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TRADE DEALS, THE DHB MECA AND UNMET NEED – HOT TOPICS AT THE ASMS ANNUAL CONFERENCE | P6
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EXAMINING THE CULTURE OF PRESENTEEISM IN NEW ZEALAND’S HOSPITALS
Senior doctors are going to work when they should be taking sick leave and this behaviour, known as ‘presenteeism’, is prevalent in New Zealand’s DHBs.
A recent survey of ASMS members into self-reported rates of coming to work unwell and amounts of sick leave taken found that 88% of all respondents had turned up to work while ill at least once over the past two years (figure 1).
Respondents variously reported stories of working through extreme episodes of illness, ‘never’ taking sick leave and feeling unable to take sick leave for themselves as well as for dependents. One respondent recounted having “a very bad pneumonia last winter – but managed to do a full outpatient clinic, while being seen myself in ED!” and another stated: “I have not taken a day off sick in 30 years. Possibly should have on a few occasions, but if you are only SMO in specialty, you feel unable to do so.”

DR CHARLOTTE CHAMBERS | PRINCIPAL ANALYST (POLICY & RESEARCH)

FIGURE 1: LIKERT SCALE RESPONSES FOR PRESENTEEISM OVER A TWO-YEAR PERIOD
Turning up to work with illness is a decision that can have serious consequences for practitioners and patients alike. Senior doctors are well aware of this risk and yet 73% of respondents reported coming to work when ill with an infectious illness over the past two years. This suggests that senior doctors are under enormous pressure to ‘present’, as well as by relatively uncompromising patients. Exposure to even mild infectious illnesses can be fatal. Presenteeism can also lead to an increase in the number of errors made while at work. While the risk to patients can be considerable, this behaviour can negatively affect the health and wellbeing of senior doctors. Research has found that people who are unwell but still come to work are twice as likely to experience significant coronary events compared to those who take sick leave. There is also a clear relationship between high rates of presenteeism and symptoms of burnout in doctors.

Doctors are renowned for taking very little sick leave and appear to work through illness at a higher rate than other professional groups. Fifty-four percent of respondents reported taking one or fewer days of sick leave over the past year (Table 1). Female and younger senior doctors were more likely to come to work unwell than their older male counterparts. Those working in larger departments were more likely to take sick leave than those with few SMOS. Length of time worked in the profession had no influence on coming to work infections but the greater the number of years worked meant that respondents were less likely to display presenteeism than their younger colleagues. These patterns were consistent with findings from other research into doctors’ presenteeism in New Zealand and internationally.

**TABLE 1: GROUPED ESTIMATES OF SICK DAYS AND DAYS WHEN SICK LEAVE SHOULD HAVE BEEN TAKEN OVER THE PAST 12 MONTHS**

<table>
<thead>
<tr>
<th>Days</th>
<th>Number of days sick leave taken n/1,816(%)</th>
<th>Number of days present at work when sick leave should have been taken n/1,816(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>660 (36)</td>
<td>390 (21)</td>
</tr>
<tr>
<td>1</td>
<td>533 (18)</td>
<td>218 (12)</td>
</tr>
<tr>
<td>2</td>
<td>296 (16)</td>
<td>217 (12)</td>
</tr>
<tr>
<td>3 to 5</td>
<td>528 (18)</td>
<td>630 (35)</td>
</tr>
<tr>
<td>6 or more</td>
<td>191 (11)</td>
<td>211 (12)</td>
</tr>
</tbody>
</table>

So why do ASMS members turn up to work despite serious illness, and what can be done about it? Respondents ranked ‘feelings of duty to patients’ as the single most important reason influencing their presenteeism behaviour (35%). Having clinics or theatre sessions already booked and not wanting to burden colleagues were two other top reasons ranked (27% and 24% respectively). Figure 2 summarises these trends.

**FIGURE 2: GROUPED RANKED REASONS CITED BY RESPONDENTS AS REASONS THEY WOULD TURN UP TO WORK WHEN UNWELL**

Anecdotes and statements provided by nearly 40% of respondents gave additional insight into why senior doctors work when unwell. Many discussed their presenteeism with reference to the barriers they perceived around taking sick leave, with sick leave and presenteeism described as two sides of the same decision-making process. Sixty-six percent of respondents emphasised lack of cover as a core issue affecting their ability to take sick leave as illustrated by the following comment: “There is no redundancy in our senior roster for sick leave cover. SMOS are not only expected to cover for other SMOS’ sick leave, but also RMO and MOSS staff groups too. We routinely have 1-2 sick calls per shift, more on weekends. This sick cover is on top of a massive amount of extra locum cover the department currently needs and senior staff are getting ‘locum fatigue’. Shifts go under-staffed on a daily basis.”

Comments like this suggest that senior doctors are keenly affected and aware of the pressures on New Zealand’s public health system, and feel particularly vulnerable due to the limited scope for short-term sick leave cover. It suggests that under-recruiting of DHBs has served to create workplaces where legitimate sick leave is viewed as an additional burden on top of existing heavy workloads. These insights into presenteeism strongly suggest the need to devise practical solutions to assist with enabling senior doctors to feel able to take leave. Investing in the senior medical workforce to enable DHBs to ‘staff up’ and have better buffers for short-term sick leave is likely to pay dividends in the long term.

Presenteeism behaviour, however, is unlikely to decrease if individuals are operating in environments where working through illness is viewed as ‘normal’ or ‘at work’, ‘necessary’ behaviour. As another respondent stated: “I have overheard my work colleagues criticise another colleague for taking sick leave many times. This is because in medicine there is never enough staff available and if someone is off sick your work load becomes ridiculous.”

Another shared a story of receiving criticism for taking too much sick leave: “About five years back when my GP asked me to take 2 weeks off work because of work related stress, AND I only took one week off. I received a letter from top management at [DHB] noting that I had taken a week off and how important it was to reduce the number of sick days, I felt very unsupported by that letter and it still stings when I think of it.”

Comments like these suggest that management pressures as well as collegial expectations play an important role in encouraging presenteeism. Nevertheless, this also reflects the high value placed on the support of colleagues where senior doctors will work through illness in order to avoid overburdening their peers. Thirty-eight percent of respondents made connections between the ‘culture’ of senior doctors and expectations about working through illness. As one respondent noted: “Recently I tried to challenge our culture of working despite being sick, and was told by my colleagues that if the SMOS stayed at home when they were sick there would be no one to look after the patients. Our unit has a strong ‘SMO superman’ culture where SMOS are expected to work when sick, and not thought of as unwell.”

Another comment stated simply “Taking sick leave when not dead is generally seen as ‘letting the side down’.”

Creating an environment that fosters work-life balance, including greater recognition of the challenges faced by working parents who have ongoing responsibilities for dependents, needs more explicit support. Management and those in leadership positions need to lead the way in changing the view that sick leave represents weaknesses. Taking legitimate sick leave must be reframed as responsible and healthy behaviour. Nevertheless, finding a middle ground where it is ‘ok’ to take leave without being seen to be ‘letting the side down’ will require better buffer cover arrangements as well as a shift in attitude and culture.

The research also suggests that notions of wellness need to be expanded to encompass the significance of psychological illness as well as fatigue and burnout. Encouraging a culture within the medical workforce that recognises the impact of having workers who are struggling as a consequence of depression, fatigue and emotional exhaustion would be an important step in recognising these factors as legitimate reasons to take time off work. As one respondent summarised: “Short staffing with pressure to keep sessions going puts pressure on individuals to turn up despite being unwell. Management [are] not encouraging of appropriate sick leave taking. [There is] culture in medicine of being bullet proof. Psychological stress or personal crises [are] not seen as valid reasons for being absent.”

It is clear from this research that the senior medical workforce is under stress. Solutions to this clear and present issue must prioritise patient health and safety while continuing to find strategies to improve staffing levels and morale. Presenteeism poses clear risks to patients and practitioners alike. Turning up to work while unwell highlights the value placed on medical professionals’ duty of care, but also the tensions in defining responsible behaviour.

**SUMMARY OF RESEARCH FACTS**

**Definition of presenteeism used:** Attending work when an individual is too unwell, fatigued or stressed to be productive.

**Response rate:** 1190/3,740 (33.2%) responded to at least two questions in the survey. 1006/3,740 (48.2%) completed the survey in its entirety and 660/3,740 (17.6%) left comments for qualitative analysis.

**Respondent characteristics:** 41% female and 59% male.

**Measures of presenteeism:** Likert scale answers over a two-year period and quantitative counts over a one-year period.

**Variables:** Age (according to five categories), gender, length of time in the profession (four categories), primary DHb and number of senior medical officers in the respondent’s department.

**Quantitative data:** Non-parametric Spearman’s rank correlation coefficients and Kruskal-Wallis test as appropriate. A two-tailed p-value ≤ 0.05 was taken to indicate statistical significance.

**Qualitative data:** Retrospective process with codes generated from emergent themes until theoretical saturation point reached. Additional quantification of themes per total number of comments.

A full copy of the report on this research, including details of the methodology and references, is available as a Health Dialogue from the ASMS website at http://www.asms.org.nz/?p=4007
Superheroes, preparing for next year’s national DHB MECA negotiations, international trade deals, bullying and unmet health need – just some of the topics on the agenda at this year’s ASMS 27th Annual Conference.

More than 120 delegates attended the two-day conference in Wellington in November. The capital obliged in typical fashion: one day of perfect weather, one day of wind strong enough to strip the enamel from your teeth.

As always, the conference featured a line-up of stimulating presentations about a wide range of issues relevant to the work of New Zealand’s medical specialists. There were also plenty of opportunities to network with colleagues from other parts of the country, with a cocktail function the night before and a dinner for delegates at the end of the first day of the conference.

In his opening address to the conference, ASMS National President Dr Hein Stander talked about the increasingly toxic environment that doctors were working in. DHBs were under pressure to do more with fewer resources, and this pressure was being transferred onto the workforce. The challenge for the ASMS, he said, was to actively seek to shape the environment so that patients were at the centre of the health system.

Elizabeth Berryman, the immediate past president of the New Zealand Medical Students Association, spoke next, focusing on the results of surveys on bullying within the medical profession. She described her own experience of being bullied daily for a period earlier this year. This resulted in nightmares, tears and worry, and she questioned whether she was good enough to be a doctor. The situation changed when she bumped into ASMS National Secretary Dr Jeff Brown and told him what was happening.

“He said: you don’t need to do this alone, we can support you,” Elizabeth Berryman told the Conference. “That was the best thing I could hear. I didn’t need him to do anything but just needed to know that the support was available.”

Superheroes don’t take sick leave – that was the title of an address by Dr Charlotte Chambers, ASMS Principal Analyst (Policy & Research), on the results of a survey into presenteeism. This revealing survey of ASMS members employed by DHBs found that senior medical staff were routinely going to work when they were ill. The results are described in more detail in a separate article in this issue of The Specialist.

Canterbury forensic psychiatrist Dr Erik Monasterio discussed the implications of the Trans Pacific Partnership Agreement (TPPA) for New Zealand’s health system. This followed up his conference presentation last year in which he spoke eloquently about the risks for health care and sovereignty. He was critical of the Government’s ongoing lack of engagement with people concerned about the TPPA.

“Democracy is not a toy to be roughly handled or broken just because it doesn’t suit an incumbent government’s agenda,” he told delegates, and he thanked the ASMS for its involvement in a wider campaign for greater transparency around the TPPA.

Executive Director Ian Powell gave an address outlining the ASMS’s strategic...
direction towards next year’s national DHB MECA negotiations, including linking the objective of the approach to strengthening patient-centred care. Following breakout groups and report backs, the Conference voted unanimously to endorse this approach.

HEALTH MINISTER’S ADDRESS

Health Minister Dr Jonathan Coleman acknowledged the work of senior doctors and dentists in the health system, saying he knows that it was not an easy job and that everyone worked extremely hard. He outlined his priorities in the portfolio (eg, childhood obesity, non-communicable diseases, health IT, and primary care), and reiterated the importance of clinical engagement in health decision-making.

“I tell every DHB Chair and CEO that you have to be talking to your doctors,” he said.

Questions from the conference floor included the need for a sugar tax as part of initiatives to combat childhood obesity (the Minister argued there wasn’t enough evidence to support this), the lack of engagement on the TPPA (they would have to agree to disagree, he said) and the cap on further loans for medical school students who already have a degree (a case of “watch this space, we know we need to address this issue”).

The next session began with a few poignant words by ASMS West Coast Branch-President Dr Paul Holt (which included the sense of abandonment of the families by government, including over the failure to address accountability and the watering down of the new health and safety legislation) and a minute’s silence to remember the people who died in the Pike River disaster five years ago that day.

Council of Trade Unions Economist and Director of Policy, Dr Bill Rosenberg, discussed the Pike River disaster in more detail and outlined the need for a strong system of workplace health and safety.

Dr Ken Clark, the Chief Medical Officer of MidCentral DHB and Chair of the national group of CMOs, talked about the challenges involved in addressing bullying, sexual harassment and other inappropriate behaviour in the medical profession. Effective support, empowered bystanders, good leadership and accountability were needed, he told delegates.

Former Council of Trade Unions President Helen Kelly, with much eloquence, humour and passion, spoke of the need for unions to be seen as public institutions doing valuable and valued work. Unions provided a voice for working people and were influential in getting people to think about work-related issues. They had had a number of successes and were securing pay rises, winning cases, and pushing back on issues like health and safety. She was given a standing ovation at the end of her address.

OTHER PRESENTATIONS INCLUDED:

• Canterbury general surgeon Associate Professor Phil Bagshaw on a research project (partly sponsored by ASMS) into unmet health need (see separate article)

• ASMS National Secretary Dr Jeff Brown on the medicine stories project (see separate article)

• Dr Zarko Kamenica from the Medical Protection Society and Matthew McClelland, QC, on dealing with the Coroners Court

• New Zealand Medical Association Chair Dr Stephen Child on issues of professionalism, leadership and trust.
TIME FOR SOCIALISING AFTER DAY ONE OF THE CONFERENCE

THE IMPROVISORS

DR GEOFF SHAW SPEAKS TO A TOPIC

ANGELA BELICH

WARWICK HOUGH

ONE OF THE BREAKOUT GROUPS IN DISCUSSION

DR BILL ROSENBERG

DR PAUL WILSON, ASMS NATIONAL EXECUTIVE

LEN POWELL
Seven years ago I had what seemed to be a severe allergic reaction. I was in a meeting when clinicians were told: “that will have to change”. My throat started to close up, I found it difficult to breathe and I became extremely agitated. Was I having an extreme reaction to change? We have all been exposed to change throughout our careers. In health care nothing stands still and things are forever changing. I had never reacted to change in this way before. Had I perhaps developed an acute case of tropophobia (the fear of change)?

Fortunately, around the same time, the word ‘change’ became unfashionable in the health sector and was replaced by integration, regionalisation, transformation and the more euphemistic term ‘new models of care’.

So did I have tropophobia? In retrospect, no, I did not. I did not fear change as such but I had reacted to the hidden allergens of clinicians being told to change without being asked for our thoughts or input. The ‘In Good Hands’ document saw the light not too long after and being told to change without being asked for our thoughts or input. I wanted to look at some of the changes that have occurred over the past two to three years, and introduce some potential areas of change for the future.

MEMBERSHIP

As an organisation, we are going from strength to strength. Our membership numbers have been steadily climbing over the years and the past three years have been no exception.

MEMBERSHIP GROWTH

<table>
<thead>
<tr>
<th>YEAR</th>
<th>TENANCY</th>
<th>PERIOD</th>
<th>STAFFING</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/9</td>
<td>THE TERRACE</td>
<td>9 YEARS</td>
<td>6</td>
</tr>
<tr>
<td>2013/4</td>
<td>BRANDON STREET</td>
<td>6 YEARS</td>
<td>9</td>
</tr>
<tr>
<td>2014/5</td>
<td>WHOLE FLOOR</td>
<td>2 YEARS</td>
<td>12</td>
</tr>
<tr>
<td>2015/6</td>
<td>1 YEAR</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

The non-DHB sector is a growing area of membership, with 204 members currently. According to our membership rules, we may represent any doctor who is salaried and requires an annual practising certificate to perform their salaried job, aside from those who work in universities, or government departments (excluding ACC). There is a significant scope for recruitment across the sector.

The ASMS responded to the increase in demand and created extra positions, and successfully recruited Steve Hurring and Sarah Dalton. The bigger team also meant we had to restructure to keep the team as efficient as possible. Having said that we tend to still operate in ‘fighting fires’ mode and continue to not have much, if any, capacity to be more proactive in our approach.

The ‘Know your MECA’ workshops have been well received and we will continue. Further expansion of our Industrial Support workforce is envisaged for 2016.

Communication

In 2013 the National Executive established the position of Director of Communications and Cushla Managoh was appointed from a strong field of applicants. Communication in its broadest sense has improved dramatically. We have a from-the-ground-up redesigned website that is also mobile friendly and easily searchable. Additionally we now have a Facebook, Twitter and LinkedIn presence and following. The Specialist and all our publications have been refreshed and improved to also include our gifted name, Toi Mata Hauora.

Research

We are all well aware of the big contribution Lyndon Keene has made since his appointment. During National Executive discussions it become clear that the ASMS, in its professional and policy role, lacks capacity for independent research.
This makes it difficult to comment, promote or influence health policy. Further, we clearly need more data and information on the state of the ASMS workforce and to enhance our ability to ‘measure’ members’ opinions and communicate with ASMS members via electronic surveys, etc. A further research position was created for a Principal Analyst and Lyndon was promoted to Director of Policy and research. Dr Charlotte Chambers came on board in June 2015 and hit the ground running.

Membership surveys have become a very useful and powerful tool.

THE OFFICE

More staff inevitably means more physical office space is required. Previously the ASMS National Office occupied part of the 11th floor of a central Wellington building but, following our expanded staff numbers, we now occupy the entire floor. Yvonne Desmond and her team expertly redesigned and redecorated the whole area.

RELATIONSHIPS AND INFLUENCE

We have welcomed a new Minister of Health, Jonathan Coleman, and a new Director General of Health, Chai Chuah. We have met with Dr Coleman in his office and also welcomed him to the ASMS premises for a meeting. Similarly, the National Executive has met with Chai Chuah in our board room and Ian Powell continues to have regular scheduled meetings with him.

We have strengthened our relationships with the New Zealand Medical Association (NZMA), New Zealand Medical Students Association (NZMSA), and Health Workforce New Zealand (HWNZ). A meeting with the Council of Medical Colleges was constructive and we continue to work with the Resident Doctors Association (RDA), Ministry of Health (MOH) and various other parties (including the NZMSA) on promoting good behaviour. We have also met with Dr Andrew Connolly, Chair of the Medical Council of New Zealand.

CLINICAL LEADERSHIP REVISITED

Distributive and formal clinical leadership have been revisited, with the publication of two documents and a survey on distributive clinical leadership. A great deal of thought, time and work have gone into these, and we hope our thinking on this issue will have the desired effect.

NATIONAL EXECUTIVE INTROSPECTION

It all started with a short conversation at the end of the 2013 ASMS Annual Conference. A further conversation and a few email exchanges followed the 2014 conference. Julie Prior, clinical lead for medical officers, proposed that an additional position be established on the National Executive, to be held by a medical officer to provide a voice and representation for this group within the ASMS and thus reflect that the Executive represents all its members. I placed the topic on the agenda of a National Executive meeting and this led to interesting discussions. Now, let us have a look at the composition of our membership (it now also includes 204 non-DHB members). Further, taking our membership distribution into account, we have to ask ourselves whether our current regions or electorates are still appropriate. (http://www.asms.org.nz/wp-content/uploads/2015/04/ASMS-Constitution-2014-amendments_162343.2.pdf) The main question remains: Does the National Executive represent its members, including smaller groups and members in smaller DHBs and non-DHB members?
Discussions became quite broad at times but in the end three topics started to emerge from formal and informal National Executive exchanges:

- representation on the National Executive
- governance of the ASMS (specifically also the role of the National Executive)
- succession planning

This is the first National Executive to have a three-year term. We decided to have a National Executive only, full day meeting, to discuss the above topics and general business. The meeting was held off site on the 13th of August. It was a very successful day and in future will become part of the National Executive's annual calendar. The meeting produced quite a few ideas and actions, and these are described below.

REPRESENTATION ON THE NATIONAL EXECUTIVE:
FROM THE ASMS CONSTITUTION:
11 The National Executive
11.1 The Association shall be managed by a National Executive of ten members or such other number as a conference may decide.
11.2 The National President and Vice President shall fill two of the positions on the National Executive and the other positions shall be filled by elected regional representatives.
11.3 The boundaries of the regions or electorates established for the purpose of electing the members of the National Executive shall be decided and may be amended from time to time by an annual or special conference, on the recommendation of the National Executive.
11.4 Two regional representatives shall be elected from each of the following regions:

- REGION 1 being the members elected within the boundaries of the Northland, Waitakere, Auckland and Counties-Manukau district health boards;
- REGION 2 being the members elected within the boundaries of the Waikato, Bay of Plenty, Lakes and Taranaki district health boards;
- REGION 3 being the members elected within the boundaries of the Taranaki, Hawke’s Bay, Mid-Central, Waikato, Hutt Valley, and Capital & Coast district health boards;
- REGION 4 being the members elected within the boundaries of the Nelson-Marlborough, West Coast, Canterbury, South Canterbury, Otago and Southland district health boards.

A decision was made to establish a short life working party or subcommittee consisting of two current National Executive members and a number of general members to consider changes (if any) to the constitution. The working party should conclude and present their findings and suggestions to the National Executive’s July 2016 meeting for consideration.

GOVERNANCE AND THE EXECUTIVE
National Executive members are very aware of the strife other national peak bodies may be experiencing and our own governance functions are under review. We have found that the ASMS may be at risk of having too many people involved in certain activities and processes and we are developing a ‘tighter’ structure. The working party should conclude and present their findings and suggestions to the National Executive’s July 2016 meeting for consideration.

PATIENT-CENTRED CARE: IMPROVING QUALITY, SAFETY AND SQUEEZING BUDGETS TOGETHER

Patient-centred care is well established on political agendas internationally, including New Zealand. But despite its prominence, and the growing evidence of its importance for quality, safety and efficiency, even the limited range of performance indicators currently available show there is a long way to go before it can be said to be truly happening.

On the individual patient-senior medical officer (SMO) level, New Zealand fares relatively well. New Zealand Health Surveys show 9 out of 10 people treated by medical specialists view the quality of care they receive as good or very good. On the other hand, only 47% of New Zealanders surveyed by the Commonwealth Fund on their view of the health system agreed that “It works well, minor changes needed only” (only 3 of the 11 comparable countries in the survey got beyond 50% approval). New Zealand also recorded particularly poor results in indicators of access to care to both primary and secondary services.

There is a well-accepted definition of patient-centred care, modern concepts are based largely around research conducted in 1993 by the non-multipolar Picker Institute, in conjunction with the Harvard School of Medicine. This research identified eight dimensions of patient-centred care:

- respect for patients’ preferences and values
- emotional support
- physical comfort
- information, communication and education
- continuity and transition
- coordination of care
- the involvement of family and friends
- access

These features define the patient’s perspective for the first time. In New Zealand, of course, most of these features are underscored, directly or implicitly, in the Code of Health and Disability Services Consumers’ [sic] Rights.

Research shows there are many benefits from patient-centred care when properly implemented. When health care administrators, clinicians, patients and families work in partnership, the quality and safety of health care rises, costs decrease, and provider and patient satisfaction increase.

Specific benefits include fewer deaths, decreased emergency department return visits, fewer medication errors, fewer infection rates, and reductions in both the underuse and overuse of medical services. In the care of patients with chronic medical conditions, studies indicate that patient-centred approaches can improve disease management, increase patient and doctor satisfaction, increase patient engagement and task orientation, reduce anxiety, and improve quality of life.

A patient-centred care approach has also been linked to improvements in long-term outcomes in cardiac patients and is seen as integral to preventative care.

Further, it has been acknowledged that, to succeed, a patient-centred care approach must address staff needs, because the staff’s ability to care effectively for patients is compromised if they do not feel cared for themselves. Once the patient-centred care approach is firmly established, a positive cycle emerges where increasing patient satisfaction increases employee satisfaction, and this, in turn, improves employee retention rates and the ability to continue practising patient-centred care.

An underlying reason why a comprehensive patient-centred care approach has not been well established in New Zealand’s DHBs, despite all of these benefits and more, is that it requires health professionals to spend more time with their patients and, where appropriate, their families. This requires an upfront investment in services, especially the medical and dental specialist workforce, at a time when government funding is squeezed budgets tighter. It is clear that next year’s ASMS DHB multi-employer collective agreement (MECA) will therefore be to generate the SMO capacity required for patient-centred care to be achieved and to further facilitate a supportive culture.

Unless this happens, ‘patient-centred care’ is in danger of becoming a meaningless slogan and of being reduced to superficialities such as reported overseas where hospitals have been adopting models used by boutique hotels with greeters, greenery, and gadgetry.

Although such amenities might enhance the patient’s experience, they do not come close to achieving the goals of patient-centred care. It is for all of the above reasons that the ASMS is preparing a programme of work, including plans to liaise with patient advocacy groups, to promote the patient-centred care approach and in particular to examine what is required, from the SMO workforce perspective, to give it real meaning.

This will include discussion an access to resources, patient involvement in treatment decisions, distribution of clinical leadership. The work will also discuss issues that have become topical in 2015, such as patient access to health service performance data, and patient ‘choice’. To address the additional principles promoted by the International Alliance of Patients’ Organisations – that of patient involvement in health policy, the work will also examine the effectiveness of elected DHB board members as patients’ advocates.
GETTING THE LANGUAGE RIGHT WOULD HELP HEALTH SECTOR LEADERSHIP

Ian Powell | ASMS Executive Director

Confused language from the leadership of New Zealand’s health system is a scourge which undermines confidence by health professionals and managers. Take the drive from central government (through the Health Ministry) to require greater regional and sub-regional collaboration between district health boards that actually started under the previous Labour-led government but intensified under National’s regime (as most certainly it would have under a Labour regime).

Good Principle, Poor Execution

In principle it made good sense, and in practice it should have also. New Zealand is a small country, with a small population and, consequently, a small critical mass. On volumes alone we can’t sustain neurosurgical units or cardiac critical mass. On volumes alone we can’t sustain neurosurgical units or cardiac critical mass. On volumes alone we can’t sustain neurosurgical units or cardiac critical mass. On volumes alone we can’t sustain neurosurgical units or cardiac

It was over-hyped and over-politicised, leading to obfuscation (for example, the ‘3G’ brand of collaboration between the three lower North Island DHBs has become a toxic embarrassment).

The greater the competition, the greater the destabilisation of DHBs, whose expenditure is far greater on fixed rather than variable costs.

Murray Horne’s (Des Gorman’s) recommendations are the antithesis of the Government’s push for greater collaboration between DHBs. But the Government knew what to expect from him when they commissioned him to undertake this work. If you ask a committed proponent of market forces to write a report on health funding, what do you expect? If it looks like market forces, talks like market forces, and acts like market forces, then it is an advocated return to market forces.

RELATIONAL/ALLIANCING, NOT STRUCTURAL

But over the term of his office Minister Ryall’s language rather than resources shifted to the more sensible direction of improving integration between primary and secondary care, from ‘land grabs’ to collaboration. This was influenced by the impressive experience of Canterbury DHB’s ‘Canterbury Initiative’ based on clinically led clinical pathways across primary care organisations, in which primary care organisations were invited by government to make proposals for the primary-secondary interface. The quality of bids varied (many were poor) and DHBs were excluded from the initial process and then forced into damage control. Eventually they pandered out, with little of sustainable note emerging out of it.

The fact that no one now talks about it is a powerful message in itself.

The Health Minister, Health Ministry and the rest of sector leadership need to end this inconsistency because it confuses the sector, makes good planning incredibly difficult, is financially expensive and engenders loss of confidence in this leadership.
At times, it’s economically difficult for both hospital staff and patients that the location needs to have a specific level of staffing, then that will carry with it a requirement to have safe staffing levels.”

He draws on examples from his own DHB, which covers a population of about 100,000. The DHB’s newborn service is staffed for 9 or 10 cots in a unit, which requires two nurses available at all times.

“Because very sick babies can be born suddenly or arrive at the unit, we need to have two appropriately trained nursing staff available 24/7. Because of fluctuations in when babies are born and workload, there might be occasions when there are only one or two babies in the newborn unit - but we still need two nurses available at short notice in case more arrive.

“If you try to cover the newborn unit with intensive care unit nurses, they will have great skills, but they won’t be familiar with where equipment is or dealing with a very sick baby in the same way. So the financial imperative for DHBs generally might be to try to get by with just one nurse, but there’s a risk and it becomes a safety issue.”

Steve Bradley says the application of minimum standards is particularly important for medical specialties requiring an immediate or very quick response – eg, acute paediatrics, neonatal paediatrics, emergency medicine, intensive care, anaesthesia and obstetrics.

“I believe that it would be helpful to define safe levels of staffing for what the specialty is, and that’s for junior and senior medical staff, and nursing staff. At least to have some guidelines.”

He says these issues are relevant for all DHBs, not just at Lakes.

“The fact is, if you cut a service back to the point where you have very little leeway, then there’s a safety risk. The funding model doesn’t account for this. You may actually need to staff a department or service to a higher level than predicted by the funding model.

“I don’t know anyone who doesn’t want to do a great job. You’re in medicine to help your patients. But you also don’t want to get burnt by the system around you which pushes you to the point that you are at risk.”

The ASMS is looking at developing a potential DHB MECA clause on minimum standards, and this was discussed by delegates at the Annual Conference in Wellington in November.

There is no single reliable way of measuring a nation’s need for medical specialists, as is the case for assessing specialist workforce shortages. However, there is a range of indicators which, when assessed together, provide clear evidence of entrenched shortages – that is, where shortages have become commonplace for so many years that they become the norm. Key indicators are outlined here.

New Zealand is ranked 30th out of 32 OECD countries in terms of specialists per head of population. Only Turkey and Chile fare worse. This measurement includes trainee specialists (registrars). For primary care specialists, New Zealand is ranked 20th.

Levels of unmet need may also be reflected in some health activity and health status measurements. For example, OECD data show that out of 35 countries, New Zealand ranked 30th in the number of patient consultations with doctors (GPs and specialists) per capita. New Zealand has among the lowest rates of hospital discharges for cancers and well below average discharge rates for circulatory...
diseases, yet has higher than average mortality rates for cancers and ischemic heart disease. (Caution should be exercised in interpreting these comparisons too literally, due to variations in how health activities are measured.)

**QUALITY AND SAFETY**

One study has estimated that adverse events in our health services could cost $870 million per year, of which $590 million is due to potentially preventable events – mostly in the hospital system. While a range of factors contribute to this, there are many examples indicating specialist staffing is an important factor, including the need for sufficient time for training and supervising other doctors. Good quality training and supervision, in particular, are seen as key factors for reducing adverse events. The rates of ‘serious adverse events’ in DHBs has increased from 182 in 2006/07 to 454 in 2013/14. This increase has been put down to better reporting. It is unclear as to whether the trend reflects an increase in actual events. Increasing heavy clinical workloads have also meant many specialists are unable to find the recognised professional minimum standard of time for non-clinical duties, including time for continuing education, research, quality improvement activities, and clinical leadership.

Regarding the latter, a national survey undertaken by Professor Robin Gauld (University of Otago) of DHB-employed ASMS members on the application of clinical leadership in DHBs in 2010 found a mere 20% of respondents believed they have enough time to engage in clinical leadership activities or development programmes.

**HEAVY WORKLOADS**

While more specialists are working part-time (an observed characteristic of an aging workforce, as well as having an increasing proportion of female specialists), many continue to work long hours.

In 2015 around one in eight specialists was recorded as regularly working 60 hours or more a week. A number of New Zealand studies show high work demands have contributed to significant staff burnout, which can have a negative effect on patient care.

A major national survey of ASMS members in 2015 showed 88% of respondents turned up to work when they were sick over the previous two years, and 75% of respondents reported going to work while having an infectious illness. Workload pressures were the most cited reasons given for practising while ill, including concerns about compromising patients’ access to timely treatment and over-burdening colleagues.

**SPECIALISTS ON THE SKILL SHORTAGE LIST**

New Zealand’s widespread medical specialist shortages have been acknowledged in Immigration New Zealand’s skill shortages lists since they were established in 2004. The lists from that year onwards include almost every medical specialty. None have been taken off.

**HEALTH WORKFORCE NEW ZEALAND’S RECOGNITION OF SPECIALIST SHORTAGES**

Health Workforce New Zealand’s report Health of the Health Workforce 2013 to 2014 states: “The most important issue is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.”

**VACANCY RATES**

There are no reliable data on DHB vacancy rates. DHB budget constraints influence the number of official vacancies as only funded positions are recorded. This has meant that in 2008, for example, the DHB’s official vacancy rate nationally was approximately 10% of positions, but data collected by ASMS in specific DHBs indicated there were up to 24% real vacancies in that year.

The latest retention trends suggest that the situation has not improved, and may have become even worse.

**AN AGREED PROXY MEASURE FOR SPECIALIST WORKFORCE NEEDS**

In the absence of any single reliable way of assessing specialist workforce requirements, DHBs and the ASMS agreed in 2010 that Australia offers a reasonable benchmark. Its population is of a similar age structure to New Zealand’s in both countries 14% of the population were aged 65 and over in 2010, and are projected to grow. Like New Zealand, Australia has roughly an equal proportion of GPs to specialists, as well as a similar proportion of nurses on a per population basis.

So while, as the Government points out, the numbers of operations have been increasing, New Zealand’s access to elective surgery and waiting times for specialists continues to lag behind many other comparable countries.
Auckland: 2 FTE for 28,000 people. Currently advertising - short of consultants, beds and community services.

Counties Manukau: 5.5 FTE for 50,000 people. Filling a shortfall with overseas-trained doctors and recruiting two locums from overseas.

Waitemata: 8.3 SMOs and 1 medical officer for 75,000 people. Well-resourced on the surface but the region is short of allied staff (eg, psychologists). Another SMO would take pressure off the service.

Waikato: 5 SMOs for 60,000 people. The workforce is very stretched.

Lake Taupō: 1 FTE for 15,000 people. As with Waikato, the service covers a large rural area so is very stretched. Both SMOs are overseas-trained and one has provisional registration.

Bay of Plentys: 2.2 SMOs and 1 medical officer for 40,000 people. No medical officer and just one house officer.

Taranki: 1.8 for 18,000 people. No allied health workforce.

MidCentral: A population of 270,000. 1 FTE and could do with another.

Waipara: 0.2 FTE for 8,000 people, in private capacity.

Hutt Valley: 1.7 FTE for 180,000.

Capital & Coast: 2.7 FTE for 350,000 people. The service needs at least 3 FTE.

Canterbury: 8.9 for 75,000 people. Includes 2.1 medical officers and 17 are not members of the Faculty of Psychiatry of Old Age (FPOA).

South Canterbury: 0.5 FTE for 15,000 people.

Southern: 2.1 FTE for 470,000 people in Otago but no SMO in Southland, which is of concern.

The numbers tell us that the workforce of psychogeriatricians is already playing ‘catch up’, but it’s a complex picture.

Dr Gavin Pilkington, a psychogeriatrician at Waitemata DHB, says psychogeriatrics became a sub-speciality in the 1990s and involves two additional years of advanced training on top of the three years of specialist psychiatry training.

He says his career in psychogeriatrics has had four distinct phases.

“The early years were fantastic because it was a new specialty, and we were welcomed with open arms. Then it became busier and we stopped doing some of what we would consider essential work, such as acting as a consultant liaison to geriatric medicine wards.”

“In the third phase, the service became very stretched and difficult to manage. We’re in the fourth phase now, where we’re trying to recover from that. We’re doing quite well at Waitemata but it varies a lot around the country - and even though we’re doing well here by comparison, we still struggle to get our job-sized non-clinical time.”

He says Waitemata gets a 1,000 new psychogeriatric referrals each year, resulting in about 150 hospital admissions.

“We’re dealing with people developing mood disorders and sometimes becoming severely unwell, people who are suicidal. It’s the level of risk that triggers their hospital admission. Some people have a diminished capacity for self-care - for example, if they have dementia. Some people pose a risk to themselves or to others, while another group of people have very complex health conditions and suddenly become unwell.”

Gavin Pilkington says one of the difficulties for the workforce is the long lag between the time it takes to understand an issue, such as the ageing of the population, and the time it takes to bring about changes in health services in order to meet the changing demand.

“We’re in the position of being reactive, rather than proactive.”

Jane Casey has 21 years’ experience as a public hospital specialist in psychogeriatrics, and she loves her job.

“Old age psychiatry is seen as the least glamorous sub-speciality but for those of us who are passionate about the field and about old people, it’s the most rewarding and diverse area to work in,” she says.

“We see it as a very privileged role to be in, being with older people who share their lives and wisdom with us.”

Even though her DHB – Auckland – has the most SMOs per population, the service is struggling to cope with demand and manage waiting lists. The region includes a high number in residential care.

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MEDICINE STORIES PROJECT - SPEAKING FROM THE HEART

"You can't bury your hands in someone's chest and give them a new heart without thinking that's pretty amazing. Medicine is full of stories. It's built around the anecdote - the history, the case study, bacteria that act like characters."

So says GP and poet Dr Glenn Colquhoun, and he wants to hear the stories that doctors tell each other. He's one of the people driving a new web-based project to collect the writings of doctors - memoirs, stories, poems, reflections, creative jottings.

The project's start can be traced to a meeting of like minds at an APAC conference organised by Ko Awatea. Glenn Colquhoun, who had just returned from a Fulbright scholarship at Harvard, talked to APAC attendees and returned with the idea of collecting the importance of stories in people's experiences.

The finishing touches are being put on the project, but the call is already going out for submissions.

"Send us your stories," says Glenn Colquhoun. "Tell us what you know, what galvanises you and makes you feel something."

"We talked about setting up a website and encouraging doctors to speak and write from the heart," says Glenn Colquhoun.

Over a few subsequent encounters and conversations with National Secretary Jeff Brown, including at our Annual Conference in 2015 where Glenn was a stellar after-dinner speaker, the idea of sharing the setting up and promoting this web-based project led to discussions about seed funding.

The ASMS was approached for funding and the National Executive, after some discussion, agreed to contribute $12,000 to help the project get off the ground.

ASMS National Secretary Jeff Brown says the project is a leap of faith but he believes it will provide a valuable forum for talking about the practice of medicine.

"We don't know if we'll get just one contribution or a thousand, but that's part of the excitement. So much of medicine involves telling stories in one way or another about what it means to be a doctor, and we just want to create a repository for these stories to give them life."

He says some countries have entire journals of medical literature which exist to collate and publish writing, paintings and other art by doctors. Confidentiality will be addressed during this process.

"Stories, poems and other writings can be sent to Glenn Colquhoun, David Galler and Jeff Brown via the email address medicine-stories-project@middlemore.co.nz. They will then be edited as needed and curated before being made available at some point to a wider audience. Any issues such as confidentiality will be addressed during this process."

"Tell us what you know, what galvanises you and makes you feel something."
WHAT INSPIRED YOUR CAREER IN MEDICINE?
I come from an academic family. My grandfather, Ranginui Walker, left the family dairy farm in Opopuki in the 1950s for education in Auckland. He went on to do his PhD and he’s always inspired us academically. My father, Stuart Walker, is an anaesthesiologist at Middlemore Hospital in Auckland. My mother’s side of the family came from Tokomaru Bay on the East Coast and worked on sheep stations. Honest, hardworking people of the land. I was interested in science at school so I went off to Auckland University to do a Bachelor of Science. While I was doing that I also did farm jobs as a labourer and that was what led me to be interested in a career as a vet. It was a way of combining science with the outdoors. I completed a veterinary degree at Massey University and found that I enjoyed the small animal medicine more than the rural work. I worked at the Auckland SPCA and then as an assistant lecturer in small animal medicine at Massey for a time. It’s a roundabout way to medicine, but I’m getting there!

After doing a research project on the health hazards of eating stranded whales, I became increasingly aware of the health needs of Māori, and my horizons expanded. I started to ask myself if I was in the right field. I decided I want to make a contribution to Māori health. At that stage I didn’t have a mortgage or children, and as I never wanted to regret not taking the opportunity I applied for and was accepted into Auckland Medical School and retrained as a ‘vet for humans’. My background in veterinary medicine was very helpful and of course it meant that during the holidays I could focus as a vet, which made life as a student a bit easier.

I qualified in 2007 and worked as a house officer and registrar at Waikato Hospital before moving to MidCentral DHB and then Wellington to complete my training in nephrology. My wife, Megan Pybus, is a paediatrician and is from Ashhurst, and so the move back to live in Palmerston North was always something we’d been keen on.

Although I enjoyed my time as a vet, I don’t regret leaving veterinary medicine. It’s a fine career and I recommend it, but it just didn’t turn out to be for me.

WHAT DO YOU LOVE ABOUT YOUR JOB?
I really like the variety. You can go from working head down on a post-acute medical ward round to dealing with patients and their whānau in outpatient settings discussing their chronic conditions and care. At the moment I’m also contributing to a book chapter on kidney disease in disadvantaged populations, and I was recently elected to the New Zealand Medical Council, which I find extremely interesting.

It’s about making a positive contribution. That’s really important to me. Being the first Māori renal physician, and given the significant number of Māori who have renal diseases or need dialysis, I feel that I’m in a unique position to help. The focus for me is on trying to improve health outcomes for Māori with renal diseases and improving their experiences within the health system.

For me it’s about patients and their whānau. It’s what gets us all into medicine and it’s what keeps us there.

WHAT IS THE MOST CHALLENGING ASPECT OF PRACTISING MEDICINE?
With the great variety of work comes the challenge of time management. I doubt there’s a doctor out there that wouldn’t put that at the top of their list. It’s about trying to get the balance right between work and the other areas of your life. My wife and I have a six-year-old daughter, Mare, and a four-year-old boy, Tik, so we work hard to make sure we have plenty of time as a family as well as squeezing in our CME, clinical work, and other commitments.

In a wider sense, the public health system is under pressure to do more and more with constrained resources. That pressure flows through to the workforce and that makes it even more difficult to fit in all the things that are important. Advocating for resources to alleviate that pressure is essential and we need to do that collectively through our unions and other health organisations.

WHAT HAS THE TRANSITION BEEN LIKE FROM BEING A UNION LEADER TO BEING A SENIOR DOCTOR AND AN ASMS MEMBER?
Coming through medicine as a mature student, and then being an older RMO with my prior experiences, was really helpful as I had more capacity to take on roles outside of the day to day ward work. If you’re 23 and you haven’t worked before, then you’re very focussed on your immediate clinical priorities, and wider medical roles are perhaps more difficult to engage in.

Being president of the RDA was fantastic. I felt I was able contribute to the broader discussions going on about public health and as a union leader you’re supporting your colleagues so they can perform at their best within their workplaces. It was very clear to me that involving doctors in the design and development of their clinical workplaces is a really positive thing, and what clinical leadership is all about.

I also learned that so much of our public health system relies on the goodwill of doctors and other committed staff. Goodwill is the oil that keeps the wheels of the public health system moving and an important aspect of this are the relationships between the health unions and the DHBs. Even when these are difficult, you’ve got to find common ground and solutions, rather than going into separate corners and fighting.

We went through some strikes during my time as RDA president but we also developed many productive and constructive relationships with the DHBs over the years. At the end of the day, you have to make it work.

I’m still a relatively new SMO and I’m still getting used to the transition to being a senior doctor. I think I have a better understanding now of my senior colleagues and all of the roles they perform. The increased responsibility is part of why you become a doctor, for the increased ability to influence and improve. I’d like to thank the many senior colleagues who taught me and guided me over the years!

WHAT HAVE YOU LEARNT FROM YOUR UNION INVOLVEMENT SO FAR?
All of the above things but also I’ve gained a better understanding of the complexities of the health system and the number of levers within it, and how these have to work in concert.

I guess the biggest thing I’ve learnt is that you can either sit and complain about things, or you can get involved and make a difference, and that’s what I’m trying to do.

DATA ANALYSIS AND VISUALISATION DEVELOPMENT
EACH ISSUE OF THE SPECIALIST WILL FEATURE A PHOTOGRAPH OR DOCUMENT FROM ASMS HISTORY. YOU CAN FIND MORE SLICES OF HISTORY ON THE ASMS WEBSITE (WWW.ASMS.NZ) UNDER ‘ABOUT US’.

Whole Time Senior Medical Officers’ Association
of New Zealand

President:
Dr. G. Woodfield

Honorary Secretary:
Dr. T. Riordan

14th September 1851.

Dr. L. Honeyman,
Superintendent in Chief,
Auckland Hospital Board.

Dear Mr. Honeyman,

The meeting of the Auckland Branch of the Whole Time Senior Medical Officers Association, instructed me as Secretary, to write to you, Superintendent in Chief of the Auckland Hospital Board, expressing feelings of astonishment and anger, that an administrative decision to alter the terms of conference leave had been made without any consultation with any senior medical staff. The importance of continuing medical education was emphasized; it is a necessity and not a luxury. Are the medical administrators of the Auckland Hospital Board aware of the benefits to patient care of participation at medical conferences and the prestige to the practice of medicine in Auckland if invited to make a presentation?

Yours sincerely,

Dr. James Lowden

MECA clauses that you may not be familiar with are highlighted in each issue of ASMS Direct sent regularly to ASMS members. These clauses are also promoted on the ASMS website (www.asms.nz) and are reprinted here for your information.

...ABOUT LEAVE FOR ASMS ACTIVITIES?
Elected and appointed branch officers and executive members are entitled to leave on full pay to attend ASMS meetings. Make sure to give early notice but also be aware that Clause 29 provides that leave “shall” be given: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-29/

...ABOUT COVERING FOR RESIDENTS?
Where an SMO is required to cover work usually done by an RMO, you are entitled to extra pay. Generally, the situations where this applies are limited and specific, but it’s worth checking Clause 13.4 if you think this might be happening in your workplace, and that you have an entitlement. Ring ASMS and talk to an industrial officer if you’re not sure. More information is available at http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-13/

...ABOUT CLINICAL LEADERSHIP?
If you have designated clinical leadership or management duties, these should constitute a separate time allowance in your job description. In other words, these duties are extra to (not part of) your non-clinical time entitlement. This is clearly outlined in MECA Clause 11.6: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-one/clause-11/
In our modern age, technology makes it extremely easy to record dialogue and behaviour. For doctors and health care professionals, this means being aware of the situation and handling patient information. This is in recognition of the confidential and often sensitive nature of health information. As patient information is confidential and often sensitive, if a health provider decides to record a clinical interaction, they must ensure that they comply with the Code.

A CLINICIAN WISHES TO MAKE AN AUDIO OR VIDEO RECORDING

The Health Information Privacy Code 1994 (the Code) was established to ensure that health agencies (including individual practitioners) abide by strict rules when handling patient information. This is in recognition of the confidential and often sensitive nature of health information. As patient information is confidential and often sensitive, if a health provider decides to record a clinical interaction, they must ensure that they comply with the Code.

A recording made without the patient’s knowledge is an example of where collection is likely to be deemed unfair. In some circumstances, additional safeguards require that explicit consent is gained from the patient before a video or audio recording is made. A successful complaint against a health agency that breaches one of the rules of the Code can lead to proceedings in the Human Rights Review Tribunal, with possible penalties including an award of damages of up to $100,000.

A PATIENT ASKS TO MAKE AN AUDIO OR VIDEO RECORDING

The Code only applies to health agencies and does not have any role where a recording has been made by a patient. It is possible that the Privacy Act 1993 could apply in circumstances where personal information of the doctor was included in a recording made by a patient, though this would be unusual.

Patients may ask to record a clinical interaction for a variety of reasons, such as an insurance or ACC claim. In such an instance, the Medical Council of New Zealand (MCNZ) requires you to consider the patient’s request, and if you do not consent, ask the individual to arrange consultation with another doctor.

The MCNZ refers to the case of Jackson v ACC, which upheld the patient’s privilege to record a consultation, though also acknowledged that doctors have a privilege in deciding how a medical assessment should take place. The doctor must be able to reasonably and clearly justify a refusal to allow recording. Such circumstances might include:

- the presence of a recording device will hinder the open sharing of information and views;
- a recording will not convey relevant non-verbal cues that affect an assessment;
- the recording (or a transcript) may be edited in ways that alter its significance, and/or
- the subsequent use of the recording will be outside your control and could be used to misrepresent your actions or views.

Medical Protection is aware of cases involving doctors with factitious complaints arising from examining the recording. You should contact your obligations when dealing with covert recordings. It is important to contact Medical Protection or your medical defence organisation (MDO) as soon as possible.

A PERSON MASKERADAS AS A PATIENT AND RECORDS THE INTERACTION

Medical Protection is aware of cases where individuals have presented to doctors with factitious complaints to manipulate and covertly record consultations for their own purposes. We recently assisted a member following a complaint made to the MCNZ by a journalist alleging inappropriate prescribing. The journalist had pretended to be a patient and had presented to several GPs seeking to obtain medication with the potential of abuse by deception and, at least in one case, intimidation. This was done to form the basis of a newspaper article and a covert recording of one consultation was used by him in his subsequent complaint to the MCNZ. After considering the response from the doctor detailing the circumstances, the MCNZ took no further action.

In summary, the doctor-patient relationship is based on mutual trust. Recording consultations without the knowledge or consent of one party inevitably undermines this trust, damaging the relationship and the potential effectiveness of care. However, with recording devices a ubiquitous feature of modern life, it is best to assume all consultations are potentially being recorded.

NOTES


2. www.livesequery.org

3. The Health Information Privacy Code 1994, Rule 2


5. The Medical Council of New Zealand (MCNZ)’s Non-Terminating Point for Medico-Legal Assessment of Patients for Third Parties Doctors (Dec 2010)

6. Jurisdictional Guidelines for Medico-Legal Assessment and Testimonies (Oct 1992, Table 6-8 and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, Section 52)
ASMS SERVICES TO MEMBERS

As a professional association we promote:

- the 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 more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

OTHER SERVICES

ASMS services also include:

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

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WE PAY OUR ADVISERS COMMISSION IN NICE ROUND FIGURES.

Zero commission is not the traditional remuneration model for advisers in the financial services sector. But then, MAS is hardly your traditional financial services provider.

Zero commission. It's just one more way MAS acts with your best interests in mind.