NZAGS Executive Committee Zoom Meeting 12 November 2019 7.30pm

In Attendance: Julian Speight (President), Graeme Roadley (Vice-President, Andrew Moot (Past-President, Peter Shapkov (treasurer), Bronwen Evans (executive Director/Secretary), Nagham AlMozany, Rowan French, John Lengyel, Vanessa Blair, Usha Shan, Jasen Ly, Aleksandra Popadich, Gowan Creamer, Nigel Henderson, Grant Coulter,

Apologies: Simon Bann, David Moss, Peter Stiven, Ashwini Pondicherry

2. Minutes of the previous meeting on 10 September 2019

Does anyone wish to make any changes or corrections? No.
can anyone confirm the minutes are correct?

Rowan French
seconded by Peter Shapkov

Matters arising from the minutes

3.1 Southern Cross Update – Vanessa Blair

Vanessa had been through the previous minutes and reading some of the feedback she received from members and planned of how to move forward. She organized a meeting with Southern Cross to see where they saw the APP situation from their point of view. The meeting ran for two hours. They had a lot to say:

1. What they are trying to do with their AP Providers is share more of their data with us to let Surgeons have a greater awareness of what data they collect and analyses and how that could be used.

Any Southern Cross affiliated provider surgeon can login and look at their data. They create scatter diagrams showing things like pricing, volumes etc. and you can clearly see where you sit against everyone else and it's also very clear to see the outliers.

2. They are very concerned with the outliers. They are interested in the fairness of pricing for all concerned e.g. the patient and the surgeons and southern Cross.

The example they gave of unfair and unethical pricing revolved around a colonoscopy which took 40 minutes, the consultation and follow up with 20 minutes, they added on a procedure on the bottom which took 10 minutes, the anesthetist charged an extra $90, the hospital was $300, and the surgeon was $3800.

Southern Cross wants to use the data they have collected to demonstrate to surgeons how this is unacceptable behavior and will ruin the overall affordability of private health insurance.

(Bron: they have been saying that for the last five years, since we've been meeting with them, but nothing seems to be changing. Surely, it's up to them to change the outlier's contracts not penalize other surgeons by restricting APP etc.)

3. Went on to talk about what they do well, which is health technology assessments. They are sending Vanessa a list of the areas that we might be interested, and, Vanessa, would like to look at the genetic testing. Southern Cross told her they were considering Pathways she would have to go through to look at whether this could be added.
4. They are going to look at listing various procedures that will only be able to be done by approved providers.
5. Southern Cross is concerned with follow-ups and how many times a patient is seeing the surgeon post-surgery.

Southern Cross is positioning themselves around value and quality, that's their buzzwords. Southern Cross are looking at preferential providers in terms of their processes. There has been some tendering done. Southern Cross are looking at various pathways to provide value to their members. For example, there is a head and neck group who have approached Southern Cross to trial a head and neck pathway. Vanessa raised the concern that this was giving preferential treatment, and how did they go about selecting who would go on these pathway's trials. They said it was the surgeons who approached them. In other words they're just trying to find cheaper ways to deliver surgery to the members. Vanessa told them that this sort of thing should come back through the societies and they agreed with that.

To finish up they mentioned they had been to some overseas conferences that included people like BUPA, where they were talking about pathway contracting. Vanessa asked him to clarify what they meant by pathway contracting? Were they talking about managed-care? They got quite defensive about that and didn't say much more and didn't really define what pathway contracting meant.

Coming back to the last minutes and looking over what Vanessa thought she would do. She did raise the issue about how, as an individual, it was more difficult to engage with Southern Cross then if you were with a company or a hospital. Vanessa stressed there had to be a better way for individual affiliated providers to engage with Southern Cross and vice versa, that was seen to be a fair pathway for everyone.

They did acknowledge this and said that they've been looking at what's going on overseas and have come to the conclusion that it might be a good idea to hold an informal meeting (attendance isn't recorded) but minutes and feedback is recorded, that any general surgeons could attend.

Given all of this and Vanessa is struggling to see how we should move forward, what is the role NZAGS plays, how can NZAGS contribute and engage in a really productive way, are SX going to listen to us anyway?

Southern Cross commented on how the NZAGS private practice representative changes quite regularly, (Bron: not true Ian Burton was the PPR for over 7 years, the President changed every two) and of course we often lose the history of what's been going on previously. Vanessa commented on the fact that we didn't have a proper pathway that went through our membership for feedback on anything at Southern Cross is doing and therefore everyone is doing something different and experiencing something different which is been frustrating for both Southern Cross and for the individual surgeons. There needs to be a functioning relationship between surgeons and the insurance companies we need each other.

NZAGS should invite any insurance providers to attend our annual scientific meeting. Stephen Child is speaking at this year's conference and I believe NIB are taking a stand.

Action: that for future conferences an invitation is put out to all main insurance providers to take a stand at a conference and if they would like a speaking slot that they be given one. (SX. NIB, Sovereign, Partners Life)

Southern Cross has a speaking slot because they are a gold sponsor. Vanessa raised concerns that this was not ethical considering no other insurance company has a speaking slot, but it was pointed out that it must be an educational talk it cannot be a sales talk and ANY company can apply to be a Gold Sponsor.

Grant: surgeons can have issues with all insurance companies. I've just had an issue with NIB. They blacklisted me for lapcoly charge because I charge everyone my Southern Cross price and this was viewed too high, so they blacklisted me as a bad surgeon. It took me six months to get my name cleared off the blacklist on the website. Jasen's colleague had the same issue. Worse still, the patient was told the surgeon wasn't qualified.

Anything over $3000 for a lapcoly means you are blacklisted. NIB is also comparing your price to you colleagues pricing, if higher then you get blacklisted. The problem is the two insurers are charging different amounts. With SX we cannot charge patients less than the APP price, so I make sure everyone gets the same price, but that price isn't appropriate with NIB.

Rowan: Are we being blacklisted and we don't know it? Outliers still a problem. Does the society have a role to make a statement about unethical charging?

Julian: Would like a workshop on 'pricing' issues in these contracts with a competition lawyer as we don't really understand the situation.

Graeme: We need specific issues in writing from members so we can look at this instead of antidotal stories.

Vanessa: agree that having a session with an appropriate lawyer would be a good idea, but it would be quite expensive and feel that the membership should vote on whether we get some legal advice on contracts and our position in terms of pricing.

Vanessa is suggesting that we look at the process of the private practice representative role on the executive.

Action: do we set a meeting time at the annual ASM where we call for anyone who is interested in talking about insurance issues to attend so that we are fully aware of what our members are facing and concerned about regarding the insurance companies. We will ask the members if they would like this. In other words we hold a private practice session. That's good then give us a list of concerns that we could address as an executive for the following 12 months and if we do it on an annual basis we can collect concerns and give feedback during the year.

Action: A statement to members about ethical charging. Maybe a yearly reminder.

Action: perhaps get an estimate of the cost and ask the membership whether we should go ahead and do it. (Bron: we would have to be very precise in what we were after in order to get a realistic quote from any lawyer, because often they don't know how long it's going to take them.)

Action: To have a full day workshop. Perhaps the lawyer in the morning, then a meeting with each individual insurance company in the afternoon. Competition issues means they won't talk specifics in front of each other. NIB, SX, Sovereign, and Partners Life. Vanessa is going to ask her friend who is a lawyer about who we could get.

Action: Letter to NIB about this practice and stress we may look at legal action if surgeons names are being brought into disrepute on a public forum. Need to look at the wording to see if it's libelous. We need to ask them to tell you if you are blacklisted. The surgeon needs to be contacted about this.

3.2 ASM New Plymouth Update – Nigel Henderson

The training day is completely sorted and everything is ready. The dinner is also sorted and under control. We have the majority, if not all the speakers required. Rhys Thomas is a speaker coming from the UK. The theme of the conference is 'When Things Go Pair Shaped.' Basically, looking at managing major trauma scenarios and disaster situations with speakers from Christchurch and the aftermath of the shooting and the earthquake.

We are also going to run through some complication scenarios with other specialties involved. Rural general surgeons and how they would look after post-surgery complications.

We have a mix of local, other New Zealand speakers and international from the UK and Australia.

The last session is going to be on managing colonoscopies including the Ministry of Health head of health workforce.

3.3 NZNB – update if any

No meeting since last time, next meeting is 6 December.

4. Reports

4.1 President Report – Julian Speight

Julian has bene away for 3 months has some things to discuss but in the agenda below.

4.2 Executive Director - Bronwen Evans

Practice Visits the pack is now ready and simply need to confirm dates – 4 surgeons volunteered. Probably only do 2.

Audit coming 30 November so accounts being organized.

4.3 Treasurer – Peter

Looking good financially up about $56k on Oct last year. Balances are good. $1.59m equity. $1.569m in assets.

Will be spending some of this over the next twelve months – Claire will be talking under 6.

4.4 Training – Simon and David not on call sent apologies

Claire – Simon thought that for the IT investment needed for the move to the new assessment competency-based training programme, we should be transparent about the costs. Therefore, we should have a user pay model and the trainee fee would increase by a yet to be determined amount to cover IT. Back of the envelop calculation $400 - $600 a year per trainee. NZBiGS Board thought might be low. And having looked at some costings from a supplier that may be right.

Process suggested was NZBiGS to approve an amount, then the Training committee to approve and then take the recommendation to the Executive to sign it off.

The College would simply collect our fee and our fee would be split into two lines – admin and IT. We asked the college to collect for us for two reasons – debt collection, and part-payments. We don't have an account person to spend the time needed on this, they do.

Present to TC in March and then NZAGS will do road shows to individual hospitals in June 2020 about the new training competency assessment programme.

5. Business Items

5.1 Management Report October 2019 – been read and received.

List of names who are they. That is those who have not paid their subscriptions for 2019.

5.2 Medical Council proposed policy on publication of orders and directions, otherwise known as a naming policy – Alex Popadich

If a surgeon has been found wanting they will publish the order regarding the outcome of the investigation and the name of the surgeon. Already have this power they are simply stating they are going to do this more often.

If they don't get the decision right it can profoundly affect your ability to practice in NZ and your mental health. There are some issues that should be named i.e. sexual assault etc.

There is a lot of legal jargon and I'm not a lawyer so how am I supposed to comment. What should we be worried or concerned about.

John – the doctor investigated may be named, and they will name people more often. They already have this power. I don't think it's right. Should not be named they have already been through a long official and stressful process. Naming is a step too far.

MC want feedback, and it's been sent to all individuals to comment, should NZAGS comment on this to our members? Should we canvas our members for an opinion on our behalf.

MC are probably just formalizing what they already do. Their role is to protect the public not create sensational news stories. Therefore, would expect only very serious cases to be made public as MC are not there to titillate the public.

Action: Alex is going to ask a friend about any concerns we should have

5.3 Election – anyone stepping done

Jasen is stepping down from the Younger Fellow. It's Grant last year. Jasen is moving across. To take Grant's position.

There is no young fellow position so Jasen can actually stay on. If we are continuing to have a Younger Fellow position then we should update out rules. They should have a vote. Should shop over. Update the executive rules.

Action: Bron to look at the Executive rules under the constitution extend to 3 years if they want. Bron has found a Young Fellow, Mark Stewart from Nelson has accepted this role.

5.4 Post Fellowship Education and Training Program in Trauma Surgery
Grant – vague on details but can improve in principle. Only got it in Aussi hospitals.

Julian – for the Rural PFT NZ fellows are able to apply, so assume the same for trauma. Auckland probably and maybe Hamilton and Christchurch the only trauma centers in NZ.

John – Talked about this in the training meeting. The trauma fellowship is only listing Australian hospitals. Aussi has designated trauma hospitals, NZ doesn't. Where in NZ would they work? Therefore they go on fellowships then don't come back to NZ.

Action: Grant to draft a reply and send to Bronwen. What trauma is being covered. Are there any NZ hospitals this could be done through? Why 2 years. Need this information.

5.5 Auto Charging credit cards for subs – should we offer this? Bronwen

An issue with our website subscription service. It sends out the invoices but the firewalls of the hospitals and Hotmail etc. are blocking the emails sent from our website as it's not a known site like Xero etc. So that is why the password help function is causing issues too. Password help is working, but the emails to reset your password are not getting through. Working with Meta Digital to try and fix it. So, there is a manual list in Xero of those not paid because this issue has just been picked up.

Simon Bann is helping the IT guys look at how we can get around the firewall block.

So a way round this is to auto charge the credit card rolling 12 months.

Action: Yes, the executive would like this to happen.

5.6 PDSB Meeting – Mesh Update Andrew Moot

PDSB First meeting last month. Looking at the cultural safety aspect of surgery competencies. Should there be a 10th competency or should it be embedded in the 9 already there? Maxine Ronald said most of indigenous societies are saying it has to be a separate competency or otherwise if embedded in one of the 9 it is ignored.

Mentioned Private Practice programme. Andrew Hill was a bit critical of the programme as no evidence. Critical about positioning it as a way to tick the reflective practice – well it is!

Mesh – at GSA meeting there was a session on mesh. Aussi seem to be more advanced on setting up a mesh registry. Some surgeons in Aussi looking at putting together a hernia society. Some of the hospitals in NZ have requested information from surgeons around how many procedures did you use mesh. Something going on between MoH, Mesh Downunder and Victoria University. We have not been engaged in this, where are they going with this?

Should use our website move to give public information on mesh. There is a Patient Information document developed by Rowan Collinson and Sze-Lin Peng for rectal mesh and NZAGS should load it on website. Helpful to have all views. Steve Kelly had an article in Medical journal which we should share too. Andrew and Rowan Collinson article can't go online for at least 6 months.

Action: President to contact MoH to find out what is going on in this area. Not sure who we should address.

Action: Andrew Moot to send all documents about Mesh that we can use now to Bron to list on the website.

Action: Anyone can send Bronwen articles to load on website – for members only or for public. Then we need an executive board member to approval what can go on our website. Useful clinical articles that we can share. Who will be Bron's contact for approval – Vice-President?

Remove the pelvic floor article as the writer has been dismissed. Can't we ask NZ society for feedback?

5.7 Update Committee List – Please send Bron any changes to your details please and any committees you are on.

6. <u>General</u>

6.1 Ratify Graeme Roadley onto the RACS Surgical Oncology Committee - agreed
6.2 Ratify Magda Sakowska MoH onto the Provation Committee - agreed
6.3 Sola for the Gastro trainees

We are happy to offer the Gastro trainees a trial on SOLA. One Gastro trainee is currently trailing it. This could be a way to build a relationship with Gastro.

Not just about giving access, it's IT support and admin support. But not a huge work increase. Any changes to SOLA they would have to pay for.

Marianne wants to announce and show something in November but the new assessments etc. won't be ready until 2021. They can trial the current logbook in 2020.
NZAGS needs to trial the assessment area in 2021 without worrying about Gastro.

We are happy to let them look at the logbook. They are also looking at Jet a UK programme but it's clunky compared to SOLA. They want SOLA so we are aligned. They need an online logbook asap.

Just adding in trainees and supervisors for a trail is not onerous maybe an hour. So we can do that at no cost. Admin control will stay with NZAGS, Claire. So she will have to be able to see their data but she'd keep it confidential.

After the trial, if they like it, we can sell them the SOLA source code which we own. They can then develop their system and we can share any source code changes moving forward.

6.4 Claire – IT developers assessment prototype

Heard that it's going to cost more to complete the prototype than they budgeted and it requires a further $15-$16k to test the assessment system. Therefore, can the Executive approve the overrun.

Julian: Not unexpected but can we limit the risk of this happening again? Can't keep having this happen. Think we have to go through with the prototype.

Claire: Their original quote was before the full scoping meeting so it was a guestimate. If we don't do this we don't have anything to test. The full cost of about $100k for the working system is likely to be more now that they have looked into this. So the extra $15k is for the prototype which is part of the $100k which is now likely to be more.

Executive agrees to the additional $15k. We own the code so could move developers if this keeps happening. But if we start again it will cost us more to get them up to speed.

7.1 Face To Face in November each year.

Should NZAGs Executive have one or two F2F meetings a year.
Maybe we decide in June meeting if we need to have a second face to face. In other words, if there is something on the agenda that would be better discussed face to face then we will meet F2F rather than a zoom meeting. Most believe we need two face to face meetings a year due to the Friday ASM meeting only be 4 hours now because we support the training day. Supporting the training day is doubly needed in smaller hospital locations due to staffing levels.

To be discussed further at the March 2020 ASM Executive Meeting.

Meeting closed at 10.00pm