SHORTAGE OF GYNAECOLOGICAL ONCOLOGISTS LEAVES SERVICE VULNERABLE

Kicking off work for the day means different things for different people – time to catch up with family or friends, to go for a run, read a book (or write one), plan a trip, or tackle the mountain of laundry that’s grown in our absence. The boundary between work and personal time is not always clear-cut, of course, but for many of us there comes a point in the day when we are able to shake off the tethers.

For Cecile Bergoll, however, the work day often just bleeds into the work evening. When the sun goes down and the clocks tick over and the buildings begin to cool, she rolls up her sleeves to do all of the things she couldn’t get to earlier: correcting letters, analysing data for business cases, contributing to annual reports, polishing presentations. And on some of her days off, she operates on patients.

“There is so much to do,” she says.

Dr Bergoll is a gynaecological oncologist based in Wellington, and one of a handful scattered around New Zealand. For a country of this size it has been estimated we need at least 11 gynaecological oncologists distributed across Auckland, Wellington and Christchurch, instead, we have just 7 of them, and they’re struggling to cope.

By the 1990s, however, the new sub-specialty had begun to make its presence felt, and in 1997 Peter Sykes returned to New Zealand after a period of sub-specialty training overseas. He was this country’s first certified gynaecological oncologist.

But while the number of sub-specialists has grown in stops and starts since then, securing funding and positions, and then recruiting to them, has been very difficult.

“It’s not exactly rocket science. It takes a while to train a sub-specialist, and there’s an international market.”

Associate Professor Peter Sykes, Canterbury: “It takes a while to train a sub-specialist, and there’s an international market.”

About a thousand New Zealand women a year are diagnosed with a gynaecological cancer, most commonly uterine cancer (about 40%), followed by ovarian cancer (34%), cervical cancer (15%) or vulval/vaginal cancer (7%). Up to 70% of women with gynaecological cancer require radical surgery and/or specific radiation therapy procedures.

Historically the treatment of these cancers fell to general gynaecologists but in recent decades a new sub-specialty has emerged to bridge the medical words of oncology and gynaecology – known as gynaecological oncology, and nested within its parent specialty of obstetrics and gynaecology.

The sub-specialty first appeared in the United States and Australia during the 1960s/70s, and by the 1980s both countries had solid training programmes in place. It was slower to take root in New Zealand – affected at least partly, says Peter Sykes, by the fallout from the ‘Unfortunate Experiment’ at National Women’s Hospital in Auckland, which was exposed by Sandra Coney and Philida Bunkle in 1987. Significant public mistrust made obstetrics and gynaecology (and its fledgling subfields) a less attractive option for many doctors.

In addition, the lure of Australia and other countries has been strong. Three years of sub-specialty training is provided in Australia – and many of the registrars who have gone to Australia to train have subsequently decided to stay there.

“That’s hardly surprising,” says Peter Sykes. The Australian gyna-oncology centres are bigger,

“Gynaecological oncology in New Zealand provides a world class service in less than world class conditions. We need to be staffed appropriately.”

Dr Bryony Simcock, Gynaecological Oncologist, Wellington and Christchurch: “There is so much to do,” she says.

Associate Professor Peter Sykes, Canterbury: “It takes a while to train a sub-specialist, and there’s an international market.”

About a thousand New Zealand women a year are diagnosed with a gynaecological cancer, most commonly uterine cancer (about 40%), followed by ovarian cancer (34%), cervical cancer (15%) or vulval/vaginal cancer (7%). Up to 70% of women with gynaecological cancer require radical surgery and/or specific radiation therapy procedures.

Historically the treatment of these cancers fell to general gynaecologists but in recent decades a new sub-specialty has emerged to bridge the medical words of oncology and gynaecology – known as gynaecological oncology, and nested within its parent specialty of obstetrics and gynaecology.

The sub-specialty first appeared in the United States and Australia during the 1960s/70s, and by the 1980s both countries had solid training programmes in place. It was slower to take root in New Zealand – affected at least partly, says Peter Sykes, by the fallout from the ‘Unfortunate Experiment’ at National Women’s Hospital in Auckland, which was exposed by Sandra Coney and Philida Bunkle in 1987. Significant public mistrust made obstetrics and gynaecology (and its fledgling subfields) a less attractive option for many doctors.

By the 1990s, however, the new sub-specialty had begun to make its presence felt, and in 1997 Peter Sykes returned to New Zealand after a period of sub-specialty training overseas. He was this country’s first certified gynaecological oncologist.

But while the number of sub-specialists has grown in stops and starts since then, securing funding for training and positions, and then recruiting to them, has been very difficult.

“‘There’s been no funding for training in this country,” says Peter Sykes.

“All the O&G has been focused on obstetrics roster cover so gynaecology oncology has been a Cinderella, less of an immediate need than other things.”

In addition, the lure of Australia and other countries has been strong. Three years of sub-specialty training is provided in Australia – and many of the registrars who have gone to Australia to train have subsequently decided to stay there.

That’s hardly surprising,” says Peter Sykes. The Australian gyna-oncology centres are bigger,
THE SPECIALIST who stand to benefit from their expert have spent years training and working in disaster for the medical specialists and "This service needs to be properly resourcing," says ASMS in inadequate resourcing of gynaecological oncology. "The ASMS is very concerned by the shortages in the medical workforce and the service is made vulnerable by this. It's not just about the money. It's about the mix of things. Here you might be working on your own, having to set up a service." "It's tough yakka doing that. I did it for the South Island at one point. I was in the hospital seven days a week, and I did that for a decade. People are working very hard to make sure the service works." New Zealand sub-specialists have also struggled to get proper recognition of the need for their service from district health boards (DHBs), he says. In 2010 the Ministry of Health asked a group of doctors, nurses, managers, patient representatives to audit gynaecological cancer services in New Zealand. Their report, 'It Takes a Team', was submitted in July 2011 to the New Zealand Gynaecological Cancer Group (NZGCC) and is available online at http://www.health.govt.nz/publication/it-takes-a-team_national_plan_for_gynaecological_cancer_services_22_july_2011.pdf The report’s findings include:

- All women with gynaecological cancer should have timely and equal access to appropriate multidisciplinary specialist cancer services, but this was not the case in New Zealand.
- Gynaecological cancers comprise about 10% of all cancer cases and 10% of all cancer deaths in New Zealand.
- Evidence shows women generally have better outcomes if they are treated by a sub-specialist trained gynaecological oncologist and reviewed by a multidisciplinary team.
- A review had found that, on average, women with ovarian cancer treated by a gynaecological oncologist as part of a multidisciplinary team lived an additional 11 months.
- The New Zealand Cancer Registry shows that Maori and Pacific women have a significantly higher incidence of ovarian and cervical cancers than non-Maori and non-Pacific women. Maori women also have poorer survival rates for cervical and endometrial cancers.
- Gynaec-oncology in New Zealand is a small, vulnerable but essential service for women and their families. The report identified the following challenges with service provision:
  - Building a sustainable workforce
  - Achieving equitable access to services based on need
  - Aligning the funding and purchasing framework with optimal provision
  - Collecting data on quality and outcomes
  - There was a strong rationale for improving national coordination and planning of services. However, no one at that time had the mandate or capacity to agree on the best way to develop and use New Zealand’s gynaecological cancer resources.
  - There was no clear decision mechanism to ration access to gynaecologists.
  - The lack of national coherence also meant that a localised standard of referral pathways and no nationally agreed clinical guidelines.

"Burnout is a real concern for this group and such heavy workloads are not sustainable. It’s not sensible to have a situation where the service is made vulnerable by the absence of any one specialist." "This service needs to be properly funded and resourced to ensure it is sustainable. If it collapses due to inadequate resourcing, that would be a disaster for the medical specialists and other dedicated health professionals who have spent years training and working in this area, and also for the many women who stand to benefit from their expert treatment and care.

"The shortages in this area is part of a bigger picture of stretched resources in the medical workforce which needs to be addressed."
THE RISKS OF PRIVATISING THE WELLINGTON REGION’S LABORATORY SERVICES

At the time this article was written for publication, his decision was not known. However, concern about the clinical and operational risks of privatisation was so strong, the ASMS asked Drs Jeannette McFarlane and Anja Werno to outline the essential points the Minister must consider when reaching his decision.

The Wellington region DHBs (Capital & Coast and Hutt Valley) are attempting to merge the community and hospital laboratories, and privatise the latter. Local clinicians, including pathologists, were excluded from the privatiation decision, and no details are yet available, but it appears likely the successful bidder will be a subsidiary of one of the two large Australian laboratory companies, Healthscope and Sonic Healthcare (49% shareholding of Aotea). Both companies are listed on the Australian Securities Exchange.

Subsequently, however, Aotea has withdrawn its bid, citing strong criticisms of the DHBs’ process. If the privatisation proceeds the hospital laboratories would be run by Healthscope.

As specialists committed to the long term future of laboratory services in New Zealand, we hope the Minister of Health will reflect very carefully when making any decision.

Once public hospital laboratories become privatised there is effectively no back-up if parts of the service fail, and no way to reinstate pathology in the public health system. Small, highly specialised services such as immunopathology will be very vulnerable and may collapse entirely. The private company’s bid will cover only the most basic investigations, and all of the extra unfunded work that public laboratories currently do will be lost. Highly specialised and innovative tests might not be offered, or they might be sent to public laboratories at other DHBs within New Zealand, provided they are not already privatised, or the tests will be sent to an overseas provider at substantial cost with diminished control over quality. Alternatively, there is a significant risk that patients will be asked to pay for these investigations themselves.

There are very strong incentives for Healthscope to underprice their bid for the contract in the expectation that they would be able to renegotiate later. Once unconced and the other laboratories closed, the DHBs would in practice have very little control or governance role.

In other regions, the privatisation of laboratories and changes of contracts between private providers have proved much more problematic than expected, and there are continuing issues that will take many years to resolve.

In some instances, DHBs have had to engage in lengthy and costly legal action, money that was effectively taken away from patient care.

Seemingly simple matters like achieving compatibility between computer software systems have required substantial investments that had not been allowed for.

We appreciate that the DHBs need to spend money that was largely hidden from hospital management but should consider the long term consequences of any decision. We believe that the proposal is an inherently high risk venture that will destabilise the health services of the wider Wellington region for years to come and, in reality, is unlikely to achieve the savings promised by those promoting privatisation.

We would strongly urge the Minister of Health to evaluate all options for the future of laboratory services in the Wellington region and take the advice of local specialists before making any decision.

PROOF-READING

- Auckland Region District Health Boards: Review of transition for existing laboratory services provider – a report by Graeme Miller and Anja Werno, 30 September 2010

Any change of ethos if the laboratories are contracted out to a private provider risks losing the hospital culture that underpins those working relationships.

We believe that the proposal is an inherently high risk venture that will destabilise the health services of the wider Wellington region for years to come and, in reality, is unlikely to achieve the savings promised by those promoting privatisation.

We would strongly urge the Minister of Health to evaluate all options for the future of laboratory services in the Wellington region and take the advice of local specialists before making any decision.

Any change of ethos if the laboratories are contracted out to a private provider risks losing the hospital culture that underpins those working relationships.
Saturday 20 December 2014, and I find myself alone in Auckland. I’d arrived a day early for the Jethro Tull concert the following evening, and friends were due to join me the next day. Later that afternoon, I strolled down Queen Street to the Viaduct. The concert the following evening, and my friends were due to join me the next day. Later that afternoon, I strolled down Queen Street to the Viaduct.

About 9pm I wandered along to an upmarket restaurant in a wide spectrum of human and social experience. I found two excellent publications both by Max Rashbrooke: “Inequality: A New Zealand Crisis” (279 pages) and also a shortened version of the original book, “The Inequality Debate: An Introduction”, which contains an excerpt of the original book’s first two chapters, updated by Max Rashbrooke. I read the latter and found the information quite stunning.

Some facts and figures from the book:
- How much does an individual have to make in a year to get into the top 10 per cent of income earners in New Zealand - $300,000 for a single person, $500,000 for a couple? The answer is just $76,000.
- The wealthiest 1 per cent of New Zealanders together own three times as much as is owned collectively by the poorest 50 per cent of the population.
- About 700,000 New Zealanders live below the government’s official poverty line, and a great many children.
- One major report on children’s welfare ranked New Zealand 28 out of 30 developed countries, better only than Mexico and Turkey.
- 13,000 New Zealanders have incomes lower than the official poverty line.
- One possible factor, beyond globalisation and productivity, for stalling work incomes is the world’s declining power. Union membership in New Zealand fell from near 70 per cent of all workers in 1980 to just over 6 per cent in 2014 (WAI). Over the same period, the share of national income going to wages and salary earners dropped from 60 per cent in the 1980s to just 50 per cent by 2002. This is lower than in almost any other developed country.

Max Rashbrooke covers a many topics in this book, as well as the income inequality and comparative data with other countries, etc. The chapter “The Great Divergence” opens with the following paragraph: “In the two decades [1980s and 1990s] framing these changes, the gap between the very rich and the very poor grew bottom of the income ladder in New Zealand opened up more rapidly than in any other comparable society.”

I am not a politician and I don’t understand economics. I am a salaried medical officer working in the New Zealand public health system. I asked myself where does health and in particular access to health care fit into all of this? ‘Dirty Politics’ aside, we live in a world that policymakers (government) create. They determine the regulations that govern our daily lives, the level of funding for public services and the law we need to live by. And, more importantly how big business and the “Mighty rich” get taxed. Treasury obviously has a big role to play. They can either create a convergent society (reducing the inequality gap) or a divergent society (increasing the inequality gap). Rising inequality by 3 Gini points, that is the average increase recorded in the OECD over the past two decades, would drag economic growth by 0.35 per cent per year for 25 years: a cumulated loss in GDP at the end of the period of 8.5 per cent. Rising inequality is estimated to have knocked about 10 percentage points off growth in Mexico and New Zealand.

My question remains: what is the inequality gap when it comes to access to health care in New Zealand?

What does the New Zealand public and Government expect of a publicly funded health care system? Where does access to health care rank as far as basic human rights are concerned? What do we see as adequate minimum standards of living? Access to health care is a human right. This right is guaranteed in the New Zealand Constitution (Bill of Rights 1990) which enshrines the international Convention on Human Rights.

Inequality? Where does the New Zealand health care system reducing or increasing access to health care when the New Zealand public and Government expect of a publicly funded health care system?

If you are turned away from the public health system there are a few options available to you:

1. Accept your current health problem and go without further assessment and treatment.
2. Wait for your health condition to worsen or become more urgent and then appeal to the Ministry of Health to assess your health needs.
3. If your long-term health problem becomes more acute, you can apply for a political donation to the MP of your choice, but this is a referral process and your primary care doctor would still have to take you through the process of assessment and treatment.

Is there evidence that we have inequality in access to health care?

Yes, we do.

In the Ministry of Health report “Health of New Zealand Children” 2011-12 (http://www.moh.govt.nz/publication/health-new-zealand-children-2011-12) one in 6 (16.7%) sick or injured children missed out on after hours medical care due to cost. Rates are higher for Maori and Pacific children. Where is the inequality when MoH is providing same care to all children and does not differentiate between economic status of children.

In my experience it is an inequality in access to health care in New Zealand.
PUBLIC HEALTH SALARIES SEND NEGATIVE MESSAGE

New Zealand’s economy grew by 3.5% in the year to June 2014 and is expected to grow at a similar pace in the next two years, making it one of the fastest growing in the western world. This economic recovery, following the global recession, has been underway since the June quarter of 2009 — in other words, for more than five years. But whose recovery is it?

Recovery for the public health service has become equated with real operational funding cuts conservatively estimated at half a billion dollars since 2009/10, when inflation and demographic changes were taken into account (see the ASMS publication Health Dialogue Ready Check). The myth of unsustainable health funding and what the Treasury figures actually show, available from www.asms.org.nz). Since most operational spending is to pay for the health workforce, inevitably it is the health workforce that feels the pinch when budgets are squeezed.

A recent State Services Commission (SSC) report, Human Resources Capability: Confidence that many district health board employees have increased in some time, and salary rates have been slipping backwards.

The SSC report reveals that in 2013/14 the average pay increase for public health service employees was just 0.7% — less than half the 1.6% inflation rate for the year to June 2014. Further, the SSC says that over the four years from March 2010 to June 2014 public health service pay increased by 5.9% on average — 3% lower than the inflation rate over that period. That gap will increase further by the time the next round of multi-employer collective agreements (MECAs) are negotiated. Treasury’s inflation forecast for the year to June 2015 is 1.6%, and a further 2-2.5% in June 2016.

The SSC report also revealed another disturbing trend that public health sector wages have fallen behind those of the general private sector workforce. The average 0.7% increase for DHB employees in 2013/14 compared with an average pay increase of 1.8% for the general private sector workforce. And over the last four years the 5.9% average increase for public health service employees companies with 6.4% for the private sector - and the gap has been widening.

This sends a clear message to young New Zealanders that working for the public health service is not well rewarded financially and that they would be better off pursuing careers elsewhere. This does not help with the recruitment and retention of staff, which is in urgent need of improvement in many areas.

Not everyone has fared badly in the public health service: those in the private sector have gained in the private sector. Securing a viable, well-functioning health system for the future may well depend on it.

That’s a disturbing trend that public health sector wages have fallen behind those of the general private sector workforce. The average 0.7% increase for DHB employees in 2013/14 compared with an average pay increase of 1.8% for the general private sector workforce. And over the last four years the 5.9% average increase for public health service employees companies with 6.4% for the private sector - and the gap has been widening.

This sends a clear message to young New Zealanders that working for the public health service is not well rewarded financially and that they would be better off pursuing careers elsewhere. This does not help with the recruitment and retention of staff, which is in urgent need of improvement in many areas.

Not everyone has fared badly in the public health service: those in the private sector have gained in the private sector. Securing a viable, well-functioning health system for the future may well depend on it.

As for today’s health employees, it is reasonable to guess they will be expecting fairer treatment, conscious of the value of the workforce approaching retirement, coinciding with growing service demand, the future-proofing of the public health system is more than ever dependent upon attracting and retaining younger generations of workers. Clearly the wise and salary trends of recent years are pushing against that desired state.

For today’s health employees, it is reasonable to guess they will be expecting fairer treatment, conscious of the value of the workforce approaching retirement, coinciding with growing service demand, the future-proofing of the public health system is more than ever dependent upon attracting and retaining younger generations of workers. Clearly the wise and salary trends of recent years are pushing against that desired state.

For today’s health employees, it is reasonable to guess they will be expecting fairer treatment, conscious of the value of the workforce approaching retirement, coinciding with growing service demand, the future-proofing of the public health system is more than ever dependent upon attracting and retaining younger generations of workers. Clearly the wise and salary trends of recent years are pushing against that desired state.
It is time to revisit the funding of our impressive public health system and, in particular, the statutory bodies responsible for the provision of health care (both through direct provision of services or through funding of services) – district health boards. This is looking ahead but with a nod to past endeavours.

PBF AND ECONOMIES OF SCALE

First we have the Population Based Funding (PBF) formula. There is a tendency to dismiss the PBF which distorts from the real issues. The PBF is not perfect. How could it be given the diversity and complexity in and between DHBs? But the PBF is superior to what it replaced, which was a system largely, if not completely, based on historical precedent. Since its inception, the PBF has been refined and refined. Further refining will probably be the order of the day.

But the PBF only becomes a strain for some DHBs if funding in general is inadequate. The better overall DHB funding, the less the pressure is on those DHBs with low or no critical mass they require in order to provide these services. This also applies to those DHBs which have two base hospitals. Southern (Dunedin and Invercargill) is in the worst position in this respect but Nelson Marlborough and Bay of Plenty are also affected.

There is still a problem with PBF on critical mass issues. Even smaller DHBs such as Tairawhiti, Whanganui, Wairarapa, West Coast and South Canterbury have to provide relatively comprehensive 24/7 hospital services. They miss out on economies of scale because of the disproportionately higher critical mass they require in order to provide these services. This also applies to those DHBs which have two base hospitals. Southern (Dunedin and Invercargill) is in the worst position in this respect but Nelson Marlborough and Bay of Plenty are also affected.

There is a case for establishing an initial ‘foundation stone’ in the funding formula based on the necessary funding for secondary and tertiary services that DHBs are expected to provide. (This is less applicable to the more dispersed and smaller primary care services.) DHBs could be located in different categories reflecting factors such as size and number of base hospitals. The PBF would not apply to this, which might act like an ‘economies of scale adjuster’. To some extent the happen already but there is a case for making this foundation more explicit and a bigger proportion of DHB funding, with the reduced balance determined by the PBF.

WORKFORCE INVESTMENT STRATEGY

But a much bigger issue than this deserves investment strategy. We are forced to focus on the negative picture that the data provides.

This is starkly summarised by the following:

- From 2009/10 to 2014/15, total health operational funding as a proportion of Gross Domestic Product fell from 6.56% to 5.99%.
- Treasury estimated a real fall in health Domestic Product from 6.56% to 5.99%.
- Treasury estimated a real fall in health Domestic Product from 6.56% to 5.99%.

At the same time, the workforce (especially when both are wrapped around by distributive clinical leadership) is the main driver of quality and financial improvement in health systems. Because of this, the deficit the debate over health funding narrows down to the financial deficit discussed above.

In practical terms DHBs received about $7.5 billion funding in last year’s Budget (2014/15). This includes an increase of about $300 million, $1 billion in 2014/15, DHBs were underfunded by $94 million just to cover increased costs and demographic changes. When the costs of new services (DHBs are expected to provide) are taken into account, the shortfall is likely to be well over $100 million.

Is the issue $11.5 billion or $300 million? There is a serious lack of a workforce investment strategy in DHBs. Along with technology, the workforce (especially when both are wrapped around by distributive clinical leadership) is the main driver of quality and financial improvement in health systems. Because of this, the deficit the debate over health funding narrows down to the financial deficit discussed above.

In practical terms DHBs received about $7.5 billion funding and the deficit is $100 million. In 2010-11, the leadership of the DHBs was not up to the challenge. Financial pressures are much greater now than then (especially when compounding effects are factored in).

Despite being betrayed by disingenuous behaviour in 2010-11, the ASMS is still up to the challenge. The two questions are whether DHBs are up to the challenge and whether the Government is prepared to push them to meet it.

If not, then we are back to debating the inadequacy of the $300 million or so each year. This is not smart; it is wasteful.

I N A N O T E

I A N P O W E L L | A S M S E X E C U T I V E D I R E C T O R

M A R C H 2 0 1 5

What inspired you to become a doctor?
I was inspired by a family GP carrying out a home visit for my younger brother. I was about four at the time and living in Newcastle, and the visit made such an impression on me that I told my mum I was going to be a doctor like Dr Turner. My parents were aspiring and upwardly mobile, and nothing else leapt out at me in the same way as medicine while growing up. I was probably fairly naïve about what was involved with medicine, but I remained comfortable with the idea of becoming a doctor.

After training in London and working as a consultant in England for eight years, I moved to New Zealand in the year 2000. It was a time in my life when I could move halfway around the world, and I settled immediately in Northland, where I’ve stayed since.

Northland is a lovely place to live. It’s warm and easy to get out into the countryside. It’s a place with a lot of history. This is my home now. I was president of the local amateur theatre company for six years and I’m still on the committee. I’ve built the stage and set, sold the tickets, acted in productions, and I hope to get back into acting this year.

From a professional point of view it has the challenge of being relatively deprived so we are able to help people a great deal.

What do you love about your job?
Medicine is always different and interesting. I enjoy the collegiality with others, and the opportunity to work alongside other professions.

“Medicine is always different and interesting. I enjoy the collegiality with others, and the opportunity to work alongside other professions.”

In gynaecology, we’re doing a lot to improve the quality of life for people. It’s not usually life and death as such, but it’s very much about the quality of life people are having. On the obstetrics side, it’s about trying to make childbirth safer and with as little intervention as possible. It’s always a balance of risks and the challenge is to get that balance right.

What is the most challenging aspect of practising medicine?
Getting it right for the patient and trying to stay in tune with what your patient wants as an individual, and the wishes of their whanau. A lot of people aren’t empowered to make their own decisions but there’s a family approach. I found that challenging when I arrived from England. I still work hard to get my head around it, and it really highlights the importance and value of good communication.

There have been a lot of changes to the way medicine is practised. I grew up on a one-in-two roster, which would not be tolerable to most people today. So one of the broader challenges involves reshaping the provision of medicine with the changed approach of doctors in terms of how they wish to work. And it’s not just the young, new doctors - more people generally don’t want to work a one-in-two roster.

It’s challenging for patients, too. They have to let go of the idea of having their own doctor, especially in general practice, and accept that they’re being looked after by the whole practice rather than a single GP.

Why did you decide to become a branch officer for the ASMS?
While working as a consultant in England, I was a branch secretary for the British Medical Association and had managed to resurrect the Lancashire branch of the BMA, which had become moribund. I’m a very benign unionist. I believe we should be responsible and also be militant when needed – but employers also need to be responsible.

I’ve always believed that things needed to be done and I’ve got reasonable organisational skills which could be put to good use.

“If nobody else is going to stand up and take on the task, then I’ll put my hand up.”

I’m always happy, though, if someone else wants to stand for a branch role.

What have you learnt from this experience so far?
It’s a very slow process to see any achievement. Communication is the key for local issues. More recently, we’ve seen an increasing need for SMOs to resolve issues amicably within a department rather than going out and involving management. A collegial approach can be very effective, rather than a managerial approach.
The Specialist

A is then obliged to investigate and resolve.

complaints and reports that management

irritation or anger that in turn generate

intemperate outbursts of frustration,
tension and stress are frequently behind

Unfortunately, it's a sad reality that
time and resources to deal with them.
mix of heavy workloads and inadequate

In our experience, the reaction of members

who receive complaints and are summoned to

a meeting varies. Some are

some infomral meetings may result in a safe

or informal outcome but many do not.

To meet the challenges posed by these changes

in working conditions and models of care, ASMS

is developing policies and practical advice to

members about both recovery time and shift

work. Previous issues of The Specialist have

developed policies and practical advice to

members about both recovery time and shift

work. Previous issues of The Specialist have

their being 'specialist-led', with senior medical staff

seeing out of hours and on weekends.

anaesthetics. In other services, notably obstetrics

and paediatrics, clinical demand has resulted in

their being 'specialist-led', with senior medical staff

serving from home or on-site overnight and on weekends.

To meet the challenges posed by these changes

in working conditions and models of care, ASMS

is developing policies and practical advice to

members about both recovery time and shift

work. Previous issues of The Specialist have

their being 'specialist-led', with senior medical staff

will seldom be so.

will seldom be so.

成员 about both recovery time and shift

work. Previous issues of The Specialist have

their being 'specialist-led', with senior medical staff

being on-site overnight and on weekends.

The ASMS industrial team recently convened a

meeting of three senior Emergency Department

situation and the need to build into an ED's

job size and hours of work adequate recovery

time. The Association has now put together a

encompass a meeting of three senior Emergency Department

members and industrial officers Henry Stubbs

and Steve Hurriung to begin this work. The group

met in the Association office on 12 February to

begin the work of gathering information about

medical staffing numbers (specialist, medical

officers and SHOs) in emergency departments

around the country, length and rotation of ED

shift, allocation of non-clinical time, weekend

frequency, on-call arrangements, total hours of

work, remuneration packages and numbers of

presentations, etc. Over the next few months,

from this material, we will produce a report for

distribution and wider discussion among our

ED membership.

Our goal is to produce a set of national

guidelines and standards for staffing levels,
hours of work and remuneration for our members

about the country, whether in metropolitan or

provincial hospitals (large and small).

BREATHE DEEPLY

RESPONDING TO

COMPLAINTS OR A

SUMMONS TO A MEETING

A ll too often, tension that arises in the

workplace is the product of a volatile

mix of heavy workloads and inadequate
time and resources to deal with them. Unfor-

luckily, it’s a sad reality that
tension and stress are frequently behind

Unfortunately, it's a sad reality that
time and resources to deal with them.
mix of heavy workloads and inadequate

In our experience, the reaction of members

who receive complaints and are summoned to

a meeting varies. Some are

some infomral meetings may result in a safe

or informal outcome but many do not.

To meet the challenges posed by these changes

in working conditions and models of care, ASMS

is developing policies and practical advice to

members about both recovery time and shift

work. Previous issues of The Specialist have

their being 'specialist-led', with senior medical staff

being on-site overnight and on weekends.

The ASMS industrial team recently convened a

meeting of three senior Emergency Department

situation and the need to build into an ED's

job size and hours of work adequate recovery

time. The Association has now put together a

encompass a meeting of three senior Emergency Department

members and industrial officers Henry Stubbs

and Steve Hurriung to begin this work. The group

met in the Association office on 12 February to

begin the work of gathering information about

medical staffing numbers (specialist, medical

officers and SHOs) in emergency departments

around the country, length and rotation of ED

shift, allocation of non-clinical time, weekend

frequency, on-call arrangements, total hours of

work, remuneration packages and numbers of

presentations, etc. Over the next few months,

from this material, we will produce a report for

distribution and wider discussion among our

ED membership.

Our goal is to produce a set of national

guidelines and standards for staffing levels,
hours of work and remuneration for our members

about the country, whether in metropolitan or

provincial hospitals (large and small).
Specific MECA clauses that you may not be familiar with are highlighted in each issue of ASMS Direct, a national e-newsletter sent out to all members at regular intervals. These clauses are also promoted on the ASMS website (www.asms.org.nz) – and reprinted here for your information.

DID YOU KNOW…

… about your leave entitlement for professional meetings?

If you are elected, seconded or appointed to colleges and professional associations, you are entitled to leave on full pay if these activities are part of your job description. More information is in Clause 29 of the DHB MECA: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-29/.

… about part-timers and reimbursement of CME and work expenses?

Work-related (e.g., annual practising certificate) and continuing medical education (CME) expenses for part-timers (i.e., with a total job size of less than 40 hours per week) will usually be calculated on a pro-rata basis. However, if you're a part-timer with no other income from medical or dental practice, you are entitled to the same reimbursement as a full-timer, i.e., 100%.

More information is available in the DHB MECA:

… about leave during the illness or accident of a close family member?

If you are employed by a DHB you're entitled to reasonable leave on full pay if a close family member becomes ill or has an accident. That’s right, Clause 27 of your DHB collective employment agreement provides for sick leave not just when you’re sick, but when someone important to you is also unwell or injured.


… about bereavement leave?

If you are employed by a DHB you’re entitled to reasonable leave on full pay “on the bereavement of someone with whom you have a close association.” Your entitlement is found in MECA Clause 27.1 and is not limited in time (e.g., to only three days) or to the death of a close or immediate family member. Each case should be considered sensitively and recognised your particular culture and family responsibilities.


… about job descriptions?

The DHB is required to consult you whenever it plans to employ a senior medical or dental officer in the same service or on the same roster. Clause 52.1 of the DHB MECA says you are to be consulted on the need for the appointment, the nature of the role, and the skills and so on required.


We’ll publish something from the vault in each issue of The Specialist to highlight the history of your organisation. You can also find more documents on the ASMS website under ‘About Us’.

This issue: a letter from the Department of Labour confirming ASMS registration as a union under the Labour Relations Act 1987. We’ve been looking through some of the documents and photographs which record important moments in the history of the ASMS.

We’ll publish something from the vault in each issue of The Specialist to highlight the history of your organisation. You can also find more documents on the ASMS website under ‘About Us’.

This issue: a letter from the Department of Labour confirming ASMS registration as a union under the Labour Relations Act 1987.
**GOOD HANDOVERS PROVIDE CONTINUITY OF CARE AND CAN HELP TO AVOID ERRORS**

Whether you work in a public hospital or in private practice, the same principles apply when transferring patients to the care of another doctor.

When handing a patient over to another doctor for treatment – whether between shifts, between phases of care, or between community and hospital care – problems can occur when the patients’ safety at risk. The effectiveness of handovers will depend on the timeliness, accuracy, and completeness of the information given, and whether it is understood by your colleagues.

A lack of consistent processes, absence of best practice guidelines and limited use of protocols mean that handovers can be fraught with risk.

**GOOD HANDOVERS**

The Medical Council of New Zealand (MCNZ) guidelines require doctors to inform patients why and how information about them is shared with other health professionals, and seek their permission to do so. If a patient does not agree, information should not be passed on unless disclosure is necessary to ensure appropriate ongoing care.

Once permission has been sought, a good handover should be a two-way process where information is exchanged and opportunities are given to ask questions and reaffirm that the information exchange has been successful. It should be structured and focused on making suitable arrangements for the patients’ medical care, with minimal interruptions.

Checklists can help with the management of common conditions. For example, a successful handover requires:

- a senior clinician to lead the handover
- a shared understanding of the plan of action, who is responsible for each aspect of the patients’ care and what is required
- designated handover time within working hours (at least 30 minutes for large hospitals)
- involvement of all health professionals, as more information is needed for high-risk patients
- a clear method of contacting the doctor responsible for a particular patient
- awareness of potential risks
- informing the patient of who will be responsible for their care going forward
- clear documentation.

What is perhaps most important about improving the quality of care, is to continually examine how it is delivered. Changing an existing process is not easy, but just focusing on one or two things in your handovers might make a lot of difference to you and your patients.

**REFERENCES**

2. The Medical Council of New Zealand (2013) Good Medical Practice, sections 50, 51
4. Medical Council of New Zealand (2013) Good Medical Practice, sections 46, 47, 49
5. Medical Council of New Zealand (2009) Improving measurement in clinical handover, Quality and Safety in Health Care, 18:1
6. Royal College of Surgeons in Ireland (2012) Revised guidance on safety in handover
7. Medical Council of New Zealand (2009) Social and Behavioural Aspects, sections 85, 86

**ASMS SERVICES TO MEMBERS**

As a professional association we promote:

- right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists.

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MCUA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of the workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

**OTHER SERVICES**

www.asms.org.nz

Have you visited our regularly-updated website? It’s an excellent source of collective agreement information and it also publishes the ASMS media statements.

We welcome your feedback as it is vital in maintaining the site’s professional standard.

ASMS job vacancies online www.jobs.asms.org.nz

We encourage you to recommend that your head of department and those responsible for advertising vacancies seriously consider using this facility.

Substantial discounts are offered for bulk and continued advertising.

**ASMS DIRECT**

In addition to The Specialist, the ASMS also has an email news service, ASMS Direct.

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden, at ke@asms.org.nz

To contact the ASMS

Association of Salaried Medical Specialists (ASMS)

Level 0, The Bayleys Building, 36 Brandon St, Wellington

Postal address: PO Box 10763, Wellington 6143

P 04 499 1271
E 04 499 4500
W www.asms.org.nz

Have you changed address or phone number recently?

Please email any changes to your contact details to: asms@asms.org.nz
WE CAN’T HOLD IT DOWN FOR LONG.

Until 31 March 2015, you can get a MAS vehicle and equipment loan at a special rate of just 8.95% p.a.*

Now’s the time to take advantage of this highly competitive offer from MAS. Whether you need a loan because your practice could do with an equipment upgrade or perhaps you like the idea of parking a new car outside it, contact us today on 0800 627 658 or email loans@mas.co.nz.

- Easily arranged over the phone
- No hidden costs
- No application fees
- No early repayment penalty

Call us today:
0800 627 658
Email loans@mas.co.nz
Visit us online at mas.co.nz

*Interest rates are subject to change. Medical Securities Limited’s (MSL) normal lending criteria apply for all credit and loans, and your application is subject to acceptance by MSL. This offer is available for new loans only.