ISSN 2324-2787

JUNE 2013 | ISSUE 95

The Specialist

The newsletter of the Association of Salaried Medical Specialists

# The impact of changing demographics on the specialist workforce

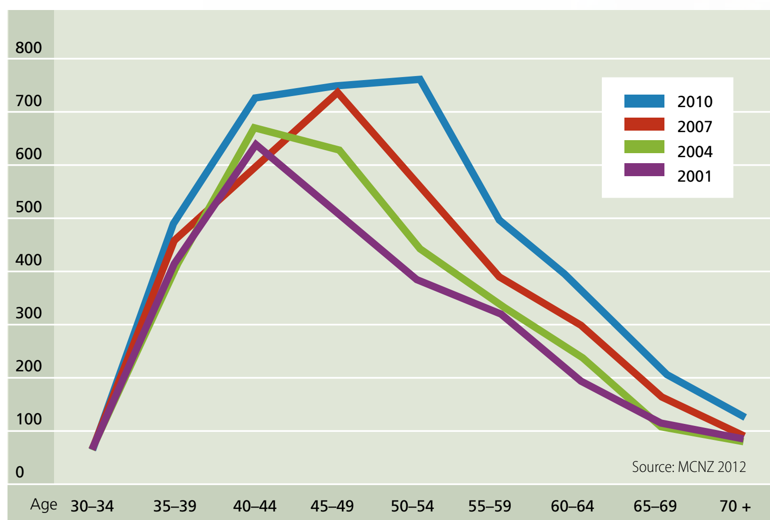
The ageing of the specialist workforce, the increasing proportion of female specialists, and the growing desire for better work-life balance across all generations will together add significant pressure on district health boards to improve recruitment and retention over the coming years.

The ageing of the specialist workforce is illustrated in Figure 1, showing how the largest group of doctors has shifted from the 40–44 age group in 2001 to the 50–54 age group in 2010. Each year there is a sharp drop-off in numbers for those groups above the peak age group. As the peak age group becomes older, the drop-off becomes more severe.

*On recent trends approximately 19% of the workforce is likely to be lost over the next five years from the effects of the drop-off of specialists from age 55.*

On recent trends approximately 19% of the workforce is likely to be lost over the next five years from the effects of the drop-off of specialists from age 55. When the Senior Medical Officer Commission examined these trends in 2009 it commented that owing to the lack of data "it is difficult to interpret what this means. It seems likely to reflect a loss of SMOs to the system through early retirement and emigration".

**FIGURE 1:** NUMBER OF SPECIALISTS BY AGE GROUP




## Reduced hours and worsening shortages

According to Medical Council data, the ageing of the workforce has a further impact: Of the older specialists who remain in practise many tend to reduce their work hours. In 2010, 17.6% of specialists were aged 60-plus and 37% of them worked less than 40 hours per week, including 22% of those aged 60–64 and 46% of those aged 65–69 (Figure 2). Over the next five years, despite the losses from early retirement, the proportion of specialists aged 60-plus is likely to increase to more than 20% of the workforce, based on current trends.

The loss of a greater number of specialists as they approach retirement age, combined with the trend for the remaining older specialists to reduce their work hours,

*the proportion of specialists aged 60-plus is likely to increase to more than 20% of the workforce, based on current trends.*

ASMS

Executive Director
**Ian Powell**

Assistant Executive Director
**Angela Belich**

Senior Industrial Officer
**Henry Stubbs**

Industrial Officer
**Lyn Hughes**

Industrial Officer
**Lloyd Woods**

Industrial Officer
**Steve Hurring**

Executive Officer
**Yvonne Desmond**

Membership Support Officer
**Kathy Eaden**

Admin Officer
**Terry Creighton**

Admin Assistant
**Ebony Lamb**

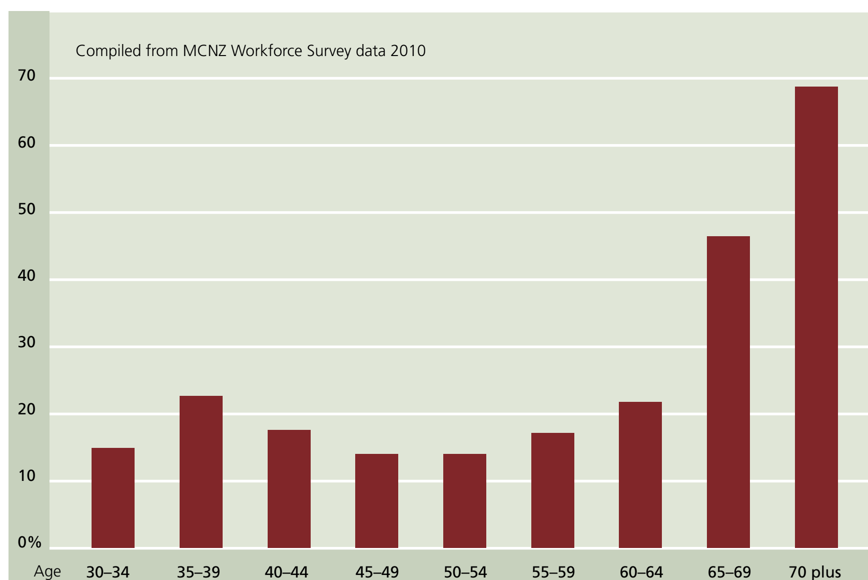
Researcher
**Lyndon Keene**

Level 11
Bayleys Building
Cnr Brandon St &
Lambton Quay
PO Box 10763
Wellington
New Zealand

Ph 04 499 1271

www.asms.org.nz

**FIGURE 2:** PROPORTION OF SPECIALISTS PER AGE GROUP WORKING LESS THAN 40 HOURS PER WEEK AS AT 2010




will require a concerted effort from DHBs to avoid worsening shortages at a time when service demand grows.

As a 2011 Ministry of Social Development report, *The Business of Ageing*, put it, "As baby boomers begin to reach 65 … sectors [including health and education] will need to find ways of retaining workers and/or attracting new workers. Health is one area where future workforce planning is critical. In addition to the ageing of the current health workforce, a proportionately larger older population will increase demand for health care and services."

## Gender, generation and work-life balance

The increasing number of women in the workforce is another key factor. In 2011 women comprised 27% of the specialist workforce, compared with 19% in 2000 and 13% in 1990. Gender statistics for practising registrars indicate the proportion of female specialists will continue to increase. In 2011 52% of registrars were women.

Women outnumbered men in vocational training for: emergency medicine (51%), obstetrics and gynaecology (73%), paediatrics (69%), pathology (64%), public health medicine (68%), palliative medicine (71%), rehabilitation medicine (75%), rural hospital medicine (67%) and sexual health medicine (83%).

*Because women tend to work fewer hours than men, the working life contribution for female medical practitioners, when measured in total time worked, is estimated at about 80% of that of a male medical practitioner.*

Because women tend to work fewer hours than men, the working life contribution for female medical practitioners, when measured in total time worked, is estimated at about 80% of that of a male medical practitioner. This must be taken into account in projected workforce requirements.

Furthermore, there is evidence suggesting growing interest in work-life balance for both male and female doctors. The Health Workforce Advisory Committee observed in 2005 that lifestyle and work-life balance aspirations are changing throughout all working populations. "These new aspirations may be more characteristic of generation than gender."

The same observation was made in a 2004 report on the public hospital medical workforce by the Australian Medical Workforce Advisory Committee: "Twenty eight hospitals (out of thirty four) identified that newer generations of doctors differed from previous ones in their emphasis on family and lifestyle issues, and that this affected recruitment and retention."

*These new aspirations may be more characteristic of generation than gender*

Of the specialists in New Zealand working less than 40 hours per week in 2001, approximately 40% were under the age of 50; by 2010 that proportion had increased to 44%.

Health Workforce New Zealand's Executive Chair, Professor Des Gorman, acknowledged in an *NZMJ* editorial in 2011 that the medical workforce was becoming "increasingly feminised and part-time", adding: "the key issues that are germane to the number of doctors in our workforce are recruitment, migration and retirement, and all three require address".

Two years on, there is little indication as to how this might happen.

**Ian Powell**
*Executive Director*

PRESIDENT'S COLUMN

# My background and initial thoughts

On 1 April 2013 I became the National President of the ASMS. The decision to stand for president was not one that I made lightly. It was a decision that would also impact on my family, friends and colleagues. I had to ask myself if I have what it takes. The problem is, you do not really know what it takes; the position does not come with a job description.

I was privileged to see Jeff Brown in action during my years on the Executive but then, I am not Jeff Brown. I will have to find my own way and do my own thing but at the same time this is not a "job" I will be doing unsupported. The ASMS has a strong membership, a fantastic and supportive Executive and national office staff, dedicated and professional Industrial Officers and an Executive Director that is second to none. We have recently also appointed a researcher. In short, the ASMS has become a mature organisation with significant ability and influence with a strong will to improve health care in New Zealand.

After a lot of thinking I consulted with my family, friends and colleagues (my four fellow paediatricians kindly agreed to take up the "slack" that my absences away from Gisborne might generate). I am proud to be part of the New Zealand health care system and what better way to influence its future than being part of the ASMS and taking on the challenge of the Presidency. I made my decision.

I was born in South Africa. I studied at the University of Pretoria and specialised in Paediatrics at the University of Stellenbosch, Cape Town. I have lived and worked in four different countries and participated in their health care systems. My first consultant position was in Newfoundland, Canada where I worked for two years after which we moved to the UK where I worked as a consultant for the next eight years. My family and I decided it was time to get back to the sunny southern hemisphere and get our work-life balance sorted (yeah right!). We moved to Gisborne in 2004 and this is where we still work and live.

## Interesting times

"May you live in interesting times" is a well know Chinese curse. What is less well known is the fact that this is only level one as far as Chinese curses go. Level two is "May the government be aware of you" and level three follows with "May you find what you are looking for".

The government is well aware of the ASMS and it is just a matter of time before they realise I exist. Doubly cursed then because we do live in interesting times.

We have an information age, running alongside a technological age. We have global warming to contend with thanks to the leftovers from the industrial age. A bit closer to our individual homes, the affordability of health care is spiralling out of control, not just in NZ, but across the world.

The nature of health care has also changed quite dramatically over the past 25 years or so. Twenty five years ago I would guess (sorry, before the information age) 70 to 80 percent of our work consisted of dealing with acute medical conditions. We dealt with severe gastro-enteritis, pneumonia, sepsis, measles, meningitis, acute injuries and surgical conditions etc. and went home after a hard day's work knowing that what we did that day saved lives. We were providing *acute* health care. Today we know that an ever increasing percentage of our practice consists of disease management. These are diseases brought on by lifestyle changes, choices and advanced age; obesity, stroke, diabetes, cancer, dementia, to name but a few.

The burden of chronic disease management and an aging population are putting increasing pressure on the system. We are given targets to meet and we are being told on a near daily basis that what we are doing is no longer financially sustainable.

Unfortunately financial sustainability is not a problem that you or I can shrug our shoulders at and say: "I will be retired by the time this becomes a crisis" and leave it for the next generation to sort out. We have long gone past the point where double-sided printing will save our current system. We need new thinking, wisdom and solutions.

## The Information Age

This brings me back to the information age and Arthur C. Clark. He was a British science fiction writer, inventor, and futurist. *2001: A Space Odyssey* was perhaps his best known work. In 1945, he envisaged a satellite global communication system and in 1963, his idea won him the Franklin Institute's Stuart Ballantine Medal. He also commented on the Information Age and said that it is vital to remember that data is information not knowledge. Knowledge is not wisdom and wisdom is not foresight.

We are bombarded on a daily basis with health care data. We spend time and effort collecting data. We should not make the mistake of responding to, or planning on the basis of information alone. We need knowledge, wisdom and foresight. We need frontline clinical leaders and clinicians to interpret and translate data into knowledge. With increasing knowledge we can develop wisdom and obtain the insight to plan the future shape of our healthcare system.

The ASMS has been lobbying and working hard to get clinical leadership established. Four years have passed since *In Good Hands* was tabled. A lot of progress has been made since then, but with the ever increasing reality of financial pressure we run the real risk of returning to the age of managerialism. There is overwhelming evidence that a clinician-management partnership is the solution to a safer, higher quality, more efficient and financially sustainable health care system. My plea is for us to continue on the path of clinical leadership, to continue to invest in it by giving clinical leaders and clinicians the time that is needed to truly contribute to the partnership.

ASMS researcher, Lyndon Keene has produced some fantastic work since taking up his position, debuting with *The Public*

*Hospital Specialist Workforce: Entrenched shortages or workforce investment*? It is disappointing and disheartening to hear the Minister of Health dismiss such a publication, which was based on research and knowledge, as an ASMS attempt to enhance its position during MECA negotiations. His subsequent article in the March *Specialist*, "The flight of the IMGs", continues to add to our knowledge and the conclusion must be taken seriously and heeded.

The ASMS's MECA is an important and hard fought, living document, but the ASMS is so much more than a MECA or a salary scale.

I believe the ASMS is, and will be part of the solution. The challenge we face requires a team effort. The ASMS and its nearly 4000 members can turn information into knowledge and in collaboration with other health care providers we can develop a better and sustainable health care system for all New Zealanders.

The ASMS and our members will continue to work hard for better health care in New Zealand. Toi Mata Hauora.

**Hein Stander**
*President*

# Tribute, and thanks, to Jeff Brown

*By David Jones, former ASMS Vice President*

When, in 2003, then ASMS National President David Galler asked me to stand for the National Executive again after a two year absence I did not take much persuasion as being part of the Executive is such good fun and the information flow is a buzz. What I did not appreciate at the time was that I was part of David's cunning succession plan in advance of his (unknown to others) imminent departure to work for then Minister of Health Annette King.

When the new Executive assembled and I met everyone, it took me very little time (no more than half a day) to see that the successor to the resigning President was already there for everyone to see, complete with flamboyant shirt on his back and leadership written all over his forehead. He did not disappoint, and in the six years I served as ASMS Vice President in support of Jeff, my appreciation of his qualities only grew.

As Committee Chair he demonstrated the knack of knowing when to let discussion flow and when to call a halt and crystallise the decision. This is quite an art with a committee of people who have strong views and flowing tongues. When visitors, whether friends or foe, attend our meeting, he was always courteous, guiding discussion fairly and constructively and with discretion.

His work ethic has been exemplary, displaying good efficiency and productivity as well as notching up the hours.

He developed impressive mastery of what was happening around the country in the Health Sector and amongst the membership. Most importantly - vital for an organisation like ours - he has not been afraid to take himself and the association along paths that others perhaps may be hesitant to pursue. That's what leaders are for.

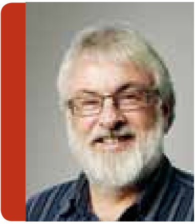
A few "non-core" points need to be acknowledged, too.

Jeff's a fairly serious bloke but always displayed a decent amount of humour. His jokes at the Annual Conference cocktail party usually struck a good note and sometimes got the delegates rocking.

His poetry he takes more seriously than almost anything else in his life, I think. Full marks to him for weaving that literary form into articles he has written in ASMS publications and the speeches given at Conference and Exec meetings throughout his tenure.

The sartorial idiosyncrasies have been uplifting for most, challenging for some, offensive to none. Long may the shirts continue, even if they do not necessarily become enshrined in the Presidential job description.

I have had the privilege to serve on the Executive with numerous fine people and several excellent presidents. Jeff Brown is up there with the best of them.



EXECUTIVE DIRECTOR'S COLUMN

# Was Winston Churchill wrong?

In recent years from time to time I've adapted one of Winston Churchill's famous sayings to the New Zealand health system. He once said that the Americans always make the right decision but only after they have exhausted all other options.

My adaptation was that the same can be said for our public health system. Paraphrasing, I've commented that first our health leaders tried managerialism (late 1980s), then they tried commercial competition plus managerialism (1990s), then they tried cooperation with the residual of managerialism (early to mid-2000s), and then they tried clinical leadership.

## Emerging policy parameter

The first official promotion of clinical leadership came with former Health Minister Annette King who used her annual 'Letters of Expectations' to DHBs to promote the concept with an expectation of compliance by DHBs. They were good statements but the responsibility to implement was left to DHBs without any additional political grunt. Her successor Pete Hodgson seemed much less interested. However, despite only being in office for a year, the next health minister David Cunliffe accelerated clinical leadership to a new level by facilitating, in 2008, the *Time for Quality* agreement between the ASMS and DHBs.

*First they tried managerialism, then they tried commercial competition plus managerialism, then they tried cooperation with the residual of managerialism, and then they tried clinical leadership.*

Then came Tony Ryall. In his first few months as minister he commissioned and adopted the *In Good Hands* policy statement on clinical leadership (2009). This took *Time for Quality* further by strengthening the emphasis on the *distributive* part of clinical leadership. In other words, clinical leadership is more than simply having empowered formal positions of clinical leadership. It was about all senior doctors having the time to be involved and empowered in professional and organisational leadership activities beyond their immediate clinical practice and their DHB providing the supportive culture to enable this. The potential gains are immense – clinical, quality, organisational and cost effectiveness (a far superior bang for the health buck).

## Capacity and culture deficits

The policy framework was excellent but two things were required – senior doctors and dentists in DHBs needed time for this expanded role and DHBs needed to have the right supportive culture.

The Robin Gauld survey, in 2010, of ASMS members employed by DHBs confirmed what we suspected. They did not have the time. Only 20% of respondents said they had sufficient time to be involved in leadership and project activities in addition to their clinical work. This is consistent with the oft reported observations of members that they do not have sufficient time for the non-clinical activities that they should be doing and which they are entitled to under their MECA. 'Clinical creep' is a trend experienced by many. Further, too many senior managers obstruct the proper recognition of non-clinical time thereby short-changing senior medical officers, patients and the public health system.

*Only 20% of ASMS members had sufficient time to be involved in leadership and project activities in addition to their clinical work.*

It also confirmed in advance the conclusion in the ASMS's publication early this year, *Public Hospital Specialist Workforce*, that the senior medical staff workforce in DHBs is over-stretched. DHBs depend on a critical workforce in an environment in which entrenched shortages are the norm.

It is significant that, prior to the earthquakes at least, Canterbury was the one DHB that was in a strong position for recruitment and retention. Its blend of the secondary/tertiary mix and the unique lifestyle of a larger urban location surrounded by an easily accessible rural environment was attractive. Because Canterbury had a stable specialist workforce it was better placed than larger DHBs to at least further develop clinical leadership and innovation. They were also able to encourage innovative management which was sufficiently confident to see distributive clinical leadership as an opportunity rather than a threat. It is not surprising that Canterbury rated highly among the larger DHBs for clinical leadership in the Gauld survey.

*The problem with spread sheet doctors is that they can't operate, can't diagnose, can't do outpatient clinics and have no bedside manner.*

One of the benefits of this enhanced clinical leadership was a much more integrated primary-secondary relationship known as the 'Canterbury Initiative' that underpinned a strong local health system that coped so well when the devastation of the quakes hit and the chaos of the aftermath followed. I'm not confident that other local health systems would have coped as well had they been hit by similar devastation.

This leads on to DHB culture. Prior to the global economic recession of late 2008, the culture of DHBs was mixed – the

good, the bad and the underwhelming. But overall there were positive signs as the principles of distributive clinical leadership seeped into the system. Nevertheless the residual influence of managerialism remained an obstruction in various places.

## Return of managerialism

Unfortunately the global recession brought out the worst rather than the best of our health leaders, including in DHBs. It encouraged a shorter term approach to decision-making. From a position of acknowledging that the state of the specialist workforce in DHBs was the government's number one problem they have evolved to denying the existence of the problem, enabled by the ability to produce more spreadsheet hospital doctors. The problem with spreadsheet doctors is that they can't operate, can't diagnose, can't do outpatient clinics and have no bedside manner. They have no general or vocational scope of practice.

*We are also seeing increasing examples of resurgent managerialism because even though less effective, it is an easier path for short-term thinkers to go down.*

ASMS members and other DHB staff are being expected to do more with relatively less funding. The government refuses to invest in their specialist workforce and DHBs have walked away from their responsibility to advocate for this. Investment is needed in order to produce the level of human intellectual capacity necessary to reduce financial wastage and improve sustainable efficiency and effectiveness. Instead it relies on the top-down, bureaucratic Health Benefits Ltd process and micro-management by financial threats, intensive monitoring, phone calls and 'text terrorism'.

This is intensifying the pressures on the already entrenched shortages. Those health leaders who should know better are simply disregarding this frontline reality. They display as much commitment to those at the clinical frontline as many World War I generals to their troops in the trenches.

Furthermore, we are also seeing increasing examples of resurgent managerialism because even though less effective, it is an easier path for short-term thinkers to go down. For the first time in around a decade a specialist was threatened with disciplinary action for invoking his right under the MECA to participate in public debate and dialogue (ironically in support of government policy). Increasingly we are seeing more reviews and other decisions that are inconsistent with the principles of *Time for Quality* and *In Good Hands*. Senior medical officers are cast in the role of reactors to proposals, rather than being in the engine room of proactive development. We are seeing signs of more hard line adversarial employer attitudes in DHBs than we have since at least the 1990s. There are also worrying signs of increased managerial bullying.

In this tight financial environment distributive clinical leadership has shifted from the front foot to the back foot in response to this capacity and cultural deficit. We are less well placed to achieve the benefits of clinical leadership than we were before *In Good Hands* was published.

*In the tight financial environment distributive clinical leadership has shifted from the front foot to the back foot in response to this capacity and cultural deficit.*

Given the Gauld survey revelation, it is extraordinary that there is so much innovation led by senior doctors in DHBs. If what is achieved already is through only 20% having sufficient time, imagine what it could be if it was 80% (or even 100%). The mind boggles. But what we do know is that our public health system, which currently punches above its weight, would be far more financially efficient and cost effective than it is now. It could be unrecognisable.

## Whiskey and the half full glass

The fact of the matter is that if senior medical staff all had sufficient non-clinical time as required under the MECA, and if we could recruit and retain the additional workforce capacity that would be required, our public health system would achieve these objectives of financial efficiency and cost effectiveness.

*As my father used to say, the cup is half full but if it doesn't seem like it put a drop of whiskey in it and it will be.*

The ASMS receives many membership observations, reports and complaints of increasing disengagement. It is easy to get demoralised in this environment where so much benefit to quality, efficiency and cost effectiveness is potentially so close but still so far away. But the goal is still worth fighting for. As my father used to say, the cup is half full but if it doesn't seem like it put a drop of whiskey in it and it soon will be.

Well, where does this leave Winston (Churchill that is)? In fact, he is an overrated political commentator. Had it not been for his empowering inspirational leadership in World War 2 he probably would have been considered to be an ineffective incompetent politician. And as for the Americans – how often do they eventually make the right decision and how often do they fail to exhaust the options to making the right decision?

**Ian Powell**
*Executive Director*

REMEMBER TO VOTE BY 28/6/13

# Settlement vote on new DHB MECA due this month

As this edition of The Specialist goes out, ASMS members who work in DHBs will be receiving a ballot paper so they can vote for or against a proposed settlement of the DHB ASMS MECA. The National Executive recommends the proposed settlement and asks DHB members to vote in favour.

Ballot material including a Special *MECA Bulletin* outlining the proposed settlement has been mailed out with voting closing at **5pm on Friday 28 June**; the material will also be emailed to members whose addresses are known.

The results of the ballot will be considered by the National Executive to assess whether the ballot gives a mandate to accept or reject the proposal. The Executive will decide whether or not to ratify the settlement. The full proposed settlement can be downloaded from the Association's website **www.asms.org.nz.** *The Special MECA Bulletin* along with a 'tracked changes' version of what the MECA would look like is also available on the website. DHB members are strongly encouraged to vote.

## Online voting now available

For the first time members will have the option to vote online by following a link on our website. A freepost envelope is provided for those who prefer the postal option.

The ballot process has been assigned to **Electionz.com** who will act as Returning Officer. Each member has been allocated a unique and random PIN and password which will be printed on the voting paper and effectively validates that member as being eligible to vote. Ballot papers are barcoded to allow automated counting and analysis.

## If you haven't received a ballot paper. . .

If you are an ASMS DHB member and haven't received a ballot paper (which will include your pin and password) please, call the Voting Helpline,
**toll-free: 0508 666 557.**

Online voting is encouraged.

## Voting Helpline: 0508 666 557

ASMS
Association of Salaried Medical Specialists

www.asms.org.nz

# Why the *Living Wage* matters to our health

*By Annie Newman, Service & Food Workers Union*

What's the relationship between body mass index and $18.40? It may sound odd but it is an intimate issue. Put a different way, the health of our communities is closely linked to living standards and $18.40 per hour is the current New Zealand Living Wage that provides the income necessary to survive and participate in society.

New Zealand is 23rd worst out of 30 developed nations for income inequality[1] and evidence suggests that high levels of inequality are correlated with poor outcomes across a raft of social indicators, such as violence and obesity.[2] In fact, US research involving interviews of 350,000 adults annually shows that reductions in the inflation-adjusted minimum wage across states explains 10% of the increases in average body mass since 1970.[3]

*Living Wage campaigns have emerged around the world as a response to growing poverty among the working poor and New Zealand is no exception*

Living Wage campaigns have emerged around the world as a response to growing poverty among the working poor and New Zealand is no exception. *Living Wage Aotearoa New Zealand* is a broad-based community/union alliance that aims to address the growing crisis of poverty in this country.

Deborah Littman and Guy Standing with *Living Wage* community supporters.

An estimated 270,000 children may be living in poverty and 40% of those children are in households where at least one adult is in full time work or self-employed.[4] This is a crisis that the community pays for whether or not they are living in poverty.

*An estimated 270,000 children may be living in poverty and 40% of those children are in households where at least one adult is in full time work or self-employed*

The impact of low income on health outcomes is well known. The National Health Committee stated that income is the single most important determinant of health[5]. Poverty means people reduce the amount of fresh fruit and vegetables they eat, delay visits to the doctor, turn off the heating, and cluster in cramped accommodation. The cost of poor health outcomes of a growing number of New Zealanders is borne by individuals, families, communities and society in general through demands on the public health dollar.

## Funders and publicly funded bodies

While fragile local communities impact on us all, the health sector workforce provides a microcosm of the larger problem the Living Wage Movement seeks

1 Organisation for Economic Co-operation and Development. (2010). *Incidence of FTPT employment - common definition.* http://stats.oecd.org/index.aspx?DatasetCode=FTPTC Retrieved 24/04/2013

2 Wilkinson, R.G. and Pickett, Kate. 2009. *The Spirit Level: Why more equal societies almost always do better.* Allen Lane, 174

3 Leigh, J. Paul. *Raising the minimum wage could improve public health*, retrieved March 8, 2013 from www.epi.org/blog/raising-minimum-wage-improve-public-health

4 Ministry of Social Development. (2012) *Household Incomes in New Zealand: Trends in Indicators of Inequality and Hardship 1982 to 2011* www.msd.govt.nz/about-msd-and-our-work/publications-resources/monitoring/household-incomes/ Retrieved 25/04/2013

5 National Health Committee (1998) *The social, cultural and economic determinants of health in New Zealand: action to improve health.* Wellington: National Health Committee.

to address. This problem is how we target the funders; the bodies that hold the purse strings. Public funding passes through many hands before the care givers, the homecare workers, the kitchen, cleaning and security staff receive their wages. Very often, the wages have not come from a public institution but an agency, a labour hire group or a contractor who has competitively tendered for a service and has little room to move at the bargaining table.

*...the health sector workforce provides a microcosm of the larger problem the Living Wage Movement seeks to address.*

*Living Wage Aotearoa NZ* is a community/union response that seeks to influence those decision-makers who may not be the employer bargaining at the table but who hold the resources to address the problem of low pay. *Living Wage Aotearoa NZ* is calling for publicly-funded bodies to lead by example ensuring their employees are paid a living wage and that they incorporate the living wage and job security into their procurement policy and partnerships with social and environmental agencies. It also calls for corporates and other ethical employers who can pay to lead the private sector.

The NZ Living Wage of $18.40 was determined by the Family Centre Social Policy Research Unit and is based on the needs of a family unit of two adults and two children where there are 1.5 full time equivalent hours worked. The report released in February is available from the Living Wage website (see below).

Already 130 organisations have signed up to a statement of support for a Living Wage, including health sector organisations such as Health Care Aotearoa, union health centres, the Women's Health Action Trust, Well Health, and the Mental Health Foundation of New Zealand. The statement reads: *A living wage is the income necessary to provide workers and their families with the basic necessities of life. A living wage will enable workers to live with dignity and to participate as active citizens in society. We call upon the Government, employers and society as a whole to strive for a living wage for all households as a necessary and important step in the reduction of poverty in New Zealand.*

## ASMS members

ASMS members are respected professionals in the health sector. Your endorsement of and involvement in the campaign reinforces the message that this is about the health of our Nation. The voice of ASMS members is a powerful voice to add to the growing Living Wage Movement.

There are many ways you can help this growing Movement. Are you part of a community, faith or other network that can offer support in principle by signing a statement endorsing the Living Wage or by becoming active in a local network? Can you make a donation or offer particular skills to the campaign? Or do you just want to sign up for regular updates about Living Wage Aotearoa New Zealand? Go to the website for information or to make email contact **www.livingwagenz.org.nz.**

*Living Wage Aotearoa NZ is calling for publicly-funded bodies to lead by example ensuring their employees are paid a living wage.*


# Support service for doctors

MAS and the Medical Protection Society have joined forces to bring their members an important support service. The support service provides access to a free professional counselling service. Doctors seeking help can call.

**0800 225 5677 (0800 Call MPS)**

The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling or support.

The service is completely confidential.

# MPS: providing expert opinion

*By Dr Alan Doris, MPS Medical-Legal Adviser and Head of Medical Services in New Zealand*

Providing an opinion as a medical expert is an interesting and rewarding role and the Medical Protection Society regards it as an integral part of professional practice. However, it is an aspect of medical practice where there is often a lot at stake for the involved parties and therefore a careful approach is essential.

While, in general, evidence given in court should be that which a witness has heard, seen or otherwise experienced directly, there are some circumstances in which a witness can give an opinion and expert evidence is one.

Expert evidence is admissible in court if the court is likely to obtain substantial help from the opinion in understanding other evidence in the proceeding or to understand a significant issue. An opinion expressed by an expert that is common knowledge, or which addresses the ultimate decision before the court, would not usually be admissible.

## Differing practices and circumstances

Practices differ as to the selection of medical experts and there is no formal register of medical expert witnesses in New Zealand as there is in some countries. Several medical colleges maintain lists of interested and suitable members who may be approached by parties wanting an expert opinion from their field. Some Colleges also offer training in being an expert witness, maintain a register of suitably trained Fellows and issue guidelines.

Currently there is no common standard across the medical profession and experts with a varied range of training, knowledge and experience can be engaged to provide an expert opinion. In court hearings, whether criminal or civil, an expert must abide by the rules of court. These require impartiality on the part of the expert whose first duty must be to the court.[1]

The Code of Conduct for Expert Witnesses also requires an expert witness to detail their qualifications as an expert; specify the issues that the expert addresses and confirm that these are within their area of expertise; state the facts on which their opinions are based, and the reasons for forming the opinions. If directed to do so by the court, expert witnesses must confer with each other and try to reach agreement on matters within their area of expertise, and indicate the areas on which they disagree and why.

In New Zealand, most expert medical opinion is provided for deliberations in less formal settings than a courtroom. As well as criminal, civil, coroner's courts and tribunals, bodies such as the Health & Disability Commission, Medical Council and the Accident Compensation Corporation may seek expert medical opinion to assist them.

In some cases, the expert opinion may strongly influence the outcome of the process and therefore it is very important that the evidence provided is valid, robust, relevant and given by an appropriate expert. Though the standards required of expert opinion given in other settings are less clearly stipulated, the standards required by the Code of Conduct for Expert Witnesses should be aimed for.

## A landmark court decision

In 2011 a Supreme Court decision in the UK effectively changed the longstanding principle that an expert witness is immune from being sued[2], and this is likely to be influential in New Zealand. This case involved a clinical psychologist who had given an expert report for the complainant as he sought damages from an insurance company having been involved in a car accident. Initially a diagnosis of post-traumatic stress disorder was made. However, after discussion with experts for the defence, the clinical psychologist revised her opinion to diagnose the less serious condition of an adjustment disorder. She also stated that the complainant had been "very deceptive and deceitful in his reporting", implying that the complainant had consciously misled expert assessors.

As a result, the complainant's case was settled out of court. Several years later, the complainant took action against the clinical psychologist, claiming she had been negligent in changing her report, which resulted in him receiving a much lower monetary settlement than he would otherwise have received. The clinical psychologist attempted to defend this charge by arguing that as an expert witness she was immune to an action in negligence against her.

In what has been described as a landmark decision overturning the approach that the courts had taken for the preceding 400 years, a majority of the UK Supreme Court decided that such immunity for expert witnesses should not apply and an expert could be sued for negligence in these circumstances.

It is no simple matter being an expert medical witness and it is important for an expert to be aware of both their duties to the court or instructing agency, and their accountability to the public through the Medical Council. The Medical Council requires that doctors who are asked to give evidence or act as a witness in litigation or formal proceedings must be honest in all spoken and written statements, and make clear the limits of their knowledge and competence.

The Council's guidance on non-treating doctors performing medical assessments of patients for third parties states that concerns about a non-treating doctor providing an opinion on a matter outside his or her scope of practice, or a non-treating doctor's competence, should be directed to the third party or the Medical Council.[3]

1 High Court Rules [Schedule 4] Code Of Conduct For Expert Witnesses, July 2002

2 *Jones v Kaney* [2011] UKSC 13

3 Medical Council of New Zealand, *Non-treating Doctors Performing Medical Assessments of Patients for Third Parties* (December 2010)

## ASMS services to members

**As a professional association we promote:**

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

**As a union of professionals we:**

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for around 3,000 doctors and dentists, over 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

## Other services

***www.asms.org.nz***

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

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

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

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

Substantial discounts are offered for bulk and continued advertising.

**ASMS email broadcast**

In addition to The Specialist the ASMS also has an email news service, ASMS Direct. This is proving to be a very convenient and efficient method of communication with members.

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

## How to contact the ASMS

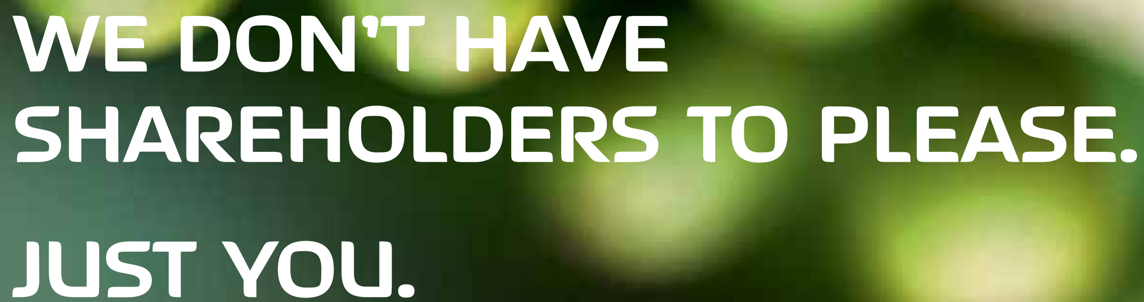
Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
Cnr Brandon St & Lambton Quay, Wellington

| | |
|---|---|
| Telephone | 04 499-1271 |
| Facsimile | 04 499-4500 |
| Email | asms@asms.org.nz |
| Website | www.asms.org.nz |
| Post | PO Box 10763, Wellington 6143 |

# 25th Annual Conference

## Thursday 28 to Friday 29 November 2013

Mark it in your diary today!




# JUST YOU.

No shareholders means we're not going to push you into something you don't need. Instead you can trust us to take the time to understand your unique situation, and only then offer recommendations on what we think is best for you. It's the way we've always done it – for over 90 years.

Talk to us today about becoming a Member.

*Call us today*
**0800 800 627**
Visit us online at **www.mas.co.nz**