for a population of approximately 200,000.

## Aim

The aims of this pilot study were to validate a data collection instrument in order to:

1. Investigate the illness pathway of people dying of stroke living in Singapore, New Zealand (Otago) and Australia (Melbourne); and
2. Undertake a comparison of the needs of people dying of stroke between these countries.

The results of this pilot study will be used to inform a larger study of 300 records to pursue clinical aspects that emerge as significant in the treatment and care of people who die of stroke. The numbers chosen for the pilot represent approximately ten per cent of a total number of 300 records of all people who died from stroke over all three sites.

Each site gained approval from their human research ethics committees and the lead researchers also gained ethical approval from the Monash University Human Research Ethics Committee to conduct the study.

## Method

A retrospective medical record review of patients who had died of stroke aged 18 years and over during 2008 to 2011 in Australia, New Zealand and Singapore was conducted. Because it was a pilot study, an agreed small sample of five

female and five male patient records were sought from each site (n=10). With assistance from neurologists or medical records staff, the records selected were those that first met the above inclusion criteria (Australia n=10, New Zealand n=10, Singapore n=7).

Data were collected by the researchers in each country, using one template with items developed and agreed by them and then reading each medical record accordingly. Demographics; Admissions and Emergency Department (ED) presenting problems; primary diagnosis, co-morbidities, medications and cause of death; provision of care and treatment, including Health Professionals (HPs) and services used; as well investigations, treatments and clinical pathway were recorded. Any concerns of patients, relatives or next of kin, and HPs that were documented in the records were also collected. The common template enabled each researcher to collect the same data and no identifying data such as medical record number, name, or address was collected. One researcher (JB) managed the data as it came in from each site. She was involved in preliminary analysis of the descriptive statistics and led electronic and telephone discussions with each researcher regarding the consistency of the data.

Quantitative data were entered into SPSS software (version 18.0) and descriptive analysis conducted. Qualitative data were thematically analysed for common patterns of concern for patients, relatives and HPs. [22]

## Results

### Demographics

Twenty-seven records (Australia n=10; New Zealand n=10; Singapore n=7) were examined (Table 1). The Australian sample was older (median age=87.5) than the New Zealand and Singapore samples (median age=70); however, the greatest age range was New Zealand (20-95). In Singapore and New Zealand, most patients had lived at home with family carers (spouses and children); for one person in Singapore, a maid assisted in care. In contrast, half of the Australian sample had lived in a nursing home with staff as their primary carers. Living arrangements varied from one person who lived alone with no carer, to others who lived with family. All patients in all countries had died in a public hospital.

### Admission and emergency department presenting problems

Most patients in Singapore (100%) and Australia (80%) were transported to the ED by ambulance. In contrast, 38% of patients used an ambulance in New Zealand. The number of admissions per patient in the study period, ranged from one to ten (Australian mean=4.4; New Zealand mean=8.5; Singapore mean=3.5). The most frequent presenting problem on last admission in all countries was 'altered conscious state'/'unresponsive'/'collapse' (16/27; 59.3%), followed by stroke/stroke symptoms (9/27; 33.3%).

**Table 1: Demographics, place of residence and primary carer for Australia, New Zealand and Singapore**

	GENDER (N)	AGE RANGE (MEDIAN)	PLACE OF RESIDENCE		ILU*	HOSTEL	NURSING	HOME	PRIMARY CARER N (%)					
			OWN HOME	FAMILY HOME					SELF	SPOUSE	PARENT	CHILD	SIBLING	STAFF
Australia	Male (5)	78-86 (84)	2 (20)	0	0	2 (20)	1 (10)	5 (50)	2 (20)	2 (20)	0	0	0	6 (60)
	Female (5)	97-92 (91)												
New Zealand	Male (5)	56-88 (69)	9 (90)	1 (10)	0	0	0	3 (30)	6 (60)	1 (10)	0	0	0	0
	Female (5)	20-95 (71)												
Singapore	Male (4)	56-65 (63)	5 (71.4)	2 (28.6)	0	0	0	1 (20)	2 (60)	0	3 (42.8)	1 (14.3)	0	0
	Female (3)	58-78 (77)												
<b>Total</b>	<b>27</b>	<b>(74)</b>	<b>16 (59.3)</b>	<b>3 (11.1)</b>	<b>3 (11.1)</b>	<b>2 (7.4)</b>	<b>1 (3.7)</b>	<b>5 (18.5)</b>	<b>6 (22.2)</b>	<b>10 (37.1)</b>	<b>1 (3.7)</b>	<b>3 (11.1)</b>	<b>1 (3.7)</b>	<b>6 (22.2)</b>

\*IDU = Independent living unit

Australian patients most frequently remained in ED (5/10; 50%), New Zealand patients were most frequently transferred to a general medical ward (8/10; 80%), and Singaporean patients to an Intensive Care Unit (ICU) (5/7; 71.4%).

#### Primary diagnosis, comorbidities and cause of death

Using the classifications identified in the patient records (haemorrhagic, ischaemic and non-specified stroke), the most frequently presenting primary diagnosis in Singapore was haemorrhagic stroke (100%). In New Zealand, both haemorrhagic (40%) and ischaemic stroke (40%) frequently occurred. However 50% of strokes were unspecified in Australia, making further analysis difficult. Patients presented with a range of cardiovascular, respiratory, musculoskeletal, gastroenterological and psychological comorbidities and cancers. For many, this was not their first admission for stroke. Deaths from aspiration pneumonia

(New Zealand n=2) and nosocomial pneumonia (Singapore n=2) as a complication of stroke were also identified.

Fifty per cent of Australian patients died on day of admission, with 40% living from one to two days, and up to 27 days (10%). In New Zealand, 20% of patients died on day of admission, with 60% living for one to five days and up to 27 days (20%). In contrast, in Singapore, 57.1% of patients lived for ten to 55 days.

#### Provision of care and treatment

##### *Health professionals and other services providing care*

In all countries doctors and clinical nurses were the most frequent providers of care (table 2). The range of other HPs varied, however, physiotherapists, occupational therapists and dieticians were identified in each site. In Singapore, a pharmacist and stroke nurse were recorded as providing care, with a PC nurse identified in three Australian records (Table 2).

**Table 2: Health professionals and services providing care in each site**

HEALTH PROFESSIONALS/SERVICES PROVIDED	PATIENTS N=10 (%) AUSTRALIA	PATIENTS N=10 (%) NZ	PATIENTS N=7 (%) SINGAPORE
<b>Medical staff</b>			
Registrar	10 (100)	10 (100)	7 (100)
Intern	0	10 (100)	0
Internal Medicine Consultant	0	6 (60)	0
Intensive Care Consultant	0	2 (20)	5 (71.4)
Neurologist/Neurosurgeon	0	1 (10)	7 (100)
Vascular Consultant	1 (10)	1 (10)	1 (14.3)
Endocrine Consultant	1 (10)	0	0
Orthopaedic Consultant	1 (10)	0	0
General Practitioner	6 (60)	2 (20)	0
Radiologist	0	0	4 (57.1)
Anaesthetist	0	0	4 (57.1)
<b>Nursing staff</b>			
Clinical Nurse	10 (100)	10 (100)	7 (100)
Stroke Nurse	0	0	3
Palliative Care Nurse	3 (30)	0	0
Diabetes Clinical Nurse Consultant	0	1 (10)	0
Case Manager	0	0	4 (57.1)
Pain Management	0	1 (10)	0
<b>Allied health staff</b>			
Pharmacist	0	0	6 (85.7)
Physiotherapist	4 (40)	3 (30)	3 (42.8)
Speech Therapist	4 (40)	3 (30)	0
Occupational Therapist	3 (30)	2 (20)	3 (42.8)
Dietician	1 (10)	2 (20)	2 (28.6)
Social Worker	0	2 (20)	3 (42.8)
Podiatrist	0	1 (10)	0
Aged Care Assessment Team	1 (10)	0	0
<b>Community care staff</b>			
Home Help	2 (20)	0	0
Meals on Wheels	2 (20)	0	0



Of those records where a care pathway was identified, the stroke pathway was the most frequently followed (Australia 40%; New Zealand 30%; Singapore 42.4%). A palliation pathway was identified in only two records (Australia and New Zealand); however, palliative care was documented in 60% of Australian and 80% of New Zealand patient records. Not all care that is considered 'routine' care for severely ill patients was captured in the data. A 'Dangerously Ill List' (Singapore n=1) was also identified.

*Investigations and treatment*

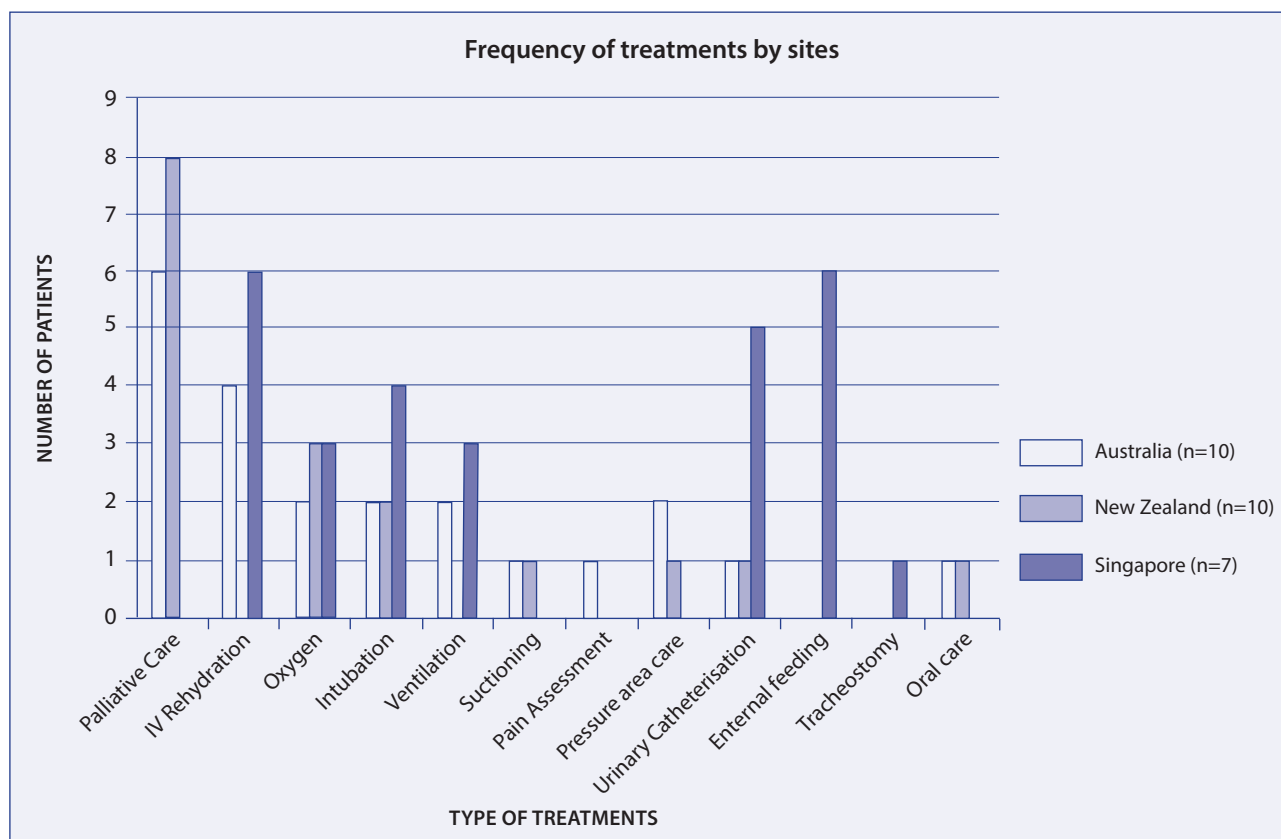
The majority of patients had blood tests (Australia 80%; New Zealand 100%; Singapore 100%) and CT scans (Australia 60%; New Zealand 60%; Singapore 100%) to investigate their condition. All were prescribed multiple medications for multiple comorbidities, including stabilisation while in ICU (Australia m=9.6; New Zealand m=6.3; Singapore m=14). Morphine, benzodiazepines and antipsychotics were more frequently prescribed in the Australian sample, compared to no/little usage in New Zealand and Singapore. While most medications seemed appropriate for the presenting comorbidities, a detailed assessment for best practice was not undertaken.

Figure 1 shows the range of treatments, (other than medicines) received by patients. Palliative care (not further specified) was provided in Australia (n=6) and New Zealand (n=8), while intubation, ventilation, urinary catheterisation and enteral feeding were more prevalent in Singapore. This may be attributed to the fact that 71.4% of Singaporean patients were transferred to ICU. In comparing the qualitative data in each record, it was evident that care activities such as pain assessment, and oral and pressure area care which are considered to be routine nursing practice in each country, were not captured in the data for this study.

**Concerns of patients, relatives and health professionals**

In Australia, there was some evidence of patient, relative and HP concerns documented in medical records, however, little was documented in Singapore and New Zealand. Documented concerns are reported in Table 3 for all sites and concerns related to EOL decision-making and are outlined.

**Figure 1: Identified treatments for each site**



**Table 3: Concerns of patients, relatives and health professionals**

	CONCERNS DOCUMENTED
<b>PATIENTS:</b>	
<b>Australia</b>	<ul style="list-style-type: none"> <li>Deterioration in condition; patient unable to verbalise concerns (n=4)</li> <li>Moaning and grimacing, stiffening when arm moved (n=1)</li> <li>Prepared to die (ID5); very open about not wanting resuscitation (ID7)</li> <li>Current NFR† certificate used to determine wishes (n=1)</li> </ul>
<b>New Zealand</b>	<ul style="list-style-type: none"> <li>Became unsettled when turned (n=1); Used hand squeeze signals (n=1)</li> <li>DNR† (n=2); Advanced directive for health care (n=1)</li> <li>Unable to verbalise (n=1); Unable to recall fall (n=1)</li> <li>Remained unresponsive (n=3)</li> </ul>
<b>Singapore</b>	<ul style="list-style-type: none"> <li>Deterioration in condition; patient unable to verbalise concerns (n=7)</li> </ul>
<b>RELATIVES:</b>	
<b>Australia</b>	<ul style="list-style-type: none"> <li>Agreed to NFR, including no cardiopulmonary resuscitation &amp; intubation (n=7)</li> <li>Requested to be contacted when condition deteriorates (n=10)</li> <li>Advised no interaction that would cause suffering/no aggressive treatment (n=4)</li> <li>Requested patient be made comfortable (n=1), with no further assessments to be performed (n=1), and no enteral feeding (n=1)</li> <li>Concerned about deteriorating quality of life and frailty (n=1)</li> <li>Family wished to be present through palliation (n=2)</li> <li>Difficulty in making decision not to treat (ID7) (e.g. antibiotics, investigations)</li> </ul>
<b>New Zealand</b>	<ul style="list-style-type: none"> <li>Wanted explanation of cause of death and autopsy (n=1)</li> <li>Aware of severity of condition, watching and waiting (n=2); Present at death (n=1)</li> </ul>
<b>Singapore</b>	<ul style="list-style-type: none"> <li>Felt deprived of the opportunity to hear the patient's last wishes because they were not allowed to be with the patient before she became comatose. (n=1)</li> <li>Financial concerns (n=2)</li> <li>Grieving upon patient's sudden deterioration (n=1); No carer (n=1)</li> <li>Family requested that active treatment and ventilatory life support continue until the return of son from overseas (n=1).</li> <li>Despite being advised of poor prognosis, family requested active management and ICU re-admission (n=1).</li> <li>Family reluctant to reveal diagnosis and risk of deterioration to the patient because they thought this would cause them to be anxious and adversely affect their condition (n=1).</li> </ul>
<b>MEDICAL STAFF</b>	
<b>Australia</b>	<ul style="list-style-type: none"> <li>Too unwell to be transferred to a palliative care unit (n=1)</li> <li>Extensive discussion with family to arrive at NFR decision (ID6)</li> <li>Wean off oxygen, to palliate (n=1); Obesity made intubation difficult (n=1)</li> <li>Severe pre-morbid conditions (obesity, cheyne-stokes breathing) (n=1)</li> </ul>
<b>New Zealand</b>	<ul style="list-style-type: none"> <li>Visited several times to accurately assess advance directive (n=1)</li> </ul>
<b>Singapore</b>	<ul style="list-style-type: none"> <li>Patient's wife intimidating &amp; unaccepting the fact of low survival (n=1)</li> </ul>
<b>NURSING STAFF</b>	
<b>Australia</b>	<ul style="list-style-type: none"> <li>Difficulty with pressure area care (n=1)</li> <li>Awaiting medication order for management of symptoms (n=1)</li> <li>Aspiration - Concern that lack of swallowing reflex might lead to aspiration (n=1); vomiting and aspiration (n=1)</li> <li>Concern lack of spontaneous breathing &amp; decision not to introduce fluids and antibiotics may lead to pneumonia (n=1)</li> <li>Ensure pain relief as necessary (n=2)</li> <li>Deterioration – malodorous urine, incontinence (treated with urinary catheter), hypothermia (n=1); Poor glycaemic control (n=1)</li> <li>Family had difficulty arriving at decision not to treat with antibiotics and further investigation (ID7); Pacemaker deactivated (n=1)</li> <li>Sacral pressure area sore present on admission (n=1)</li> </ul>
<b>Singapore</b>	<ul style="list-style-type: none"> <li>Stroke Nurse attempted to discuss Advance Care Planning with the family, who were initially keen, but then decided only to explore when patient condition was more stable (n=1)</li> </ul>

**Table 3: Concerns of patients, relatives and health professionals *continued***

	CONCERNS DOCUMENTED
<b>ALLIED HEALTH</b>	
<b>Australia</b>	<ul style="list-style-type: none"> <li>Occupational therapist noted depression &amp; poor insight into condition (n=1)</li> <li>Inability to swallow &amp; cough (n=1); Recommended no oral intake (n=1)</li> <li>Unsuitable for speech therapy due to deterioration of condition, recommended review as necessary (n=1)</li> <li>Patient unable to complete own activities, heavily reliant on wife (n=1)</li> </ul>
<b>Singapore</b>	<ul style="list-style-type: none"> <li>Patient's wife verbalised acceptance of patient's prognosis when medical social worker provided support to family (n=1)</li> <li>Social worker provided information on procedure for settling hospital bills, funeral management and gave written material as a reference (n=1)</li> </ul>

\* More than one concern was expressed in individual case records

† NFR and DNR: not for resuscitation and do not resuscitate

### *Challenges to advance care planning*

Deterioration in patients' conditions left many unable to verbalise their concerns, wishes and needs. In Singapore, relatives felt deprived of the opportunity to hear the patient's wishes (n=1). In Australian records (n=2), patient wishes were followed in relation to Not-for-Resuscitation (NFR) because previously arranged NFR orders were available and confirmed. There was no detail documented however, of what care constituted 'NFR'. In New Zealand records NFR orders were available for two patients. For one however, the advance directive witnessed by his general practitioner was continually challenged by an assortment of medical staff to ensure that this was still what he wanted, even though his family supported his directive. In one Singaporean record, there was evidence of the stroke nurse's attempt to discuss advance care planning with the family; initially they were keen to do so, but changed their mind, hoping to discuss ongoing care with the patient when the condition stabilised.

### *Challenges to EOL care and decision-making*

For those patients unable to communicate, there was recorded evidence of family members becoming their proxy decision-makers. While some relatives appeared ready to make these decisions, others found it a challenge, for example in agreeing to NFR orders (including no cardiopulmonary resuscitation, intubation, antibiotics, enteral feeding or further investigations). There was evidence that HPs spent considerable time with relatives to provide information to enhance the decision-making process.

There was also documentation in a number of Australian records identifying relatives' requests that no action that caused harm or suffering be undertaken, and documentation in all countries requesting comfort care. In two Australian

records, patients had stated that they were prepared to die (AID5) and were 'very open about not wanting resuscitation' (AID7). Across all sites, there was documented evidence of relatives requesting to be notified when the patient's condition deteriorated so they could be present at EOL. Other relatives were present throughout the dying process, while for one Singaporean family, regret was verbalised, because of not being allowed to be with the patient before the patient became comatosed.

Further, deterioration in one Australian patient resulted in them being deemed too unwell to be transferred to a palliative care unit, and in other instances, concern that aspiration and pneumonia would occur due to lack of swallowing reflex and vomiting (Australia and New Zealand). One Singaporean family requested ongoing life support with a ventilator to await the arrival of a family member from abroad.

### *Questioning of EOL decisions*

Records indicated that in some instances relatives were not happy with the prognosis and treatment. For example, in New Zealand one family wanted an explanation of cause of death and requested an autopsy; and in Singapore one wife was intimidating and unaccepting of a poor prognosis, while another family requested continuation of active management and ICU re-admission despite a poor prognosis.

## **Discussion**

### *Principal findings*

The findings of this pilot study concur with previous stroke statistics for each country, [1-3] which showed that while stroke happens suddenly, and death can occur on the same day of admission for 20% (New Zealand) to 50% (Australia)

of patients, many had been admitted previously for stroke symptoms. Additionally, the majority of patients lived from one to five days (Australia 40%; New Zealand 60%), being transferred to stroke or general medical wards. The findings of this pilot study confer with what is known about the Asian population, namely, that haemorrhagic stroke was more prevalent in the Singaporean sample than Caucasian samples. [23, 24] Due to the severity of haemorrhagic stroke in the Singaporean sample, many patients were transferred to ICU, with about half of the sample living for ten to 55 days. The higher number of medications used in this Singapore sample are also likely to be due to the severity of stroke and active intensive care management. While there would seem an opportunity for palliative care expertise in EOL management of stroke patients in all countries, there was little evidence of formal service involvement. This study supports the work of others that patients and their families require care teams to abide by previously written advance directives, and assist those who do not have these, to make informed EOL care decisions so that requests for measures to reduce suffering and comfort care can be actualised. [13, 15]

In relation to investigations and treatments, patients in all countries were equally investigated with blood tests and CT scans, and multiple medications were prescribed for comorbidities. It was not the aim of this study to examine best practice in relation to investigations and treatments; however, this is also an area for further study. More invasive interventions were carried out in Singapore, where most patients went to ICU for ongoing care. However, the longer-term use of technology and invasive treatments is an area for further study, particularly where relatives insist on such care when patients have poor prognoses.

Various patient, relative and HP concerns were identified in the records, many related to the impaired consciousness and deterioration in patients' conditions. Of particular concern was the lack of documented advance care plans and directives, and where these were present, hospital staff appeared to have difficulty following them. Consequently, the role of family in decision-making was vitally important. This finding supports that of others where palliative care is seen as important in the care of stroke patients, [16, 17] where families require support with explanations about prognosis, surgery, withdrawal of technological support, and artificial nutrition. Thus there would seem to be a number of areas where PC referral could make a difference to this cohort and their families. Ensuring symptoms, in particular pain, are managed in an unconscious patient, is vital in good EOL care, and this is the PC services' area of expertise.

#### *Implications for health services managers and policy makers*

In New Zealand stroke service provision is provided by the District Health Boards (DHBs) of which there are 20 throughout the country. These are funded by the Ministry of Health (MoH). Each DHB is responsible for its own area and is administered by a board of up to 11 members, four of whom (including the Chair and Deputy Chair) are Ministry appointments. The remaining seven are publicly elected through local government elections. DHBs are expected to plan and deliver health services in an ethical manner to provide effective care and support for those needing such services.

Stroke management in New Zealand is delivered according to the *New Zealand Clinical Guidelines for Stroke Management* (2010) where all DHBs are required to provide stroke services and that all those admitted to hospital with stroke should be managed in a dedicated stroke unit cared for by a multidisciplinary team with expertise in stroke and rehabilitation. However in an audit of DHBs carried out in 2009, only eight DHBs provided dedicated stroke units.

In the New Zealand system stroke patients are admitted to ED. Half die either on the same day or the following day and only those who are expected to survive are referred to a stroke pathway or stroke unit.

As highlighted in this study, EOL decision-making can be a challenge, even when advance care plans have been documented, [25-28] with hospital staff being unclear about the legal status of these plans/directives and NFR orders. [29, 30] It is therefore imperative for health service managers and policy makers to ensure advance care planning is discussed and documented early, that the position of such documentation is made clear within their organisations, so that patient wishes can be implemented where they have been made known.

In the New Zealand site, there was no interaction between stroke services and PC services although PC was documented in New Zealand patient records. Having this documented did not mean a referral to PC services, what it meant was that the patient received palliative of symptoms provided by the staff on the Neurology ward. However this may not be the case in other areas of the country.

In addition, formal communication channels need to be opened between those managing and delivering stroke services and those delivering PC services. However, given that PC has evolved around EOL care of people with cancer, [31, 32] there may be a resistance to engaging PC services

in the EOL care of people with non-malignant conditions. This may simply be that the PC team is not resourced to extend support beyond cancer care. This too is an area for further study. Engagement with PC services can assist with EOL decision-making and the provision of EOL care so that patients and their families can spend time together in a safe and dignified manner.

#### *Study limitations*

Caution needs to be taken in interpreting results and making comparisons between countries that have different health care systems and cultural contexts. In addition, the small sample for this pilot project may not be able to be generalised to all people admitted to hospital with stroke; however as noted, the care trajectory remained reasonably consistent before death.

#### *Future research*

This was a small pilot study; however it justifies a larger study to give a more comprehensive understanding of the EOL care needs of people dying from stroke, with the aim of informing the provision of PC for them. This study could also compare best practice in PC for stroke patients, including the appropriate use of medicines. In addition, interviews with carers and families about their concerns could be conducted to bridge the gap in documentation identified in this study. We suspect that a much broader discussion would have been conducted, but not documented; reasons for this could also be explored with HPs.

### **Conclusion**

While stroke happens suddenly and time to death is often short, there is space for PC in the management of stroke patients to assist in EOL decision-making and symptom management.

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## The changing oral health situation in Australia and moving towards primary oral health care

LA Crocombe, L Slack-Smith, E Bell and T Barnett

### Abstract

**Background:** Oral health has a substantial influence on quality of life and has been linked to general health, yet there is much work required to determine its optimal management.

**Methods:** This discussion paper drew upon government reports, research literature, existing reviews and media releases to discover the challenges and opportunities when incorporating dentistry into primary healthcare.

**Results:** Oral health outcomes have improved over the generations, the dental practice service mix has changed, the number of dental clinicians has increased and the workforce mix is changing, possibly leading to a change in perspectives on work-life balance. There is unequal access to dental care alongside a dental workforce maldistribution. Dental care is funded separately

to general healthcare and is largely supplied by the private sector. Subsidised dental care has been managed by the states but federal politicians of major political parties are investigating new funding arrangements.

**Conclusions:** The challenges to incorporating dentistry into primary healthcare are great. However, major political parties are interested in oral health. The oral workforce is going through a process of rapid change in practitioner number, type and possibly attitudes, thereby giving an opportunity to modify its delivery systems.

**Abbreviations:** CDDS – Chronic Disease Dental Scheme; GYPOHT – Graduate Year Program for Oral Health Therapists; VDGYP – Voluntary Dental Graduate Year Program.

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### Introduction

*Primary healthcare is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community*

*and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health.* [1]

Periodontal (gum) disease and tooth decay are common conditions in Australia and dental disease has a substantial effect on people's quality of life. For example, over 17% of people aged 15 years or more avoid certain foods due to dental problems, and the impact of oral disease is large when measured by indicators such as restricted activity and days of work lost. [2] Expenditure on dentistry in Australia was \$7.7 billion in 2009-10 or 7.5% of total health funding. [3] As an industry, dentistry is big business.

For those who can afford it, excellent dental care is available in Australia. [3] However, many people do not have adequate access to dental care, including frail and older people, [4] rural residents, [5] Indigenous Australians, [6] people with physical and intellectual disabilities, [7] and people of low socio-economic status. [8] A reason some people do not receive adequate dental care is that the costs of such care are largely covered by the individual. Less than 19% of dental costs are covered either by state or Commonwealth

Governments. [3] Dentistry is largely supplied by the private sector, and historically, this has usually been by male dentists over 50 years of age. [9]

Oral health outcomes have improved over the generations. For those who lived through World Wars I and II, dentistry frequently involved extracting teeth and making dentures. For the next generation, dentistry involved restoring teeth leading to 'the repeat restoration cycle' [10] of filling and then later refilling the same teeth as restorations collapsed or more tooth decay occurred. The latest generations have not suffered from poor oral health to the extent of previous generations. [2,5]

Subsidised dental care has historically been supplied by state governments via school dental services and public dental services for eligible adults. [2] It has been suggested that Australia may not be providing the types/format of services needed in the future. [11]

Yet, with the exception of lifetime fluoridation exposure, [12] the potential causes of poor oral health are the same as those that cause poor general health: social determinants, [13] poor hygiene, [14,15] poor diet, [16] lack of access to primary oral healthcare [17] and smoking. [18] Research is showing links between oral health and general health. For example, diabetes and periodontal disease are two chronic diseases that are biologically linked. [19] The common oral and general health risk factors and the links between oral and general health suggest primary oral healthcare should be incorporated into primary general healthcare.

The aim of this paper is to investigate the current changes in oral healthcare, and in the context of these challenges and opportunities, to determine if incorporating primary oral healthcare into primary healthcare will be challenging for policy makers, health managers, clinicians and the public.

## Methods

This discussion paper drew upon government reports, the research literature, existing reviews and media releases to discover why oral health was separated from, rather than integrated with general health; why population oral health outcomes have improved; changes in the dental practice service mix and in the oral health workforce; and recent changes in Commonwealth Government spending on oral health. The paper described the challenges and opportunities faced by policy makers, health managers, clinicians and the public when incorporating dentistry into primary healthcare.

## Results

The crucial characteristics of contemporary medicine stem from the seventeenth-century view of health where the body was described using the Cartesian machine metaphor:

... I assume the body is nothing else than a statue or machine ... indeed, the nerves of the machine I am describing to you may very well be compared to the pipes of the machinery of fountains, its muscles and its tendons to various other engines and devices which serve to move them ... its heart is its spring... [20]

One consequence of the machine metaphor was that the body was split into parts that were treated separately, with the mouth being one such part.

A narrow biomedical approach to health that saw healthcare as the way to improve population health prevented policy makers from engaging the wider determinants of health such as the physical and social environment in which people live. [21] Hence, faced with a tooth decay epidemic in the early twentieth century, the government response was to establish schools to produce health workers specifically trained to treat oral diseases. Dentistry has been separated from health ever since.

Due to increased fluoride exposure and improvements in dental care, more people have retained their natural teeth. [2,5] However, this has created a paradox in that the more teeth that are retained, the more teeth that are likely to require treatment in the future. Private dental practice has changed to reflect not just this greater retention of teeth, but also the increased use of services by adults. The pattern of practice has shifted towards fewer visits to the dentist per year, but more services provided per visit, so that there has been a stable annual number of services supplied per dentist. [22] The mix of services per year by dentists has shifted from simple restorative, denture and extraction services to diagnostic, preventive, more complex restorative and root filling services.

Another major change has been a recent large increase in dentist and oral health therapist training places, although how the different dental clinicians work in a team has not always been elucidated. After over a century of only five dentistry schools in Australia, four additional schools have opened, with more planned. In addition, the existing schools have grown larger. There is also a large increase in the number of dentists coming from overseas. [23] The concern has been that, without a large increase in targeted government funding, consumers who are currently receiving dental care may receive more elaborate services,

while consumers who are not able to access dental care, will remain poorly serviced. [11] Concurrently, some dental practitioners could be un- or under-employed.

Not only is the number of dental practitioners rapidly increasing, but their make-up is also changing. [24] The proportion of women in dentistry is increasing. Moreover, many dental students have a cultural background other than Australian. [25] These changes, coupled with the increasing proportion of younger dental practitioners in the workforce, may bring a different perspective by workforce members to dentistry, particularly with respect to the work-life balance. The changes number, make up and possibly attitudes of members of the dental workforce may give an opportunity to modify delivery systems such as the development of dental practitioner teams, incorporating primary oral healthcare into primary healthcare, and improving access to primary oral healthcare.

In November 2007, the then Health Minister, Tony Abbott introduced the Chronic Disease Dental Scheme (CDDS). [26] To be eligible for dental care, the person had to have a chronic medical condition and complex care needs and their oral health had to be impacting on, or likely to impact on, their general health. The Scheme was halted by the Gillard Government in November 2012 after some controversies. It was much more expensive than first envisaged, some dentists were found not to have satisfied some of the Scheme requirements, and whether all referrals to dentists from medical practitioners were appropriate is open to question.

On 1 July 2008, the Rudd Government introduced the Medicare Teen Dental Plan [27] to help with the cost of an annual preventative dental check. It was available for teenagers who receive certain government benefits and were eligible for Medicare.

In the 2011/12 Budget, the Government announced the Voluntary Dental Graduate Year Program (VDGYP) [28,29] to support 50 newly graduated dentists and provide them with a structured program for enhanced practice experience and professional development opportunities, whilst increasing dental workforce service delivery capacity, particularly in the public sector.

*The National Advisory Council on Dental Health Final Report* [17] was released in February 2012. Its policy options were an individual universal capped dental benefit entitlement for children; a means-tested individual capped dental benefit entitlement for adults; and for both groups, improved access to public dental services. The aspiration

was that these policy options would lead incrementally to a universally accessible dental scheme. The Minister's response to the report [30] indicated a preference for a dental scheme that targeted the financially disadvantaged; addressed workforce and infrastructure constraints; did not duplicate existing state dental services and was fiscally responsible.

The oral health spending in the 2012-13 Budget was \$515.3 million, over four years. This included \$10.5 million for oral health promotion and the development of a National Oral Health Promotion Plan; \$35.7 million for an expansion of the VDGYP; \$45.2 million for a Graduate Year Program for Oral Health Therapists (GYPOHT); \$77.7 million for a Rural and Remote Infrastructure and Relocation Grants for Dentists; and \$450,000 to a non-government organisation to coordinate pro-bono work by dentists. [31]

Although some saw the Budget as an exciting increase in dental funding, the Budget actually reduced Federal Government dental spending from over \$1 billion per year under the CDDS [32] to \$515.3 million, over four years. The 2012-13 Budget funding was largely focused on supplying dental care to those people currently not receiving these services. Most of the spending was scheduled to start in 2013-14. Thus, the policy was reliant on the Labor Party winning the next Federal election or a replacement government continuing with the same dental care reforms. There is an opportunity for the VDGYP and GYPOHT programs to work together so that dental teams may be established, but the separate funding of the two schemes may work against this.

More recently (August 29, 2012), the Minister announced a \$4.1 billion dental package with \$2.7 billion over six years for dental care to 3.4 million children in families eligible for Family Tax Benefit A capped at \$1,000 per child over a two year period and \$1.3 billion for low income adults, including pensioners, concession card holders and those with special needs. [33] The subsidised treatment to children was not planned to start until January 2014, while the other, a more restricted \$1.3 billion pledge to treat adults in public clinics was planned to start in July 2014. Hence, this announcement had similar caveats to those announced in the 2012-13 Budget.

The Government's focus on improving access to dental care will be very expensive. Senator Walsh in his book *Confessions of a Failed Finance Minister* advised that 'dental treatment has the potential to be a bottomless fiscal pit which no Commonwealth Government should go near'. [34]

Further research into primary oral healthcare is required to assist health managers, dental clinicians, policymakers and the public to improve community oral health.

### Conclusions

The challenges to incorporating dentistry into primary healthcare are great. On the opportunities side, major political parties are interested in oral health. The dental workforce is going through a process of rapid change in practitioner number, type and possibly attitudes, thereby giving an opportunity to modify its delivery systems.

### Acknowledgements

The authors are chief investigators with the Centre of Research Excellence in Primary Oral Healthcare. The research reported in this paper is a project of the Australian Primary Healthcare Research Institute, which is supported by a grant from the Australian Government Department of Health and Ageing. The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Primary Healthcare Research Institute or the Australian Government Department of Health and Ageing.

The authors wish to thank Dr Anne Read for her valuable critical review of this paper.

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## Manuscript Preparation and Submission

### General Requirements

#### Language and format

Manuscripts must be typed in English, on one side of the paper, in Arial 11 font, double spaced, with reasonably wide margins using Microsoft Word.

All pages should be numbered consecutively at the centre bottom of the page starting with the Title Page, followed by the Abstract, Abbreviations and Key Words Page, the body of the text, and the References Page(s).

#### Title page and word count

The title page should contain:

1. **Title.** This should be short (maximum of 15 words) but informative and include information that will facilitate electronic retrieval of the article.
2. **Word count.** A word count of both the abstract and the body of the manuscript should be provided. The latter should include the text only (ie, exclude title page, abstract, tables, figures and illustrations, and references). For information about word limits see *Types of Manuscript: some general guidelines* below.

Information about authorship should not appear on the title page. It should appear in the covering letter.

#### Abstract, key words and abbreviations page

1. **Abstract** – this may vary in length and format (ie structured or unstructured) according to the type of manuscript being submitted. For example, for a research or review article a structured abstract of not more than 300 words is requested, while for a management analysis a shorter (200 word) abstract is requested. (For further details, see below - *Types of Manuscript – some general guidelines*.)
2. **Key words** – three to seven key words should be provided that capture the main topics of the article.
3. **Abbreviations** – these should be kept to a minimum and any essential abbreviations should be defined (eg PHO – Primary Health Organisation).

#### Main manuscript

The structure of the body of the manuscript will vary according to the type of manuscript (eg a research article or note would typically be expected to contain Introduction, Methods, Results and Discussion – IMRAD, while a commentary on current management practice may use a less structured approach). In all instances consideration should be given to assisting the reader to quickly grasp the flow and content of the article.

For further details about the expected structure of the body of the manuscript, see below - *Types of Manuscript – some general guidelines*.

#### Major and secondary headings

Major and secondary headings should be left justified in lower case and in bold.

#### Figures, tables and illustrations

Figures, tables and illustrations should be:

- of high quality;
- meet the 'stand-alone' test;
- inserted in the preferred location;
- numbered consecutively; and
- appropriately titled.

#### Copyright

For any figures, tables, illustrations that are subject to copyright, a letter of permission from the copyright holder for use of the image needs to be supplied by the author when submitting the manuscript.

#### Ethical approval

All submitted articles reporting studies involving human/or animal subjects should indicate in the text whether the procedures covered were in accordance with National Health and Medical Research Council ethical standards or other appropriate institutional or national ethics committee. Where approval has been obtained from a relevant research ethics committee, the name of the ethics committee must be stated in the Methods section. Participant anonymity must be preserved and any identifying information should not be published. If, for example, an author wishes to publish a photograph, a signed statement from the participant(s) giving his/her/their approval for publication should be provided.

## References

References should be typed on a separate page and be accurate and complete.

The Vancouver style of referencing is the style recommended for publication in the APJHM. References should be numbered within the text sequentially using Arabic numbers in square brackets. [1] These numbers should appear after the punctuation and correspond with the number given to a respective reference in your list of references at the end of your article.

Journal titles should be abbreviated according to the abbreviations used by PubMed. These can be found at: <http://www.ncbi.nih.gov/entrez/query.fcgi>. Once you have accessed this site, click on 'Journals database' and then enter the full journal title to view its abbreviation (eg the abbreviation for the 'Australian Health Review' is 'Aust Health Rev'). Examples of how to list your references are provided below:

### Books and Monographs

1. Australia Institute of Health and Welfare (AIHW). Australia's health 2004. Canberra: AIHW; 2004.
2. New B, Le Grand J. Rationing in the NHS. London: King's Fund; 1996.

### Chapters published in books

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Further information about the Vancouver referencing style can be found at <http://www.bma.org.uk/ap.nsf/content/LIBReferenceStyles#Vancouver>

## Types of Manuscript - some general guidelines

### 1. Analysis of management practice (eg, case study)

#### Content

Management practice papers are practitioner oriented with a view to reporting lessons from current management practice.

#### Abstract

Structured appropriately and include aim, approach, context, main findings, conclusions.

Word count: 200 words.

#### Main text

Structured appropriately. A suitable structure would include:

- Introduction (statement of problem/issue);
- Approach to analysing problem/issue;
- Management interventions/approaches to address problem/issue;
- Discussion of outcomes including implications for management practice and strengths and weaknesses of the findings; and
- Conclusions.

Word count: general guide - 2,000 words.

References: maximum 25.

### 2. Research article (empirical and/or theoretical)

#### Content

An article reporting original quantitative or qualitative research relevant to the advancement of the management of health and aged care services organisations.

#### Abstract

Structured (Objective, Design, Setting, Main Outcome Measures, Results, Conclusions).

Word count: maximum of 300 words.

#### Main text

Structured (Introduction, Methods, Results, Discussion and Conclusions).

The discussion section should address the issues listed below:

- Statement of principal findings;
- Strengths and weaknesses of the study in relation to other studies, discussing particularly any differences in findings;
- Meaning of the study (eg implications for health and aged care services managers or policy makers); and
- Unanswered questions and future research.

Two experienced reviewers of research papers (viz, Doherty and Smith 1999) proposed the above structure for the discussion section of research articles. [2]

Word count: general guide 3,000 words.

References: maximum of 30.

NB: Authors of research articles submitted to the APJHM are advised to consult 'Writing a research article: advice to beginners' by Perneger and Hudelson (2004) and available at: <<http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191>> This article contains two very useful tables: 1) 'Typical structure of a research paper' and 2) 'Common mistakes seen in manuscripts submitted to this journal'. [3]

### **3. Research note**

#### **Content**

Shorter than a research article, a research note may report the outcomes of a pilot study or the first stages of a large complex study or address a theoretical or methodological issue etc. In all instances it is expected to make a substantive contribution to health management knowledge.

#### **Abstract**

Structured (Objective, Design, Setting, Main Outcome Measures, Results, Conclusions).

Word count: maximum 200 words.

#### **Main text**

Structured (Introduction, Methods, Findings, Discussion and Conclusions).

Word count: general guide 2,000 words.

As with a longer research article the discussion section should address:

- A brief statement of principal findings;
- Strengths and weaknesses of the study in relation to other studies, discussing particularly any differences in findings;
- Meaning of the study (eg implications for health and aged care services managers or policy makers); and
- Unanswered questions and future research.

References: maximum of 25.

NB: Authors of research notes submitted to the APJHM are advised to consult 'Writing a research article: advice to beginners' by Perneger and Hudelson (2004) and available at: <<http://intqhc.oxfordjournals.org/cgi/content/full/16/3/191>> This article contains two very useful tables: 1) 'Typical structure of a research paper' and 2) 'Common mistakes seen in manuscripts submitted to this journal'. [3]

### **4. Review article (eg policy review, trends, meta-analysis of management research)**

#### **Content**

A careful analysis of a management or policy issue of current interest to managers of health and aged care service organisations.

#### **Abstract**

Structured appropriately.

Word count: maximum of 300 words.

#### **Main text**

Structured appropriately and include information about data sources, inclusion criteria, and data synthesis.

Word count: general guide 3,000 words.

References: maximum of 50

### **5. Viewpoints, interviews, commentaries**

#### **Content**

A practitioner oriented viewpoint/commentary about a topical and/or controversial health management issue with a view to encouraging discussion and debate among readers.

#### **Abstract**

Structured appropriately.

Word count: maximum of 200 words.

#### **Main text**

Structured appropriately.

Word count: general guide 2,000 words.

References: maximum of 20.

### **6. Book review**

Book reviews are organised by the Book Review editors. Please send books for review to: Book Review Editors, APJHM, ACHSM, PO Box 341, NORTH RYDE, NSW 1670. Australia.

### **Covering Letter and Declarations**

The following documents should be submitted separately from your main manuscript:

#### **Covering letter**

All submitted manuscripts should have a covering letter with the following information:

- Author/s information, Name(s), Title(s), full contact details and institutional affiliation(s) of each author;
- Reasons for choosing to publish your manuscript in the APJHM;
- Confirmation that the content of the manuscript is original. That is, it has not been published elsewhere or submitted concurrently to another/other journal(s).

## Declarations

### 1. Authorship responsibility statement

Authors are asked to sign an 'Authorship responsibility statement'. This document will be forwarded to the corresponding author by ACHSM on acceptance of the manuscript for publication in the APJHM. This document should be completed and signed by all listed authors and then faxed to: The Editor, APJHM, ACHSM (02 9878 2272).

Criteria for authorship include substantial participation in the conception, design and execution of the work, the contribution of methodological expertise and the analysis and interpretation of the data. All listed authors should approve the final version of the paper, including the order in which multiple authors' names will appear. [4]

### 2. Acknowledgements

Acknowledgements should be brief (ie not more than 70 words) and include funding sources and individuals who have made a valuable contribution to the project but who do not meet the criteria for authorship as outlined above. The principal author is responsible for obtaining permission to acknowledge individuals.

Acknowledgement should be made if an article has been posted on a Website (eg, author's Website) prior to submission to the Asia Pacific Journal of Health Management.

### 3. Conflicts of interest

Contributing authors to the APJHM (of all types of manuscripts) are responsible for disclosing any financial or personal relationships that might have biased their work. The corresponding author of an accepted manuscript is requested to sign a 'Conflict of interest disclosure statement'. This document will be forwarded to the corresponding author by ACHSM on acceptance of the manuscript for publication in the APJHM. This document should be completed and signed and then faxed to: The Editor, APJHM, ACHSM (02 9878 2272).

The International Committee of Medical Journal Editors (2006) maintains that the credibility of a journal and its peer review process may be seriously damaged unless 'conflict of interest' is managed well during writing, peer review and editorial decision making. This committee also states:

'A conflict of interest exists when an author (or author's institution), reviewer, or editor has a financial or personal relationships that inappropriately influence (bias) his or her actions (such relationships are also known as dual commitments, competing interests, or competing loyalties).

The potential for conflict of interest can exist whether or not an individual believes that the relationship affects his or scientific judgment.

Financial relationships (such as employment, consultancies, stock ownership, honoraria, paid expenses and testimony) are the most easily identifiable conflicts of interest and those most likely to undermine the credibility of the journal, authors, and science itself... [4]

## Criteria for Acceptance of Manuscript

The APJHM invites the submission of research and conceptual manuscripts that are consistent with the mission of the APJHM and that facilitate communication and discussion of topical issues among practicing managers, academics and policy makers.

Of particular interest are research and review papers that are rigorous in design, and provide new data to contribute to the health manager's understanding of an issue or management problem. Practice papers that aim to enhance the conceptual and/or coalface skills of managers will also be preferred.

Only original contributions are accepted (ie the manuscript has not been simultaneously submitted or accepted for publication by another peer reviewed journal – including an E-journal).

Decisions on publishing or otherwise rest with the Editor following the APJHM peer review process. The Editor is supported by an Editorial Advisory Board and an Editorial Committee.

## Peer Review Process

All submitted research articles and notes, review articles, viewpoints and analysis of management practice articles go through the standard APJHM peer review process.

The process involves:

1. Manuscript received and read by Editor APJHM;
2. Editor with the assistance of the Editorial Committee assigns at least two reviewers. All submitted articles are blind reviewed (ie the review process is independent). Reviewers are requested by the Editor to provide quick, specific and constructive feedback that identifies strengths and weaknesses of the article;
3. Upon receipt of reports from the reviewers, the Editor provides feedback to the author(s) indicating the reviewers' recommendations as to whether it should be published in the Journal and any suggested changes to improve its quality.



For further information about the peer review process see Guidelines for Reviewers available from the ACHSM website at [www.achse.org.au](http://www.achse.org.au).

### Submission Process

All contributions should include a covering letter (see above for details) addressed to the Editor APJHM and be submitted either:

(Preferred approach)

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All contributors are requested to comply with the above guidelines. Manuscripts that do not meet the APJHM guidelines for manuscript preparation (eg word limit, structure of abstract and main body of the article) and require extensive editorial work will be returned for modification.

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