BURNOUT IN NEW ZEALAND’S SENIOR MEDICAL PROFESSION | P3

RESPECT, PATIENT SAFETY AND TEAM WORK | P7
Half of all ASMS members who responded to a survey in November 2015 are likely to be suffering from very high levels of burnout. This worrying statistic was one of the core findings from the recently released report into levels of burnout in the New Zealand senior medical workforce. Burnout is an issue of serious concern for the senior medical workforce, with clear implications for the health and wellbeing of individual doctors, as well as their patients.

This study is the first to assess levels of burnout in the New Zealand senior medical workforce using the Copenhagen Burnout Inventory (CBI). The results suggest that burnout is prevalent across the New Zealand senior medical workforce, with particularly high scores for individuals’ physical and psychological exhaustion across all DHBs. Work-related burnout scores were also high, with 42% scoring with high work-related burnout. This increased to 47% for women who responded to the survey. Women in general had statistically significant higher burnout scores than their male counterparts. Nearly 60% of women surveyed scored as having high personal burnout. Women aged 30–39 had the highest burnout scores, with nearly 71% in this demographic scoring with very high burnout. Both genders in the 30–39 age bracket had high burnout scores, with 62% scoring as having high levels of personal burnout.

There were significant differences according to medical specialty for work-related and patient-related burnout. Those working in emergency medicine and dentistry topped the work-related burnout prevalence, with 57% and 50% respectively. Those working in psychiatry had 49% work-related burnout and 30% patient-related burnout. Dentists also had 23% patient-related burnout. Across all respondents, patient-related burnout was only 16%.

The average hours worked across the week for respondents was 61.5 hours. This included hours on call and time spent at home doing administrative duties. There was a clear correlation between greater hours worked and higher overall and work-related burnout. Those scoring as burnt out had worked 64.5 hours on average over the week prior to the survey.

• 47% worked more than 14 consecutive hours in the survey, which was also correlated with higher overall and work-related burnout.
The DHBs scoring particularly poorly for mean rates of burnout were those with members numbering between 101 and 200. These DHBs include Nelson Marlborough, Hutt Valley and Northland, which also ranked highest in the burnout prevalence scores. ASMS members at Hutt Valley DHB, for example, had 63.3% prevalence of personal burnout, and Nelson Marlborough had 61.5% prevalence of work-related burnout as well as correspondingly high mean burnout scores across these categories.

Analysis of the qualitative comments cross-cut by DHB did not reveal any particular trends as to why this may be so, other than key points relating to workload that are consistent across the board. The differences according to DHB nonetheless do suggest that there are some factors that might be increasing work-related burnout at certain DHBs that would benefit from further investigation.

The high scores for work-related burnout, as well as the positive correlations between hours of work and work-related burnout, suggest that the impact of work and working conditions is a significant contributor to feelings of exhaustion and fatigue. The relatively low incidence of patient-related burnout suggests that the majority of respondents attributed their fatigue and feelings of exhaustion to factors other than their interactions with patients, although some specialties did find interactions with patients a source of burnout.

Compared with other studies using the CBI, the findings from this research suggest the levels of personal and work-related burnout in ASMS members are significantly higher than baseline scores found in Danish human service workers. Scores for patient-related burnout, however, were similar to those found in other studies, and in some instances were lower. The scores for personal- and patient-related burnout were very similar to those found in the German study of physicians, which also had a similar sample size.

Increasing mean and burnout prevalence scores were strongly correlated with worsening self-rated health status, suggesting that burnout has a clear relationship with poor health, although directionality cannot be inferred from the findings. A multiple regression analysis also found poor health status to be a significant independent factor associated with burnout. Given the high rates of presenteeism found in the burns study conducted by Surgenor et al., which was based at Canterbury DHB in 2006-2007, the findings from their study, which used the Maslach Burnout Inventory (MBI), found prevalence of burnout was relatively low, particularly for emotional exhaustion and depersonalisation. It is worth noting that Canterbury has subsequently experienced considerable upheaval, in part due to the earthquakes of 2010 and 2011.

Mean burnout scores for Canterbury as reported in this study were 46.5 for personal burnout and 42.9 for work-related burnout, and were around the middle range of burnout scores for DHBs. Notably, however, Surgenor et al. found that longer working hours and less medical experience were both independent factors that increased the odds of scoring as burnout for emotional exhaustion in the MBI. This is similar to the results of the multiple regression analysis in this study, with age possibly acting as a proxy for length of medical experience.

Overall, the findings from this survey provide an important insight into the psychosocial health of senior doctors and dentists working in New Zealand’s public health sector.

The high proportion of this critical workforce currently feeling tired, worn out and uncertain is of great concern. Further research is needed to consider the extent to which these high levels of burnout are affecting patient care and whether burnout is influencing other workforce trends, including retirement intentions.

Meanwhile, these findings act as a clear call to government, health policymakers and DHB chief executives to urgently address burnout and help those already afflicted. The clear emphasis on staffing levels, hours of work and poor resourcing suggests major changes to better resource DHs and improve management culture are required.
GENDER AND BURNOUT

The research identified a spike in the prevalence of burnout for women in general, but specifically among women aged 30–39 who had over 70% high personal burnout. Men in the same age group had 51% high personal burnout, which is still high but much lower than their female counterparts. Women surveyed were significantly more likely to score as burnt out across personal and work-related measures of burnout than their male counterparts. Being female also significantly increased the odds of scoring ≥50 for personal and work-related burnout by 2.1 and 2.6 times respectively.

The trend for women to have worse burnout scores held when cross-cut according to age and self-rated health status.

The literature on connections between gender and burnout is varied. Some studies find that male physicians are more likely to experience burnout than women, whereas others have found the opposite. Hence, research into levels of burnout in Australian medical graduates, women, and medical students found females had significantly higher burnout scores than their male counterparts, although possible contributing factors were not explored.

One study found no significant difference in burnout scores held when cross-cut according to age and self-rated health status.

The possible connections between life stage, gender and burnout, however, must also be considered in light of the culture of medicine. In previous research on the ASMS membership women in the same 30–39 age group scored very highly for rates of working through illness. In contrast, this previous study referenced stress and tensions manifesting between the expected norms of professional behaviour and commitments to family life and self.

The variations in gender burnout scores appear to be at least partly related to which tool is used to measure burnout. In one study, the burnout scores varied according to gender depending on whether they were reporting the CBI scores or the MBI findings. In their research, females had higher scores for personal and client-related burnout than their male counterparts, whereas men had worse burnout scores according to the MBI.

Both prevalence and mean personal burnout scores peak for women aged between 30 and 39. This may reflect particular life-stage issues, such as the challenges around establishing oneself as an early career specialist and possibly being involved with the demands of young children. For example, one woman in the sub-group of 35–39-year-olds who left comments noted: “I have a small toddler at home and am currently pregnant. Not sure that is more exhausting - work or home?”

Future research would benefit from having additional questions about the number of dependents and their care arrangements as a variable against which to analyse the findings and to investigate this trend further.

To this end, the ASMS is currently investigating levels of interest for setting up a network in women in medicine network that, at least initially, could seek to provide support, advice and mentoring for women who may be experiencing different issues in burnout.

As some authors have noted, there was the hardest part of being a female in the medical workforce is resisting the notion that we should work in our own time to keep up with our paperwork. Family and childcare commitments mean that I can’t work from home in my own time and, quite frankly, I won’t allow myself to fall into that habit. This is something that I have managed to do in the UK. I don’t want to see such a change in culture in my future.

If members were interested in such a network, or had other suggestions, please make contact with Charlotte Chambers either by email or phone O4 499 1271.

REFERENCES

Harm]. How can we stand idly by when we're in fact violating the first commandment of medicine: “When we tolerate the harm of our patients, we are involved in causing harm.”

The organisation surveyed 1,200 recently hospitalised people and found a striking link between respectful treatment and turnover, and it is clear why it has become increasingly important. Workforce issues were tentative and largely unspoken before, but are emerging as the primary concern now, and there is a word of the day: “respect.”

“Being respected isn’t just about personal details, their health conditions, their names,” says Dr O’Sullivan. “It’s about acknowledging the fact that each person is an expert in themselves, their story of belonging. I was part of the team. There were times we did receive robust feedback on our performance, but we never felt as if we were being ‘attacked’ or bullied. On Friday afternoons, all of the senior doctors joined us in Easy Riders for a beer and a social chat before they headed home. In Easy Riders, we were all equals, friends and colleagues.”

Supporting her son’s arguments, Dr O’Sullivan explains how the respect that went on between a doctor and his patient was so natural that it became a matter of common decency, and the cornerstone of the therapeutic relationship.

Dr O’Sullivan gives an example of a patient who was taking care of his mother, and was feeling extremely burdensome and overworked.

A national shortage of psychiatrists is a problem that has reached far beyond New Zealand. Child and adolescent psychiatrist Martin O’Sullivan, who works at Whangarei Hospital, says it’s an ongoing struggle to recruit and retain psychiatrists in this area. While the psychiatry service is usually short by one or two FTE, at the moment it’s down by several people — and that puts pressure on existing staff.

“Respect is a two-way street. If you don’t give respect, you don’t deserve to receive it. Atul Gawande, a surgeon and respected writer, points out in an article ‘Cowboys and pit crews’ in the New York Times: ‘The practice of medicine no longer be delivered by individual doctors but requires coordinated care similar to that of pit crews. He makes the point: ‘And they include teamwork, the recognition that others can save you from failure, no matter who they are in the hierarchy.’

There is no question that services here are stretched,” says Dr O’Sullivan. “In a community like Northland there are high levels of adversity, poverty, alcohol and drug use, and there is a sense of widening gap between the haves and the have-nots. It’s a stressful environment for psychiatrists to work in.”

The Northland shortage is part of a bigger national and international picture. Overall, New Zealand is below average among OECD countries in terms of salaries and levels (including registrars) per population, with 1.6 specialists per 10,000 population in 2016, compared with the OECD average of 1.7.

A glance at the New Zealand medical registrar shows that as at July 2016, there were 566 vocational registrars (voc reg) psychiatrists with New Zealand addresses. That works out at 1.2 psychiatrists per 10,000 population, based on current population estimates.

The state of the mental health and addictions workforce has been on the minds of health-care makers for a while, and various reports have been published. Earlier this year ASMAs made a submission to the Ministry of Health on its draft Mental Health and Addiction Workforce Action Plan 2016-2020. A full copy of the ASMAs submission, which is available at: http://www.asmas.org.nz/wp-content/uploads/2016/03/Submission-to-MOH-Draft-Mental-Health-and-Addiction-workforce-action-plan_165979.3.pdf

The Ministry’s action plan acknowledged shortages in the specialist workforce and anticipated a doubling of demand for mental health and addiction services by 2020. Despite this, ASMAs noted in its submission that the workforce issue was tentative and largely dependent on the availability of funding.

For my adult psychiatry colleagues there has been higher than usual vacancy rates in the DHBS’s psychiatric inpatient unit in recent years, resulting in staff who are very unwell by the time they enter the hospital system.

On-call work is more onerous, and psychiatrists in the region do a high proportion of first on call. All of this has led to some historic tensions with management over hearing and acting upon clinical requests. With the specialist job intake and retention factors, such as the relationship with management, are definitely improving but still a concern to be addressed.

“Colleagues tell me that there’s a very high threshold for admission to Whangarei Hospital’s adult inpatient unit,” says Dr O’Sullivan. “When patients are admitted, they are often very ill with high levels of aggression or high risk of suicide. It’s very challenging to provide treatment in these circumstances and to know that people are not fully recovered by the time they leave the hospital.”

Martin O’Sullivan moved to New Zealand four years ago from a role as Clinical Director at the Mater Hospital in north Dublin and a stint as a consultant with the South London and Maudsley NHS at Guy’s Hospital in south London. He came here for a year but fell in love with the place. His experience gave him a realistic understanding of resource difficulties, but he thinks Northland’s issues need to be addressed.

Recruiting and retaining psychiatrists has been an ongoing battle, he says. “There is a small pool of potential applicants and if people know there are problems with retaining here it can be hard to attract people to the area. The fact we don’t have a clinical director is an additional problem for the service. The reality for local clinicians is that they have so much to do and it’s almost impossible to take on additional leadership responsibilities.”

The answer, at least in Northland, requires an effective clinical and managerial partnership that provides opportunities for real collaboration and shared decision-making. The service also needs a clinical director and the inpatient unit needs to expand its bed numbers to ease some of the pressures on psychiatrists.

It’s a very real situation here. That’s one of the first things that struck me. Ultimately, it’s our families or whānau who take on the burden of receiving people who are still quite unwell back into the community. While it’s stressful for psychiatrists we should not forget our families who bear the brunt of these resourcing issues.

### DHB MECA NEGOTIATIONS

You can keep up to date with the progress of the ASMS–DHB MECA negotiations through our weekly updates at http://www.asmas.org.nz/wp-content/uploads/2016/09/DHB-MECA-Bargaining-Bulletin-6.pdf, and some of the matters that arose are also covered in Ian Powell’s column on page 13 of The Specialist.
PATH TO PATIENT CENTRED CARE

Making Time for Patient Centred Care

Lyndon Keene | ASMS Director of Policy & Research

While of course not all DHB senior management have strained relations with their senior medical staff, many senior doctors would probably agree that the general state of disharmony between themselves and senior management is mirrored in the ‘leadership and engagement’ in the National Health Service (NHS) in England, published by the King’s Fund.1

It is a striking feature of the NHS that it employs some of the brightest people in the creative arts, humanities and sciences, yet alienates many of them. Consultants are more likely to say they work ‘at rather than with’ their projects. This perhaps might underestimate both their power and responsibility when it comes to improving quality and productivity.

But being a doctor often doesn’t feel powerful. They may have no budget, no status to make demands on the administration, no power to hire and fire, and little influence over the organisation’s goals. Yet the decisions they take not only have a profound impact on patients, but on the quality of care, productivity and reputation of their employer.

The importance of ‘medical engagement’ and ‘clinical leadership’, as well as ‘collaboration’ and ‘service integration’ and now ‘patient centred care’ (which depends on all of the former), are well recognised as policies central to achieving quality of patient care.

There is no top-down, imposed way to integrate care; it will be done through distributed, engaged leadership or it will not be done at all – The King’s Fund, 2012

Quite simply, the reforms we need are only likely to be successful if clinically led – Professor Des Gorman, Executive Chair, Health Workforce New Zealand.

But aside from the isolated pockets of success, policies promoting engagement and distributed clinical leadership, which are prerequisites for successful patient centred care, have failed to gain much traction, either here or in other systems like the NHS. The complex adaptive nature of health services means the reasons for this are numerous and varied, but there are two that stand out in the literature that are inter-related: policies supporting top-down decision-making reflected in the comments opening this article, and lack of clinician time due to clinical workload.

That many of New Zealand’s senior doctors, like their NHS counterparts, feel disempowered and under-valued, is well documented in the Senior Medical Officer Commission report of 2008, and feedback from ASMS members to now suggests little if no improvement.

I am the nominated clinical leader for our service. Despite this, my ability to influence any aspect of the operation of our service is severely limited. It is this constant lack of control – the knowledge that things could be much better than they actually are but the inability to make the necessary changes – that is so sapping for me. – ASMS Burnout survey respondent 2016

I left the UK [United Kingdom] because of frustration with the stupid health care system. I came to New Zealand as the system here was much better. The bias has followed me. – ASMS Burnout survey respondent 2016

Top-down leadership, or managerialism, is typified by laying down demanding targets, leading from the front, often being reluctant to delegate or making changes little – and is the consequence of the health service focusing on targets, budgets and throughputs with recognition and reward dependent on meeting them. Such policies have been described as dehumanising health care.

They are policies that produce a kind of culture where leaders become detached from those on the front line and the consequences of their decisions – a trend discernible not just from organisational management but also from far up the chain.

As Robert Francis notes in his inquiry into the failings at Mid Staffordshire NHS Foundation Trust: “...Department of Health officials are at times remote from the reality of the impact of the service they oversee on patients.” This led to the board and senior managers prioritising and explicitly rewarding the achievement of financial targets while overlooking patient safety and basic care standards – in search of that shorthand stuff began to see finance and targets as ends in themselves. The result, in Francis’s words, was “a culture focused on meeting the organisation’s business – not that of the patients.”

The policies of top-down command and control leadership have been found incapable of accommodating the complexities of a more participative, supportive environment that is required for patient centred care.

Instead, those policies have introduced a system that enables politically oriented micro-management where, in the words of one former senior Ministry of Health official, “clinician decision space is shrinking fast.”

Worsening the effects of those policies is a well-acknowledged ‘time trap’. While the quality of the patient-doctor interaction is considered to be at the ‘heart of patient centred care’, having the time to ensure good quality care arises frequently in the literature discussing barriers to the patient centred care approach.

A systematic review of health professionals’ perceptions of the barriers and facilitators to implementing shared decision-making with patients found the most often reported barrier to be time constraints (18 of 28 studies). The review included the views of more than 2,784 health professionals (most of them doctors) from 15 countries. Time barriers can be directly or indirectly related to the quality of interactions between patients and doctors. Senior doctors need time to have the (sometimes many) conversations with the patient and family, especially if the patient has difficulty understanding the information, and recognising an aging population will lead to increasingly complex needs. They need time to undertake clinical supervision and continuing professional development to maintain good quality communication and cultural competency skills in a constantly changing environment with changing expectations. They need more time for multidisciplinary teams and delivering better integrated care. All of which are key factors in delivering good quality patient centred care.

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As ASMS surveys of heads of department in two DHBs, to ascertain the adequacy of current senior doctor staffing levels in two DHBs, to ascertain the adequacy of current senior doctor staffing levels in New Zealand, our service is severely limited. It is this constant lack of control – the knowledge that things could be much better than they actually are but the inability to make the necessary changes – that is so sapping for me.

The Disposition and Mobility of Medical Practitioners in New Zealand, 2012

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In order for patient centred care to become a reality, the immediate task is to address senior medical workforce shortages, not only to ensure safe staffing levels but also to enable senior doctors to find the time for all the activities associated with developing patient centred care.

In addition, policies that impede patient centred care must be replaced with policies that facilitate the best quality interaction between patient and doctor.

a ‘bottom-up’ approach that, from the senior medical workforce perspective, includes, critically, policies that foster clinical engagement and distributed clinical leadership in practice.

The ASMS’s first four short papers on patient centred care have focused on the topic from mostly a senior medical workforce perspective. Future work will consider other aspects of patient centred care, such as exploring strategies that have been shown to support patient and community engagement.

REFERENCES


3. The King’s Fund (2012).


A DAY IN THE LIFE OF AN ASMS INDUSTRIAL OFFICER

SARAH DALTON | ASMS INDUSTRIAL OFFICER

Job sizing is an important aspect of our work. Its aim is to support SMOs to regulate their individual and collective workloads, and to offer an evidence-based approach to managing staffing. Increasingly, we find that clinical and support staffing is pared back, so that members often find it challenging to use their leave entitlements; but also that cuts to nursing and allied staffing mean senior doctors have to work outside of their scope – to the detriment of service efficiency, teaching and patient care.

Disagreements and differing interpretations about CME entitlements, for example, are a frequent occurrence. So, from time to time, we work with our branch officers and HR staff to develop guidelines that help all parties better understand the provisions in the collective agreement. This can involve anything from meetings, to drafting and reviewing documents, to running seminars and member workshops.

Direct contact with our members is at the heart of our work.

When I sit down with SMOs in a particular service to discuss call or availability requirements, we often touch on a raft of clinical and workplace issues that are constantly being juggled and balanced. Members feel a real sense of frustration that the goodwill they put into their work on a daily basis does not always appear to be reciprocated as management quickly claw back allowances when staffing changes occur. Senior doctors value genuine engagement and discussion – particularly when it relates directly to provision of clinical services within their own department or service. We spend quite a bit of time working with members on how best to tackle changes to call and related staffing issues.

Committees and meetings are the bane of everyone’s life. Although much of our work is at the pointy end and focused on MECA education, engagement and enforcement, we also like to be proactive and want to be part of positive developments in workplace culture and conditions. That’s the thinking behind meetings like workplace health, safety and wellbeing committees, and our regular JCC meetings between ASMS and each DHB.

HEALTH SYSTEM LEADERSHIP DEFICIT HIGH RISK FOR PATIENTS

IAN POWELL | ASMS EXECUTIVE DIRECTOR

In respect of hierarchy, much of our health system leadership is located with the Minister of Health, Ministry of Health and at the top echelons of DHBs (boards, chief executives and senior management). This does not ignore the role of agencies such as the Health & Disability Commissioner and Health Quality & Safety Commission, but while they influence, they don’t lead on policy and operational matters.

I have been reflecting for some time on the quality and capacity of this leadership, which has come into sharper focus as the impact of ongoing health funding shortages become apparent. While funding has increased in absolute terms, it has not kept up with the increased costs of providing health care driven by increased demands on the health system, which, in turn, are driven by factors such as the aging of the population, population growth and increasing poverty. Since 2010, an estimated $1.5 billion (at least) has been sucked out of the DHBs.

There is a narrative that financial adversity brings out the best of leadership. This is a myth.

The far greater likelihood is that it brings out the worst and exposes serious leadership deficits.

DHB CHIEF EXECUTIVE LEADERSHIP

I have been known from time to time to be critical of DHB chief executive performance, either individually or as a group. But earlier this year I was outflanked by someone who publicly:

• expressed doubts about whether the talent is there to take up the high-salaried positions running our 20 DHBs
• asserted that we lacked a good system for developing talent for and training executive management, including chief executives

Jonathan Coleman in an interview with the Otago Daily Times. His comments were backed up by the name of some or all of them to the Minister of Health, Ministry of Health and at the top echelons of DHBs (boards, chief executives and senior management). This does not ignore the role of agencies such as the Health & Disability Commissioner and Health Quality & Safety Commission, but while they influence, they don’t lead on policy and operational matters.

There is a narrative that financial adversity brings out the best of leadership. This is a myth.
HEALTH MINISTER WALKS AWAY FROM CLINICAL LEADERSHIP

But then we have to consider the signals the Government gives DHBs. ASMS was disappointed to learn that, for the first time for many years, the Health Minister’s annual letter to DHBs contained no reference to clinical leadership as one of their priorities. We formally wrote to the Minister expressing our serious concern over this policy shift. Jonathan Coleman, in reply, maintains that he is still committed to clinical leadership, but this is unconvincing.

Further, the message that this gives to chief executives and senior management teams is unambiguous – clinical leadership emblemed at all levels and in the culture of DHBs is not a priority; other things are more important. These other more important things included ‘Living within our means’ and deficits and achieving heavily monitored targets that only apply to that small part of what public health services do that can be counted. ‘Living within our means’ and deficits in particular are best achieved through medium to longer term decision-making based on distributive clinical leadership rooted in an engagement culture and sufficient workforce capacity to deliver. But all the incentives reinforced short-term decision-making, creating a high risk of poorer longer term financial performance occurring on someone else’s watch.

It is reasonable for Dr Coleman to chastise chief executive leadership. But it would also be reasonable for him and his government to take responsibility for creating the environment that has exposed the sector’s leadership deficits and risks to quality of care.

WHAT ABOUT THE HEALTH MINISTRY?

In this context, the direction of the Ministry of Health needs to be considered.

Director-General Chai Chuah has a focus on leadership in general terms but not clinical leadership in particular. In doing so, he misses the boat.

He refers in general terms to three types of leadership in a manner that seems more structurally rigid rather than organically dynamic: strategic thinkers, high performing implementers and networkers. Linking to the revised new health strategy he identifies five themes:

1. people-powered
2. closer to home
3. value and high performance
4. one team
5. smart system

But, in the absence of specific contexts and application, these are merely slogans that can mean all things to all people. Because they are so high level, they are unlikely to resonate with the sector.

Substantive innovations in the health sector require three things:

1. workforce
2. technology
3. distributive clinical leadership.

The Ministry’s direction appears to accelerate the importance of technology, making the two drivers ‘also run’. But, if we neglect workforce and clinical leadership, then the benefits of technology are minimised at best and lost at worst.

BACK TO DHBs, BURNOUT RESPONSE

Coming back to DHBs, the reaction to the scary results of ASMS’s recently published burnout survey is instructive.

Before the official release of the burnout survey, ASMS had written to chief executives in all the 20 DHBs giving them a heads-up of this pending event and expressing interest in discussing the results with each of them as soon as possible. The letters did not call for a substantive response other than perhaps acknowledging the need to discuss the survey results with us.

The DHBs have a national shared services agency called DHBs Shared Services (DHBSS). Its main role is to provide advocates for the DHBs’ collective bargaining teams, employment relations advice to DHBs and secretarial support for national DHB meetings (eg. chief executives and chief medical officers).

Upon becoming aware of ASMS’s heads-up, DHBSS drafted a recommended letter of response for chief executives that was dismissive of the survey results, downplayed the significance of SMO burnout, falsely asserted that ASMS had reached an agreement with the HR general managers at a national meeting over how the results of the survey would be handled and missed barely relevant data.

The reference to the HR general managers was a regular national meeting in May where ASMS gave a presentation on the preliminary results of the survey. The minutes of the meeting recorded some agreements reached between the HR managers after ASMS representatives departed. But these were then cut-and-pasted into the recommended letter. When read in the context of preceding and subsequent paragraphs, it suggested ASMS had breached a national agreement to the survey results agreed between ASMS and the HR general managers.

A small number of chief executives, in effect, copied the DHBSS letter on to their own letterheads and posted them off to ASMS. On the other hand, most chief executives appear to have binned it. While the main response is good, it remains disturbing that the DHBs’ shared services agency can provide such poor quality and disingenuous advice over such a serious and threatening issue as SMO burnout.

Let’s leave the final word to the Ministry of Health. In a recent circular promoting attendance at a national health symposium being organised for November, the Ministry trumpeted that over “...the two days we will explore the techniques of Exponential Organisational Strategy and Disruptive Innovation. We will look at how they can transform the health system...”

At a time of under-funding, under-investment in the health professional workforce, overworked and overstretched specialists, and alarmingly high burnout among senior doctors, the best we get from our central government leadership is exponential organisational strategy and disruptive innovation. If this doesn’t mean Mid Staffordshire culture and outcomes, here we come, then what does?

DINNER AND PRE CONFERENCE FUNCTION

A pre-conference function will be held at The Boatshed on the evening of Wednesday 16 November, and a conference dinner will be held on Thursday 17 November at Te Marae, Te Papa. These are a great opportunity to mingle with conference delegates and others in a relaxed social setting and, of course, to enjoy some of Wellington’s fine hospitality!

LEAVE

Clause 29.1 of the MECA includes provision for members to attend Association meetings and conferences on full pay. The ASMS makes all travel and accommodation arrangements for ASMS delegates to attend its 28th Annual Conference. Please contact our Membership Support Officer, Kathy Eaden, at ke@asms.nz if you have any questions about your arrangements.

ASMS 28TH ANNUAL CONFERENCE

THURSDAY 17 & FRIDAY 18 NOVEMBER 2016
THE OCEANIA ROOM, TE PAPA, WELLINGTON

DINNER AND PRE CONFERENCE FUNCTION

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www.asms.nz
Burnout, the burden of being on call, progress on the DHB MECA negotiations, and staff safety - these were top of the agenda when ASMS branch officers gathered in Wellington in August for their annual national workshop.

Branch officers (or their representatives) from around the country attended the day-long workshop, along with National Executive members and staff from the ASMS national office.

As always, the workshop featured lively presentations and discussion on topics relevant to ASMS members.

“The annual workshop is an opportunity for branch officers to discuss pressing issues for their members at a local level and to also influence and contribute to the work being undertaken by the ASMS,” says ASMS Executive Director Ian Powell.

Questions tackled during the day included ways to challenge ‘the new normal’ involving shortages and shortcuts becoming business as usual, ideas to improve SMO cover arrangements and health and safety priorities.

Following opening remarks by ASMS National President Dr Hein Stander, the workshop discussed the following topics:

- Giving up call - Tauranga Branch President Dr Matthias Seidel and Senior Industrial Officer Lloyd Woods
- Staff safety - Counties Manukau Vice President Dr Sylvia Boys and Industrial Officer Sarah Dalton
- MECA report back - Ian Powell
- Burnout research findings - ASMS Principal Analyst Dr Charlotte Chambers presented on this as part of the ASMS’s publication of the results on the same day
- JCCs and building branch engagement, introduction to mapping - Ian Powell and Lloyd Woods.
The ASMS has been recording the salaries of specialists and medical and dental officers working at DHBs throughout the country since 1993. Information is requested from DHB human resources about the number of senior medical and dental staff on each step of the salary scale as at 1 July 2016, whether they are ASMS members or not. The salary steps are those derived from the ASMS DHB multi-employer collective agreement (MECA), which came into effect on 1 July 2015. The current findings reflect the number of people on each step rather than full-time equivalents.

In addition to recording numbers of senior medical and dental staff per salary step, the survey requests a breakdown of these numbers by gender. This provides an insight into the gender composition of senior medical and dental staff according to DHB, as well as allowing us to track changes in this regard since the data became available over 10 years ago.

The figures report an increase in the average specialist salary of 5.7% from $192,861 to $203,910. This increase is likely due to progression through the salary scale but may also be influenced by wider margins between the higher steps as negotiated by ASMS in the previous MECA negotiations. The highest average salary for medical and dental officers this year is at Whanganui DHB ($203,164) and the lowest is again at Counties Manukau DHB ($190,462).

There was a decrease in the average medical and dental officer salary of 2.8%, compared with the previous year. Contributing factors may be medical officers at the top of the scale retiring without necessarily being replaced or there may be instances where individuals are transferring to the specialist scale as a result of obtaining vocational registration (including, for example, in rural hospital medicine).

As at 1 July 2016, there was a total of 4,560 specialists and 484 medical and dental officers employed across New Zealand’s DHBs, giving a total senior medical workforce of 5,044 individuals. In respect of gender, 2,946 (64.6%) of specialists were male and 1,614 (35.4%) were female. This represents an increase in the number of male specialists of 5.2% and an increase in the number of female specialists of 5%. Proportionately, this 64:35 gender balance has not changed from the previous year. For medical and dental officers, 256 (52.9%) were male and 228 (47.1%) were female. This represents a decrease in the number of male medical and dental officers of 1.5% (four fewer) and a decrease in the number of females of 4.4% (11 fewer) from 2015.

In 2016, 1,802 (40%) of all specialists were on the top step of the salary scale, compared with 1,629 (38%) in 2015. In terms of the gender distribution on this top step, 432 (24%) were female and 1,370 (76%) male. For medical and dental officers, 232 (48%) were on the top step, comprising 102 (44%) females and 130 (56%) males. For both specialists and medical and dental officers, the overwhelming majority were on the top step with the next largest grouping of specialists being on step 5 (499 individuals). The next largest grouping of medical and dental officers was on step 1 (64 individuals).

In 2009/10, Core Crown Health Expenses were 6.67% of gross domestic product (GDP). For 2016/17, Core Crown Health Expenses are forecast to be 6.26% of GDP. If Core Crown Health Expenses had maintained the proportion of GDP they had in 2009/10, they would be $1.08 billion higher in 2016/17.

SOURCES:
Budget Economic and Fiscal Update, New Zealand Treasury, May 2016.

NOTE: CORE CROWN EXPENSES
These are the day-to-day spending that does not build or purchase physical assets by the core Crown. This is an accrual measure of expenses and includes non-cash items such as depreciation on physical assets. Core Crown Health Expenses include some expenditure outside of Vote Health, such as spending for the Health Research Council.

SOURCE:
Budget Economic and Fiscal Update 2016.
The ASMS has had members employed outside of DHBs for many years and our membership has steadily grown. Our aim is to recruit employees who are working outside of DHBs wherever it is possible and, given a majority of doctors join, to negotiate collective agreements for them. There is tremendous scope, particularly with GP practices, although it is difficult to determine where GPs are employees rather than owners or contractors.

Currently, we already have 226 members employed across almost every part of the New Zealand non-DHB sector by 48 different employers. We have two MECAs outside of DHBs, the larger covering 12 hospices (with a thirteenth currently being included) and 37 members. The smaller is our MECA covering union health centres in the wider Wellington region, with four employers covering 20 members. We have 13 single employer collectives covering 117 members as shown in the table below.

<table>
<thead>
<tr>
<th>Employer</th>
<th>Type of employment</th>
<th>Number of members</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>Branch and Senior Medical Advisors</td>
<td>31</td>
</tr>
<tr>
<td>Ashburn House</td>
<td>Mental health</td>
<td>3</td>
</tr>
<tr>
<td>NZ Blood Service</td>
<td>SMOs</td>
<td>4</td>
</tr>
<tr>
<td>Central Otago Health Services (Dunstan Hospital)</td>
<td>SMOs</td>
<td>7</td>
</tr>
<tr>
<td>Family Planning</td>
<td>SMOs</td>
<td>21</td>
</tr>
<tr>
<td>Hokianga Health</td>
<td>General practice</td>
<td>6</td>
</tr>
<tr>
<td>Te Runanga Ta Rangatira</td>
<td>iwi-based general practice</td>
<td>17</td>
</tr>
<tr>
<td>Ngati Porou Hauora</td>
<td>iwi-based general practice</td>
<td>3</td>
</tr>
<tr>
<td>Golden Bay’s Community Health</td>
<td>General practice</td>
<td>6</td>
</tr>
<tr>
<td>Otago Union Health Centre</td>
<td>Union health general practice</td>
<td>3</td>
</tr>
<tr>
<td>Christchurch Union and Community Health</td>
<td>Union health general practice</td>
<td>6</td>
</tr>
<tr>
<td>Compass Health</td>
<td>Sexual health services</td>
<td>6</td>
</tr>
<tr>
<td>Waitaki District Health (Oamaru Hospital)</td>
<td>SMOs</td>
<td>4</td>
</tr>
</tbody>
</table>

The remaining 52 members are spread across 18 employers that are just as diverse as the list above.

We encourage you, as ASMS members, to mention to colleagues outside of DHBs that the ASMS is very interested in providing membership coverage outside of the DHBs and that they are most welcome to contact one of the ASMS industrial officers.

Panel discussions in Auckland and Wellington on the rights and responsibilities of professionals ‘speaking out’ were stimulating and well-attended, report the organisers.

One of the speaking-out events was held in Auckland on 11 August and the other in Wellington the next day, immediately after the ASMS branch officers’ workshop. Both events were organised by the education union New Zealand Educational Institute Te Riu Roa in conjunction with several other unions, including ASMS, the New Zealand Nurses Organisation, Public Service Association, Tertiary Education Union and the New Zealand Post Primary Teachers’ Association.

The idea was to spark a conversation about the importance of speaking out for democracy, good outcomes and for good policy-making.

ASMS members Dr Joshua Freeman and Dr Erik Monasterio spoke at the events – both have spoken out publicly previously on issues such as the Trans Pacific Partnership Agreement. Other speakers included Jessica Walker, a high school teacher from Brisbane who has been active in speaking out for refugees, physicist and author Professor Shaun Hendy, and principals from schools in Auckland and Wellington who have spoken out about the introduction of national standards.

More than 100 people attended the Wellington event alone; a mix of doctors (including ASMS members), nurses, teachers, public servants and scientists.
Intensive care specialist David Galler has been telling tales. His book, Things that matter: Stories of life & death, is a collection of his personal experiences and reflections on practising medicine for quarter of a century – and he says he loved writing it.

“Really, really enjoyed it. I still can’t quite believe I’ve produced this book.”

“For doctors, writing is an opportunity to express our feelings about some of the profound things we come across. So much of what we do is not black and white, it’s grey, and we want to help people to understand that.”

Dr Galler has been an intensive care specialist at Middlemore Hospital in Auckland for 25 years. He is also the clinical director at Ko Awatea and a former ASMS National President, and is one of the leaders of the innovative doctors’ writing website, the Medicine Stories Project (http://themedicinestoriesproject.co.nz/).

He wrote the book when he took a year’s leave of absence from Middlemore to live in Samoa and work voluntarily for the National Health Service of Samoa during 2015.

“Life in Samoa was less complicated than it is at home in Auckland so although I was really busy working and on call everyday, when I did have time I wrote. I had a spot on our verandah that overlooked a lovely garden. I mapped out the things I wanted to discuss, and then worked on the book.

“What surprised me was how difficult it was to sit still! I couldn’t believe the level of distraction that I was used to. Being still was quite an achievement, rewarded with the pleasure to think and remember, and to let the connections between things come to me.”

The book is available for sale online and in bookstores.


**REVAMPPING PASSION – LAUNCHING THE MEDICINE STORIES PROJECT**

DR JEFF BROWN | ASMS NATIONAL EXECUTIVE, ON BEHALF OF THE MSP TEAM

Last October we went fishing. A gentle cast onto the ocean of emotion.

A website for doctors to send stories, to expose their jottings to inspection, to open their notes for others to read. We offered editorial and literary advice to gently polish the pearls. We caught the eye of doctors from the breadth and depth of medical practice, netting poems and prose submissions that took our breath away.

Over the first six months, the Medicine Stories Project was clicked on and viewed, stories searched, blogs read, and the web team collected data on what pages and portions grabbed most interest. We have used this data to revamp the website to bring your stories to the front, refreshed the design to enhance accessibility, added a list of stories by doctors in Aotearoa New Zealand over the centuries, and highlighted the authors of the stories we publish.

In the months since last October, passion has shone through. Windows have been opened into your minds. Your submissions have generated admiration, respect and wonder. Now we are ready for more.

Our website has been relaunched. Our fishing is fleet. Whatever your hook, whatever your catch, whatever your passion, we have revamped our repository for your writing. Be brave and leap into our harbour of hope.

http://themedicinestoriesproject.co.nz/
During this period, I did my British exams in occupational medicine, and then the Australian exams.

I was deployed in Iraq for six months with the United Nations Special Commission, following the Gulf War, where I was the New Zealand national officer, in charge of the New Zealand team of military people in Iraq and the Senior Medical Officer for the UNSCOM. My predecessors were directly involved with overseeing the medical aspects of locating and dealing with chemical weapons of mass destruction. By the time I was there, most of those chemical stockpiles had been destroyed but we were still searching for residual supplies and monitoring the sites where they had been developed or stored.

The medical team looked after the military personnel and the scientists who came into Iraq to do all these inspections. That was interesting because there were some very unkind and unwell scientists who came to Iraq for two weeks at a time, into 50 degrees Celsius heat which played havoc with their heart disease, diabetes and other chronic medical conditions. Some of the people coming into Iraq were US or other military experts on munitions, chemical weapons, etc and they were usually extremely fit and well-acclimatised, but other people were arriving from a civilian background from countries such as Germany, Britain, etc and they weren't necessarily in good health.

**HOW DID YOU END UP WORKING FOR WAITEMATA DHB?**

I left the Navy in 1997 as the Director of the naval medical service. That was about as far as you could go in a clinical position. I would have had to go to Wellington into a non-clinical role if I wanted to progress that career further. I decided to join a group of occupational medicine colleagues in private practice.

Within a few months, I was also asked by a colleague at North Shore Hospital to provide short-term cover as he was going to be off work for a number of months due to a skiing injury. In the end he didn't come back to the job so I ended up accepting a permanent position almost by default. At that time I was doing 50-50 public and private work. Now I work three days at the hospital and two days in private practice. I'm 0.7 FTE for Waitemata.

**WHAT DO YOU LOVE ABOUT YOUR JOB?**

I love seeing working people getting on with their daily lives, and helping them to do that.

I enjoy the clinical components, seeing people and hearing their narratives, assisting them through some difficult times in their lives. There's a lot of variety in this role.

**WHAT COMPANY IS THE MOST CHALLENGING ASPECT OF PRACTISING MEDICINE?**

It's difficult when a person's health may be precluding them from continuing to work - they're just not up to doing the job any more, and we're trying to assist them with coming to terms with that.

It's also difficult sometimes to determine when a condition a person has developed is an injury. For example, if someone has a sore back which they think is due to their work but it becomes clear subsequently that it's not, that actually they've had back pain for a long time and it's likely to be from age-related changes etc, then that requires some working through. We might have to help them understand the situation is not as simple as they might have thought.

Unlike some colleagues who are restoring vision or doing hip operations, staff tend to be rather sceptical or worried that when they deal with occupational health, perhaps feeling that they may be denied some health entitlement.

The other factor is that we're dealing with a lot of well-qualified medical, nursing, and other clinicians, so they are more likely to question or challenge the advice they're given, as well as often seek ‘corridor consultations’ with clinical colleagues. Since occupational health staff often also work in the hospital environment as well as in this department, I think that gives staff a degree of reassurance that we understand what they do.

**WHAT HAVE YOU GAINED FROM YOUR ASMS INVOLVEMENT?**

My main motivation for joining the ASMS was to better understand the support systems for SMOs within the DHB.

It's wonderful to have a service that can provide good advice and support to SMOs as they move through a range of issues, not just MECAs and conditions of service issues, but also issues to do with their careers, sabbaticals, sick leave, and health issues.

ASMS has always been there with SMOs as a safety net. In my role, I might be providing advice as to whether someone can continue to work or whether we should be offering medical retirement to some of those people. It's good to know that there is that union support.

Fortunately I haven't had to avail myself of advice from ASMS in a crisis, but I'm always grateful that ASMS is there. If my job was being disestablished or there was an employment situation, I know where I would turn to for support.
As the ‘baby boomer’ generation of specialists approaches the standard retirement age in New Zealand, questions have been raised as to how the health sector will respond to the expected increasing specialist workforce attrition rates over the next 10 years.

Medical Council of New Zealand data show that in 2004 the largest group of specialists practicing in New Zealand fell in the 40-44 age group. By 2014 (the latest figures available), the largest group had shifted to the 50-54 age group. In 2004, 40% of the workforce was aged 50 or over, by 2014 it was 55%. More than 10% of the specialist workforce is now working over the traditional retirement age (Figure 1).

Medical colleges are among those who have raised concerns about looming retirements and how they could exacerbate current workforce shortages.

A report prepared for Health Workforce New Zealand (HWNZ) in 2011 acknowledges that “older doctors are working fewer hours and many are retiring earlier” and suggests strategies to retain doctors in their older years. They include ways to improve job satisfaction, satisfaction (including interventions to reduce stress), changing work roles, introducing more part-time and job-share positions and more flexibility in work hours, retraining in other specialties, and career and succession planning.1

However, it notes there is limited discussion in New Zealand on how to influence and if possible delay the retirement age of doctors and urges that “increasing focus on strategies to retain doctors in medicine is needed now.”

Four years later, HWNZ acknowledges medical workforce aging trends in its workforce aging trends in its report. “Increasing focus on strategies to retain doctors in medicine is needed now.”

As a recent European report notes, the aging health workforce is leading to an “upcoming massive replacement need, even with gradually growing workforce sizes.” It also points to a growing trend in Western countries for the younger generation of doctors to place greater importance on work-life balance. “Not accommodating these and other trends by means of strategic thinking and planning may well lead to increasing global competition for scarce medical resources.”

The report to HWNZ in 2011 notes the lack of such strategic thinking and planning in New Zealand and calls for more research about doctors’ intentions with respect to retirement, and what would keep them in practice to enable longer term workforce planning.

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The aging specialist workforce in many countries is leading to increasing use of IMGs to fill the gaps opened up by retirements, and is therefore creating an increasingly competitive market for doctors to which New Zealand is especially vulnerable.

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To help fill the research void, the Association is undertaking a study of senior doctor retirement intentions, with preliminary findings to be released later this year.

REFERENCES
n update of the Health of Older People Strategy is currently under way, with the call for submissions recently closed.

The Association has raised a number of concerns in its feedback to the Ministry of Health (http://www.asms.org.nz/wp-content/uploads/2016/03/Submission-to-MOH-Draft-FOOHp_16591.2.pdf) though most of the goals aspired to in the draft strategy appear reasonable as far as they go. An underlying question is whether there will be funding available to implement the programmes to achieve those goals.


Much has been said about the effects of the aging population on the nation’s health services. To put this in perspective, relative to recent funding trends, around 40% of government health spending is for those aged 65 and over. Since 2009/10, the population in that age group has increased by an estimated 24%. Over the same period, the shortfall in government health expenditure has been conservatively estimated to have accumulated to more than $1 billion.3

To look at the issue from an international perspective, New Zealand has until now had some advantage in health funding over many comparable countries in that our population is relatively young. Currently, around 14% of the population is aged 65 or over and it is estimated this will increase to around 17% by 2001. OECD data shows that, in 2013 (the latest data available), 14 western European countries already recorded 17% or more of their populations as in that age group.4

Their average spending on health totalled $4,203 (US$ PPP) per person in that year, compared with New Zealand’s $3,486, suggesting New Zealand has some catching up to do over the next five years.

First, current funding trends will need to be reversed.

MSA submission to the Ministry of Health:

NOTE:

a. The 14 countries are Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Netherlands, Portugal, Spain, Sweden, Switzerland, United Kingdom.
b. Purchasing Power Parity (PPP) equates the purchasing power of different currencies, taking into account the relative cost of living and inflation rates in different countries.

REFERENCES:


MCAs clauses that 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.

DID YOU KNOW...

That when you are appointed to a job in another city you are generally entitled to relocation costs. This provision is described in the MECA as “by negotiation” between you and the employing DHB, although we see the general principle as being that relocation should be cost neutral, so it’s important to engage with them before you move. Also, if the employer offers an amount that seems insufficient, you are entitled to negotiate - providing estimates and quotes is usually helpful. Overall we would expect that your new employer would cover travel costs for you and your family, plus the cost of moving your household, along with reasonable settling in costs (eg, rental car and accommodation for a few weeks). Reimbursement of relocation costs requires receipts as well as agreement, so it is important to keep these.

DID YOU KNOW...

That the clinical director of your department (or a nominated SMO or SDO from the department) must sit on any SMO or SDO appointments committee. The local senior staff committee (or agreed body) also has the right to nominate a further member of the interview panel, from an appropriate specialty, for SMO and senior clinical positions. You can read clause 52 here.


DID YOU KNOW...

That the call for submissions contained a request for these must be agreed with the employer.


To familiarize 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.

REFERENCES:

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

Over the last couple of years, general practices around New Zealand have been steadily rolling out a programme known generically as a patient portal, and specifically branded as ManageMyHealth by the most widespread GP practice management system (PMS).

In essence, the programme allows individual patients to access some of the information about them contained in a GP’s records and to have a more direct electronic link to the practice, enabling them, for example, to make appointments online.

How much information is available to patients varies from practice to practice, but virtually all enable access to the PMS inbox, which contains lab results, radiology reports and any letters that have been sent electronically.

For security reasons, patients do not directly access the GP’s computer.

Instead, the relevant information is uploaded to a site in the ‘cloud’ and both the GP’s computer and the patient interact with this site.

More details of the programme will be explained later in the article, but firstly – how does this affect you as a specialist working in a DHB or in private practice?

The most important change is that your patients will be able to view any information that is sent electronically to their GP’s records and to have a more direct electronic link to the practice,
the GP. This can significantly change how quickly your patient will know about the results of tests you have ordered if you have arranged for a copy to go to the GP. Many will see the results before you do. Before the introduction of the patient portal, any results copied to a GP would have been filed in the patient inbox, the GP would be aware of the result, and the patient would only find out if they contacted the practice and specifically asked for those results. Now, as soon as a result has been filed, the patient is automatically notified that there has been ‘activity’ on their site, and they are invited to view that new activity.

A GP is able to choose to not upload any particular result by ticking a box, but the default position is for the information to be uploaded. As you will be aware, primary responsibility for informing patients of results lies with the person who ordered the test and patients are entitled to be informed of any results in a timely fashion. If a particular result is ticked to not be uploaded, the GP will have to remember to go back to that result at a later date and ‘un-tick’ it so that it is available. At a practical level this becomes very cumbersome, and the majority of results will be uploaded directly.

Clearly most results will not be problematic, and there is unlikely to be any negative impact on the patient from learning the result.

More difficult are the results that are mildly abnormal, and will require interpretation that takes into consideration the full clinical picture. The patient is likely to contact the GP to ask for an explanation of this result and the GP may be in a position where the only safe answer is to say that they are unable to give a full explanation and direct the patient back to you, the person who ordered the test. GPs may not feel able to provide an interpretation of the result because it is a test that is not ordered frequently in general practice, or a more common one and the GP is not aware of the full significance of the result.

Depending on how quickly you review your results, you may be in the situation of being asked to contact a patient about a result before you have seen that result.

The most problematic issue will be the truly serious result; the unexpected melanoma or malignant polyp.

Although the person who receives a copy of a result is not primarily responsible for managing that result, there is a responsibility to ensure that appropriate action is being taken. The GP is now in the challenging position of needing to decide whether or not to upload such a result. They are also faced with the dilemma of whether they should inform the patient in a more empathetic way, such as by arranging a consultation, or whether the decision is that this is the responsibility of the doctor who took the sample. None of us looks forward to delivering bad news.

Some multidisciplinary hospital teams have started heading their letters with ‘Information embargoed – do not upload to ManageMyHealth’. Many GPs have concerns about this approach as it means that the GP will be in possession of significant information relating to their patient, but is in effect muted from sharing this with their patient. MPS is not aware of any complaints relating to this that have gone to the Health and Disability Commissioner, but anticipates that this approach would be carefully examined if a complaint was lodged.

GPs who are offering patient portals have also had to review how they manage aspects of patient care. There are options available for patients to view their notes, as well as their long-term medications, diagnoses, allergies etc. While patients have always had the right to ask for copies of notes, this is relatively uncommon. The knowledge that patients can immediately view what has been recorded tends to focus the mind of the doctor writing the notes. This can only be a good thing.

Patient portals can also enable patients to request repeat prescriptions online, to make appointments online and, if agreed with the GP, set up a secure email link. This has the potential for ‘virtual consulting’ by email, and is another relatively new challenge for GPs.

At this stage, only around 5% of the population is enrolled on a patient portal, but with active encouragement from the Ministry of Health, this number will steadily increase. Some of your patients currently have access to the benefits of this system, and we all need to consider whether we should to change our practice accordingly.

The potential immediacy that the system allows creates challenges for both primary and secondary care providers, but the overall benefits for patients are clear and the feedback from patients is overwhelmingly positive.

OTHER SERVICES

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.

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

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 DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

OTHER services

www.asms.nz

Have you visited our regularly updated website? It’s an excellent source of collective agreement information and
WE PAY OUR ADVISERS COMMISSION IN NICE ROUND FIGURES.

0%

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.