THE SPECIALIST

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Our condolences to all ASMS members who lost family members, friends and colleagues in the act of terrorism in Christchurch on 15 March 2019, and our admiration and support for all who worked under extreme pressure during this terrible time.

Kia kaha.

ASMS
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SHOCK AT CHRISTCHURCH TRAGEDY; ASMS MEMBER AMONG THE FALLEN

The following special message was sent to all ASMS members on Monday 18 March.

Following the shock and disbelief of the tragedy in Christchurch on Friday, the enormity of the incident is now beginning to sink in as the identities of the dead and seriously injured become known. To our Muslim members and to all who have relatives and friends in Christchurch, we offer our condolences, love and support at this time of such terrible grief.

We are very sad to pass on that one of our members, Amjad Hamid, died in Friday's tragedy.

The Stuff website reports that Dr Hamid, 57, was an SMO and rural hospital consultant at Hawera Hospital. Prior to that he was a senior doctor with a special interest in cardiology, and worked for Canterbury DHB and as a locum at other DHBs around the country. He lived in Christchurch with his wife and family but travelled to Hawera for work. He was well-liked for his kindness, compassion and sense of humour. Stuff reported that he was a hard-working doctor, deeply committed to caring for his patients, and a thoughtful team member who was supportive of all staff. When he returned to Hawera Hospital he often brought fresh baklava from a bakery in Christchurch for everyone.

Dr Hamid has been a valued member of the ASMS and our condolences go out to his family and colleagues.

We want to acknowledge the fantastic job done under extreme pressure by SMOs and others on the front line and in support services to give the seriously injured the best possible chance of survival and recovery. We thank them for all they have done. And there is much more still to be done.

Once again, the resilience and strength of the people of Christchurch is being tested, having been pushed to the limit and beyond following the earthquake. The mental health of Christchurch public is already at a very low point and many mental health staff are already exhausted, so supporting the community now will be an extra major challenge.

SUPPORT AVAILABLE

We understand that a number of members may be struggling or need support following this terrible event.

You might wish to check your own College's advice on these matters but in the first instance members are reminded of access to EAP counselling or indeed to the MPS confidential counselling service that can provide up to six sessions. We very much encourage anyone who is struggling to make use of these services.

Please don't hesitate to contact your ASMS industrial officer if you find yourself struggling with additional workload or you are having any difficulty arranging cover, or need any other assistance from ASMS.

OFFERS TO HELP

There have also been many messages of support from DHBs and ASMS members around New Zealand, including offers to help Canterbury DHB staff in whatever way is possible and appropriate. We understand from SMOs in Christchurch, however, that teams are managing the situation as well as possible at present, working shifts so that staff get breaks and delaying scheduled elective workload. The message from the CDHB SMOs is that they are incredibly grateful for all the support offered. They will consider asking for help if needed at a later date if fatigue and emotional exhaustion become significant.

Ministry of Health Director-General Ashley Bloomfield has asked us to let members know that any requests for clinical or other support will be coordinated through the DHB emergency management infrastructure. Please let your local manager or clinical director know if you are interested in assisting if needed.

MESSAGES OF SUPPORT

ASMS has received many messages of support from around the world and it is clear from the expressions of compassion that this event has had a profound effect well beyond our shores.

Health Minister David Clark wished to pass on his acknowledgement of the "exceptional work" being undertaken by senior doctors in extreme circumstances.

Professor Martin McKee from the London School of Hygiene and Tropical Medicine sent us the following message:

"The world was shocked by what happened in Christchurch, but especially those of us who have been welcomed as visitors to New Zealand. I recall so well going with ASMS colleagues to Christchurch and experiencing such a strong sense of community after the earthquake. As someone brought up in Belfast and who worked in Bosnia, I have seen the effects of hatred at first hand. My thoughts are with everyone affected by this atrocity, including the health professionals caught up in the events or helping the survivors."

Professor Geoff Dobb, President of the Australian Salaried Medical Officers' Federation (ASMOF), who attended last year's ASMS Annual Conference, sent this message:

"I write on behalf of ASMOF and our members to offer our condolences to the families of the New Zealanders killed in the dreadful events in Christchurch and support to our colleagues caring for the injured. The scale and nature of the attack on innocent people during a religious service have clearly shocked us on both sides of the Tasman. Our thoughts are with your ASMS members at this time and we send our best wishes to all, and especially those involved in the ongoing care of the victims."

Council of Trade Unions Secretary Sam Huggard expressed his gratitude for the work of all public service personnel following the Christchurch tragedy.

"Injustice, intolerance and racism has no place in our communities nor anywhere in the world. I am so deeply sorry for our friends in the Muslim community in Christchurch for the devastation that this horrific act of violence and terror has caused," he wrote in an email to unions.

The British Medical Association issued a media release condemning the attack and also contacted ASMS directly. The full statement is available at **https://www.bma.org.uk/news/media-centre/press-releases/2019/march/bma-responds-to-mosque-attack-in-new-zealand**.

Please take care in the coming days and weeks, and draw on support if you need it. Our thoughts are with you all.

Kind regards

Murray Barclay
National President

Ian Powell
Executive Director

"We can't solve the problems by just fixing the problems in the hospital, but we also can't solve them by just fixing the problems in primary care."

HEALTH SECTOR REVIEW GRAPPLES WITH FUTURE DEMAND

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Both workers and employers need to think about future needs and challenges in health and adapt to cope with a changing population, says Health and Disability System Review chairperson Heather Simpson.

Workforce and potentially contractual changes could be necessary to equip the health system for demographic and technological pressures.

Health and Disability System Review chairperson Heather Simpson made that comment in an interview with *The Specialist* in late January about the review tasked with looking at the structure of the health system.

It might be desirable for Resident Medical Officers (RMOs) and Senior Medical Officers (SMOs) to be covered by a single contract to foster patient-centred care, she says, emphasising the group's thinking is still at the broad-brush stage.

"You've got different collectives between your SMOs and your RMOs so if we're expecting people to work more in teams across specialties and in an integrated system then their working conditions are going to have to be related in some way.

"How, I don't know. But if you're trying to make any sort of system work and you haven't thought about how the people work together then it's unlikely to be effective," she says.

TERMS OF REFERENCE

The review team had its first meeting last August after being formally established by Health Minister David Clark, and the panel appears to be taking its time finding its feet.

It has a big task. The terms of reference stipulate identifying opportunities to improve the performance, structure, and sustainability of the system with the goal of achieving equity of outcomes for Māori and Pacific people (**https://systemreview.health.govt.nz/about/terms-of-reference/**).

It is also expected to mop up a few of the health issues Labour promised to review before the 2017 General Election. A highly anticipated review of primary care funding has been folded in, as well as looking at the population-based funding formula and the financial charges levied on Crown capital.

"It's early on in a review that's got another year to go, so I'm not going to give you the answers now," says Ms Simpson, referring to the March 2020 deadline to deliver the panel's final report. Its interim report is due in August.

The panel is talking to the sector through DHB and community-level visits. An online survey was quietly added to the review website in February. Consultation is pitched at the sector, rather than the public. The New Zealand Health Strategy, which reflects the public's view and was widely consulted, is a key reference document, she says.

LOOKING AT THE BIG PICTURE

It made sense for the review to look at the entire system.

"We can't solve the problems by just fixing the problems in the hospital, but we also can't solve them by just fixing the problems in primary care."

While Ms Simpson is giving little away, the panel did not appear likely to recommend a radical shake-up.

"It's not a review which says the system is broke, let's throw it all out and start again. It's a review that says the system is working okay in parts. It's got pressures, it's not in crisis in that sense, but there is big divergence in outcomes between different population groups, and looking forward we surely ought to be doing better than that."

NUMBER OF DHBs

Perhaps the most anticipated question in the sector is whether the number of DHBs should be reduced. Ms Simpson says that question will be considered later. The interim report is to contain only issues, not recommendations, so the panel's views on such matters will not be clear until next year.

"I have promised I won't be making any comment about that until much later on."

She is more willing to talk about the lack of cooperation between DHBs, but gives little detail as to what might foster effective relationships. It won't entail more top-down control, she insists.

"I haven't said anything about top-down control."

Asked for an example she cites duplication of ward design when DHBs undertake building work. There ought to be off-the-shelf options available for the sector, she says.

"There's nothing in the legislation that stops people cooperating at the moment so therefore there's nothing in the structure that stops them doing it, there's nothing that says you cannot have the same shaped ward."

"We don't have a culture of national cooperation between all the DHBs on these sorts of things."

Asked if DHBs charging each other for services engenders competition rather than cooperation, Ms Simpson says that fact should not deter them from working together.

Too often good things happening clinically in one part of the country are not replicated, she says.

Health and disability sector review panel members (left to right): Lloyd McCann, Brian Roche, Win Bennett, Margaret Southwick, Heather Simpson (Chair), Shelley Campbell, Peter Crampton.

A NEW RESOURCE?

The panel seems likely to recommend a new institutional resource for considering evidence in the New Zealand setting.

It might be a new agency along the lines of NICE (National Institute for Health and Care Excellence), in the UK, or something that sits in the Health Quality & Safety Commission or Ministry of Health, she says.

New Zealand is unique among health systems because of its small dispersed population, and a domestic source of information and evidence is a major deficit, she believes.

Overseas comparisons often have limited use in the New Zealand context, she says, but confirms she is looking at the National Health Service's recent trial of integrated care systems. While the relationship between primary and secondary care is different in the UK, the lessons are relevant.

Asked if the panel might recommend free GP visits, she says she won't make any comment.

"Obviously our fees at the initial point of entry into the system have always been an issue and a difference [between the UK and New Zealand]. But there isn't evidence that that's the only difference that's causing the inequity of outcomes.

"We can certainly learn from what they've found in the NHS and the new NHS 10-year plan is obviously relevant and is talking about a lot of the issues we are talking about here.

"In terms of how do we better integrate, plan primary-level services, the solutions are likely to be different here than there simply because the environment we're working in is different, our population is different, the health needs are different."

FOSTERING COOPERATIVE CLINICAL GOVERNANCE

Where she wants New Zealand to follow the UK's lead is in fostering "co-operative clinical governance", but she is cautious when asked about the distributed clinical leadership model advocated by ASMS. Ms Simpson says there needs to be caution around innovation without evidence, reiterating the need for DHBs to follow each other's lead when they find something that works.

"If that means every DHB should work out how to do it themselves I would be concerned we are not making the best use of the evidence we get from that work."

Poverty is not in the review's purview, she states firmly, and she is not convinced material hardship and life circumstances are key barriers preventing access to primary health care.

"Have you got evidence of that?" she retorts to a suggestion transport costs, work commitments, and childcare are impediments that effectively block many people from primary care, on top of the co-payment.

Asked about a recent *New Zealand Medical Journal* editorial co-authored by panel member Professor Peter Crampton, which argues for the need to consider public ownership of GP practices, Ms Simpson says the panel is "nowhere near" proposing any particular business model.

"The article was co-authored by one of the panel members and so presumably represents some of his thinking on one aspect of primary care delivery.

"The panel as a whole is nowhere near proposing any particular ownership or business model for GP practices. Our initial focus will be much more on how we can achieve better integration both

"If you're trying to make any sort of system work and you haven't thought about how the people work together then it's unlikely to be effective."

"I will be talking with unions as part of this process. I think we do have to look seriously at how the nature of work is going to change. I'm interested in having that discussion and I know unions are thinking about it as well."

horizontally and vertically to improve equity of outcomes for consumers.

"I am certain however that over the coming months there will be ample opportunity for many alternative models to be discussed."

More access to primary care is crucial, she agrees, but she rejects a suggestion that this will put more pressure on secondary services, arguing that early detection eases pressure on the system.

The reality is there will always be huge demand, she says, and that demand is growing because of changing demographics and more patients with co-morbidities.

FUTURE PRESSURES SIGNAL NEED FOR CHANGE

The health workforce will need to change to cope with future pressures.

"I will be talking with unions as part of this process. I think we do have to look seriously at how the nature of work is going to change. I'm interested in having that discussion and I know unions are thinking about it as well."

She identifies two separate issues as providing impetus for workforce change – career expectations and patient-centred care.

People's career expectations had changed, not just in respect of work-life balance, but in how they want their careers to develop.

"The health workforce, especially the specialists, is still on a training and career model. In other careers people change direction more often."

Whether that sort of change was possible, or even desirable, in health, she was not yet sure.

The system needs to do more to accommodate patients, which had not really been its ethos in the past, she says.

"We do need to look at and talk to people about how we can develop workforce collective contracts, which are going to address the challenges we need. We know we are going to have a more complex mix of co-morbidities...

"How do we get that teamwork across specialties which again has not always been characteristic of the system?"

IMPORTANT ROLE FOR UNIONS

Unions will play a key role in shaping the future of health.

"I think that unions are going to have to, as they think about the nature of work, as they think about what is good for their parts of the workforce, part of that nature of work is how they are going to work with others who are potentially on different contracts so that will need to be thought about."

"It's no different than in other industries where workforces have to work together to make the thing effective."

"I'm certainly not saying that's the union's job to solve but they're going to have to think about that in terms of representing the interests of their members.

To a question about automation, she says it reinforces the need for patient-centred care.

"The challenge for the medical profession is what they need to do is the people-to-people bit, the caring bit. And that will I suspect become a more significant part of what they're expected to do, rather than have all the knowledge in their head."

POPULATION-BASED FUNDING FORMULA

Ms Simpson says the review will not recommend scrapping the population-based funding formula, as it makes sense to distribute money on a population basis.

She appears unlikely to be swayed by DHBs' complaints about the formula, tacitly suggesting, as health ministers have tended to, that there is no way of pleasing everyone.

Of the DHBs visited thus far, "every single one has said they are penalised. So the other half must be going to say they will benefit", she says drily.

Of the capital levies on Crown capital, another bugbear for DHBs, she indicates that rather than the budgetary impost itself, the key questions are the way builds are planned and how they are owned.

Central government ownership of hospital buildings will be considered.

"We are looking at capital, whether decisions should be made locally. How it's funded.

"It's not so much the capital charge. But from our point of view it's more how should we be planning and funding major capital expenditure. That's somewhat random at the moment. It's not clear to everybody what is determining what is on the 10-year plan.

"Is there a consensus around where the next hospital is going?"

While major projects are approved by the Capital Investment Committee the rationale behind its decisions is not always clear, creating uncertainty in the sector.

DHBs were originally tasked with long-term planning, but it was dropped.

"If you are spending this sort of money, are we really doing it on just an annual plan basis?" she says.

ASMS INPUT TO THE HEALTH AND DISABILITY SYSTEM REVIEW

ASMS is preparing a series of papers to submit to the review panel advocating policies which we consider critical for securing a more efficient and accessible public health service. They will focus on goals such as developing genuine patient-centred care through clinically-led integrated services and the importance of addressing SMO workforce shortages to achieve them.

Health sector review Chair Heather Simpson

"Arguably, the most pressing requirement for ASMS members and for the health of New Zealanders is to correct severe, chronic understaffing of SMOs across the DHBs."

THE YEAR AHEAD

PROF MURRAY BARCLAY | ASMS NATIONAL PRESIDENT

ASMS is 30 years old in 2019 and the Association has achieved much in this time, not the least being a well-developed MECA that provides for good baseline working conditions for members employed by DHBs, and protection for those times when members are more vulnerable in their employment.

And yet we are seeing increased strain on the SMO workforce to a level not seen previously and ASMS may be needed now more than ever. We witnessed progressive erosion of health funding as a percentage of GDP for 10 years, resulting in crumbling, overcrowded buildings and staff shortages across what seems to be all parts of the health workforce.

For SMOs, our research indicates that New Zealand DHBs are around 20% under-staffed for the workload that we are currently already doing, not accounting for unmet need. Therefore, on average, each SMO may be working 20% beyond their contracted workload. This would appear to be a major driver for our 50% burnout rate, presenteeism and predicted (in 2016) 25% rate of SMOs leaving the workforce within the following 5 years.

Other health workforce groups appear to be feeling the same pressures, with industrial disputes and strikes being a routine facet of the contract negotiation landscape in the past 12 months.

The RDA strikes have been particularly difficult for many SMOs, who have no choice but to cover resident doctors' workload during strikes as we know that the buck stops with us. It has not been easy for SMOs having to rationalise the RDA MECA position, which appears to make resident staff less available and less helpful to SMOs, whilst also reducing resident doctor training opportunities, and at the same time pushing ourselves to cover the resident staff during the strikes when many SMOs are already over-worked.

Up to half of SMOs were RDA members once, and there will be associated loyalty and an attempt to empathise with the RDA safer hours case. On the other hand, DHBs seem to see the RDA situation as an opportunity to disempower the RDA because of the potential back-up of the STONZ MECA. It is unexpected that a Labour Minister of Health appears to be complicit with this attempt to disempower a union, and is not prepared to demonstrate leadership by facilitating a resolution to the strikes. Both sides seem equally polarised and determined, with patients being the main victim, as well as SMOs and also service managers who are in a constant state of strike preparations. It demonstrates how selfless and committed many SMOs must be to public health provision to have avoided openly complaining about this situation more.

For our part, ASMS has made a number of overtures to the Minister and DHBs, with offers to facilitate conversations with the RDA and DHBs to help address Schedule 10 unintended consequences. The RDA has agreed to this initiative, whilst the Minister and DHBs have preferred to gamble on 'winning' and continue down the road of confrontation. This was a potentially avoidable dispute if the DHBs had accepted our initiative last September, which, at that stage was wider than Schedule 10.

So what needs to happen in the next 12 months? Our round of MECA negotiations starts early in 2020. ASMS will need to be well prepared. The market for SMO recruitment is global and a large proportion of SMOs in New Zealand are international medical graduates. Some current RDA members may also be dissuaded from working for New Zealand DHBs due to their recent experience with MECA negotiations.

So, to facilitate a rapid increase in SMO numbers in New Zealand to address SMO burnout, approach doctor/patient ratios that are comparable to other comparable countries, and start addressing large unmet patient need, our MECA needs to be internationally competitive and New Zealand DHBs need to be seen as employers of choice internationally. ASMS will be gathering the necessary data to illustrate where we stand internationally on SMO salary and conditions, and also to determine how patient outcomes match up with comparable countries where this data is available.

There are some preliminary indicators of gender inequity in New Zealand DHB SMO salaries. ASMS has now initiated research projects to help determine more conclusively if there is significant gender inequity, following which there may be some specific actions required to address and correct this.

Arguably, however, the most pressing requirement for ASMS members and for the health of New Zealanders is to correct severe, chronic understaffing of SMOs across the DHBs. A prime goal for ASMS is to establish a safer SMO staffing Accord with DHBs, facilitated by the Health Minister, which enables the systematic calculation of appropriate SMO FTE across departments in the form of job sizing (first service and then individual sizing) as provided for in our current MECA. This would be similar to the Accord agreed to for the nurses, as facilitated by the Health Minister, which includes the Care Capacity Demand Management tool. Our proposed Accord should be more straightforward to reach agreement on in that we are simply asking for the systematic application of mechanisms already in our MECA. However, again, the Minister is taking advice from the DHBs and standing back, taking a 'safe' hands-off approach, whilst observing a worsening situation for the wellbeing of SMOs and the health of New Zealanders. We remain hopeful that the Minister will eventually show the necessary leadership.

Lastly, a major task for the ASMS Executive this year is to recruit a new Executive Director. With 30 years experience as the face of ASMS and success in negotiating on behalf of us all, Ian Powell will not be easy to replace but the Executive will be doing our best to ensure ASMS remains in good hands.

BURNOUT ON THE FRONT LINE: AN ANAESTHETIST'S STORY

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Some days, Jessica* felt the urge to "drive into a truck" because of stress, depression, and burnout.

It got so bad she took a week off to recover. Ideally, it would have been longer, but the anaesthetist says that would have meant cancelling surgical lists.

"It should be longer than a week because I wasn't well equipped to come back; it was difficult.

"Part of me worried that I was dumping on my colleagues. It's always been a stressful job but we are trained to cope with the stress of the job dealing with human life.

"What we are not trained to cope with is having to provide ever-increasing levels of care with ever-decreasing resources," she says.

It's hard to keep a sense of perspective when you are dealing with life and death. As a doctor, your physical and mental health conditions can seem trivial compared with those of patients.

"When I'm sick, all my patients are sicker. I have a cold, they have cancer."

IMPORTANCE OF COLLEAGUES

Collegiality is a key factor in surviving.

Her burnout sometimes manifests as rudeness or anger. A colleague devised a way of raising it in a non-confrontational manner.

"They know my stress behaviour patterns."

"I can be short, sharp... it can come across as rude," she says.

Colleagues used to ask if she was OK, and that made her defensive. One came up with a code phrase to make her stop and think during times when she is "not being the person I want to be".

The code is: "Do you need a cup of tea"?

"[My colleague] knows I hate tea and I don't drink it."

In response, she doesn't take time out. Instead, she responds by saying that she does not need a drink, and then refocuses. But it's enough to make her take stock and think about how she is feeling and acting.

"It de-escalates what could be stressful... It's not accusatory or judging. It's an innocuous phrase that gives me pause for thought."

DIFFICULTY OF SEEKING HELP

The stigma around mental distress makes doctors reluctant to ask for help.

"If I broke my wrist it would be fine. But tell someone you're stressed, depressed, getting to the point of wanting to drive into a truck, there is still stigma associated with that."

Since her week off last year she has been on medication, which made a big difference.

"The thing that is really important for me is I feel it is stigmatised. I feel like I have to drive my car into a brick wall [in order to get help].

"It shouldn't have to get to that point."

"You internally think you just have to keep going."

MAKING DO TO GET THROUGH

The public did not realise how under-funding and under-staffing was affecting the health system, she says.

Staff had adopted a make-do mentality to get through, including swapping bits of equipment back and forth so that each doctor could use what they needed for patients.

"If I need a piece of equipment I have to go around and try to find it, and if they are all in use, I have to change my plan for my patient."

Out-of-hours coverage is "horrendous" in her District Health Board, with only one on-call anaesthetist, so on a busy night patients had to be prioritised. Unlike other doctors, anaesthetists can only oversee one patient at a time. For Jessica it can mean covering specialties that she doesn't have up-to-date training in, including, in her case, intensive care.

It also means difficult decisions, she says, like whether to agree to an elective operation during out-of-hours, when a surgeon might be keen to book a procedure, but the anaesthetist must consider the possibility of emergency or acute work.

"We are vulnerable, exposed. That level of stress I wasn't trained to deal with."

She says there is "very little friction" between anaesthetists and surgeons, and the teams are "hugely supportive" of one other.

Jessica says the police force has a good model for dealing with work stress in the form of mandatory counselling, both at regular intervals and immediately after dealing with a distressing case. She says there is nothing to stop the health system adopting something similar.

In the meantime, support from colleagues is invaluable.

"We look out for each other. It's sort of like an extended dysfunctional family," she says.

**Name changed to protect identity*

"I feel like I have to drive my car into a brick wall [in order to get help]. It shouldn't have to get to that point."

"When I'm sick, all my patients are sicker. I have a cold, they have cancer."

ASMS research published in 2016 revealed a burnout rate of 50% among senior doctors and dentists in New Zealand's DHBs.

The finding was based on a survey conducted the previous year of 3740 members, of whom 40% responded. The survey used the Copenhagen Burnout Inventory to measure levels of fatigue and exhaustion. Prevalence in New Zealand was higher than in comparable countries.

Other findings from the survey included that burnout was more prevalent in female doctors aged between 30 and 39, with 7 out of 10 experiencing it. Also, 42% of respondents attributed their burnout directly to their work.

STANDARD FOR SUSTAINABLE WORK

DHBs, services and colleagues have committed to protecting SMO well-being (Preamble to ASMS DHB SMO MECA 2017-2020). SMOs suffering fatigue or other factors detrimental to their well-being will not be able to maintain excellent safe clinical practice and risk burnout.

1. DHB chief executives, management and DHBs should not require or expect additional work from staff without providing additional resources.
2. Departments must be correctly job-sized for their workload. When a department or service has been job-sized and staff shortages identified, a plan should be developed to fill vacancies; inaction may be a breach of the Health and Safety at Work Act.
3. ASMS has proposed a safe staffing accord with DHBs using job-sizing to determine adequate staffing levels and address the national workforce shortfall. The Government, DHBs and the Association will agree a planned implementation of this accord. Once it is reached, DHBs should implement this plan in a timely and transparent way.
4. Each department working shifts should have a shift system in place which has been agreed to be safe by SMOs, the Association, and the relevant DHB.
5. Recovery time provisions should be in in place in each service or department to allow for recovery from fatigue following after-hours call.
6. Departments and services should be staffed so that call rosters are never greater than a real 1 in 3 and fair arrangements in place so that SMOs can take a call holiday because of illness, disability, age, parental or other family responsibilities without impacting unduly on the call obligations of other SMOs.
7. Accessible processes, including restorative processes, should be operating to deal with relationship issues between staff, and inappropriate behaviour.
8. DHBs must have agreed protocols to allow SMOs access to annual leave, CME leave, sabbatical and/or secondment leave, short and long-term sick leave, including sick leave to care for dependents.
9. Departments should work to identify and support individuals who may be particularly at risk of burnout, for example, early-career stage SMOs and those returning from longer periods of leave, eg, parental leave or long-term sick leave.
10. Such support might include confidential collegial mentoring and/or the provision of confidential counselling or professional supervision.
11. Appropriate confidential occupational health services must be provided by the DHB.
12. The workplace should be designed to allow physical space for non-clinical work and rest-breaks, and good quality overnight accommodation.
13. Staff must be supported and protected from violence, threats, or verbal abuse from patients, with protocols in place to deal with any such incidents.

FOCUS ON PREVENTION FOR BEST USE OF HEALTH DOLLAR

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Recently departed chair of the Medical Council Andrew Connolly reflects on his time at the helm of the medical regulator.

Awareness of "cultural competency" and health equity is stronger after his five years at the helm of the Medical Council, recently departed chair Andrew Connolly says.

He is reticent about taking credit for progress in various areas of the Council's work, emphasising the work of council members past and present, as well as staff and committee chairs.

Mr Connolly, a colorectal and general surgeon at Auckland's Middlemore Hospital, has stepped down as chair after serving the maximum nine-year term on the Medical Council's board.

Asked to name his proudest achievement, he cites cultural competency and its link to health inequalities and says the Council helped foster a healthy debate.

"It goes to the heart of understanding our patients."

Poor patient outcomes for Māori and Pacific people raise challenging questions about unconscious bias.

Many professional colleges have taken up the issue as well as the health regulator, he says.

Life and work differ for doctors with Māori or Pacific heritage.

"If you are a Māori doctor living in your home community you probably leave the hospital at 5pm and may well then go to the marae. Is that recognised in your Continuing Professional Development (CPD)? Are there extra increased demands on you because of your culture? I am proud the profession has grasped that."

"The issue of how Māori doctors are supported and represented within college was stimulated by a member of the profession coming to me and talking about it," he says.

CPD has been another focus, particularly to keep pace with changing requirements in Australia.

"We've been clear we don't want to muddy the waters around CPD and how we identify doctors who are not competent to practice."

Mr Andrew Connolly

"If something is shown not to be delivering benefit, the challenge to clinicians is to ask, 'why do you keep doing it'?"

"If you are a Māori doctor living in your home community you probably leave the hospital at 5pm and may well then go to the marae. Is that recognised in your Continuing Professional Development (CPD)?"

INDIVIDUAL CLINICIAN OUTCOMES NOT A GOOD INDICATOR

Of the push for transparency around health outcomes and performance, Mr Connolly opposes the public release of individual clinician data.

Naming doctors potentially disguises the effect of the wider team and could breed an overly risk-averse culture where difficult cases are refused.

But he would like to see more comparative performance data to illustrate differences by service and geographical area.

He says the Ministry of Health has access to vast amounts of information not disseminated to clinicians.

Rather than focusing on mortality statistics, which "don't tell us much", he would prefer finer measures, such as loss of independence among older people. That would help clinicians and patients choose the right interventions.

He believes it would be useful to identify outliers in respect of ordering diagnostic tests or other investigations to see who is out of step with their colleagues.

"If something is shown not to be delivering benefit, the challenge to clinicians is to ask, 'why do you keep doing it'?"

Referring to the New Zealand Resident Doctors' Association industrial action, he says it is important to examine the causes of fatigue and then, if resolved, if all attachments would still need Schedule 10.

Using data to better effect is crucial for getting more from the health dollar.

"If we want to have the best health system a country of this size can provide, I think we need to make sure we get value for the dollar."

He supports the *Choosing Wisely* campaign to improve the tailoring of treatment plans.

"We have to give patients better information so they can make good decisions."

ARTIFICIAL BARRIERS TO RIGHT PLACE OF CARE

The DHB system effectively creates "artificial barriers" because of the cost of sending patients to other centres. It is a barrier to getting the patient to the right place and a burden for some DHBs, he says.

He doesn't have a view on whether there are too many DHBs – "it's whether they work".

He hopes the Health and Disability System Review addresses the issue of DHB boundaries.

Of recent controversy about access to cancer drugs, he believes the wrong questions are asked. Chemotherapy is a last resort in a spectrum that starts with prevention and prompt treatment.

"What we know is mortality rates are worse than other countries, but other countries have screening, have had for a long time. The outcome when we find [cancer] and do something is pretty good."

"If we put our emphasis on chemo, that's a disservice to the public. It's an answer for some people, probably too many people but the emphasis should be on having fewer people need the chemo," he says.

EXPANDING TRAINING OPPORTUNITIES

Changes to intern education championed by predecessor John Adams have started bearing fruit. By doing away with mandatory training structures, first-year house surgeons can experience a wider choice of specialties. He hopes this encourages more to enter the likes of psychiatry and obstetrics.

He says the strategic thinking of council staff is "fantastic", and he praised the work of Wellington urologist John Nacey, who chairs the Council's education committee.

The council has a role in encouraging doctors to work in smaller centres.

Creating trainee spots in the regions gives senior doctors in those areas mentoring opportunities.

"Most of us enjoy training young folk, so let's maximise that, so that those in smaller towns have a registrar."

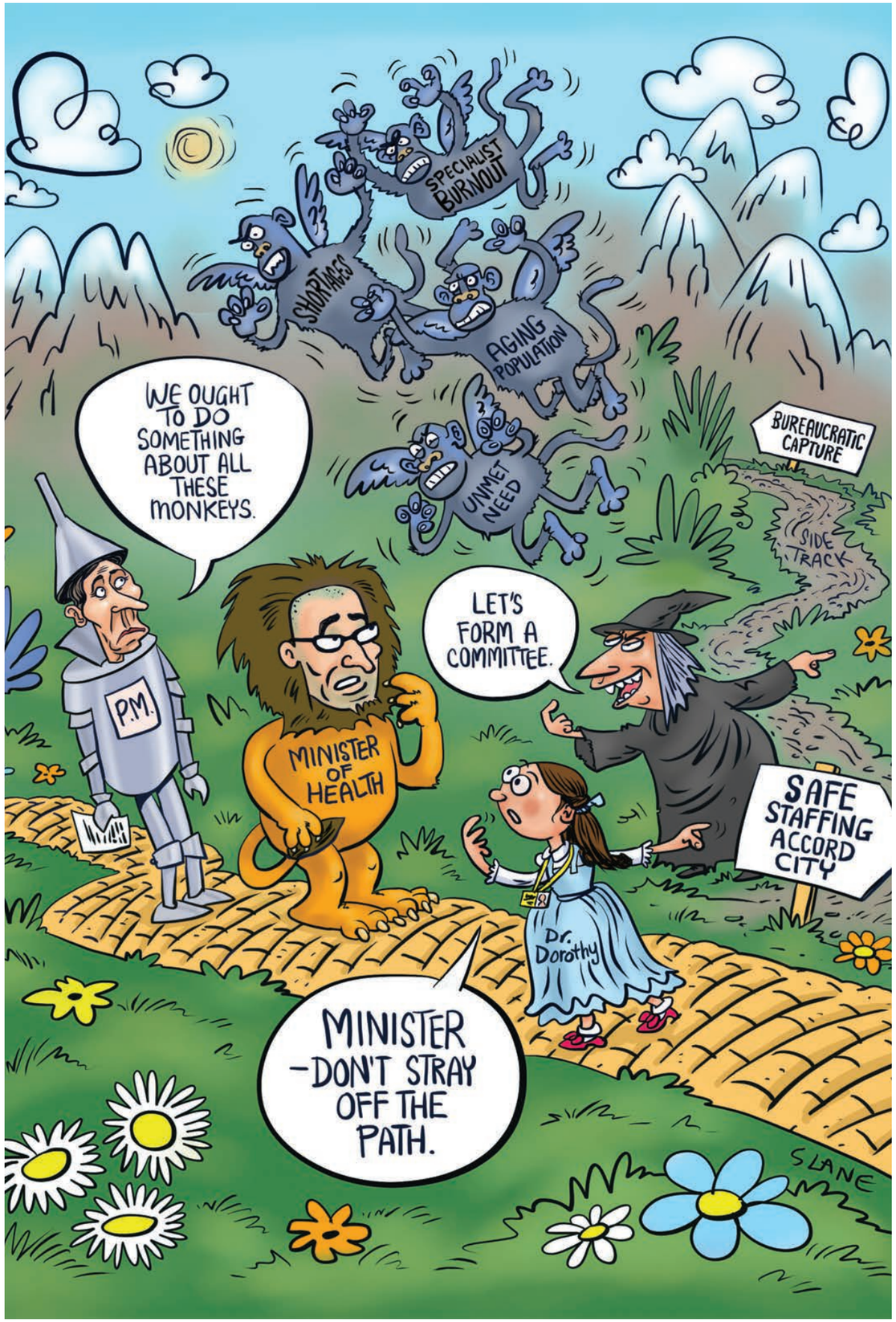
He would like to see further devolvement of training opportunities, saying training programmes finish in major centres, but that need not be the case.

A passionate advocate of generalism, he says there is a danger of "dumbing down" generalism in the push towards sub-specialisation.

"If we look at what we need, it's acute decision-making that you get from generalist training."

"I get really worried about smaller New Zealand towns not attracting specialists because the perception is the interesting work has to go somewhere else – that's not the case."

"I get really worried about smaller New Zealand towns not attracting specialists because the perception is the interesting work has to go somewhere else – that's not the case."



"As much as we need better and safer buildings, we need specialists even more."

DOROTHY, WICKED WITCH, WIZARD OF OZ AND THE GOVERNMENT ON LIVING STANDARDS FRAMEWORK

IAN POWELL | ASMS EXECUTIVE DIRECTOR

The Government, specifically Prime Minister Jacinda Ardern and Minister of Finance Grant Robertson, is promoting a commendable initiative which is expected to be a central feature in its Budget on 30 May for the new financial year commencing 1 July. As an associate finance minister, Minister of Health David Clark is expected to be involved in this initiative.

The initiative is called the 'Living Standards Framework', which is about population and workforce wellbeing. The attraction is the recognition of promoting wellbeing not only to help prevent illness but also as a yardstick for promoting and assessing the economic performance of the country. Economic performance is not just GDP growth, current account balance, or inflation; it is also about human wellbeing.

This is exciting stuff, but it is only going to be meaningful if it translates to tangible effective measures below the macro umbrella. Nowhere is this more important than the wellbeing of the senior medical and dental workforce in our public health service provided by district health boards.

Best estimates based on surveys of clinical leaders in seven medium to large DHBs to date are that we have specialist workforce shortages of about 20%. These shortages are much higher than the official vacancies in all these DHBs, often by a factor of 3 to 1. What more damning evidence is required than the shocking 50% burnout rate experienced by our highly qualified over-worked senior doctors or the high rate of them working while sick (even infectious at times).

On top of this, ASMS research published in 2016 showed a quarter of the workforce intended to leave DHB employment in the next five years because of a mix of demographics, job dissatisfaction and burnout.

SAFER SMO STAFFING

ASMS has proposed a safer staffing accord along similar lines to that achieved by nurses as part of their collective agreement settlement last year. The nurses' safe staffing accord was both initiated and brokered by Dr Clark, despite reluctance from DHBs. His role was commendable.

ASMS has suggested something similar for the SMO workforce, but in contrast to his hands-on approach during the nurses' dispute, Dr Clark's attitude is non-committal. While the context is a bit different, given Dr Clark was understandably anxious to put an end to nursing industrial action, we believe there is the same need to show leadership. It would be disappointing if he was to be one of those health ministers (like his predecessor) who only reacted to a workforce crisis when it generates too much industrial noise.

If an accord along the lines we have proposed was enacted, it would gradually generate the workforce capacity for SMOs to have time to engage in complex service planning and provide leadership and stewardship. It could reduce the impact of adverse events, which harm patients and cost the health sector millions of dollars. The benefits would be improved patient-centred care, timelier access to health care, and better financial performance in our DHBs. This was the conclusion of a report jointly developed by ASMS and the DHBs in 2010.

The proposed accord requires no additional funding, nor contractual changes. Instead, it would first involve explicitly recognising the precariousness of specialist shortages in DHBs and then requiring DHB leaders to do what they are already contractually obligated to do to fix it through job sizing, and improved recruitment and retention actions.

David Clark has grasped the seriousness of the deterioration through neglect and poor decisions of hospital buildings. He is to be applauded for the steps he has taken so far to help turn this around. But hospital specialist shortages are even more serious. As much as we need better and safer buildings, we need specialists even more. Buildings don't diagnose, treat or operate on patients and the quality of their bedside manner is unproven.

Our health minister inherited rather than caused this workforce crisis. But the longer he delays championing the solution, the more likely it is that he becomes the problem. I'm reasonably confident that Dr Clark as a literate man has read and enjoyed the Wizard of Oz. If so, Dorothy would be the best role model for him to follow.

"It would be disappointing if David Clark was to be one of those health ministers (like his predecessor) who only reacted to a workforce crisis when it generates too much industrial noise."

"Increasingly we are having to choose between almost equally sick patients, and just hope that no-one comes to harm in the meantime."

WORKING IN AN OVER-LOADED AND UNDER-RESOURCED SYSTEM

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Middlemore Hospital emergency department (ED) specialist Sylvia Boys says doctors are being forced to take short-cuts because of under-staffing, putting them and their patients at risk.

"Increasingly we are having to choose between almost equally sick patients, and just hope that no-one comes to harm in the meantime."

Time spent on patient assessment and diagnosis has effectively been shortened to make the department's work flow.

"We're ordering investigations on limited info, providing antibiotics or pain relief early without complete assessment, to make sure people get care they need, which introduces significant risk and uncertainty."

Dr Boys says most health and disability complaints are caused by system overload and lack of staff, rather than incompetence or recklessness.

"Currently the only way we're managing to achieve the throughput we do is considerable corner cutting.

"We are having to take short-cuts to make the work flow happen," she says, adding that she suspects the Health and Disability Commissioner takes insufficient account of the pressures when assessing complaints.

"The health and disability process is exceedingly distressing to doctors.

"The complaints ending up at the Health and Disability Commissioner are often about system failure that results in bad outcome, rather than individual practitioners being negligent or reckless," Dr Boys says.

PRESSURE ON ED

Emergency departments bore the brunt of wider pressure on the hospital. Patients turned away from other departments often become so ill they turn up in the ED.

Dr Boys recently conducted her own tally over several days of how many of her patients had been trying to get help from other services. It revealed about 25% had been unable to access a primary or secondary health service.

A common example is women with heavy menstrual bleeding who are waiting for a gynaecologist appointment. They were usually low on the wait list if they were not suspected of having cancer.

"We get at least one woman a week severely anaemic with long-term heavy menstrual bleeding.

"Each of the GP referrals are accompanied by a genuine need for treatment.

"The emotional stress of that is very real for those clinicians. They are all starting to see cases that have deteriorated that they have not been able to see in a timely manner."

She saw burnout frequently among colleagues. As a "gross generalisation" she says it manifests differently in men and women; the former became short and terse, while women were more prone to sadness.

She says reducing the emphasis on the 6-hour ED treatment target is sensible because it had become unrealistic.

Data on the 6-hour target is still collected but is no longer publicised.

Dr Boys says the target had become all about getting patients out within six hours, which defeats its purpose as a supposed measure of good practice and timely treatment.

"The [health] ministry has stopped publishing it because they realised we had so much gaming and it was becoming a perverse target when we weren't meeting the other criteria."

Also, when patients were stuck in the ED it was often due to bed block in other wards, rather than anything within ED's control.

"The complaints ending up at the Health and Disability Commissioner are often about system failure that results in bad outcome, rather than individual practitioners being negligent or reckless."

Back row L-R: Shameem Safih, Michael Howard, Willem van der Merwe, Scott Pearson, Andrew Ewens, Tanya Wilton, Lloyd Woods, Sylvia Boys, Norman Gray, Tom Morton. Front row L-R: Amy Leuthauser, Andre Cromhout, Jonathan Casement, Ben Barry.

SHIFTWORKERS' MEETING

A group of 12 selected ASMS members gathered in Wellington in March to discuss issues particular to shift work, including fatigue and the impact of unsociable hours on their professional and personal lives.

The one-day workshop was initiated by the ASMS National Executive and facilitated by Executive member Andrew Ewens, who is an emergency medicine specialist at Auckland's North Shore Hospital, with organisational support from ASMS Senior Industrial Officer Lloyd Woods.

Andrew Ewens says ASMS wanted to canvass the concerns of shiftworkers working mainly in hospital emergency departments and intensive care units.

"It was a very useful meeting and it has given us a lot to think about and follow up."

He is acutely aware of how working all hours of the day and night can affect a doctor's physical and psychological health.

"Shiftwork can be hard. Many of us get very fatigued by the end of it, and then you have to go home and try to sleep.

"It affects your health, your family and social group, your responsibilities and all of the other things you need to be doing."

The issues raised at the one-day workshop will now go to a wider reference group of ED and ICU SMOs for further discussion. About 400 shiftworkers are covered by the ASMS DHB MECA.

THE MENTAL HEALTH AND ADDICTION INQUIRY REPORT: RAISING MORE QUESTIONS THAN ANSWERS

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

The panel of the Government Inquiry into Mental Health and Addiction says it has taken a 'people first' approach in writing its much-awaited report, "being guided by the needs of people and communities rather than the preferences of the various groups accustomed to the way the system is structured and services are delivered at present". The virtual exclusion of the views of such groups – presumably including those who provide the services – is perhaps one of the reasons why the inquiry report lacks substance in so many key areas, not the least relating to workforce needs.

Notwithstanding the panel's apparent selectivity, it found a 'striking degree of consensus' about a need for change, with "an emphasis on wellbeing and community, with more prevention and early intervention, expanded access to services, more treatment options, treatment closer to home, whānau – and community based responses and cross-government action". Few would argue with such views, including, most likely, the groups whose views were deemed of secondary interest.

But because of the "wide range of complex issues, our time constraints, and the risk of being overwhelmed by detail… We have not produced a strategy, a roadmap or a detailed implementation plan with comprehensive and fully costed actions."

Instead: "We have identified priority areas for action, many of which require decisive action by the Government and Parliament." They are:

- expand access and choice
- transform primary health care
- strengthen the Non-Government Organisation (NGO) sector
- enhance wellbeing, promotion and prevention
- place people at the centre
- take strong action on alcohol and other drugs
- prevent suicide
- reform the Mental Health Act
- establish a new Mental Health and Wellbeing Commission.

Of the community groups commenting on the report most were welcoming, as the recommendations contained within this list reflect what they have long been advocating. But some critics have questioned the need for an inquiry, especially given its broad brief and tight timeframe, which was always going to result in little more than a high-level analysis of issues. A *New Zealand Herald* editorial called the inquiry report "250 pages of verbiage we already knew [and]… It is not clear what any of its primary recommendations would mean in practice."

Certainly much of the report's content is familiar, and it leaves the Government with a lot of wriggle room in how it responds.

HIGH EXPECTATIONS

Whatever one's views, there is now a high expectation of delivery. However, the questions of 'What? and How? at a practical level appear no closer to being answered than when the inquiry was set up. Needs and services are not well defined. As well as the lack of a strategy, implementation plan and costings, the inquiry's call for increased funding 'in targeted areas' avoids giving any idea of figures.

Critically, one of the most urgent matters to be addressed is ensuring there is an adequate workforce to achieve the vision and direction set out by the inquiry, especially given the long lead-in time required for this. Its report acknowledges there is a 'workforce crisis', that staff are burnt out and that there is inadequate workforce planning. It sees the need for a bigger peer support workforce and 'larger proportions' of Māori and Pacific workers as priorities. There is also a need to 'grow our psychologist workforce' and to further develop the skills of nurses, support workers and allied health practitioners. Again, there is no attempt to quantify the needs.

"One of the most urgent matters to be addressed is ensuring there is an adequate workforce to achieve the vision and direction set out by the inquiry."

There is no explicit recognition of shortages in the psychiatrist workforce, despite indicators in the inquiry report of such shortages. Instead, it notes "a large jump in the number of registered psychiatrists in 2018". It is not clear, however, whether that reflects in part more doctors becoming vocationally registered but who had previously been practising as a psychiatrist (a workforce review published by Health Workforce New Zealand in 2011 estimated about 25% of doctors practising as psychiatrists were not vocationally registered.)

Equally important, many psychiatrists work in private practice and many psychiatrists and trainees are part-time. Of the 620 registered psychiatrists in 2018, mental health and addiction workforce profiles using data from the DHBs' Health Workforce Information Programme indicate there were just 438 FTE psychiatrists employed by DHBs in 2018 – just 1.7 FTEs more than in 2017 (See Vital Statistics in this issue of *The Specialist*). The lack of robust data, especially at sub-specialty level, means there is no good way of knowing to what extent services are matching need – and where the greatest pressure points are – or how they might be better matched in the future. Addressing these workforce data shortcomings must be a high priority.

The inquiry report explains that the vast bulk of funding for district health boards (DHBs) is ring-fenced to ensure specialist services[1] are provided for 3% of the population with the most severe mental health needs (a target set by the 1996 Mason Inquiry). Once that target is reached, DHBs may use any remaining funding for other mental health and addiction services, topping up non-ring-fenced funding for people with 'mild to moderate or moderate to severe needs', estimated to be around 17% of the population. It reports that in fact specialist services for the most severe cases have been provided for 3.7% of the population, which may explain in part why so many staff are burnt out if resourcing is based on the 3% figure.

The report also briefly mentions a 280-page New Zealand Mental Health Survey analysis published by the Ministry of Health 10 years after the Mason Inquiry, which estimated 4.7% of the adult population had severe mental health needs, though it is probably conservative as it excludes some people living in institutions such as rest homes, hospitals, and prisons. That report explains the older 3% figure was based on projections from overseas studies whereas the survey study provided estimates based on nationally representative data. The inquiry report does not question why DHBs continue to be funded for severe needs based on outdated data which appears to substantially understate the real service need.

The report commendably recommends that access to, and funding for, mental health and addiction services needs to be significantly increased, from the 3.7% of the population who currently access specialist services to the 20%, including those with less severe needs, who experience mental health and addiction issues each year. At the same time it emphasises priority must be based on the severity of need. Since this would then cover funding and access to the estimated 4.7% of the population with severe needs (assuming children's needs are of a similar proportion), specialist service staffing, including psychiatrists, will need to be increased accordingly.

Additionally, the report calls for psychiatrists to provide more support for those working in the community, "supporting and liaising with GPs and primary health care providers, and using a broader range of therapeutic responses, including family therapies" and also working in partnership with patients, families and whānau. ASMS has long advocated for better integrated services and a greater emphasis on patient-centred care but the evidence shows heavy clinical workloads hinder such an approach. Staffing levels must be such as to enable these approaches.

GOOD LEADERSHIP AND WORKFORCE INVESTMENT NEEDED

No one would argue with the report's emphasis on better prevention and early intervention but the effectiveness of this is by no means a given. It depends on good quality leadership at every level as well as a substantial and sustained investment in the workforce, covering a range of roles, and the means to address obstacles identified in the literature, such as lack of primary care providers'

1 'Specialist services', they are not provided exclusively by specialist clinicians, but include services such as community-based and respite care, as well as social support services (for example, vocational support, living skills and housing coordination services).

"The extent to which the Government supports a well-resourced Commission with teeth will be an early test of its commitment to addressing our mental health crisis."

time, lack of confidence in providing advice and effectiveness of interventions, inadequate reimbursements and lack of patient compliance or motivation. Ministry of Health data of recent years show increasing rates of GP and primary care nurse consultations per population has occurred while inpatient hospital rates also continue to rise. Similarly, use of primary care and other community services for mental health and addiction needs have increased well above population growth rates; this hasn't stemmed the flow of hospital admission rates for mental health, which has also risen well above population growth rates.

The report's comment that: "We expect demand for specialist services will reduce as issues are dealt with earlier, before they escalate..." is therefore highly questionable, at least for the foreseeable future. That does not negate the rationale for investing more in primary care. It is clearly much needed (see separate article 'GPs hopeful of mental health changes'). Rather, it is an argument for a more holistic approach to workforce and service planning, enabling a more holistic, integrated service, based on the best evidence. Inadequate access to secondary care and specialist support is part of the reason why primary care services are under so much pressure.

The recommendation to strengthen the Non-Government Organisation (NGO) sector does not specify whether this should be through additional funding or by shifting resources from DHBs, which is suggested in parts of the report. The report does not provide evidence to support this, other than the perceptions of some submitters. One would hope that decisions on who provides what are based on robust information on quality and cost-effectiveness rather than type of organisation. The issues identified in the report indicate a lack of transparency and accountability in contracting processes. Other reports relating to this indicate funding pressures on DHBs drive them to seeking 'savings' in non-acute or non-government-target areas. These are the issues that need to be addressed.

In considering why over the past couple of decades the mental health and addiction system 'has not shifted', despite stated intentions to do so, a key conclusion is that "a fundamental disconnect exists between stated strategic direction, funding and operational policy and ultimately service delivery".

One of its key recommendations – to extend access and funding to cover the full range of mental health and addiction needs – is a case in point. The Government of 2005 adopted this policy in its New Zealand Mental Health and Addiction Plan; lack of real action led to the policy being reintroduced in the later Government's 'Blueprint II' in 2012; again it seems to have slipped away to naught.

Issues around transparency and accountability are clearly not confined to DHB contracting processes. The re-establishment of an independent Mental Health Commission (already included in Coalition Government policy) is therefore likely to be critical to ensuring the gap between stated policy and actual delivery is closed. The extent to which the Government supports a well-resourced Commission with teeth will be an early test of its commitment to addressing our mental health crisis.

The extent to which it will front up with additional funding in the next Budget will be another – but it has its work cut out (see separate article on the upcoming Budget in this issue of *The Specialist*).

"Whatever one's views, there is now a high expectation of delivery. However, the questions of 'What? and How? at a practical level appear no closer to being answered than when the inquiry was set up."

"The mental health and addictions system is woefully underfunded, crisis-led and seems to chew up and spit out not just the patients, but the providers." Anonymous GP quoted in RNZCGP submission to mental health inquiry

GPs HOPEFUL OF MENTAL HEALTH CHANGES

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Uncertainly remains about expected changes to the mental health system as the Government is yet to signal a decisive direction following last year's Mental Health and Addiction Inquiry.

The Royal New Zealand College of General Practitioners (RNZCGP) President Dr Samantha Murton remains optimistic about the future direction of mental health, despite not yet knowing what measures or new funding will emerge from *He Ara Oranga*, the landmark report delivered late last year.

The report, the Government's response to a purported crisis in mental health, calls for a transformation in primary care to enable a broader range of services in the community.

In its submission to the inquiry, the RNZCGP called for action to address social determinants like poverty and housing, and highlighted the severe lack of access to primary care. The New Zealand health survey showed more than 500,000 New Zealanders could not afford to visit a GP. Mental health issues are often complex presentations requiring time and attention. The submission relayed some of the frustration felt by GPs at the coalface.

VERBATIM COMMENTS IN THE SUBMISSION INCLUDED:

"I have also seen a lot of depressed people and the Brief Intervention counselling service has a long waiting list because people cannot afford to pay for their own counsellors."

"The mental health service seems to be a big machine with many different compartments. From the inside it might make sense but from the outside it is difficult to find the right point of entry. I have spent frustratingly long times on the phone being transferred from one compartment to another trying to get help."

"The mental health and addictions system is woefully underfunded, crisis-led and seems to chew up and spit out not just the patients, but the providers."

"Assessing and managing [mental health] is impossible in a 15-minute consult. Not only does the history take longer, but then there are follow up phone calls for collateral histories from whānau and liaising with secondary care specialists. Then they invariably have physical health needs that are less likely to be met in this vulnerable population. I must do all this in the same time I get for a cut finger!"

In an interview with *The Specialist*, Dr Murton says the burden of providing complex mental health care is adding to burnout among GPs.

"Because we are dealing with a lot more complex stuff than we used to it can feel like you're sinking.

"How do we make sure GPs have enough time and support? We don't have the time or funding for the extra things we need to do."

The Wellington GP practice where Dr Murton works employs a social worker to co-ordinate mental health and other complex patients. An invaluable role, it attracts no additional funding. The social worker's relationships with relevant social agencies and NGOs saves time for GPs.

"Having the social worker there makes a vast difference to how we provide care. Our social worker has been with us for multiple years and we would not survive without her."

Dr Murton says the practice "thinks outside the square" with funding. It might be used for a patient's respite stay, to give a GP extra time for a complex case, or food and petrol vouchers.

Of the mental health inquiry report, *He Ara Oranga*, Dr Murton says its "intention and essence" aligned with the college's expectations. She hopes it will effect a rebalancing of primary and secondary care.

"That funding has not moved into general practice historically and it needs to.

"The burden of mental health has become significant. We are dealing with more significant issues than we used to."

By nature "an optimist", Dr Murton feels confident the sector's woes will be addressed as new measures are introduced.

"If the Government supported GPs to train as addiction specialists that would be good, as we are more holistic re physical health." Auckland CADS Medical Officer Clara Dawkins

Dr Samantha Murton

Dr Jonathan Kennedy

Wellington GP Jonathan Kennedy emphasises the role played by nurses in mental health care, whom he says sometimes get overlooked. His practice also employs a social worker: "A great resource we and our patients very much appreciate".

"The practice has a high mental health caseload, and is grateful for a long running two-weekly session with Capital & Coast DHB psychiatrist Paul French," he says.

As well as upskilling GPs, this initiative reduces referrals into community mental health outpatient clinics.

Expectations to provide more mental health care should be accompanied by opportunities for professional supervision for GPs, he says.

He worries about the patients who do not qualify for free counselling and cannot afford to pay.

"There's a whole group in the middle who can't really afford services and counselling's an ongoing cost, it's not a one-off."

Services don't always need to be free, but should be "realistically available", which in some cases meant no charge to the patient.

ADDICTION "TAGGED ON"

Clara Dawkins and Vicki Macfarlane, Fellows of the RNZCGP working as Medical Officers at Auckland's Community Alcohol and Drugs Services (CADS), say addiction fails to get the attention it needs, but things are moving in the right direction.

The service is attracting more interest and applications to work and train from doctors, including trainee GPs, than was previously the case. It reflects progress made overcoming stigma around addiction.

"When I started eight years ago, I felt stigmatised. We struggled to get doctors. That has changed," Dr Macfarlane says.

But there remains "fear" among GPs for whom addiction can represent the unknown.

There is a sense addiction is an even poorer relation to the rest of the health sector than mental health.

Dr Dawkins says doctors need to get used to asking patients about drugs in the same way they would, for instance, their coffee intake.

"Alcohol and other drugs use disorders should be considered and addressed like other chronic relapsing conditions like diabetes or COPD," she says.

Dr Macfarlane says some doctors have no prior experience of addiction in their social networks and families, and she stresses to trainees that addiction affects every strata of society.

Patients can feel "bounced around" services in both the addiction and mental health spheres, and that was something CADS has worked hard to address.

The pair say addiction gets "lumped in" with mental health but while there is some crossover, there are significant differences. For instance, physical health issues that tend to accompany long-term mental health conditions are different from those affecting people with addictions.

The mental health and addiction inquiry did not have strong representation from the addiction sector, and it felt like it was "tagged on".

The pair would like to see the accreditation of addiction specialists trained through the Royal Australasian College of Physicians, rather than solely psychiatry. GPs who undertake the further study are not recognised as Senior Medical Officers.

"If the Government supported GPs to train as addiction specialists that would be good, as we are more holistic re physical health," Dr Dawkins says.

*Note: see separate article by Lyndon Keene in this issue of *The Specialist* on the mental health and addiction inquiry report.

"There's a whole group in the middle who can't really afford services and counselling's an ongoing cost, it's not a one-off." Wellington GP Jonathan Kennedy

DR JENNY HENRY IS AN ANAESTHETIST AT NORTHLAND DISTRICT HEALTH BOARD AND THE REGION'S ASMS BRANCH PRESIDENT.

"If there is a problem, we fix it. It's a 'doing' job and that is what I like."

"The people are fantastic to work with, we have great surgeons in Whangarei, our department and the ICU are a cohesive and supportive team."

WHAT INSPIRED YOUR CAREER IN MEDICINE?

I don't think it was inspiration that led me in to medicine in the first instance. I did it because I saw it as a challenge and didn't know what else to do.

My medical career is as follows. I attended St. Mary's Hospital Medical School, University of London, where I had an amazing time. However, after six and a half years I had had enough of living in a large city and moved to Hereford for my medical house officer job. This was a 1:2, being on call for 72 hours every other weekend and the inevitable long Monday ward round. We calculated we were working an average of 108 hours a week. It was soul destroying, not character building as it was put to us by our consultants. I then moved to Torbay, Devon, where I worked as a medical SHO for 18 months followed by 8 months as an ED SHO in Jersey, Channel Islands. It was during the latter two jobs that I discovered you could be a doctor and also have a great life outside of work. Here I found my passion for the ocean and the outdoors.

Lisa Bennett, then anaesthetic SHO in Torbay and now head of ICU in Fiji, encouraged me into anaesthetics and I have not looked back. My anaesthetic training in the South West of England was awesome and I secured a consultant job in Plymouth. However, within six months I was bored with work as my scope of practice was significantly narrowed to regular lists in only a few specialties. The decision to emigrate to New Zealand was not difficult. Although I was working in the UK, I wasn't born or raised there, I never considered it home and had never planned to stay long term. My children were young, which also made moving easier. A Whangarei anaesthetic specialist job was advertised in the *BMJ* not long after, and here I am, 14 years later, in Whangarei and still loving it. Perhaps that is my inspiration.

WHAT DO YOU LOVE ABOUT YOUR JOB?

This is the easy question to answer. A huge amount, and for that I am grateful. Anaesthetics is a hands-on specialty and continues to be as a consultant. We give the drugs and see the effects straight away. If there is a problem, we fix it. It's a 'doing' job and that is what I like.

In my lifetime of anaesthetics, the new stuff, LMAs, propofol, use of ultrasound in anaesthesia and sugammadex have made a huge difference. We are continually learning.

The people are fantastic to work with, we have great surgeons in Whangarei, our department and the ICU are a cohesive and supportive team. Our current Head of Department does an amazing job.

The patients and cases are so varied. We are jacks of all trades and masters of none which makes for a much more interesting life.

And the CME leave - what's not to love about that? I am off to Antarctica at the end of the year on a conference approved by ANZCA. I can't wait.

Northland is perfect for my lifestyle and close enough to get a dose of city when needed.

WHAT ARE SOME OF THE CHALLENGING ASPECTS OF PRACTISING ANAESTHETICS IN THE CURRENT HEALTH ENVIRONMENT?

I think anaesthetics per se is relatively sheltered from the economic and waitlist pressures. We have to have the necessary drugs and equipment to do our job to the high standards demanded, otherwise patients can't have their surgery. I am very much more mindful about the sustainability aspect of our job and its environmental impact.

I think the most challenging aspect is that patients are getting bigger and older, and with this comes a greater degree of comorbidity.

HOW DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

It's only relatively recently I've become involved, and like most others, I went to JCC meetings and gained some insight into the role of the ASMS. Our branch president asked me to go to the national branch officers' annual workshop in Wellington in his place about 18 months ago and I really enjoyed meeting with like-minded people and the opportunity for networking. It's a great forum for SMOs from a range of specialties from every region in New Zealand to get together.

I then went to the ASMS Annual Conference 2017. I found it interesting and decided I would like to be more involved with the ASMS now that I have the time and energy, so I put my hand up for the Northland Region President in 2018 and here I am.

WHAT HAVE YOU GAINED OR LEARNED FROM YOUR ASMS INVOLVEMENT?

I've learned a great deal about the MECA and what ASMS really is about.

Locally I have learned how vulnerable SMOs are in some of the smaller departments and our excellent ASMS Industrial Officer Sarah Dalton has been instrumental in helping.

Personally I have gained a huge amount of confidence and thoroughly enjoy the networking.

I would like to encourage SMOs in Northland to get in touch with me if there are work issues that are relevant to the ASMS.

"I've learned a great deal about the MECA and what ASMS really is about."

ASMS TURNING 30


© TE PAPA

It's 30 years since ASMS was formed and we're marking the occasion with a special commemorative conference on the theme of why a public health service is worth fighting for.

One of the world's leading authorities on the operation of health systems, Professor Martin McKee from the London School of Hygiene and Tropical Medicine, will deliver a keynote address to the conference. You may remember his highly regarded series of presentations during his visit to New Zealand in 2014 to mark the Association's 25th anniversary.

A second international speaker will be Dr Otmar Kloiber, Secretary General of the World Medical Association, who will speak about medical migration in the context of the conference theme.

Health Minister Dr David Clark will also address the conference.

The conference will be held on Thursday 27 June at Te Papa in Wellington, and will be followed by the annual ASMS branch officers' workshop the next day.

Details of the commemorative one-day conference are being finalised and will be circulated closer to the time. If you are interested in attending, please register on the ASMS website: **https://www.asms.org.nz/asms-30th-anniversary-conference-registration/**.

The special commemorative conference should not be confused with our Annual Conference, which will be held in Wellington in November.

ASMS
TOI MATA HAUORA
www.asms.nz

WOMEN IN MEDICINE ENAMEL PIN

To celebrate and support the work of women doctors in New Zealand, ASMS commissioned New Zealand jeweller Pepper Raccoon to design a small enamel badge especially for women in medicine.

It's an original design and is available for all women in medicine, whatever their stage of medical career.

The pins cost $15 each plus shipping and can be purchased at (**https://pepperraccoon.com/search?q=asms**).

The badges were launched on the Women in Medicine Facebook page on International Women's Day, and are already proving popular.

Any questions about the badge can be directed to ASMS Communications Advisor Lydia Schumacher at **lydia.schumacher@asms.org.nz**

DEALING WITH UNPROFESSIONAL BEHAVIOUR IN DHBS

LLOYD WOODS | ASMS SENIOR INDUSTRIAL OFFICER

In August 2016 the ASMS organised a visit to Melbourne to have a briefing from the Cognitive Institute about their Professional Behaviours Programme in Australia. A visit to the Royal Melbourne Hospital was also arranged to talk to SMOs there about how the programme was working for them. This has been reported previously.

As a result of that visit, and as part of the ongoing work that the ASMS industrial team was doing looking for better ways to deal with issues of bullying and harassment generally, we started actively encouraging the DHBs to consider the Cognitive Institute programmes as a way forward. In December 2016 the Institute agreed to look at introducing their programmes and ASMS continued to lobby DHBs to participate.

Two years later we are pleased to note active engagement between the Institute,

DHBs and two private hospitals in the implementation of the Speaking Up for Safety™ and Promoting Professional Accountability Programmes.

As of January 2019, 10 DHBs are, or have implemented Speaking Up for Safety (SUFS) and/or Promoting Professional Accountability (PPA).

Of these:

- 4 DHBs have gone live with the PPA programme
- 2 DHBs are currently implementing and
- 3 DHBs will begin in 2019
- 1 DHB on hold until 2020
- 4 DHBs are considering and Dr Mark O'Brien, Medical Director from the Cognitive Institute is meeting with them in February 2019
- 4 DHBs to further engage later in 2019
- 2 DHBs have their own version or are not interested
- 1 private healthcare organisation will begin in 2019
- 1 private healthcare group considering for 2019.

Our industrial team has noticed that the incidence of complaints around unprofessional behaviour has been declining and, while there are a number of reasons for this, we believe that the Cognitive Institute programmes are making a difference. We encourage those DHBs that are holding back to make more haste to address the problems that have plagued health care employment for so long.

RESTORATIVE PRACTICE

Unfortunately, largely because of stress and the many pressures on staff in the DHB system, we will still see the occasional complaint due to behaviour that has caused offence (or very occasionally worse). We see the Cognitive Institute programmes as 'the fence at the top of the cliff' but having those programmes in place does not mean as yet that there is no need 'for the ambulance at the bottom'. And, although an ambulance is better than our previous experience in some cases where there was no ambulance but only a hearse for clearing away dead relationships and ruined careers, we do not believe that 'the ambulance' is good enough.

Time and time again we have said to HR people that punitive approaches to unprofessional behaviour do not work and, in most cases, actually make things worse. We are now strongly encouraging DHBs to look at restorative answers to the problem of relationship difficulties or breakdowns between staff. Where DHBs have trialed the restorative practice approach (given it was appropriate), it has been very successful. The opportunity for the parties concerned to discuss the root causes of the behaviour and to work out a way forward from the problem have brought about better relationships allowing everybody to 'move on'.

If you have a relationship issue at work, we strongly advise you to contact your ASMS industrial officer as soon as possible.

BUDGET 2019: WHAT CAN WE EXPECT FOR VOTE HEALTH?

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

Up until last year, successive years of estimated Vote Health funding shortfalls had accumulated to a funding gap of around $2 billion compared to spending levels in 2009/10. The 2018 Budget was the first in nearly a decade to end that trend, though it did little to begin the reversal. Since then district health boards have been clocking up deficits currently forecast at more than $370 million for the year to 30 June.

You cannot run down health funding by $2 billion dollars without consequences. Health Minister David Clark has said as much. The costs of those consequences have not only been seen in budget-induced barriers to accessing hospital services ('DHB capacity thresholds'), prolonged patient waiting times, inadequate preparation to meet the more complex needs of an aging population, increasing acute hospital admissions and high levels of hospital staff burnout, but also in falling staff salary levels relative to other sectors. Failure to address the social and economic determinants of ill health have exacerbated the impact of those consequences.

"You cannot run down health funding by $2 billion dollars without consequences."

In short, DHB budgets have been unable to cope with the rising costs of increasing demand and the cost of staff wage catch-ups. It appears a large portion of the latter has had to come from DHB operating budgets, contributing to their deficits.

ADDITIONAL BUDGET FACTORS

Two important additional budget factors this year will be how the Government responds to the much anticipated inquiry into mental health and addiction services, which has potentially huge funding implications, and the expectations that the much-touted 'wellbeing' focus of this budget will deliver something of substance.

The Government has already signalled its budget priorities will include funding for reducing child poverty and improving child wellbeing, including addressing family violence, and "supporting mental wellbeing for all New Zealanders, with a special focus on under 24-year-olds".

However, the cost of the mental health and addiction inquiry's recommendations, assuming most are adopted by the Government, will be substantial. The cost of one recommendation alone – that for extending DHB funding from the current 3% of the population estimated to need specialist services (based on overseas-sourced estimates from 1996) to 20% of the population with broader mental health and addiction needs – is likely to require hundreds of millions of dollars in additional annual spending. In Budget-speak, that would be multiplied by four over four years.

The Health Minister has repeatedly pointed out that addressing nine years of underfunding by the previous Government cannot be addressed in any single year. This was the refrain in 2018 and more of the same is likely in 2019. But such statements of the obvious are beside the point. It is more a question of what incremental steps to recovery are being planned. Is there in fact any intention to restoring health funding levels to those of a decade ago, as was indicated before the last election by those now in Government?

The Budget Policy Statement for 2019, published in December, indicates operating allowances (ie, a self-imposed cap on new spending across all of government) of $2.4 billion per year in Budgets 2019 to 2022. While this is higher than the previous Government's allowance, for Budget 2018 it was $2.85 billion, which was just enough to provide Vote Health with a small margin of funding over and above that needed to maintain current levels of service (though this appears to have been eroded by the costs of pay settlements).

STATUS QUO OR MORE?

Assuming the pattern of new spending across government is similar to last year's, unless there is an upward adjustment to the operating allowance, it appears unlikely that Vote Health will receive much more than a status quo in real terms. This will also need to include the ongoing costs of pay settlements and expected new spending for mental health and addiction services.

Current indicators for Vote Health 2019, then, suggest overall little relief from the pressures being experienced in most services. This is despite the Budget Policy Statement's assessment that: "The economy is growing at a solid rate and the outlook continues to be positive."

Treasury forecasts the Government's fiscal position to remain strong. As a percentage of GDP, core Crown expenses are expected to gradually fall from 29.5% of GDP in 2018/19 to 28.3% of GDP in 2022/23, well below the recent historical average of 30% of GDP. Net crown debt is forecast to drop to 17.4% of GDP by 2023, while surpluses are expected to reach $8.4 billion (2.3 % of GDP).

The Budget Policy Statement rationalises its austerity measures saying: "A strong fiscal position helps to maintain levels of wellbeing, giving future generations more options, and providing resilience to help manage economic change." Or as Finance Minister Grant Robertson puts it, it is about "making sure we've got the money aside for a rainy day".

The ASMS submission to the Expenditure and Finance Select Committee on the Budget Policy Statement argues that for many New Zealanders it is already raining, it has been for a long time, and it is costing the country socially and economically. (See **https://www.asms.org.nz/wp-content/uploads/2019/02/Submission-on-Budget-Policy-Statement_171333.2.pdf**).

"Current indicators for Vote Health 2019 suggest overall little relief from the pressures being experienced in most services."

SUCCESS STORY STILL A WORK IN PROGRESS

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Attention attracted by Canterbury DHB's work integrating primary and secondary care has its chief medical officer slightly nervous it could make the organisation seem smug.

"I'm slightly worried about being sold as a success story. Obviously we are, but there are always pros and cons and things that we're doing well, and things that we're not doing so well, and I don't want to upset the cynics," Sue Nightingale says.

More than a decade ago, the 2020 project was launched to stem rising demand for hospital beds and doctors.

"This has been an evolution over a decade or more and so it started with the DHB looking forward to how things were going to be in 2020; interesting we're almost there."

With the project aspiration date looming, it's worth acknowledging how far the DHB has come. Leaving behind what Dr Nightingale calls the blame game is perhaps its chief success.

Allowing time for face-to-face meetings between clinicians in different services has been a crucial element, and it remains a big challenge. It allows staff from different parts of the health system to share ideas and strategies for improving clinical pathways between secondary and primary care.

In some departments it's more difficult than others to find the time.

Naturally, doctors will prioritise patients over meetings, so it's important they have time to do both, she says.

But it's not for every doctor, either. Some prefer giving their non-clinical time to another pursuit, such as teaching, or simply devoting themselves to patients, she says.

"There is scope for people to opt out and take on extra clinical work [instead] but our challenge is when people will, we are able provide them with time. Even if they don't want to do it all, they are normally interested in something."

Respiratory medicine is a good example. Once very hospital-based, it is now less so due to initiatives like the linked care process between ambulances, community care, and hospitals for chronic obstructive pulmonary disease (COPD). A paper published in BMJ Respiratory Research in August 2018, entitled 'Reducing hospital admissions for COPD: perspectives following the Christchurch Earthquake', reported the measures introduced after the 2011 earthquake reduced bed-day occupancy for COPD by 48%.

Critical to its success was the "agreed messages" championed by a senior respected respiratory physician. "These messages were repeated in multiple education events and meetings both in the hospital and in the community."

"These were reinforced by clinical leaders from general practice, ambulance, ED and general physicians."

CDHB CMO Sue Nightingale

"I think sometimes people feel a little bit under threat, that they are not going to be needed or used. That's not going to happen, we've got so many more patients coming through, we need them desperately." CDHB CMO Sue Nightingale

"In this role your colleagues have to believe that you are trying to achieve the best outcome for your region's population, but that may mean some services don't get all the resources they would wish for." CDHB head of surgery Greg Robertson

The paper authors include CDHB respiratory physician Michael Epton.

Despite initial concerns from general practices about increased workload, the new measures were adopted with enthusiasm. Patients who had previously had little or no contact with their GP were seen more often. This enabled other interventions to happen, such as flu vaccinations and smoking cessation, leading to better overall care.

NOT BEING USURPED

With GPs doing more, hospital doctors might fear being usurped, but Dr Nightingale is adamant that's not the case.

"I think sometimes people feel a little bit under threat, that they are not going to be needed or used."

"That's not going to happen, we've got so many more patients coming through, we need them desperately."

Dr Nightingale says while GPs need to be funded for extra work it's important to de-emphasise the contractual side and find the right people to do the work. Once relationships are established, the money can follow. New Zealand is luckier in this regard than Britain's National Health Service, which has a heavily fragmented system of budgets. But our health system still incentivises providers in the wrong direction at times to worry too much about who will pay for what, she says.

The main thing is to focus on "outcomes rather than strict detail" and always ensure relationships are healthy.

"There's only so much GPs can do. We have to be mindful of the general practice workforce. There is only so much they can take on before they get completely saturated."

"We have to be thinking a bit more creatively about the primary care workforce as well."

While there has been criticism that placing more services in primary care loads cost on to patients through co-payment, she says that's not really the case.

This is because an appointment in primary care is likely to carry fewer associated costs, such as parking, travel, or time off work.

"At least with GPs all you pay is the straight appointment, not the auxiliary costs."

Also, primary care is the health home of the patient.

"They know the patients better. They know their history, their background, they probably know their family."

"They are in a much better position to actually know what's normal and what's not normal. The more that can be done in general practice is actually better care, and if you are able to save specialist care for those who need it, you can provide more of it," Dr Nightingale says.

INTERMEDIARY ROLE

Canterbury's head of surgery, Greg Robertson, a colorectal and general surgeon, sees his role as an intermediary between the many staff groups working within the DHB presenting a surgical view.

"I try to ensure each group understand the needs of the other, so all have a better chance of achieving a common objective".

That may be achieved by simply re-phrasing language, to make it more understandable for senior medical officers and likewise management, but at other times, be more challenging "if we are trying to achieve wider change".

Whenever such change is contemplated, there will be those who support it and others who may not, he says.

"As long as there is clarity about the objective, transparency and consistency around decision-making, with a patient-centric view, we can generally find a way forward," he says.

To be a successful clinical leader, doctors need to be credible to their peers.

"In this role your colleagues have to believe that you are trying to achieve the best outcome for your region's population, but that may mean some services don't get all the resources they would wish for."

Improving equity of access in Canterbury has been based around an agreed approach of allocating new resources to those specialties furthest from the national standardised intervention rates. He says this objective has been frustrated in some areas by a shortage of specialists, and in some specialties there are simply too few being trained, he says, citing orthopaedics as an example.

He feels pleased to work in a DHB whose management supports doctors and enables ready access to the chief executive.

ASMS COMMENT:

While acknowledging the benefits to patients of receiving care closer to home, it must also be acknowledged that the cost of primary care services (including 'auxiliary costs' such as taking time off work and transport, as well as user charges) is a significant access barrier for many.

While policy measures to reduce fees have lowered these barriers to some extent, mostly for children, New Zealand Health Surveys show one in seven adults report not visiting a GP due to cost. The self-evident solution, consistent with government policy intent for better access and equity in health care provision, is to lower or remove the remaining barriers.

In a recent *New Zealand Medical Journal* editorial, University of Otago academic health and business leaders consider it timely for a public debate on the question of whether primary care user charges have a place in a modern health system. We agree.

GPs ON STRIKE

LLOYD WOODS | ASMS SENIOR INDUSTRIAL OFFICER

ASMS members employed by Te Rūnanga o Toa Rangatira (aka Ora Toa) took extended strike action late last year and the start of this year in support of having their dental colleagues covered by the GP Collective Agreement.

Having GPs go on strike was a first for New Zealand but having them take five one hour 'mini strikes' followed by two separate full days of strike action was extraordinary. So, what was it all about?

Ora Toa runs five separate GP practices in areas of privation in Wellington. Four are around Porirua and one is near the Basin Reserve. Most patients are in the VCLA category and Ora Toa proudly (and rightly) notes that the health care provided is low cost and accessible predominantly to Māori, Pacific and vulnerable people.

In 2016 Ora Toa employed a dentist (later employing a second) as part of their vision of holistic affordable health care. ASMS, along with others, applauded this initiative that, although not receiving health funding, has given patients opportunities for oral health previously denied due to cost.

In the negotiations for the renegotiation of the GP Collective Agreement, the GPs noted that the two dentists were indeed part of a holistic health service and should be covered with them on one collective. The dentists had been employed on individual employment agreements to that point and these were/are not equitable with GP conditions.

To our surprise, the Ora Toa negotiators flatly refused to include the dentists and frustratingly could give no valid reason why beyond 'don't want to'. They did claim that as dentists were not publicly funded and since the collective had previously not covered dentists it was inappropriate to cover them. This explanation did not make sense.

ASMS members working in DHBs will no doubt fail to understand what the problem is given SMOs on the DHB MECA include dentists and has done from day one but these arguments fell on deaf ears.

Despite various endeavours by the ASMS team we could not change this stance in negotiations and took it back to our GP members. After much discussion and a ballot, they decided to take some limited industrial action (five one-hour strikes over five weeks) to show the management that they were serious. Despite mediation and further negotiation, the management stance remained.

Over the Christmas and New Year period these members took two further days of full strike action. This was stressful for them as they were very concerned for their patients, but they felt this was a matter of principle.

Eventually Ora Toa made a 'non-dentist' offer and a 'dentist covered offer'. The former was quite good, but the latter was ridiculous.

Part of every negotiation involves having a bargaining strategy and part of that is an exit strategy. A very wise negotiator (Maxine Gaye ex FIRST Union) used to say that "negotiations are like boxing – there is a time to box and a time to dance" and given that the strike action had not delivered the knockout the ASMS team, in consultation with the dentist and GP members, decided it was 'time to dance'.

After further discussions Ora Toa presented an offer that the team decided would be good enough to present to members without dentist coverage. This was on the condition (agreed) that a collective agreement for the two dentists would be separately negotiated.

The document was eventually ratified and signed.

Our members are to be commended for standing up for their dental colleagues. While we did not achieve our initial aim, the deal we achieved was still a good one, and the fight for a single collective covering both doctors and dentists is not yet over. This is just the end of round one!

VITAL STATISTICS

Average increase in the number of mental health and addiction clients seen by DHBs in the five years to 2016: 5400 per year

Increase in the number of DHB-employed FTE psychiatrists in 2018: 1.7 (from 436.2 in 2017 to 437.9 in 2018)

Proportion of psychiatrists practising in New Zealand who are International Medical Graduates (IMGs): 59%

Number of IMG psychiatrists who became vocationally registered in New Zealand between 2007 and 2013: 172

Number of those no longer practising in New Zealand in 2018: 64 (37%)

Proportion of DHB psychiatrists aged 60 and over in 2018: 27%

Proportion of DHB psychiatrists aged 55 and over in 2018: 45%

SOURCES:

Ministry of Health: Mental Health and Addiction service Use Series 2011/12 to 2015/16.

Te Pou o te Whakaaro Nui: DHB mental health and addiction employees: 2018 profile. *Auckland, 2018. (Employees with mental health and addiction Primary Area of Work [PAOW] codes.)*

MCNZ: Medical Workforce Survey 2016 (published 2018).

Ministry of Health: unpublished data on medical specialist workforce retention rates, 2018.

RECOGNITION FOR ASMS RESEARCH

Ground-breaking ASMS research into bullying in New Zealand's SMO workforce has been recognised.

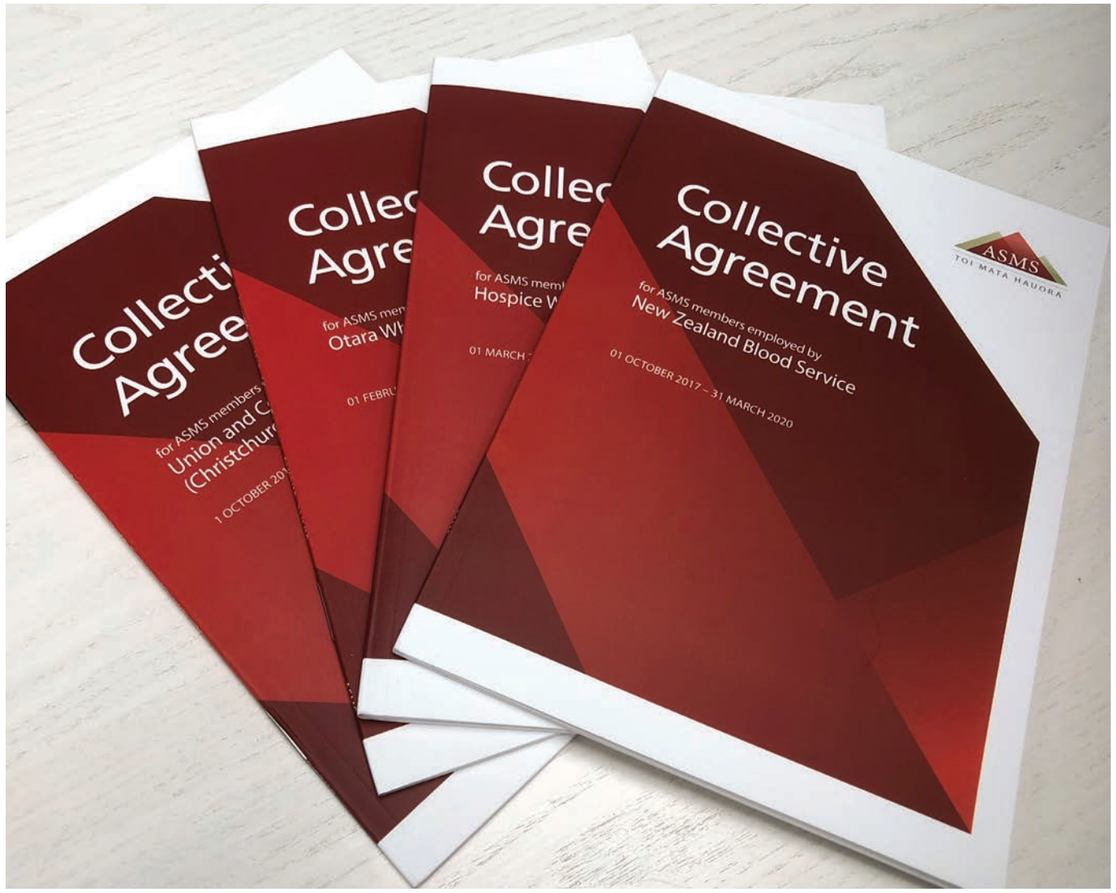
A paper by ASMS Principal Analyst Dr Charlotte Chambers, ASMS National President Professor Murray Barclay and Professor Chris Frampton from the University of Otago has won the LEW 2018 Conference *Labour and Industry: a journal of the social and economic relations at work* Best Paper prize.

The paper, *Bullying in the New Zealand senior medical workforce: prevalence, correlates and consequences*, reports on research conducted by Dr Chambers and was presented at the conference on Labour, Employment and Work (LEW 2018) in November last year.
The full findings from this research are available on the ASMS website at **https://www.asms.org.nz/wp-content/uploads/2017/11/ASMS-Health-Dialogue-Bullying-WEB.pdf**.

The conference panel said: "This is a well-crafted paper which focuses on an important work-related issue. The use and mix of data is a strength of the paper. The findings offer both academic and practical implications."

This is the second time running that the ASMS team has won the Best Paper award. Dr Chambers also won the biannual LEW prize in 2016 for her presentation and paper on burnout.

Dr Chambers with her previous award



ASMS MEMBERSHIP IS WIDER THAN DHBS

LLOYD WOODS | ASMS SENIOR INDUSTRIAL OFFICER

Although ASMS is best known for our work in the DHBs, with 90% membership density and wide involvement both around professional and industrial matters, we are also very active in the non-DHB sector.

Although only a small percentage of total membership (approximately 6%), our non-DHB membership is very important to us as we attempt to promulgate good working conditions and widen union membership across the country.

We have 17 collective employment agreements (CEAs) covering non-DHB members, including at New Zealand Family Planning, ACC, a New Zealand-wide multi-employer collective for hospices, four (shortly to be five) rural hospitals, five Union Health Centres, COMPASS Health, Ashburn House, Golden Bay and three Iwi Providers.

Membership is around 250, with 222 covered on their own collective agreements.

ASMS has a long-term strategy to unionise a great many more doctors and dentists employed in the primary sector.

We welcome applications for membership (easily done through our website at **www.asms.org.nz**) and we are more than happy to have a chat if more information is required. Our aim is to negotiate collective agreements wherever possible (given suitable numbers of members employed by the same employer) and, like our other members, salaried GPs who belong to ASMS benefit from our advice, representation and advocacy on issues important to their work.

REMOVAL OF PATHOLOGISTS FROM THE LONG-TERM SKILL SHORTAGE LIST

Last September ASMS wrote to the Minister for Economic Development, David Parker, requesting his intervention in the decision by the Ministry of Business, Innovation and Employment (MBIE) to remove pathology from the Long-Term Skill Shortage List. (See *The Specialist*, October 2018, p17-18, **https://www.asms.org.nz/wp-content/uploads/2018/10/12089-The-Specialist-Issue-116-WEB.pdf**).

The removal of pathology from this list is a mistake and will not only add further pressures to a workforce already under stress but could also impact on a wide range of other health services dependent on an effective pathology service.

We explained pathology is one of Health Workforce New Zealand's top four 'hard-to-staff specialties', and that MBIE's rationale for pathology's removal – that the number of work visas granted to pathologists 'fails the scale criteria' of at least 50 per year – is an absurdity as, even combining all the branches of pathology in New Zealand, there will never be 50 visa applicants per year.

Since then Mr Parker responded, saying he had passed the matter to his colleague, Immigration Minister Iain Lees-Galloway. Mr Lees-Galloway in turn duly responded in November 2018, which we found perplexing as it did not address any of the concerns raised in the letter but merely repeated some of the information included in it.

We sought a more considered explanation for MBIE's decision in a second letter to Mr Lees-Galloway in December. We are still awaiting a response.

CHANGES TO AREAS COVERED BY ASMS INDUSTRIAL OFFICERS

ASMS has rearranged the areas covered by our industrial officers to reflect our continuing membership growth. As a result, you might find you have a new industrial officer. If you have any questions about an aspect of your employment, please contact your ASMS industrial officer on 04 499 1271 or via email as below:

SARAH DALTON, INDUSTRIAL OFFICER
sd@asms.nz
Northland, Waitemata, Auckland

STEVE HURRING, INDUSTRIAL OFFICER
sh@asms.nz
Counties Manukau, Waikato, Bay of Plenty

PHIL DYHRBERG, INDUSTRIAL OFFICER
pd@asms.nz
Lakes, Hawke's Bay, Tairawhiti, Taranaki

IAN WEIR-SMITH, INDUSTRIAL OFFICER
iws@asms.nz
Whanganui, MidCentral, Wairarapa, Hutt Valley, Capital & Coast

LLOYD WOODS, SENIOR INDUSTRIAL OFFICER
lw@asms.nz
Nelson Marlborough, West Coast

DIANNE VOGEL, INDUSTRIAL OFFICER
dv@asms.nz
Canterbury, South Canterbury, Southern

HISTORIC MOMENTS

EACH ISSUE OF *THE SPECIALIST* WILL FEATURE A PHOTOGRAPH OR DOCUMENT FROM THE ASMS ARCHIVES. YOU CAN FIND MORE SLICES OF HISTORY ON THE ASMS WEBSITE (**WWW.ASMS.NZ**) UNDER 'ABOUT US'.

Editorial

Trouble in the Hospital Specialist Service

The hospital specialist service is maintained under increasing duress. In New Zealand, as elsewhere, specialists both part- and whole-time play an essential part in the hospitals; without them the complex mechanism of modern patient care would be unworkable, and hospitals must cease to function. Yet specialists as a group are today discouraged as never before. They are unhappy about their present working conditions and pessimistic about the chances of improving them. Especially, they are worried about their relations with the Health Department which holds absolute powers over the specialist service, yet which to many appears unaware of the needs of modern hospital medicine, indifferent to efforts to improve standards, and above all unapproachable to its own agents. The result of these doubts and frustrations can already be seen in continued specialist losses overseas and into non-hospital practice, and in failure to fill advertised specialist posts. The future is forecast in restrained language in the recent official Report of the Special Committee on the Availability and Distribution of Medical Practitioners (the A. & D. Committee):

> "If no radical change takes place, the outlook for specialist practice is not encouraging. Time can only bring an exaggeration of the present unsatisfactory position regarding service in public hospitals, the economic difficulties of many specialists, the shortage of specialists in some fields . . . and the problems of those who desire to practise as pure consultants."

Many of the problems facing specialists (or consultants) are well expressed in the A. & D. Report:

> "To become a consultant in any field of medicine demands a long and arduous training, and at very considerable expense. Once established the consultant must keep himself up to date in his specialty. It is not sufficient for him to have knowledge of new developments in the technique of diagnosis and treatment, he must also gain experience in applying them himself. He needs time for reading, for research, and for preparing contributions to scientific meetings. He should assist in the postgraduate training of other doctors. He must be able to go abroad from time to time in order to make contact with those in the forefront of his specialty in other countries."

Let us see how these needs are catered for in New Zealand.

Financial Rewards.—The long and expensive training of specialists, much of it still overseas, the consequent delay of ten or more years in their attaining full professional earning power, and their continuing need to remain up-to-date, make necessary a relatively high rate of remuneration as soon as full specialist status is achieved. At this point in his career, a specialist should be assured of adequate prospects of advancement. Yet the Government Statistician's Reports on Incomes show that specialists' earnings compare unfavourably with those of other groups in the medical profession, and advancement in the hospital service is unpredictable. The position of part-time specialists is particularly difficult. It can hardly be denied that hospital specialists, as a group, are the economically depressed class of New Zealand medicine. If to the overall inadequacy of the salary scales is added the frustration of a personal grading system which imposes successive and arbitrary bars to promotion and, as shown in these columns by Dr D. T. Stewart, makes it impossible for many applicants for specialist positions to forecast their incomes before they are appointed; if it is further recalled that both Australia and England, to take only two examples of other countries, offer very much higher incomes to specialists while living costs are comparable to those in New Zealand, then it is not surprising to learn, as emerged from a recent survey, that at least one in every four full-time specialists left the hospital service in the past five years, and that as many as 70 per cent of those remaining have considered or are considering whether to follow their late colleagues' example. Nor is it likely that present conditions will attract back to this country those of our best young doctors who have gone overseas to complete their specialist training.

Working Conditions.—The New Zealand specialist tends to be overworked as well as underpaid. For years, all classes of hospital work have been expanding much more rapidly than the medical staff attempting to deal with them. The Annual Report of the Health Department for 1960 shows for instance that in-patients in New Zealand hospitals increased by 5% and out-patient attendances by 2%. There were 8% more diagnostic X-rays taken and 14% more laboratory tests done. In the same year the number of general physicians in public hospitals rose by 1.7%, of general surgeons by 2%,

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of radiologists by 2.2% and of pathologists by 3% (all whole-time plus part-time converted to whole-time equivalents). The chronic shortage of junior medical staff forces specialists to do much of the work of those in training as well as their own. It is well recognised that many part-time specialists spend far more time doing hospital work than that for which they are paid; no less is true of whole-time specialists. Where, in this hurly-burly, is there time for reading, for research, and for those other activities which the A. & D. Report, in common with informed opinion the world over, regards as essential in the lives of specialists? Where, for that matter, is there any sign that those in control of the service appreciate these needs?

Research, under the present regime, is sorely restricted in the hospitals, because the Hospitals' Act is interpreted as not empowering Boards to spend any money on *medical* research, although they may contribute annually to the funds of the Research Institute of Launderers, Dry Cleaners and Dyers of New Zealand.

Specialists, to keep up with progress in their subjects, must buy books and instruments, borrow from libraries, join scientific societies and travel to conferences. The costs rise proportionately to the specialist's activity in his field, and proportionately also the specialist is penalised for his enthusiasm because support is inadequate.

Provision for overseas study leave is grossly inadequate in a country whose geographic isolation entails a constant risk of professional men becoming cut off from the main stream of international progress.

Clearly there is a crying need for reforms in working conditions which an increasing proportion of hospital specialists are finding intolerable. Salary scales must be made competitive, gradings must be rationalised and terms of employment made more liberal. If a crisis is to be avoided in the specialist service, the process of reform must begin now. The momentous question—and this is by far the most serious aspect of the present dilemma—is how, and by whom the reforms are to be initiated and carried out. There is no mechanism by which specialists as a body can officially approach their employers and negotiate about their working conditions. Salaries and terms of employment are laid down by Regulation. Specialists, through the British Medical Association, may make representations to a Salaries Advisory Committee. This meets at irregular intervals, deliberates in secret, and makes secret recommendations to the Minister. The Minister eventually comes to decisions for which no reasons are given. The whole process is slow and dilatory, as much as a year having sometimes gone by between the submissions and the Minister's final decision. Specialists find themselves in a supplicant attitude with few direct means of influencing those policies which will inevitably become of vital importance to their well-being.

Although there may be historic reasons for its creation, it is difficult to see how such an archaic system of unilateral dictation has survived in a country which prides itself on its advanced industrial and social relationships. Part of the fault undoubtedly lay with the specialists themselves who until recently, though profoundly dissatisfied with their lot, were unable and indeed often unwilling to analyse the reasons for their difficulties or to propose agreed alternatives to an obnoxious system. Part, too, lay with the profession as a whole. There has for too long been a failure to realise that its different branches have separate and distinctive problems which demand particular solutions; but also that these branches are complementary and interdependent, and hence that all will suffer if one group or another is dissatisfied. Lack of clear thinking on these matters has at times produced ambiguous and uncertain policies. The present Minister of Health himself has more than once deplored the fact that doctors cannot speak plainly and with one voice.

Perhaps the only hopeful sign in a clouded situation is the formation, during the past year, of a strong Central Specialists Committee of the Association in which, with the encouragement of their general practitioner colleagues, hospital and other specialists have at last become united. Simultaneously the three Royal Colleges have formed their own Conjoint Committee, and the two specialist committees have agreed to work together in the closest liaison for the betterment of conditions throughout New Zealand. For the first time, therefore, specialists can speak with a single clear voice. The committees are now at work on proposals for new and better relationships between the profession and its employers. It is of the utmost importance that these proposals, when presented to the authorities, should meet a sympathetic reception, and that a mechanism be found by which satisfactory working terms can be freely negotiated. The future of the hospital specialist service is in jeopardy if a solution to this problem is not soon discovered. With deterioration in present standards of hospital care, it is the patient who suffers. The responsibility of preventing this rests with the State.

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Clause 23 of the DHB MECA provides for annual leave on full pay – not the averaging formula used in the Holidays Act: **https://www.asms.org.nz/clause-23/**

This carries over to Clause 28 of the MECA that also entitles you, after parental leave, to return to the same or a similar position you held prior to the leave: **https://www.asms.org.nz/clause-28/**

... THAT MĀORI SMOS CAN JOIN TE OHU RATA O AOTEAROA (THE MĀORI MEDICAL PRACTITIONERS ASSOCIATION) THROUGH **TEORA@TEORA.MAORI.NZ** AND PASIFIKA SMOS CAN JOIN THE PASIFIKA MEDICAL ASSOCIATION (**PACIFICHEALTH.ORG.NZ**).

Both organisations are active across the wider health sector and we encourage members eligible to join to do so. We consider these as professional associations relevant to SMOs duties and responsibilities as per clause 21.2(f) of the MECA (Work Related Expenses).

THE THEORY OF MEDICINE OR HEALING DEFENCE – DOES IT REALLY ACHIEVE WHAT IT SET OUT TO DO?

DR ANDREW STACEY | MEDICAL ADVISER, MEDICAL PROTECTION

In September 2004 the Health Practitioners Competence Assurance Act 2003 (HPCAA) came into force. This provided mechanisms for the registration, assessment and discipline of registered New Zealand health practitioners. A single tribunal, the Health Practitioners Disciplinary Tribunal (HPDT), was created to hear and determine disciplinary charges brought by the Director of Proceedings - an independent prosecutor - or Professional Conduct Committee (PCC), a Medical Council sub-committee investigating concerns about conduct.

GROUNDS FOR DISCIPLINE

Section 100(1) of the HPCAA sets out the grounds on which the HPDT may make a disciplinary finding against a practitioner and which invoke the HPDT's power to order penalties. These include:

- professional misconduct – amounting to either malpractice or negligence, or bringing discredit to the profession
- conviction of an offence reflecting adversely on fitness to practice
- practising without holding a current practising certificate
- practising outside, or failing to observe any conditions placed on, the practitioner's scope of practice
- breaching an order of the HPDT.

THEORY OF MEDICINE OR HEALING DEFENCE

The 'theory of medicine' defence was enacted to provide room for minority views and honest differences of opinion. There are equivalent provisions in the precursor legislation to the HPCAA dating back to 1924, which appear to have been based on English legislation of the mid-1800s. Interestingly, the defence was

"The 'theory of medicine' defence was enacted to provide room for minority views and honest differences of opinion."

"Practitioners seeking to take advantage of this defence must have regard to the basic principles of medical science."

dropped from the English legislation in the mid-1900s.

The defence can be currently found in Section 100(4) of the HPCAA which states:

> "No person may be found guilty of a disciplinary offence under this Part merely because that person has adopted and practised any theory of medicine or healing if, in doing so, the person has acted honestly and in good faith."

Thus if the grounds for the defence are made out, it is a complete defence to any of the disciplinary offences mentioned above. The defence has been only raised in a small handful of cases, and no health practitioner in this country has yet been successful in invoking it.

THE BETACLOM CASE

The defence was recently raised in the betaclom case. This was a case in which the PCC laid charges in the HPDT with respect to a general practitioner who was treating eczema sufferers with betaclom, a mix of a topical steroid (betamethasone valerate 0.1%) and an anti-fungal (clomazol 1%). The HPDT was concerned about the quantities and potency of the betaclom prescribed, particularly to infants and children and those with contraindications, and considered this to be professional misconduct under Section 100(1) of the HPCAA.

With regards to the 'theory of medicine' defence, the HPDT felt that the combined product, betaclom, was nothing more than a mixture of two other well-known medicines. The fact that the GP used them in combination did not create a theory of medicine.

The HPDT's decision was appealed to the High Court where it was argued that the HPDT had placed an overly restrictive interpretation on s100(4) and had failed to explain why compounding medicines could not be regarded as a theory of medicine or healing, and thus coming within the defence.

In the High Court, the Judge felt that it was not clear what the GP's theory of medicine was. His Honour commented that it seemed to him that:

> "...to the extent he had one, [the GP's] theory of medicine or healing was that betaclom was effective and the concentration of betamethasone valerate 0.1% in betaclom was reduced because it had been diluted with the clomazol."

His Honour disagreed with the HPDT and found that using a compound of available drugs could be considered a theory of medicine or healing. However, the GP also needed to have acted honestly and in good faith to take advantage of the defence, and his Honour did not find this to have been the case. While the GP had honestly believed that betaclom was an effective treatment for eczema, this was not sufficient. It was considered relevant that the GP:

- had never tested the potency of betaclom. His assumption as to dilution was based on his common-sense deduction and there was no scientific proof for his view
- did not consult with appropriate and suitability qualified specialists about his deduction regarding dilution
- was aware of published warnings and contraindications for the use of betamethasone valerate but preferred his assumption as to dilution over these
- had researched eczema treatment but acknowledged he had 'failed' to review the available literature which demonstrated that the potency of topical corticosteroids is not reduced by dilution and is advised against. His Honour felt that review of this literature was critical to the safety of the betaclom that the GP was prescribing
- accepted that betaclom was his 'one size fits all' approach for skin conditions; regardless of each individual patient's clinical presentation
- had a casual approach to identifying side effects
- did not reassess his prescribing practice following concerns raised by fellow health practitioners
- paid little or no regard to those parts of datasheets and guidelines which discuss accepted medical practice in prescribing topical corticosteroids and unapproved medicines
- did not keep proper records
- did not consult with others, even when he knew that patients were under the care of specialists.

When all of these matters were taken into account, his Honour found that the GP did not act honestly and in good faith when he prescribed betaclom.

Two other practitioners had given evidence in the HPDT that they used betaclom and it was argued that the HPDT did not give sufficient weight to the evidence suggesting that betaclom was used by other practitioners. His Honour opined that:

> "The theory of medicine defence is not properly available where the theory espoused is the idiosyncratic view of a single practitioner, and I do not consider that the small number of practitioners who have prescribed betaclom on occasion elevates [the GP's] views as to the efficacy of betaclom and the dilution of betamethasone valerate by clomazol into views which are supported by a significant number of general practitioners."

In conclusion, his Honour found that there was no sound body of medical opinion that supported the use of betamethasone valerate in the way in which it was prescribed by the GP, and that this was not in conformity with accepted medical practice at the relevant times.

CURRENT STATE OF PLAY

The betaclom case reaffirms previous decisions. An honest belief in the effectiveness or benefits of a theory of medicine is not enough; the HPDT will undertake an objective assessment of the practitioner's actions, theory or practice and measure them against expected professional standards.

Practitioners seeking to take advantage of this defence must have regard to the basic principles of medical science; they cannot totally disregard that knowledge.

While it may have been intended that the defence would provide room for minority views, a clear distinction has been recognised between the idiosyncratic view of a single practitioner, unsupported by scientific proof or by a significant number of the practitioner's colleagues, and the adoption and practise of a theory of medicine. The defence will not protect the idiosyncratic view of a single practitioner in such circumstances.

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- 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 (MECA) covering employment of senior medical and dental staff in DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

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How to contact the ASMS

Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
36 Brandon St, Wellington

Postal address: PO Box 10763,
The Terrace, Wellington 6143

P 04 499 1271
F 04 499 4500
E asms@asms.nz
W www.asms.nz
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ASMS STAFF

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PO Box 10763, The Terrace
Wellington 6143, New Zealand
+64 4 499 1271 **asms@asms.nz**

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