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PATIENT CENTRED CARE AT THE HEART OF MECA NEGOTIATIONS WITH DHBS

The national multi-employer collective agreement covering Association members employed by the 20 DHBs expires on 30 June 2016. It ran for three years from 2013. The significance of this expiry date is that it is the legal trigger point for re-negotiation. Under the Employment Relations Act neither the ASMS nor DHBs can formally initiate bargaining for a new MECA until 60 days from the expiry date (ie, not until early May). This does not preclude, however, informal discussions which have already commenced. This includes the setting of initial formal negotiation dates from early May through to mid-July.

The expiry date does not mean that the current MECA comes to an end on 1 July. It continues in force for members currently covered by it until a replacement MECA is negotiated. Further, DHBs are required by statute for a further 12 months to offer the ‘expired’ MECA to new appointees subject to them joining ASMS. This obligation continues beyond 30 June 2017 by written agreement between ASMS and the DHBs until a replacement MECA has been negotiated.

PROCESS AND CLAIM
For the last two MECA negotiations the ASMS team has been relatively small – me as advocate, Deputy Executive Director Angela Belich, and the 10 National Executive members. For this negotiation we have significantly increased the number in the team (including the number of branch presidents and vice presidents) in order to strengthen our representativeness and combativeness. The full team includes over 25 members.

Further, the National Executive has decided to adopt a broader approach to our claim compared with recent negotiations. Base salary scales are at the centre of the claim but they will also include, for example, enhancing the penal rate for working on after-hours call rosters (and shifts), strengthening the rights of those working on shifts, increasing CME expenses reimbursement, increasing paid parental leave, recovery time, long service leave (two weeks after every 10 years), and providing experienced medical officers (non-vocationally registered) who work with nominal supervision access to placement on the specialist scale.

But outside remuneration, the most important claim is to introduce a new clause enabling (with some teeth) members to shape the minimum safety standards, including staffing levels and mixes, in their service or department.

The National Executive has considered at its first meeting of the year a draft claim which, with some revisions, will be considered by a day-long planning session...
of our negotiating team on 8 April before being finalised by the Executive at its next meeting on 14 April.

RELEVANCE OF PATIENT CENTRED CARE

Patient centred care is much more than a nice sounding slogan. Its dimensions are:

- 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 to care.

But why is this relevant to our MECA negotiations? The scene for this is nicely set by the Government’s health workforce advisory body, Health Workforce New Zealand, which recognises the vulnerability of the senior medical workforce in DHBs. In November 2014 it publicly stated that the most important issue currently is the impact of a prolonged period of medical labour shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.

This dire situation is summarised by the following underpinning features of the current state of the senior medical workforce in DHBs:

- growing unmet need of patients due to factors such as population growth, aging and increasingly entrenched poverty
- entrenched specialist shortages (high undersupply of specialist positions) as distinct from advertised vacancies
- capacity (numbers to generate the time necessary to achieve distributive clinical leadership throughout each DHB)
- welfare of senior doctors, including health and safety, presenteeism, burnout and fatigue, with consequential increasing risks for patients.

This is all very laudable but what does the MECA have to do with this? Quite simply, health delivery is labour-intensive, and senior doctors and dentists are at the core of achieving patient centred care. The MECA both provides and enables the wherewithal to achieve patient centred care. The MECA both provides and enables the necessary resources to enable senior medical staff to undertake their duties and responsibilities.

But it also needs sufficient teeth to ensure there are robust minimum standards for achieving patient centred care. Already the MECA requires DHBs to provide the necessary resources to enable senior medical staff to undertake their duties and responsibilities. Further, it expects that senior medical staff will provide the lead role in service delivery, configuration and provision with management in a support role. These are important provisions despite often being ignored by too many DHBs to one degree or another.

But more is required in the MECA, including senior doctors being able to organise a stocktake of what the minimum standards for patient safety care in their service should be, including staffing (not just medical or dental), equipment and accommodation. The MECA needs to require DHBs to be responsible for providing the necessary information and data for this stocktake.

Finally, we need a dispute resolution process in situations where there are difficult blockages in achieving these standards; the patient safety clause (41) of the current MECA could be used for this purpose.

For this level of increased recruitment and retention, the MECA requires competitive remuneration and other conditions of employment.

REHUMATOLOGY WORKFORCE SHORTAGE

The frustration is evident in rheumatologist Fiona McQueen’s voice as she recounts how, a couple of weeks earlier, she saw a 30-year-old man with long-standing back pain and discovered he had a severe rheumatic disease that could be treated.

“Getting money out of the DHBs is like getting blood out of a stone, but this is having an impact on patients,” she says. “There’s a lot of people we can’t get to see, which leaves them reliant on their GP, who may be very good but obviously isn’t a specialist in this area. It’s a real concern for rheumatologists.”

Dr McQueen moved to Invercargill last year to take up a part-time (0.4 FTE) position with the Southern DHB, after spending most of her working life as a rheumatologist in Auckland. She also works part-time (0.1 FTE) as a Professor of Rheumatology at Auckland University, and is President of the New Zealand Rheumatology Association.

She’s been at the sharp end of rheumatology service provision and training for more than 20 years, and says improvements are needed to provide the level of rheumatology treatment New Zealanders require.

“We need more publicly funded rheumatology positions, probably another 5 to 8 FTE, and we need to incentivise...
Rheumatologists diagnose and treat a range of conditions such as arthritis, autoimmune connective tissue disease, systemic inflammatory diseases such as vasculitis, spinal and soft tissue disorders, certain metabolic bone disorders, and chronic musculoskeletal pain syndromes. After graduating from medical school it takes at least seven years to train as a rheumatologist; and that the shortage of rheumatologists appeared to be worsening. Waiting lists were often used as surrogate indicators of the adequacy of service provision, he wrote, possibly because they were easier to measure than true unmet need.

Waiting lists, however, do not take account of the unmet need of patients who, due to lack of access to rheumatology services, are referred to a less appropriate specialty or managed in general practice.

More recently, a review of the musculoskeletal workforce and service published by the Ministry of Health in March 2011 (http://www.health.govt.nz/system/files/documents/pages/musculoskeletal-workforce-service-review.pdf), while not specifically about rheumatology, highlights a number of broader issues that affect rheumatologists. These include the growing number of patients who, due to lack of access to rheumatology services, are referred off to orthopaedic and rheumatology clinics, and existing barriers to improved provision of care, which include the DHB funding line is in sight, many of the new specialists have families and are feeling very settled in their current locations. ’Trainees don’t necessarily want to move or to work in the provinces,” says Fiona McQueen. “Positions there have been seen as dead-end jobs - which they’re not - and people can be very reluctant to move out of the bigger centres. There might be less support from other specialties in small areas, which can be a real issue. It means that jobs in Auckland are being snapped up, but it can be harder to recruit in other places. We need to incentivise those positions.”

There’s also the lure of Australia - Fiona McQueen says rheumatologists crossing the Tasman are able to earn significantly more money and have more access to resources and support. Issues with the rheumatology workforce and service provision have been well documented. Hutt Valley DHB rheumatologist Andrew Harrison analysed the provision of rheumatology services in New Zealand over a decade ago and subsequently reported his findings in the New Zealand Medical Journal (23 April 2004). He concluded that access to rheumatologists varied markedly, depending where patients lived, and that the shortage of rheumatologists appeared to be worsening. Waiting lists were often used as surrogate indicators of the adequacy of service provision, he wrote, possibly because they were easier to measure than true unmet need.

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The report argues for more consistency in managing patient referrals, and that a message that’s been picked up in rheumatology by Waikato DHB rheumatologist Douglas White and a team of other clinicians. They have developed a triaging tool that involves a short set of three questions to be answered by the referring GP and a further three questions for the triaging rheumatologist. It’s early days but they think that using the tool electronically can reduce the turnaround on referrals from five days to one day. Their research has been published in the international Journal of Clinical Rheumatology (August 2015) and also won an award for excellence in health improvement at last year’s APAC Forum in Auckland (https://www.1000minds.com/about/news/health-improvement-award).

“This project is about streamlining the process,” says Douglas White.

“As a country we have fewer rheumatologists per head of population than many other countries. We can’t provide the same service that rheumatologists do in other countries so we have to be selective about the patients we see. The shortage of rheumatologists is driving the need for work-arounds.”

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<th>DHB</th>
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<td>TAIOGA, SOUTHLAND</td>
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</tr>
</tbody>
</table>

Source: Andrew Harrison, from a presentation at the 2012 New Zealand Rheumatology Association Annual Scientific Meeting.

*R Service provision may have changed since these figures were compiled.*
CONSIDERATION OR PUBLIC RELATIONS?

A surge of government activity in the health sector over the past year has included a plethora of reviews, consultations and proposed legislative changes. The opportunity to have input into proposed government policies is of course welcome, but there is a disturbing tendency for consultations to occur over unreasonably short timeframes, and often involving complex issues.

For example, just over five weeks were allowed for formal feedback on the draft updated New Zealand Health Strategy. Much of the substance of the draft strategy lies in a number of other documents, including the Productivity Commission’s 500-page plus report on More Effective Social Services, and the Director-General of Health’s Capability and Capacity Review and Health Funding Review. They cover a broad range of sometimes multifaceted and controversial issues. The Health Funding Review, for instance, proposes radical changes that are sometimes multifaceted and controversial – eg, over the summer or Christmas break, when consultees are less able to respond.

The code stated: “If a consultation exercise is to take place over a period when consultees are less able to respond – eg, over the summer or Christmas break, or if the policy under consideration is particularly complex, consideration should be given to the feasibility of allowing a longer period [than 12 weeks] for the consultation.” The code was effectively an acknowledgement that many non-government organisations possessed a wealth of knowledge and practical experience to inform good policy and legislative development. A 12-week standard time limit for replies to public consultations was seen as striking a reasonable balance between the need for adequate input and the need for swift decision-making. The minimum 12-week timeframe would “help enhance the quality of the responses”, Moreover, effective consultation was considered essential for upholding those often-stated virtues of good democracy such as transparency, responsiveness and accountability.

For essentially the same reasons, since January 2012 the European Commission has also adopted a 12-week minimum period for open public consultations. The UK Government came under widespread criticism when it began watering down the 2008 code, turning it into a set of more evasive ‘principles’. The House of Lords Secondary Legislation Scrutiny Committee summed up public feelings in its comment. “It is essential that contributors should be assured of genuine engagement, and that consultation should be capable of influencing Government policy and not become a mere public relations exercise.”

This is also the case in New Zealand. The public needs to be assured of good processes and practices around government decision-making, as the results will have a significant impact on the provision of health and other services in this country. Improvement is needed.
I In December 2015 ASMS made a submission to the Ministry of Health on the draft updated New Zealand Health Strategy. This was made more challenging than it should have been due to the tight timeframe provided for feedback on a very complex document with far-reaching consequences.

Much of the substance of the draft updated health strategy lies in a number of other documents, including the Productivity Commission report, the Capability and Capacity Review and the Health Funding Review. These documents cover a broad range of complex and controversial issues; for example, the Health Funding Review proposes radical changes that resemble policies of the controversial issues; for example, the Health Funding Review proposes radical changes that resemble policies of the 1990s.

ASMS expressed support for the proposal to retain the seven principles of the original New Zealand Health Strategy. We also supported the proposed additional principle of collaborating across sector to improve New Zealanders’ wellbeing.

SERIOUS CONCERNS ABOUT THE STRATEGY

That said, there is much in the substance of the draft updated strategy which we do not support and have serious concerns about. While the draft updated strategy is presented as representing “the common view of where we want to go” (Minister’s foreword), it is in fact largely a reflection of current government policy. In essence, the “update” is an exercise in reframing the original New Zealand Health Strategy within the Government’s current policy agenda.

The updated strategy fails on a number of important points. It fails to acknowledge the efficiency and quality of New Zealand’s health system relative to comparable countries that spend more on health, it fails to acknowledge the extent of New Zealand’s current health need compared with other similar countries, and it fails to acknowledge significant health inequality that is related to poverty.

On the other hand, the challenges relating to future health spending have been overstated to the point of being alarmist, and these are used as the rationale for introducing ‘significant change’ to the current health system model. Government health spending has actually been falling as a proportion of gross domestic product, a trend that is likely to continue under current policies. This will exacerbate difficulties in accessing care in both primary care and secondary care.

The draft updated strategy misses an important opportunity to improve the cost-effectiveness and efficiency of our health services by giving a stronger commitment to distributive clinical leadership.

We think this is a critical oversight, and we have called for this to be remedied in the final document.

The draft strategy acknowledges challenges such as the ageing workforce, but no responses or potential responses are suggested. It also acknowledges New Zealand’s medical workforce is highly dependent on overseas recruits, many of whom do not stay long. However, its suggested solution – “we need to continually invest in training” – is inadequate. Nor does it recognise the importance and urgency in addressing specialist shortages in DHBs.

While the draft strategy focuses on people ‘living well, staying well’ and ‘getting well’, ‘dying well’ is also of critical importance and needs to be included in the document as part of a genuine patient-centred care approach to health care (which requires greater investment in the senior doctor workforce). At the other end of the lifespan, a greater investment in ‘starting well’ is also critical. In short, whole-of-government policy should ensure every baby should be born to a healthy mother and grow up in a healthy home.

MEMBERSHIP SUBSCRIPTION INCREASING

Delegates at the Annual Conference in Wellington last November voted overwhelmingly to increase ASMS membership subscriptions by $100 for the coming year (1 April 2016 – 31 March 2017). The National Executive’s recommendation was for a $50 increase but, on the urging of delegates from the Conference floor, this was amended to $100.

The subscription has not risen for the past four years, but an increase is now needed to fund the expansion of the industrial team with an additional industrial officer and the establishment of a new project officer position for policy and research (witness the presentation survey as a result of the latter) in the middle of last year. It also funds the further two additional officer positions which commenced in February this year. All these decisions are to ensure ASMS can provide the level of support our members require.

Further, the past four years have been funded by increased membership numbers. However, while ASMS is maintaining the same density of permanently employed DHB senior medical staff (at least 90%), the rate of increase in the number of DHB employed SMOs has declined, making this no longer an option.

While reading the two newspaper articles outlining the working lives of each of them, I thought: “It is well-deserved and it is well deserved and right and proper that they get recognised in this way.” A short paragraph toward the end of one of the articles drew my attention: “It had been a demanding career. Pringle was often on call 24 hours a day, leaving Carlo to look after the three children.” This struck a chord with me.

How many of us have experienced that tension between work and family life? It is different from the tension created by trying to achieve a work-life balance. It is more specific, more immediate and often more unpredictable. It can lead to significant friction in family dynamics whereas work-life balance is more akin to a life philosophy. The tension between our commitment to family life and work always seems to be present. Sometimes it is barely perceivable and at times very immediate and acute. Occasionally it becomes chronic and very destructive.

On the one hand we need to deliver better quality, faster and safer health services and we need to achieve this with relatively decreasing resources and higher patient expectations. On the other hand we risk burnout and compassion fatigue.

We need more time and resources.

We need to relieve the pressure to prevent the dam wall from breaking.
BOLSTERING THE HEALTH SYSTEM

There are only 24 hours in a day. No one can create more time than we have by making more of ourselves. There are many reasons why we end up not being seen in a timely manner or being turned away from our public health service. They join the ever-increasing number of patients whose health needs are not being met.

In the end we are all trying to do the best for our patients and bolster a health system that is under tremendous pressure. We are trying to keep the sky from falling on our public health service (while risking burnout and at the expense of our own health and family life). Unfortunately there is just so much any one of us can do. Occasionally the sky does fall on individual patients - for example, a patient who had been waiting for a cataract operation for six months, had his surgery cancelled at the last minute, and when he finally saw the consultant, he was told he had lost sight in one eye while waiting for his surgery. He was diagnosed three years ago with juvenile glaucoma and was reviewed every six months but due to pressure on the system his follow-up appointment was pushed back by five to six months, and by the time he saw the consultant he was told he had lost vision in his right eye. An underfunded, understaffed and under pressure health system has failed Koby Brown despite the best efforts of the front line health care workers involved.

We are all aware of the ever increasing unmet health need. These are the patients that the public health system has turned its back on. Their health needs are not being met and as a consequence their quality of life may suffer, some may lose their ability to live independently and, even worse, they can lose their sense of self-worth.

As a country we have an increasing unmet patient need, an ever increasing number of New Zealanders who are denied access to the health services they need. The system is neglecting to address their health problems (if you haven’t done so already please watch Associate Prof Phillip Bagshaw’s presentation (https://youtube/a6jMtvLnBjg) How do we as senior front line health care workers respond to that? When do we say: “enough is enough”? When do we make a stand and, like the wizard Gandalf in Lord of the Rings, shout “You shall not pass”? To now and further.

Speaking up for patient care

It is time to make a stand and speak up. Do we have the right to speak up? The DHB MECA clearly allows for this. The New Zealand Medical Council indicates that we have an obligation to speak up. The publication Statement on Safe Practice in an Environment of Resource Limitation (https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Safe-practice-in-an-environment-of-resource-limitation.pdf) states the following:

• OP: Doctors have a responsibility, as advocates for their patients, to seek the provision of appropriate resources for their patients’ care and report any deficiencies to the appropriate authorities. Where those deficiencies are serious the report should be made in writing.

• IO: Doctors must try to ensure that services are provided in a timely manner.

• 34. Doctors, like everyone else, have a right to a reasonable quality of life outside their profession and to participate fully in the lives of their families. Within this context, it is reasonable for doctors to strive for efficiency so that they can provide more services, but not at the expense of lowering the quality of those services or putting their own health and quality of life at risk.

• 35. Doctors can be at risk of burnout. Burnout is particularly likely when a doctor’s excessive workload lasts for an extended period of time. Doctors should be aware of the warning signs of burnout in themselves and their colleagues.

• 36. When doctors are unable to provide services that are both safe for themselves and safe for their patients, they should bring their concerns to the attention of management or primary health organisation (PHO) before taking any other action and should also seek advice from an appropriate agency such as a peer, their College, Association of Salaried Medical Specialists, New Zealand Medical Association, or the Rural GP Network.

We have very little doubt that the time has come for us to draw a line in the sand.

Realistically, though, will we achieve much by doing that? Surely it has been done before and the problems continue.

We need to engage with the chief executives of the 20 DHBs and work with them to find solutions. You might say we have tried that. I think it is worth another try at both an individual DHB level as well as at a national level, with the ASMS continuing to raise the profile of the problems. If that fails, it is time to engage the public. The public has a right to participate in this debate. Our message should be clear: “We have a safe public health care system but the biggest problem is access.”

Realistically we will never be able to treat everyone, but we should be able to open the flood gates on the large pool of patients with unmet health needs and relieve the pressure to prevent the dam wall from breaking. If we don’t, we risk the system being completely flooded and failing.

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WORKSHOPS

WORKSHOPS

Lloyd Woods.

I was struck by the recent case of Koby Brown (http://www.odt.co.nz/news/369451/staff-asked-man-be-dunedin) who went blind while waiting for his overdue cataract operation. I was shocked to discover that he had never been seen by the surgeon even though he had been sent for his surgical consultation three months previously.

The system is neglecting to address their health problems. (If you haven’t done so already please watch Associate Prof Phillip Bagshaw’s presentation (https://youtube/a6jMtvLnBjg) How do we as senior front line health care workers respond to that? When do we say: “enough is enough”? When do we make a stand and, like the wizard Gandalf in Lord of the Rings, shout “You shall not pass”? To now and further.

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WORKSHOPS

KNOW YOUR MECA’ WORKSHOPS

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How well do you know your entitlements under the DHB MECA?

Leave, on call, lieu days, CME, retirement, gratuity, sabbatical - these are just some of the topics up for discussion at the ‘Know your MECA workshops being run around the country by ASMS Senior Industrial Officer Lloyd Woods and Industrial Officer Sarah Dalton. They say the workshops help members understand what they are entitled to under the MECA and also aim to clear up any common misunderstandings.

“They’re proving really valuable both as a way to meet with ASMS members and to answer questions about the MECA,” says Lloyd Woods.

“We’re finding that there are entitlements members didn’t realise they have and also reminding them of things they can use.”

ASMS has had very positive feedback about the workshops, which are run at times to suit as many members as possible (early morning, lunchtime and after work).

If you would like a workshop at your DHB or site, please contact your industrial officer at ASMS, 04 499 1271 or admin@asms.nz.

More information about the DHB MECA is available at http://www.asms.org.nz/employment-advice/agreement-info/

Information about other collective employment agreements covering ASMS members is available at http://www.asms.org.nz/employment-advice/advice/

SURGERY 2016: Getting The Measure of Outcomes

For further info visit http://www.surgeons.org/about/regions/new-zealand/

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RETURN OF THE EMPIRE BY STEALTH?

Murray Horn, an unashamed marketer by training and an entrepreneur at heart, has been identified as the conscience of the Government’s health funding review. 

It is difficult to avoid the conclusion that the Government is stealthily returning to the failed market approach to health that was tried and failed in the 1990s. In that decade the Government used the lever of new health legislation to achieve this objective. Public hospitals became state-owned companies governed by competition law, and were expected to compete with each other and with the private sector.

The consequences included:

• setting back workforce planning and development several years because it did not fit in with market theory
• obstacles to critical collaboration between public hospitals including information technology (DHIs are still suffering the results of this folly)
• incentivising short-term decision-making at the expense of medium to longer term service planning
• introducing an alien and disintegrating artificial divide between the funding and provision of services
• cherry-picking of clinical services by the private sector while leaving public hospitals with the same fixed costs
• encouraging an eroding culture among health professionals of working to contract rather than to professional standards and patient care
• an inability to recruit additional staff
• an inability to reorganise work among existing staff
• doing that would be all about creating a structure more suitable for market mechanisms. It’s not about providing the best care for patients and a decent return for health professionals of working to contract rather than to professional standards and patient care.

SIDING BACK TO MARKETS

Regrettably, although we now have new legislation more consistent with the values of a universal accessible public health system that has continued under successive governments, the current Government appears to be siding back to a market-driven approach to the provision of public hospital services at least. It is all happening in the background and largely below the radar. This is of great concern, and warrants active scrutiny.

For example, when we look at the Ministry of Health executive (second tier) restructure announced recently, ASMS noted that the functions of the apparently disbanded National Health Board (currently comprising about half of the Ministry of Health) appear to be reduced. Certainly, the brand name ‘NHIB’ is out the door. But, of greater significance, there is an increased emphasis on market mechanisms such as tendering through commissioning, and the language of the market – clients and customers. Those driving this restructure appear oblivious to the huge problems with commissioning in the English National Health Service.

There are also signs of a return to the failed market health experiments of the 1990s in the updated draft New Zealand Health Strategy first developed in 2000. This strategy is required by legislation but does not require legislative amendment to change it. The lever for constructing a ‘competitive health market’ shifts from legislation in the 1990s to a strategic document enabled and required by legislation today.

The Government’s health funding review, whose controversial recommendations were leaked to the media last year, underpins the draft updated health strategy. This review clearly points to a competitive market model of health service provision. At the extreme, in the context of the Trans Pacific Partnership Agreement, it also opens the doors to more involvement of multi-national health insurance companies.

REINTRODUCING A HEALTH MARKET

The review group’s most prominent author is Murray Horn, an unashamed marketer who genuinely believes in the 1990s ideology, a former head of Treasury, a member of the now disbanded Business Roundtable, a banker, and influential in government circles. Asking him to review health funding systems guaranteed an ideological pro-market outcome.

Proposals currently being considered by the Government include opening up DHB services to competitive tendering, with indications that funding will be dispensed only if planned milestones are achieved. If they are not, then funding will go to another public or private provider. A leaked document from the funding review suggests that these mileposts will include tighter financial targets.

The proposals also suggest separating DHBs’ funding and providing roles, with the funding role eventually being carved off and given to other unidentified organisations. This was tried and failed in the discredited market experiment of the 1990s. Doing that would be all about creating a structure more suitable for market mechanisms. It’s not about providing the best care for patients and a decent return for health professionals of working to contract rather than to professional standards and patient care.

WHAT HAPPENS IF I AM UNHAPPY WITH THE EMPIRE’S DECISION?

If you believe your request has been unfairly rejected, you may contact a member of the ASMS industrial team for further advice. There are mechanisms available to ensure all requests for flexible working arrangements are properly considered.

DOES THE PART 6AA PROCEDURE COVER THE SAME CIRCUMSTANCES AS DOMESTIC LEAVE?

No. Domestic leave is leave on full pay in the event of the illness or accident of a close family member. On the other hand, the Part 6AA process covers this and many other circumstances where flexible working arrangements are necessary or desirable.
Two new faces have joined the industrial team at the ASMS national office in response to the increasing growth in our membership and the need for more advice and representation on employment and professional issues.

DIANNE VOGEL has been appointed an Industrial Officer with the ASMS. She holds a Bachelor of Laws from Victoria University and a Graduate Diploma in Business Studies (Dispute Resolution) from Massey University, and has provided advice and representation for a union previously. She is also a former nurse, and has a private practice background in employment, family and general civil litigation.

IAN WEIR-SMITH has also joined the ASMS as an Industrial Officer. He is a solicitor with extensive experience in employment law in South Africa, and has advised and litigated for the Public Servants Association in that country. He has experience in collective bargaining, mediation and representation. Ian moved to New Zealand with his family in 2015, and holds a Bachelor of Arts (with majors in law and psychology), and an LLB from the University of the Witwatersrand in South Africa.

They are currently undertaking an induction programme that includes attending our Joint Consultation Committees in the DHBs. Later on they will be allocated their specific DHB responsibilities.

LONG-SERVING ASMS MEMBER RETIRES

One of the founding members of the ASMS, Dr Mithra Vijayasenan (Vijay), has retired after many years as a psychiatrist in the Hutt Valley and Wellington region.

Dr Vijay saw his last patient at the end of February, stepping aside from both public and private practice after a long career which began in India and concluded half a world away.

He has been a familiar face at the ASMS Annual Conferences over the years (attending the founding conference in 1989), and takes pride in his ASMS membership.

“ASMS has done a lot of good work raising important issues over the years, and it represents us well,” he says. Dr Vijay was inspired to take up medicine by his parents, especially his mother, who was an early graduate of a medical college for women in India.

“When I graduated she said to me: ‘Don’t forget to do good for fellow human beings to improve their lives. You must always remember that’ – and I have. It’s what I have tried to do over the years.”

After training in both occupational medicine in India and then psychiatry in the UK, he arrived in New Zealand in 1976, impressed by what he’d heard of the opportunities here. His career since has included posts as a consultant psychiatrist, clinical lecturer, and registrar and intern supervisor in Wellington, Hutt Valley and Palmerston North where he was the Chief Psychiatrist. He was involved in setting up the new psychiatric unit in Hutt Hospital.

He has seen significant changes – and progress – in the treatment of mental health over the years.

“We have come a long way in recognising that the mind and body is inter-connected, and that we have to concentrate on the wellbeing of both.”

Dr Vijay plans to spend more time with his family, do some lecturing, provide community health advice and indulge his love of music (harmonica, guitar, accordion and double bass).

“I have a very supportive family and now I will have more time to spend with them,” he says.
WHAT INSPIRED YOUR CAREER IN MEDICINE?

Funnily enough, I think it was the esteem that the local GP had. They had a certain standing. I lived in a comfortable part of town in York, these were all guys in tweed suits and our GP was just a nice, avuncular person. Having said that, my family also has a very strong medical and nursing background. My father was a psychologist and my mother and sister were nursing. Sisters, my aunt was a Matron, and my uncle was Major General W.C. Paton who was in command of India’s medical service before the partition in India. He was a surgeon, and a pretty impressive person.

Really I wanted to do history or archeology or languages, that sort of thing, and that was politely acknowledged by my family and then we moved on. I wasn’t someone who said: I must do medicine. I kind of drifted into it, and to be honest it was more about having a really good time at Edinburgh University. If you wanted to know where the parties were, I was the man. After all, this was the 1960s. After training at Edinburgh University, I went to the United States. Initially I wanted to be a psychiatrist but after some time in New York I realised that all the people with real psychiatric problems were being hammered with large doses of tranquilisers and everyone else with mostly imagined problems were off seeing expensive psychoanalysts. I changed my mind!

I worked at a Kings County Hospital in Brooklyn, New York, for two years. I was 24 when I went there and it was the hardest work I’ve ever done. Every day I was dealing with drug overdoses, alcohol and violence. I was shot at and even attacked with an axe. One time I was trying to give someone with the DTs an injection and I went to get an orderly, but the orderly was busy shooting up, so I had to wrestle with the patient on my own to get him onto an x-ray machine. I had to do all of my own lab work. It would take me about five hours to do an admission and I was on call every other day for two years. I worked on average 100 hours a week. It was a big shock after the cruisy life I’d had in Edinburgh.

You didn’t get any sympathy from your seniors, either. The attitude was well, we’ve done it so you can do it. It was inhumane, really. I guess the good thing I got from it was resilience. I was the shyest person out at the start but I learned that I was actually pretty strong.

I was going to stay in the States and in fact I was offered a really good job in San Francisco but decided it wasn’t worth it, because the price of citizenship at that time would have meant being drafted to Vietnam, and I didn’t want that. So I went to Canada for a couple of years and did research work, studied transplantation in rats, then studied the genetics of fruit flies. I then gave up medicine altogether.

Eventually my father, who was a very parsimonious Scotman, said look, I didn’t spend all this money on your medical education to have you collecting fruit flies. So I came back to London and sat the exam for membership of the College of Physicians, and somehow passed.

After that I went to a party, met New Zealander and future wife Jan and followed her out to New Zealand. I ran out of money after a few weeks so I organised a couple of references and brought the letters into Wellington Hospital to see if I could get a job. The next day I was on duty! I worked as a renal registrar for about four years, then went to Nelson to work as a GP for a year and then as a physician for another four years. After that I went to Iraq with an Irish private company that was contracted to a hospital by the Ministry of Health in Baghdad. It was fantastic. We did two transplants a week, and there were just two of us. It was like: oh it’s Tuesday, we must be doing a transplant. It was so efficient. I learnt Arabic so I could write my prescriptions and carry on a conversation. People would come on a 20-hour bus ride just to have a 15-minute consultation with me, and they’d say it was no problem. I was there for four years, including the Iran-Iraq war. I was on holiday the day Saddam Hussein invaded Kuwait, and I decided not to return! So I came back to New Zealand and worked as the Director of Family Planning in Wellington for a while before returning to Wellington Hospital to work as a renal physician. I’ve stayed there ever since and have finally managed to settle down!

About 10 years ago I started looking at clinical ethics, and five years ago managed to set up a clinical ethics group. I’m absolutely passionate about this. Everybody talks about it as a lofty abstract pursuit, but it’s much more than that. I’m retired now and my focus is on getting the Clinical Ethics Network New Zealand up and running.

WHAT DO YOU LOVE ABOUT MEDICINE?

It’s about helping people and being trusted. As doctors we are the bridge between science and humanity. We are able to interpret things so that people understand it. It’s about being patient and dealing with a lot of different approaches to life, asking the right questions and taking your time.

The challenging aspects of practising medicine can be reduced to a couple of things. I’ve been absolutely shocked by the pervasive influence of bullying, for instance. It’s just unacceptable. I’ve seen it on ward rounds or in other areas and I haven’t hesitated to say: actually this is a public space and you are giving me a bad name as a doctor so can you stop this, please. I’m very proud of the profession so this behaviour appals me. I know of two cases where people killed themselves in which I think bullying was involved. I was the RMO liaison officer for about 10 years at one point and RMOs would come to see me and burst into tears, and we’d just work through it. I’ve always believed in the pastoral approach.

The other thing that concerns me is to work with stewardship of our public health services. We need to avoid waste and use all of our resources wisely. It’s our responsibility to take care of what we have so that there’s sustainability of our public health service. We need to avoid waste and use all of our resources wisely. It’s our responsibility to take care of what we have so that there’s sustainability of our public health service. We need to avoid waste and use all of our resources wisely. It’s our responsibility to take care of what we have so that there’s sustainability of our public health service. We need to avoid waste and use all of our resources wisely. It’s our responsibility to take care of what we have so that there’s sustainability of our public health service.
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and/or events. This will often include the recitation of facts with knowledge of what happened in a context of the issues of the day. An expert opinion. A fact witness is a person who is not an expert.

Criminal and Family Court proceedings. The situations where this can arise are varied, including at Coroners Court, where the expert's role is to provide an opinion on the medical aspects of the case. It is fundamental to the role of an expert that subject.

It is based on formal training or qualification, and the expert is required to provide an opinion on a specific issue. This is in contrast to an expert witness who is required to provide an opinion on a specific issue.

THE ART OF GIVING EVIDENCE

Increasingly health professionals are required to appear before courts and tribunals to give evidence of both a factual and expert nature to help them reach the appropriate decision and outcome. The situations where this can arise are varied, including at Coroners Court, Criminal and Family Court proceedings. There is a clear distinction between providing factual evidence and giving an expert opinion. A fact witness is a person with knowledge of what happened in a particular situation. The witness' testimony consists only of the recitation of facts and/or events. This will often include the provision of the contemporaneous patient notes made at the time and other relevant material in the patient's file. This is in contrast to an expert witness whose testimony consists of an opinion. It is based on formal training or experience that allows them to form an expert opinion on matters associated with that subject.

It is fundamental to the role of an expert that you understand that you have an overriding duty to the court or tribunal and need to be impartial and objective. There is now a standard code of conduct for expert witnesses in the Judicature Act 1992 that you will invariably be provided with and asked to read and confirm on oath that you have read it and will abide by it. If this isn't provided to you by the party that engages you, you should ask for it.

YOUR BRIEF OF EVIDENCE

By all means have a draft of your evidence prepared by a solicitor setting out the relevant areas and topics that need to be covered. However, make sure that you prepare the brief in your own words and that it is expressed from your own point of view, as this will prepare you for giving evidence on the stand.

1. Understand the question. Always listen carefully to the question. If you are unclear or do not understand it, ask for clarification. Take your time. Good witnesses think before they respond.

2. Use the ‘golden triangle’. You need to engage with the people who are making the decision. Make eye contact with the cross-examiner when he or she is asking the question, but address the court/tribunal with your answer.

3. Plan speaking. The best witnesses give short concise explanations in a straightforward way to the court. Whenever possible give a yes or no answer. If you believe that you need to expand you can answer in this manner. The answer to your question is yes, but expanded you can answer in this manner.

4. Treat each question on face value. Don’t overthink the question or treat each one as a smoking gun. Don’t try to predict where the line of questioning is heading. Focus on answering that question only. Do not volunteer other information beyond what is asked. Some cross examiners will remain silent to get you to expand. Do not feel obligated to fill in that silence. Simply sit quietly and wait for the next question.

5. Take your time. The evidence is often being transcribed. Use this as an opportunity to pause and collect your thoughts. There is no rush. You will not be criticized for taking time to consider and answer your questions.

6. Keep calm. Your credibility may be affected by your composure and professionalism. You are not an advocate, you are an expert. A skilled cross examiner may try to unsettle you and some can be aggressive and at times barding on insulting. Remain calm and stay focused.

7. Make concessions. Don’t be concerned if you have to make a concession. Be prepared to do so. It often enhances your credibility rather than harms it. It confirms that you understand your role as an expert witness. This can include modifying previous answers to questions if you subsequently become aware that they might be erroneous.

8. Defend your opinion. While it is appropriate to be objective, you are there to defend the opinion that you have provided to the court. You should be robust in your opinion and not allow a cross examiner to undermine it with vague assertions and contrary opinions.

9. Wait for an ‘open question’. A skilled cross examiner will try to control your answers by asking you closed questions which require only short answers or yes or no responses. Cross examination is an opportunity to put your position before the court again and an open question allows you to do that. It is an opportunity that should be seized upon by you when you are absolutely confident of your position and you are only restating the evidence you have already provided.

CONCLUSION

There is no substitute for preparation. The mantra ‘prepare, prepare and prepare again’ should play over and over in your mind prior to any occasion where you are required to give evidence in a formal court or tribunal setting. Make sure you have all relevant documents collated and easily accessible. When giving your evidence remember the four golden rules and write them on a pad while you are giving evidence:

1. Deflect to the golden triangle.
2. Make sure you understand the question.
3. Answer the question as concisely as possible.
4. Stay quiet.

Bear in mind that lawyers are not infallible and are often as nervous as you. These excerpts, apparently from real trial transcripts, attest to this:

Lawyer: “How many autopsies have you performed on dead people?”
Doctor: “All my autopsies were on dead people.”

And:
Lawyer: “Doctor, did you say that the deceased was shot in the woods?”
Doctor: “No, I said he was shot in the lumber region.”

And finally:
Lawyer: “Now Sir, I’m sure you are an intelligent and honest man.”
Doctor: “Thank you. If I weren’t under oath, I’d return the compliment.”

THE SPECIALIST
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.org.nz) and are reprinted here for your information.

ABOUT CME TRAVEL TIME ON TOP OF CME DAYS

That the MECA provides for CME travel on top of your CME days? Clause 36.2(a) provides for ‘reasonable travel time’ as needed to undertake approved CME activities. Many DHBs have travel time guidelines in place – it’s sensible to check these when you apply and to agree on travel time before you leave. http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-five/clause-36/

ABOUT TIME IN LIEU OVER PUBLIC HOLIDAY

That time in lieu for working a public holiday can only be claimed once? That means, where a public holiday is Monday-said, if you work both the actual day and the Monday, you can only claim one alternative (or lieu) day. You will be paid at the appropriate rate for all days you work, but one public holiday only generates ONE alternate day of leave. http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-24/

ABOUT SECONDMENTS

That MECA clause 36.4 means you can apply for a secondment of two weeks, every three years? Secondments must be to a recognised unit for the purpose of your professional development and to upgrade your skills. Most DHB’s have an application process similar to that for sabbaticals. http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-five/clause-36/
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.