SPEAKING TRUTH TO POWER | P5
MECA 2020 - A HEALTHY WORKFORCE | P8
RIGHTING WRONGS ON GENDER PAY | P10
MORE WAYS TO GET YOUR ASMS NEWS

You can find news and views relevant to your work as a specialist at www.asms.org.nz. The website is updated daily so please add it to your favourites or online bookmarks to remain up to date.

We’re also on Facebook, Twitter and LinkedIn, and links to those pages are at the top of the ASMS website homepage.

<table>
<thead>
<tr>
<th>ISSUE 122</th>
<th>MARCH 2020</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>SAYING THANKS AND LETTING GO</td>
</tr>
<tr>
<td>4</td>
<td>PRESSURE POINTS AND PRIORITIES</td>
</tr>
<tr>
<td>5</td>
<td>SPEAKING UP FOR PATIENTS</td>
</tr>
<tr>
<td>7</td>
<td>MPS ASKED TO UPHOLD SMOS’ RIGHT TO SPEAK OUT</td>
</tr>
<tr>
<td>8</td>
<td>YOUR RIGHTS AND RESPONSIBILITIES AS PATIENT ADVOCATES</td>
</tr>
<tr>
<td>9</td>
<td>MECA 2020: A HEALTHY SMO WORKFORCE</td>
</tr>
<tr>
<td>10</td>
<td>A BIT OF MECA HISTORY</td>
</tr>
<tr>
<td>11</td>
<td>NEWBIE NEGOTIATORS</td>
</tr>
<tr>
<td>12</td>
<td>GENDER PAY: PUTTING RIGHT TO WRONG</td>
</tr>
<tr>
<td>13</td>
<td>UNMASKING THE CHALLENGES AND REWARDS OF HOSPITAL DENTISTRY</td>
</tr>
<tr>
<td>14</td>
<td>“NOT UNWELL ENOUGH”</td>
</tr>
<tr>
<td>15</td>
<td>2020: A WATERSHED YEAR FOR HOSPITAL SERVICES?</td>
</tr>
<tr>
<td>16</td>
<td>A HELPING HAND IN THE PACIFIC</td>
</tr>
<tr>
<td>17</td>
<td>TESTING POSITIVE AT FAMILY PLANNING</td>
</tr>
<tr>
<td>18</td>
<td>HAERE MAI TO MINISTRY OF HEALTH MEMBERS</td>
</tr>
<tr>
<td>19</td>
<td>NEW ADDITION TO ASMS INDUSTRIAL TEAM</td>
</tr>
<tr>
<td>20</td>
<td>WOMEN IN MEDICINE</td>
</tr>
<tr>
<td>21</td>
<td>IMPORTATION OF MEDICATIONS</td>
</tr>
<tr>
<td>22</td>
<td>FIVE MINUTES WITH DR YAN WONG</td>
</tr>
<tr>
<td>23</td>
<td>MORE PUBLIC SCRUTINY OF DHBS</td>
</tr>
<tr>
<td>24</td>
<td>VITAL STATISTICS</td>
</tr>
<tr>
<td>25</td>
<td>BRIEFLY...</td>
</tr>
<tr>
<td>26</td>
<td>SPECIAL HONOUR FOR DOCTOR KILLED IN CHRISTCHURCH MOSQUE ATTACKS</td>
</tr>
<tr>
<td>27</td>
<td>DID YOU KNOW?</td>
</tr>
<tr>
<td>28</td>
<td>Q&amp;A COVID-19</td>
</tr>
<tr>
<td>29</td>
<td>COMING UP IN THE NEXT ISSUE OF THE SPECIALIST</td>
</tr>
</tbody>
</table>
Whichever way we look at it, it’s going to be a big year. We’re already in bargaining for a new ASMS DHB MECA. The Simpson Review of the health and disability system will land sometime soon – possibly even as this goes to print, and there’s an election looming. Oh, and there’s also the evolving Covid-19 pandemic on our doorstep. We have a lot on our plates.

Meanwhile, we have the long-standing issues of creaking and failing hospital infrastructure, long-term staff shortages and challenges to continuity of care. The latter is partly due to understaffing and partly due to changes to some workforce patterns without proper reference to the impact on others: tired doctors, fed-up doctors, doctors who are not listened to, doctors who don’t feel heard.

When I was an industrial officer (up until about three months ago), I worked at the coalface, tackling the short-staffing, plant breakdown, and ‘fed-up-ness’, at close quarters. Now I’m trying to look upwards and outwards to see what leverage we can get further up the tube. Sorry for the weird metaphors ... it’s an occupational hazard when a former English teacher tangos with Ministry officials and HR leads. I’ve already decided that the national workforce pipeline is more of a wetland, of dubious water quality, with a tangle of small creeks issuing forth. This particular project needs gumboots and careful stepping, not to mention some kind of platform where the colleges, Ministry, DHBs and unions can stop long enough for a chat, lest we become completely mired in the swamp.

On the bright side, I’m not tackling all these things on my own. For starters, you – our members – are very good at letting us know what matters. Please keep in touch. Next, and crucially, your representatives at branch and executive level are working hard to keep staff and membership joined up and heading broadly in the same direction.

On the bright side, I’m not tackling all these things on my own. For starters, you – our members – are very good at letting us know what matters. Please keep in touch. Next, and crucially, your representatives at branch and executive level are working hard to keep staff and membership joined up and heading broadly in the same direction.

Ehara taku toa i te toa takitahi, engari he toa takitini – success is not the work of an individual but the work of many.

A number of you will have had direct experience engaging with our support staff, comms, policy and research teams and, of course, with our industrial officers. I am very proud of the work they do for you, and for the support they show to each other, and to the work of the Association.

MIND-SHIFT

All this means it’s ok for me to stop thinking like an industrial officer – whatever that means – and change up a bit. For those of you who have shared important ideas and experiences with me over the last five years, thank you! You’ve trusted me to walk with you through some good times, some truly horrible times, and a lot of irritatingly ‘why do we even have to do this?’ times. My phone and email contacts are still the same, and you are always welcome to make contact. For those of you in the north, you can rest easy knowing that our new northern industrial team is ready and able to pitch in on industrial matters, while I take some time to get to know our people across the central and southern regions, gumboots always at the ready.

No matter where we arrive, after the bargaining is settled, the Simpson Review has landed, the votes are counted and a Government sworn in, one thing I’m very confident about is that we will continue our journey together: Ehara taku toa i te toa takitahi, engari he toa takitini – success is not the work of an individual but the work of many.

Notwithstanding all of the above, I wish you plentiful non-clinical time, a written recovery time arrangement, a decent MECA settlement, and a peaceful 2020.
These are interesting times for ASMS and our members. We are setting a path with a new Executive Director after 30 years, we have initiated MECA bargaining at an interesting time pre-election, we’re facing a Covid-19 pandemic, and the health of New Zealanders is already under serious threat due to widespread shortages of senior medical and dental staff and other health care workers.

As noted previously, the Government’s spending on health as a percentage of GDP has decreased steadily over 10 years (Figure 1), and the current Government’s focus on fiscal responsibility to try and survive more than one term has prevented sufficient correction of health spending. It appears that the health of the Labour party is of higher priority than the health of New Zealanders.

Over the 10 years, we have observed high levels of senior doctor burnout and fatigue, growing patient waiting times, and a reducing range of medical conditions that qualify for specialist medical care. It appears that the reduction in health investment is now leading to sky-rocketing acute hospital care demand, i.e. double the rate of population growth.

The winter peak of overran emergency departments and hospital gridlock is becoming more difficult to cope with each year, and this system overload is now also occurring frequently at other times throughout the year. It is of major concern that a Covid-19 pandemic, on top of the usual winter influenza peak, which could stretch our hospitals and staff beyond breaking point.

One very positive piece of recent news is the additional funding being made available for new hospital buildings. Routine hospital maintenance has suffered due to prolonged underinvestment, and the additional funding is sorely needed. At this stage, however, there has been no significant movement on the even more pressing need for adequate hospital staffing. Adequate numbers of high-quality staff would have an even more positive influence on the health of New Zealanders than new hospital buildings.

This is the setting for our MECA negotiations. ASMS research over the past 5 years has highlighted fatigue, burnout, staff shortages averaging 24% (Figure 2), a gender pay gap of over 12% (more on p10), and an average 67% pay gap with Australia (see BERL research on the ASMS website), with 1,700 New Zealand trained specialists working in Australia. SMOs have few avenues to leverage for improvements to these conditions or to reduce doctor migration, and the Ministry stranglehold on DHB finances makes it difficult for DHB management to make the required corrections.

The MECA is our best tool to improve and maintain SMO well-being. You will see in the ‘MECA Matters’ updates that we are negotiating important new clauses focused heavily on well-being. The DHBs do recognise the importance of SMO well-being.

Of course, the most effective way to improve doctor well-being is to ensure there are enough doctors for patient workload. This requires not only widespread job and service-sizing but also salaries and conditions that are sufficiently competitive to retain our trainees and attract international medical graduates. It is important that our MECA can compete with Australian contracts because we are in the same labour market. The MECA negotiating team is keen to collaborate with DHBs on restructuring the salary scale to give us the best chance to retain and attract early career SMOs in particular. DHB commitment to this collaboration is unclear at this early stage, but we are optimistic. If the DHBs step away from collaboration, it is possible that negotiations may be difficult and prolonged. No one will want this to happen, especially with elections looming.

Lastly, the Executive is keen to increase the flow of information between members and National Office to ensure we understand members’ views and to aid negotiations. Over the coming weeks and months we plan a series of single-question or short surveys with rapid feedback that members should find quick and interesting.
The importance of senior doctors speaking up when they have unresolved concerns about patient safety is repeatedly raised at ASMS forums, not least at the most recent annual conference. When they do speak up, it can lead to significant improvements for patient care.

The pernicious impact of health care staff not feeling able to speak up when service standards become unsafe is well-documented. Among the worst cases is the tragedy of Mid Staffordshire Hospital in England where, largely due to cost-cutting and staff shortages, hundreds of patients died as a result of poor care that was allowed to persist for more than four years. It was eventually exposed, not by those with immediate duty of care to patients, but by the National Health Service regulator, and a woman whose mother had died.

Though Mid Staffordshire is an extreme example of a health system breaking under the strain, the pressures of increasing hospital workloads have also been playing out in New Zealand, as outlined in the recent ASMS report *Hospitals on the Edge*. The cover of that publication – a hospital crumbling over a cliff-top – depicts the erosion of hospital services over many years. That erosion might have occurred more rapidly were it not for a small number of senior doctors who put their heads above the parapet to speak out when inadequate resourcing made services unsafe. In some cases, their voices led to sweeping changes.

In the winter of 1996, amid the 1990s’ market-driven health reforms, seven patients needlessly died in Christchurch Hospital. Senior doctors, whose fears had been dismissed by management, were forced to go public with their concerns, which were then detailed in a report titled *Patients are Dying*. It sparked a major investigation by the Health and Disability Commissioner and resulted in a major emergency department redesign and expansion.

In 2004, senior doctors again warned that budget constraints were dragging the emergency department back to crisis levels. Their alarm prompted another urgent independent review, which found major deficiencies and recommended further extensive changes. The DHB’s response eventually led to the development of the internationally recognised ‘Canterbury Initiative’, creating stronger integration across hospital and community services.

At Waikato DHB in 2016, orthopaedic surgeons went public with complaints that...
they no longer had faith in management and that Waikato Hospital was no longer a safe place to practise elective surgery. The exposure prompted the DHB to recruit more staff.

In 2017, senior doctors wrote to the Ministry of Health heavily criticising Waikato DHB’s management style. They went public again the following year with scathing comments on the DHB’s procurement of a virtual health technology contract. The chief executive resigned in late 2017, and the board was sacked by the Minister in May 2019.

Late last year, frustrated senior doctors at Palmerston North Hospital wrote a letter to their DHB, copying in the Ministry and the Health Minister, saying a crisis over the lack of adequate facilities and space was affecting their ability to meet the surgical and medical needs of the people of Manawatu. The letter was sent by the combined medical staff executive group, backed by 80 senior hospital doctors. It led to an urgent visit by health officials and constructive discussions about how senior doctors could help to improve the facilities.

In other words, the time when speaking up becomes more vital – when staff are burnt out and disengaged – is precisely when staff are less likely to do so.

More recently, Middlemore Hospital intensive care specialist David Galler and Palmerston North paediatrician Jeff Brown, with support from ASMS, spoke out against the Government’s decision to allow the food industry to continue self-regulating fast food advertising. And in this edition of The Specialist, North Shore anaesthetist and ASMS Vice-President Julian Fuller is raising concerns about the effects on patients when they don’t pass treatment ‘thresholds’ (see p14 “Not unwell enough”).

Very occasionally, even senior DHB management and board members have raised their heads over the parapet.

In 2018 Dr Lester Levy, then chair of Auckland, Counties Manukau and Waitemata DHBs, slammed a lack of funding for a law change to give compulsory treatment to the worst drug and alcohol addicts.

In 2017 the then acting chair of Canterbury DHB, Sir Mark Solomon, publicly attacked the Treasury and the Ministry of Health over protracted funding issues. Capital & Coast DHB Chief Executive Ken Whelan stepped down in 2010 because he said the Government was forcing him to cut so many costs, he feared he would start cutting into muscle and undermine patient care.

RELUCTANCE AND FEAR

An ASMS national survey of members in 2018/19 on clinical leadership found that while most felt able to speak to their colleagues about patient safety concerns, there was a reluctance to raise concerns further up the chain. Less than half of respondents felt able to speak out to their Chief Medical Officer or equivalent, and only a quarter felt able to bring concerns to the attention of the Chief Executive. Just 4% said they felt able to speak out to the media.

This is despite the provision in the ASMS DHB MECA that enables senior doctors and dentists to comment publicly “on matters relevant to their professional expertise and experience”, after having discussed the issues with the employer. It is also despite efforts by the Health Quality & Safety Commission and some DHBs to encourage staff and patients to speak up through various ‘speak up’ programmes.

Further, Otago University surveys of health professionals in 2012 and 2017, covering similar issues, found a decline in staff saying that it is easy to speak up about patient care concerns.

Reasons often include fear of retaliation or repercussions, a lack of skills in speaking up, concerns about upsetting colleagues, or an attitude of “it’s not my job.”

An extensive American study published last year found, unexpectedly, that the willingness to speak up is not simply about teamwork training, psychological safety training, attempting to create an environment that values staff raising concerns, or any one policy. Rather, the biggest drivers of speaking up related to workforce well-being. The lower the levels of burnout and professional frustration, and the higher the levels of organisational engagement, decision-making and regular constructive feedback on performance, the more likely it is that staff will feel comfortable about speaking up.

In other words, the time when speaking up becomes more vital – when staff are burnt out and disengaged – is precisely when staff are less likely to do so.

Christchurch surgeon and Canterbury Charity Hospital founder Dr Phil Bagshaw and University of Canterbury academic Pauline Barnett asked whether advocacy by doctors should be an obligatory component of medical professionalism in a paper published in the New Zealand Medical Journal – ‘Physician advocacy in Western medicine: a 21st-century challenge’ – in December 2017.

Speaking to Radio New Zealand after publication of the paper, Dr Bagshaw, one of the doctors behind the 1996 Patients are Dying report, said we need to question whether doctors should be vocal or not – and what the consequences are if they’re silent.

“Doctors are the people best placed to see things going off the rails,” he said.

“If we aren’t the ones who can see where the problems are, then who can? And I think the public expects us to speak out on their behalf.”
A SMS has called for amendments to the Public Service Legislation Bill, which is currently before Parliament.

The Bill reorganises the State sector and gives stronger powers to the State Services Commissioner, who will be renamed the Public Service Commissioner.

In presenting ASMS’ submission on the legislation, ASMS Deputy Executive Director Angela Belich said the key issue for senior doctors and dentists is whether it will fetter their ability to speak out in defence of patients, to critique standards or to defend the public health service.

She told MPs that the right to speak out was essential in the 1990s when attempts to privatise the public health system were met with principled professional critiques from specialists.

The right to speak out is protected by Clause 40 of the Collective Employment Agreement covering senior doctors and dentists and schedule 1B of the Employment Relations Act.

But Angela Belich said the present State Sector Code of Conduct has been used by DHBs, particularly around elections, in a way that has had a chilling effect on this important freedom.

For example, she said, policies have been put in place requiring all communications to go through DHB communication teams. This had led to a reluctance by ASMS members to comment when funding or contracting issues will affect continued employment or the viability of a service.

ASMS is concerned that any further restriction on the rights and obligations of senior doctors and dentists and other health professionals to speak out publicly over issues of funding, deteriorating infrastructure and burgeoning unmet need may mean New Zealanders lose access to the advice from the experts they pay for and depend on for their protection against ill-founded policies.

Angela Belich called for the Bill to be amended so that the Public Service Commissioner must give effect to the right of senior doctors and dentists to speak publicly on matters related to their professional expertise.

“The Commissioner should be an ally of the public in upholding the public’s right to know, which is dependent on our members’ right to tell,” she said.

The Select Committee is due to report back on the Bill on 28 April.

The full submission is on the ASMS website: www.asms.org.nz under publications.

YOUR RIGHTS AND RESPONSIBILITIES AS PATIENT ADVOCATES

The ASMS-DHBs Multi-Employer Collective Agreement (clauses 39-41) includes a number of provisions regarding members’ responsibilities to their patients, their patient advocacy roles, processes for resolving any concerns about patient safety, and the right to speak publicly.

- The parties recognise: (a) the primacy of the personal responsibility of employees to their patients and the employee’s role as a patient advocate.

- In recognition of the rights and interests of the public in the health service, the employer respects and recognises the right of its employees to comment publicly and engage in public debate on matters relevant to their professional expertise and experience.

- In exercising this provision employees shall, prior to entering into such public debate and dialogue, where this is relevant to the employer, have advised and/or discussed the issues to be raised with the employer.

- Employees who have serious concerns over actual or potential patient safety risks shall make every reasonable effort to resolve them satisfactorily with the employer.

- Where either the Association or the employer believes that the serious concerns remain unresolved, they shall develop a process for resolution of these concerns.

These are under-used provisions that members are encouraged to consider making greater use of. Similar provisions on the rights to speak publicly are reinforced in Schedule 1B of the Employment Relations Act.

It’s usually up to the Executive Director or the President to speak publicly on behalf of ASMS although branch officers also can, if they have ASMS clearance. However any member, or group of members, may go public with their concerns as outlined above, speaking as individuals or with a collective voice.

Any member who has a current concern and needs advice or assistance to resolve it should contact a local ASMS branch representative and/or an industrial officer.

ASMS is developing guidelines and advice for members around speaking up for patients. Look out for it shortly.
MECA 2020: A HEALTHY SMO WORKFORCE

LLOYD WOODS | SENIOR INDUSTRIAL OFFICER/LEAD MECA ADVOCATE

Meeting New Zealand’s health needs relies on the retention and growth of our specialist workforce. Right now, New Zealand has too few senior doctors, and many patients are missing out. We also know that SMOs/SDOs are working to exhaustion and near burnout, and we need to see greater investment in the specialist workforce.

That is why we have ambitious goals for this year: safer workplaces, improved well-being conditions, and mechanisms to tackle recruitment and retention. All will help deliver better patient-centred care.

Our ambitions can be seen with the large number of claims we’ve tabled in the MECA negotiations.

There are 55 claims covering issues such as gender pay equality, fair recognition for working anti-social hours, better recovery time after shifts, and safe staffing.

We have also tabled a set of principles to help us tackle the trans-Tasman salary divide, which was highlighted in last year’s Business and Economic Research Ltd (BERL) report. The salary claim is challenging. It needs some creative thinking, and we need salary scales that look ahead so we can level the recruitment playing field.

At the time of writing, four days of MECA talks have been held. There are now another eight days scheduled before June.

KA MUA, KA MURI

“Ka mua, ka muri” – “We must look back in order to move forward.”

History shows us that MECA negotiations are never easy (see box). In previous years the DHBs have intentionally and successfully dragged them out. In some cases, they’ve delayed a salary increase and avoided backpay. On occasion we have called on members to stand up to achieve a result. We hope that won’t be the case this time, but it might be.

What we do know is that the DHBs would like to move as many matters as they can outside the scope of MECA bargaining. They are worried about the size of the settlement envelope and want to take a problem-solving approach. We have not had a good experience with working groups, including a failed attempt at a working group on afterhours remuneration, which fell out of the last MECA.

We want detailed responses to, and discussion of, our claims. We’ve spent several months developing claims for bargaining. Those 55 issues are there because they’re worth proper consideration at the table. We have learned our lessons from the past, and we are committed to making our days in bargaining focused and productive.

WHAT’S NEXT?

If we need all the scheduled negotiation days, we’ll finish bargaining in June. At that point we’ll be weighing up whether we’re close to achieving a settlement or not. If we are not very close to agreement at that point, we will most likely come back to members seeking a mandate for next steps.

Look out for our ‘MECA Matters’ bargaining updates. We welcome your feedback as we go.

We will not get everything that we have claimed, as that is the nature of negotiation, but we can assure you that our team will be doing its very best to get outcomes that all members deserve.

A BIT OF MECA HISTORY

MECA ONE – The first MECA was negotiated in 2003, combining the 21 DHB collective agreements that were in place at that time. It standardised many critical conditions such as six weeks of annual leave, salary scales with annual increments, T1.5 for afterhours duties for most DHBs, recognition of non-clinical time, and a 6% employer contribution to superannuation.

MECA TWO – Negotiations were acrimonious and lengthy. The DHBs came to the table with stated limited fiscal parameters and rejected most of ASMS’ claims for improved conditions. Worse, they sought ‘clawbacks’ to previous conditions. Members showed their resolve with stopwork meetings and a national ballot in favour of industrial action. The Minister of Health became involved and the MECA was settled with enhanced principles of engagement for members and a doubling of the cap on continuing medical education (CME) expenses to $16,000.

MECA THREE – Negotiations began in late 2009 and continued through 2010 and 2011. The slow progress was due mainly to the inclusion of joint workshops on the state of the SMO workforce, the development of a joint business case, and the use of variations to the previous MECA for an interim agreement. Settlement was achieved with a compromise between building a more acceptable salary scale but seeing members stuck on the top step.

MECA FOUR – ASMS tabled a narrow claim based mainly around salary. It was dismissed out of hand by the DHBs, but members showed little appetite for a fight and the MECA was settled with a modest salary increase aimed largely for those at the top.

MECA FIVE – Negotiations for the current MECA took around 14 months and were difficult due to the DHBs sticking rigidly to inflexible financial parameters for several months and looking for clawbacks. After 14 months a reasonable outcome was achieved, including additional steps on the top of both scales. It expires on 31 March 2020.
Negotiating a collective agreement is a long way from the day job of a medical specialist. There are several first timers on the MECA bargaining team. We asked three of them - Dr Jenny Henry (anaesthetist, Northland), Dr Tom Morton (emergency medicine specialist, Nelson) and Dr Alain Marcuse (psychiatrist, Wellington) - a couple of quick questions after the first round of negotiations.

**WHY DID YOU WANT TO JOIN THE MECA NEGOTIATION TEAM?**

**Dr Jenny Henry:** I think it’s fantastic to represent Northland and I’m interested in the entire process having never been involved in anything like this before.

**Dr Tom Morton:** Rather than shouting from the side-lines I wanted to get involved in the scrum.

**Dr Alain Marcuse:** To understand the forces forming the working environment and support my colleagues shaping the future of the health services in New Zealand.

**WHAT EXPECTATIONS DID YOU HAVE ABOUT THE PROCESS?**

**Dr Jenny Henry:** I had no expectations.

**Dr Tom Morton:** I was told not to expect anything except frustration.

**Dr Alain Marcuse:** To see a political process which is difficult to understand with my current level of expertise.

**WHAT WOULD YOU SAY TO OTHER MEMBERS ABOUT THE EXPERIENCE?**

**Dr Jenny Henry:** It's very early days. After two days it's very interesting and a massive eye-opener to the whole process.

**Dr Tom Morton:** I work in a fast-paced speciality, this is anything but.

**Dr Alain Marcuse:** Eye-opening and a steep learning curve, solidarity among colleagues.

**WHAT IS YOUR BIGGEST TAKEAWAY SO FAR?**

**Dr Jenny Henry:** How fortunate we are to have Lloyd Woods and Murray Barclay as our advocates.

**Dr Tom Morton:** You need to fight for what you believe in.

**Dr Alain Marcuse:** Every coin has two sides, and we might face a long-lasting process of bargaining.
A SMS is taking action to close the gender pay gap.

We will be asking DHBs to conduct gender pay audits and have backed it up with a claim in the ASMS DHB MECA that is currently being negotiated.

Over the years ASMS has been alerted to cases in which women have received lower job offers than their male counterparts, and others in which women haven’t been offered the same enhancements.

Historically, such cases have been viewed as one-off slips of unfairness, rather than a systemic gender issue.

Last year ASMS sought to partner with the Auckland and Waikato DHBs to undertake research into the gender pay inequality, but despite early enthusiasm, the DHBs said they had no capacity.

So ASMS decided to tackle the issue by commissioning independent research. The study by Motu Economic and Public Policy Research found an estimated gender pay gap among medical specialists of 12.5%. It was based on hourly wages earned by specialists working in DHBs. It widened even further once women had children.

The research has been shared with DHBs.

ASMS Deputy Executive Director Angela Belich says, “The Equal Pay Act has been in place since 1972. DHBs have a legal obligation to pay women the same as men. They have not met this legal obligation, and as a state sector employer, they should be making it a priority”.

As a result, an equal pay claim has been included as part of the ASMS DHB MECA negotiations. It says:

(a) Notwithstanding the above, no female employee shall in any case be paid less than the rate that would be paid to a male employee with the same, or substantially similar, skills, responsibility, and service performing the work under the same, or substantially similar, conditions and with the same, or substantially similar, degrees of effort.

(b) Each DHB will audit salaries at least once per year to ensure that the principle in (a) above is being complied with.

DHBs have given an early indication of commonality on the claim.

ASMS Research and Policy Director Charlotte Chambers says, “It shouldn’t be up to the individual to find out if their pay and conditions are unequal and remedy the problem. It’s not their responsibility”.

A GOOD GENDER PAY AUDIT

ASMS is now looking to develop what a good gender pay audit would look like. It has proposed a working group be set up between ASMS and DHBs to consider the terms of reference, scope, timing and personnel to do the foundation audit.

It would be based on the following principles:

- It must assess the salary step on appointment of all currently employed SMOs to ensure women and men of equivalent qualifications and experience were appointed at the same salary step and progressed through the scale as specified in the MECA.
It must assess all payments over and above the MECA base salary step for all currently employed SMOs (FTE above 40 hours, availability allowances, call, recruitment and retention payments) to ensure that women and men of similar qualifications and experience receive the same.

The FTE and extra remuneration of women and men in formal clinical leadership positions must be assessed to ensure that women and men have equivalent entitlements.

Any SMO found to have been underpaid because of gender will have that discrepancy rectified from the date at which it occurred.

ARE MEN BETTER AT NEGOTIATING?

ASMS National Executive member and Palmerston North paediatrician Nathalie de Vries was curious to find out more about a suggestion made in the Motu research that men may be better than women at negotiating better salaries. She posed the question on the Women in Medicine Facebook page: “On your most recent job offer, did you accept it as it was, or did you negotiate a better offer?”

Of the 337 women who responded:

- 216 accepted their first offer
- 83 negotiated a better offer
- 38 tried to negotiate a better offer but were turned down.

Dr de Vries points out that while it’s not a scientific poll and not all the women in the Facebook group are specialists, it reveals some interesting trends and prompted some salient comments from SMOs (see box).

Dr de Vries believes DHBs need to be transparent and be held to account. At the same time, she says female SMOs need support and encouragement from ASMS and their colleagues to negotiate their starting salaries, and they should ask questions if they believe there are equity issues.

ASMS is also working on strategies to ensure equal pay into the future, such as developing guidelines to ensure equitable placement on appointment, referring SMOs with job offers to ASMS industrial staff to check job offers are fair, monitoring recruitment and promotion processes, actively recruiting people to work after extended career breaks, and improving workplace flexibility for both men and women to reduce the parent penalty against women.

Together we can make the gender pay gap a thing of the past.

*quotes published with permission*
When you ask Dr Anna Dawson to describe her working day, it’s hard not to be surprised by the range of patients she sees.

Dr Dawson works as a general dentist for Auckland Regional Hospital & Specialist Dentistry, offering complex oral health treatment to some of the region’s most vulnerable populations.

Her patients include children and adults with intellectual disabilities or brain injuries, people who have had organ transplants, people who are waiting for heart surgery, and people receiving radiotherapy treatment for head and neck cancers.

Broadly, they are patients who can’t be safely treated in private or community practice or where the specialist service they require isn’t available.

There are also children whose teeth are so decayed they need specialist care, or kids in Starship Hospital who may receive dental treatment while under anaesthesia for another procedure.

“Being able to help people who are disadvantaged through no fault of their own access a service, and deliver that service to them, is very satisfying,” Dr Dawson says.

“Often our patients come in quite worried and scared, and when you say you can help and see them, the relief that provides is wonderful.”

She also feels lucky to be able to work alongside a large cross-section of medical specialists, as well as theatre staff and other dentists.

“Being able to help people who are disadvantaged through no fault of their own access a service, and deliver that service to them, is very satisfying.”

The broad group of patients Dr Dawson sees is growing, and their needs are more complex. It’s a cocktail of population growth, increased demand, and the fact that people are living longer and ageing with their teeth. More children are also being referred for specialist treatment under general anaesthesia.

The challenges on a national level were laid out in a report last year by the University of Otago – Public sector oral health service provision for high needs and vulnerable New Zealanders.

HIGHER DEMAND

Based on investigations with clinical leaders, SMOs and SDOs, it found higher demand is putting pressure on hospital dental services, there is inconsistency in provision with some DHBs having limited or no services, and staff resources are insufficient. Of particular concern were workload, training, career progression and succession planning.

Service Clinical Director at Auckland Regional Hospital & Specialist Dentistry DHB Oral Health, Dr Hugh Trengrove, says, “We are experiencing increased demand for quite complex dentistry and support services, particularly for elderly patients who’ve got multiple co-morbidities. There is concern as a profession about how we are going to look after these people”.

He adds that as the Auckland region gets bigger, it is difficult to ensure that services are equitable and reach the most disadvantaged.

“People are waiting. If they meet the access threshold to see us, we will see them. We haven’t altered our access criteria in order to reduce demand, but people are potentially waiting longer so we have to be smarter about how we deliver care.

“It would be fair to say hospital services in dentistry have traditionally been very treatment-focused. We’ve never had the time or opportunity or willingness to embrace looking at different models of care, and the time is now,” he says.

Turning down referrals is a part of the job Dr Dawson finds disheartening.

“We have a lot of standard declines around patients who are financially disadvantaged and who can’t afford standard dental care, and unfortunately we just can’t accept them”.

Public health dentistry is at the sharp end of wider public health debates on issues such as obesity, sugar tax, community water fluoridation and water-only schools. When it comes to young children whose teeth have rotted away from sugary food and drink, Dr Dawson feels she can contribute more than just treatment.

“There’s a chance to talk to their families about why this has happened and acknowledge that the things they have been doing weren’t correct,” she says.

“It’s an opportunity to reframe and give them a way forward that doesn’t leave them feeling shamed or guilty but with the power to make some changes in their family’s life”.

A HIDDEN SPECIALTY

The importance of oral health in New Zealand has been historically overlooked, despite its crossover with so many conditions and medical specialities. The University of Otago report identified what it called “the lack of visibility” of oral health within DHBs and a lack of prioritisation.

Dr Trengrove believes that’s changing, at least in the northern region where Auckland’s three DHBs along with Northland are in the early stages of developing a near to long-term plan to improve the population’s oral health outcomes.

System change and improvement spins Anna Dawson’s wheels. With the support of her DHB and colleagues, she’s spent the last two years studying for a Master of Health Leadership. The final part is a service improvement project that she aims to put to good use in her own department by looking at the service provided to head and neck cancer patients.

The bottom-line for Anna Dawson is that hospital dentistry is her ‘right fit’.
It’s a vicious circle. Non-urgent patients have their treatment deferred, their condition deteriorates to the point where they need acute care, and they in turn displace more non-acute patients.

There’s growing evidence that under current rationing processes or ‘treatment thresholds’, patients who are considered “not unwell enough” are missing out on treatment.

“I have worked as an anaesthetist at North Shore Hospital for the last 23 years and during most of that time we have been the fastest growing DHB in the country, with funding growing each year accordingly. It has always appeared superficially that patients have not had major problems accessing care, but over the last few years this has changed. And it has been brought home to me shockingly over recent months.

“Recently I was asked in private to assess a 92-year-old gentleman who had been declined a first specialist assessment (FSA) at the hospital. His problem (apart from being generally unwell and multi-comorbid) was an inguinal hernia, or groin hernia. But it was not just an inguinal hernia. It was a third-world type inguinal hernia. It was massive, larger than a large orange, containing loops of bowel.

“Before seeing him, I checked his public hospital notes and saw the ominous note: ‘Below access threshold. Return to referrer.’ And he was now forced to go the private route in order to get any treatment at all.

“A little earlier, I met a delightful 88-year-old lady for an assessment for a total hip joint replacement. She hobbled into my clinic on crutches, which surprised me. Upon asking her, she told me she had been using crutches for 12 months waiting for a first specialist appointment at the hospital. Her GP was unable to get her in because she did not meet the threshold.

“I am now told that this is probably the norm for most DHBs in this country”.

– Dr Julian Fuller

There’s also clear data to back up the anecdotal evidence (Figure 1).

“The suffering being experienced by so many patients is largely hidden”

Acute hospital inpatient discharges rose by more than twice the population growth rate in the six years to 2018. On the other hand, the increase in non-acute discharges was only half that of population growth.

These trends suggest non-acute patients in public hospitals are being displaced by the steep rise in acutes, made worse by successive years of budget constraints. The higher case-weighted growth rates indicate that priority is also being given to treating the most complex cases.

Dr Fuller says, “The suffering being experienced by so many patients is largely hidden. It must be publicly acknowledged, and DHBs need to be supported by government to urgently address this issue. What many of my colleagues and I are seeing is surely not an acceptable level of health care in a first-world country”.

There’s growing evidence that under current rationing processes or ‘treatment thresholds’, patients who are considered “not unwell enough” are missing out on treatment.
The health system faces three potentially significant turning points this year, not to mention the emerging challenges of Covid-19.

When the Health Minister David Clark was in Opposition in 2017, he spoke of the mounting pressures on public hospital services as “symptomatic of a growing crisis”. Since then, things have changed, but not for the better. As acute admissions grow at twice the rate of population growth, bed occupancy rates are hitting record highs, with many wards operating at levels exceeding clinical safety standards for prolonged periods.

ASMS President Murray Barclay said in the introduction to the Hospitals on the Edge report published last November, “There are simply too few staff, too few acute hospital beds, too many patients discharged before they should be, too many facilities unfit for purpose, and too many patients denied access to timely treatment because hospitals lack capacity.”

Up until now, and over many years, hospitals have had to cope with some policy-making shortcomings, including the short-termism driven by election cycles, which has tended to see attempts to fix complex issues with narrowly focused and simplistic ‘solutions’.

Three significant events this year will determine whether things might change for the better:

• the release of the Health and Disability System Review report
• the Budget
• the general election.

HEALTH AND DISABILITY SYSTEM REVIEW

David Clark has stressed the review would include “a strong focus on primary and community-based care. We want to make sure people get the health care they need to stay well. Early intervention and prevention work can also help take pressure off our hospitals and specialist services.”

The same idea is pushed in the Review’s Interim Report, released last year, that we must shift “away from a treatment focus towards a prevention focus”. Such thinking, however, fails to recognise the significant role that ‘treatment’ plays in ‘prevention’. It is that same idea that is seeing hospital bed numbers being cut, which in turn is leading to frequently unsafe hospital bed occupancy rates.

Further, as previously reported, the evidence from New Zealand and overseas indicates that while measures to improve access to primary care and a greater focus on prevention are much needed, they do not necessarily reduce the use or need of hospital care.

The reasons include a lack of clear evidence to determine the most effective approaches to prevention, lack of clinical time, lack of patient compliance, practitioner attitudes, and financial disincentives, among others.

There is strong, mounting evidence that integration between hospital services, primary care and social services to provide good patient-centred continuity of care is the best approach for keeping people out of hospital. In short, a well-functioning primary care service depends on well-functioning, accessible hospitals to succeed in the overall goal of health improvement.

The increasing dependence on multidisciplinary teamwork and the growing complexity of illness with an ageing population also require additional time for collaboration between health professionals, especially between primary care practitioners and hospital specialists. This requires workforce shortages to be addressed.

These are some of the key issues ASMS has been advocating for and wants to see recognised in the Review’s recommendations, which are to be delivered to the Government by 31 March.

THE BUDGET

While the Health and Disability System Review is reportedly not about fixing today’s problems tomorrow, but rather considering what is needed over the longer term, the timing of the final report’s release suggests there could well be some recommendations that have implications for this election year Budget.

Given that addressing health inequalities is cited as a high priority for the Government, immediate measures to begin to address them, particularly for Māori, must surely be high on the agenda of health budget bids. No one would argue with that.

A big question for this year’s Budget will be whether its funding signals line up with government policy aspirations.

Council of Trade Unions–ASMS analyses of the Vote Health budgets have shown successive years of funding shortfalls. If Vote Health’s operational funding in 2018/19 were to match that of 2009/10 as a proportion of GDP, a further $1.7 billion would have been needed.

A continuation of the current fiscal austerity approach would risk a situation where the ‘strong focus’ on primary care happens at the expense of hospitals, and the likely outcome would be an even tighter bottleneck to accessing non-acute hospital care, which in turn would create greater pressure on primary care and, eventually, acute services.

To avoid this, both primary care and hospital care services require significant boosts in investment.

THE GENERAL ELECTION

Despite hospital wards bursting at the seams and staff struggling to cope with growing workloads, health is not considered a top election issue for most political commentators who have so far expressed their views on the matter. Opinion polls commissioned by various independent organisations, however, indicate a tight race where any number of single issues that may emerge during the year could affect the election outcome.

The recommendation of the Health and Disability System Review, the Government’s response, Vote Health, and the ensuing public debates on them all will be critical factors in determining whether health becomes a deciding issue in this year’s election.
Samoa’s devastating measles epidemic is no longer headline news, but its impact is etched in the mind of Hawke’s Bay specialist Dr Ross Freebairn.

The outbreak, which began last October, has killed 83 people – mostly babies and young children. More than 5,600 people were infected, and the country was put under a state of emergency for six weeks leading up to Christmas. Schools were closed, travel and public gatherings were restricted, and red flags were placed outside the homes of people who hadn’t been vaccinated.

The outbreak was caused by low vaccination rates, made worse by the tragic deaths of two children in 2018. The deaths were the result of nurses mistakenly mixing the MMR vaccine with a muscle relaxant instead of water, but initially the deaths were blamed on the vaccine itself. That led to local fears around vaccines, which were then exploited by anti-vax campaigners.

In early December the epidemic was at its height. The number of cases was spiralling, health services in Samoa couldn’t cope, and the call went out for international assistance.

Dr Ross Freebairn, an intensive care specialist from Hawke’s Bay Hospital, was part of the emergency response team sent from New Zealand to help.

He says the scale of the outbreak was clear the minute he arrived at Tupua Tamasese Meaole Hospital in Apia.

“The ICU is supposed to be seven beds but is only staffed for about half that number nursing wise, so really it can only run three or four patients at best. When I arrived, there were 12 patients and up to 70 paediatric patients being treated elsewhere in the hospital, along with six temporary HDU beds in an AUSMAT tent.

“The registrars were working 30+ hour shifts, and because it was too far to go home between shifts, nursing staff were sleeping in the ICU storeroom”.

He, along with Dr David Closey (Christchurch), and later with Dr Chris Poynter (Auckland) and Dr Leinani Aiona-Le Tagaloa (Middlemore), provided clinical support in the ICU overnight, relieving the burden on the sole intensive care and paediatric registrar assigned to overnight cover.

“One of the things that concerned us is that the whole health system had ground to a halt. They did no elective surgery. They couldn’t do anything other than fight this stream of children coming in with severe disease”.

Shortages of staff, medication and medical supplies, along with language barriers, were also challenging, not to mention the heartbreak. The majority of patients and victims were under two years old.

“The ICU was an open unit, so children were dying next to parents who were sitting with their own seriously ill children. That was difficult,” says Dr Freebairn.

Dr Freebairn stresses he was part of a team of New Zealand and overseas medical professionals who were able to provide care in a difficult environment.

“Elizabeth Powell and her team from MFAT had arranged for further rotation of nursing and medical staff to relieve us at the end of rotation, including additional staff from Starship and other New Zealand hospitals”

He’s relieved that thanks to a huge push, vaccination rates in Samoa have risen and the measles outbreak has slowed markedly.

Dr Freebairn believes that supporting our Pacific neighbours is important, and if another crisis arose, he’d be more than happy to pack his bags.
Dr Catriona Murray's patients only see the tip of the iceberg when it comes to her work at family planning. Making this visible to non-medical colleagues and managers was part of her challenge at recent Family Planning collective negotiations.

Dr Murray works at the Family Planning clinic in central Wellington and in Porirua. ASMS has supported Family Planning doctors in reaching a new collective agreement.

The growing number of administrative tasks for doctors at Family Planning was one of the major issues acknowledged in the agreement.

Dr Murray says doctors have been concerned about the increasing amount of time spent on administration.

“The patients seen by doctors at Family Planning have increasingly complex needs, and we can spend quite some time finding out what the issues are, what has been tried, and chasing the results of investigations already done.

“Nurses see many of the patients at Family Planning, and doctors support the nurses to work at the top of their scope. They’re really experienced but also need doctor support, and we are finding that we aren’t having time to do that as well as processing our own results and tasks.”

Clinical administration is now stated in the new collective agreement as a critical component of Family Planning doctors’ work. There was previously no acknowledgment of it.

Another win out of the negotiations is that Family Planning doctors are now entitled to five weeks of annual leave after five years of continuous service.

“Increased annual leave has been a priority for our members for ages, and we are pleased to have made progress on this” says Dr Murray.

The extra week brings Family Planning specialists closer towards the DHB MECA standard of six weeks of annual leave.

For Dr Murray, her first experience of contract negotiations was an eye-opener, and she was surprised to see how many people were involved. As someone who works closely with Family Planning management as part of her role as Locality Medical Advisor, she also found it strange sitting across the negotiation table.

“I'm working with the managers who are then sitting on the opposite side of the negotiating table, so for me I was a bit conflicted!” she says.

“I was really hoping it wasn’t too confrontational, and I was relieved that it was all done in a very positive way”.

Dr Murray believes having ASMS speaking up on behalf of Family Planning was particularly valuable.

“To have someone external looking at our pay and conditions, and going ‘actually, you probably deserve a little bit more’ is good. It also helps with recruitment and retention”.

The collective agreement is for 18 months. Family Planning is negotiating their contract with the Ministry of Health this year, with the hope of more funding. Dr Murray is keen to emphasise the importance of accessible and equitable sexual and reproductive health services.

“From a purely financial perspective, studies have shown that provision of contraception saves more in public expenditure for unintended pregnancies than the cost to provide the contraception. And, of course, there are also so many other benefits. We are so happy that the hormonal intrauterine systems have been subsidised, but we would love to see more money for this sector to improve access.”

The bargaining team consisted of Catriona Murray, Rachel Beresford and Carol Howell from Family Planning, along with Sarah Dalton and Miriam Long from ASMS.
HAERE MAI TO MINISTRY OF HEALTH MEMBERS

SMS is excited to welcome salaried doctors and dentists employed by the Ministry of Health as full members of the union.

Under ASMS rules, specialists working in government departments and universities have not been eligible for membership.

Over the years there have been a number of senior doctors who have moved from DHBs into positions within the Ministry, and who have wanted to retain their ASMS membership, but couldn’t.

There have also been others working at the Ministry who wanted to join.

At last year’s ASMS annual conference, a resolution was passed changing the rules to allow those working in government departments to become full members.

An agreement was also reached with the PSA (Public Service Association) to move members over to ASMS.

Negotiations are now underway to secure a collective agreement for Ministry of Health members whose pay and conditions are generally much poorer than those of members working in DHBs.

Dr Jane O’Hallahan, who is the National Screening Unit Clinical Director at the Ministry, says she and her colleagues wanted to belong to a union that will advocate for them and understand what they do.

“We are no different from other doctors in the sector. We have the same level of training and the same professional development.

“We move between DHBs and the Ministry, so we know that ASMS understands our contribution,” she says.

ASMS looks forward to working with its newest group of members.

NEW ADDITION TO ASMS INDUSTRIAL TEAM

In January we welcomed Georgia Choveaux to the ASMS industrial team. She has been employed to fill the gap left by Sarah Dalton’s appointment to Executive Director. Georgia will be working as part of ASMS’ northern industrial team alongside Steve Hurring and Miriam Long, covering Northland, Waitematā, Auckland, Counties Manukau, Waikato and Bay of Plenty DHBs.

Georgia brings a wealth of knowledge from her previous position at the New Zealand Nurses Organisation where she worked as campaigns advisor during the union’s last MECA negotiations and before that as an organiser.
Women in medicine

By Sarah Laing

Eily Elaine Gurr was born in Thorndon, Wellington, in 1896. She graduated MB, ChB from Otago in 1923, and spent a year as house surgeon at Tauranga Hospital.

Elaine arrived in Dublin in 1924 to do postgraduate study. There, she qualified as a licentiate in midwifery, gained antenatal experience in London and was getting close, Mrs Brown.

On her return, Mrs P. Dr Maui Pomare asked her to set up the country's first antenatal clinics. Feeling isolated, she moved to Auckland, where she set up a general practice specializing in obstetrics and gynaecology.

The more married supported her money wisely, so when it paid dividends, she endowed the chair of general practice at Auckland & Otago in perpetuity and supported the animal hospital.

Home & Family are the foundation of New Zealand, and we general practitioners are the family guardians.

Oh! A letter from the Queen!

Eily married & invested her money wisely, so when it paid dividends she endowed the chair of general practice at Auckland & Otago in perpetuity and supported the animal hospital.

Elaine lived to 100 & died in her North Shore home. Her patients were her family to the end.

Women in medicine

By Sarah Laing

Eily Elaine Gurr was born in Thorndon, Wellington, in 1896. She graduated MB, ChB from Otago in 1923, and spent a year as house surgeon at Tauranga Hospital.

Elaine arrived in Dublin in 1924 to do postgraduate study. There, she qualified as a licentiate in midwifery, gained antenatal experience in London and was getting close, Mrs Brown.

On her return, Mrs P. Dr Maui Pomare asked her to set up the country's first antenatal clinics. Feeling isolated, she moved to Auckland, where she set up a general practice specializing in obstetrics and gynaecology.

The more married supported her money wisely, so when it paid dividends, she endowed the chair of general practice at Auckland & Otago in perpetuity and supported the animal hospital.

Home & Family are the foundation of New Zealand, and we general practitioners are the family guardians.

Oh! A letter from the Queen!

Eily married & invested her money wisely, so when it paid dividends she endowed the chair of general practice at Auckland & Otago in perpetuity and supported the animal hospital.

Elaine lived to 100 & died in her North Shore home. Her patients were her family to the end.
Importation of Medications

Doctors are increasingly receiving queries from patients regarding the importation of medications. This can take several forms:

- A treatment not approved by Medsafe in New Zealand but recognised overseas (e.g. some new oncology treatments).
- Treatments approved in New Zealand, but not funded and prohibitively expensive in New Zealand (e.g. until recently, certain treatments for hepatitis C).
- Patients purchasing medication via the Internet (e.g. PDE5 inhibitors).
- Treatments obtained from overseas that are at no cost (e.g. part of a pharmaceutical company compassionate supply).

Patients having medicines sent from an overseas supplier are required to prove they have a ‘reasonable excuse’ for the importation. ‘Reasonable excuse’ includes a prescription from a New Zealand-authorised prescriber. Medicines purchased over the Internet, for example, are held at the border, and patients require a prescription from a doctor for their release.

So, what are the medico-legal risks involved in helping patients in this regard? What is the doctor taking responsibility for?

Medsafe’s website outlines its concerns that medicines being imported may be of poor quality, not conform to the label (in either ingredient or dose), be contaminated with harmful substances, or simply be counterfeit. A doctor should make a patient aware of these risks.

Medsafe’s prescription form states: “If a prescriber provides a prescription for a medicine that has been intercepted at the border, they take on all the responsibilities of prescribing including responsibility for the quality and appropriateness of the medicine for that patient.”

The stipulation of taking responsibility for prescribing is likely inconsequential given a doctor takes responsibility for his or her prescribing of all medication.
anyway. However, it would seem onerous to hold a doctor responsible for the quality of the medicine. Doctors do not take that responsibility for medicines in New Zealand, so it would seem unreasonable to hold them accountable for the quality of imported medication. To date, this does not seem to have been traversed by any regulatory body or court. No civil action is likely to arise for damages against a doctor (unless they are reckless) who has prescribed a medicine for a patient who has obtained it from overseas and developed an adverse event. That would likely be covered by ACC.

The first consideration is ensuring the patient is ‘under the care’ of the doctor. Then there needs to be a robust informed-consent process. The doctor will need to advise the patients of the risks involved with obtaining medication overseas as outlined on the Medsafe website. Although the quality of the product simply cannot be guaranteed compared to a New Zealand regulated product, this may be less relevant for a compassionate supply from a US pharmaceutical company, but nevertheless many other imported medications are from countries with less stringent quality control systems.

Secondly, the Code provides consumers with the right to services of an appropriate standard. When a patient seeks to obtain medications from overseas, the doctor will need to bear in mind the rights under the Code and weigh them against each other to determine whether it is appropriate to be involved. The patient has the right to make an informed decision, be free from financial discrimination, have services provided that respect their independence, and have services provided in a manner consistent with his or her needs. For example, with regard to importing hepatitis C medication, there was a large financial discrepancy between obtaining it in New Zealand (where it was not funded) and obtaining the generic medication from overseas. After being fully informed, a patient should therefore have the right to choose whether they access the medication from overseas if they can’t afford it in New Zealand, presuming it is appropriate and necessary.

Finally, it remains the doctor’s responsibility to ensure the appropriateness of the patient’s care and treatment, including medication prescribed and follow-up. The doctor also needs to ensure that the prescribing practice adheres to the Medical Council of New Zealand’s relevant guidelines. In certain circumstances it may be wise to have a discussion with colleagues about the appropriateness of the treatment plan and document that. Doctors remain professionally accountable for their prescribing, and more so if the medication is unapproved or for an unapproved use.

Provided a doctor is working within their scope of practice, they are not restricted by legislation in terms of which medications they can prescribe, be it an approved or unapproved medication, or for an unapproved use. In situations where the medicine is available in New Zealand, the doctor should always recommend obtaining approved medication in New Zealand rather than obtaining it overseas, as it has passed Medsafe’s tests for safety.

Having a robust informed-consent process is therefore crucial, as prescribing an unapproved medication has the potential to be seen as experimental, and it would be prudent for this to be obtained in writing. The Ministry of Health has indicated it may seek to amend the legislation, so in the future there may be additional responsibilities on doctors helping patients with the importation of medications.

This article covers a patient importing medication. If a doctor imports and supplies medication, there are additional issues and responsibilities to be aware of. Medical Protection receives frequent enquiries from specialists wanting to help patients import medications. Members can obtain further advice on this matter at advice@mps.org.nz.
WHAT INSPIRED YOUR CAREER IN MEDICINE?
It’s a vocation that combines meaningful human contact with intellectual challenge. The privilege of being part of another person’s journey keeps me turning up to work everyday.

WHAT DO YOU LOVE ABOUT YOUR JOB?
Along with being an important part of a patient’s health journey there are specific challenges (but also satisfaction) which come with working in a rural environment. With the advances of speciality medicine improving the diagnostic certainty and treatment of diseases, there’s still something beautiful about having to rely more on the good old clinical acumen in the land of rural, while we call on the support of tertiary centres when needed.

There is also a specific appeal to practising generalist medicine where you are the whole family’s doctor, rather than the doctor of a certain body system. I’m qualified in both rural hospital medicine and in general practice so sometimes when I write on a discharge summary for a GP to follow up X, I know I’d be writing to myself.

Being further away from big cities has its own challenges. One of which is keeping up with professional development. There is a wide range of fields to keep up to date on and it is very easy to be professionally isolated. The development of rural hospital medicine as a vocational scope, my involvement with university teaching and of course our tertiary-based colleagues, all help us to maintain the standard.

HOW DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?
There are disparities in pay and recognition between the rural and urban based SMOs (including GPs). Many hard to staff rural places offer less pay and less employment protection than the MECA. ASMS has a lot of room to move in the rural area. Thanks to the ASMS negotiating team, Clutha Health now has a collective agreement.

WHAT HAVE YOU GAINED OR LEARNED FROM YOUR ASMS INVOLVEMENT?
Negotiation is tricky even when you think you have a good constructive working relationship with a ‘good’ employer that genuinely cares about their employees’ welfare. I recall the huge amount of time we spent ‘negotiating’ ONE word in one clause.

With the advances of speciality medicine improving the diagnostic certainty and treatment of diseases, there’s still something beautiful about having to rely more on the good old clinical acumen in the land of rural, while we call on the support of tertiary centres when needed.
MORE PUBLIC SCRUTINY OF DHBS

**District Health Boards are coming under more public scrutiny through a year-long initiative aimed at providing more news and analysis of local body issues.**

If you are a regular news consumer you may have noticed stories on media outlets such as Stuff or RNZ, written by a ‘local democracy reporter’.

The Local Democracy Reporting project is a public interest news service supported by RNZ, the Newspaper Publishers’ Association and NZ On Air.

Eight local democracy reporters have been placed in provincial centres covering Northland, South Auckland, Rotorua, Whakatāne, Ōpōtiki and Kawerau, Taiao-whiti/Gisborne, Wairarapa, Marlborough and the West Coast.

The reporters are working out of regional newspaper newsrooms and report to the local editors. They are focusing exclusively on stories about publicly appointed or elected officials and bodies.

The project was developed to fill the gap that has developed in local body reporting due to media mergers and the downgrading of many provincial newsrooms and local papers.

It’s a year-long trial, which will be extended if successful.

VITAL STATISTICS

AUSTRALIAN-NEW ZEALAND MEDICAL SPECIALIST WORKFORCE COMPARISONS

For New Zealand to match Australia’s specialist workforce per capita in 2018, a further 1,250 specialists would have been needed.

**EMPLOYED MEDICAL SPECIALISTS - AUSTRALIA AND NEW ZEALAND, 2018**

<table>
<thead>
<tr>
<th></th>
<th>Headcounts</th>
<th>Population’</th>
<th>Specialist/1000 pop.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>37,022</td>
<td>24,992,400</td>
<td>1.48</td>
</tr>
<tr>
<td>New Zealand</td>
<td>5,977</td>
<td>4,885,300</td>
<td>1.22</td>
</tr>
</tbody>
</table>

**Sources:** Australian Department of Health, 2019. MCNZ Medical Register, 2018. Australian Bureau of Statistics

**ASSUMPTIONS**

New Zealand figures, obtained from the medical register, assume doctors holding an annual practising certificate and include a New Zealand address are employed in New Zealand. They include doctors in primarily non-clinical roles.

Australian figures also include doctors in primarily non-clinical roles (e.g. researchers, educators, administrators) who it is assumed hold specialist qualifications.

**Note:** OECD workforce data indicate New Zealand’s ‘specialist’ workforce per capita (the definition includes trainee specialists) is larger than Australia’s. However, New Zealand’s appears to include registrars not in specialist training programmes, plus medical officers. ASMS is engaged in ongoing discussions with the Ministry of Health to improve the accuracy of the data supplied to the OECD.

i Estimates as at June 2018

ii As at July 2018
DISCOUNTS FOR E-BIKERS
Discounted electric bikes are being offered to public sector staff as part of a Government initiative to reduce emissions and support healthier transport options. The Government has negotiated bulk-purchase discounts, which are being made available to interested workers in public sector organisations, including DHBs. Ask your DHB if it has signed up to take part.

TELEHEALTH UPTAKE
The 2019 telehealth survey shows uptake has increased considerably across all DHBs. Video-based telehealth technologies are now being used in 19 DHBs. There has also been significant growth in the number of clinical services represented, the frequency of usage and the types of telehealth interactions.

RESEARCH APPEAL
Dr Jill Wilkinson from Victoria University of Wellington is carrying out research on doctors and nurses who have been the subject of a Health and Disability Commission investigation in the past 10 years. She is keen to interview people about their experiences and the impact the complaint and investigation had at the time and in the years following. For more information contact Dr Jill Wilkinson at jill.wilkinson@vuw.ac.nz

CREATIVE JUICES
An art exhibition and social function to help senior doctors and dentists across the Auckland region rediscover their creativity is being held next month. Described as a ‘wellness initiative’, it will involve an exhibition of doctors’ artwork and live performances. It’s been put together in conjunction with the Association of Artist Doctors and is happening at 7.30pm Friday 3 April 2020 at the Mt Eden Village Centre.

MEDICAL COUNCIL RE-ELECTION
ASMS member and Palmerston North renal and general physician Dr Curtis Walker has been re-elected chairperson of the Medical Council of New Zealand for another 12 months.
Dr Walker also holds the position of Kaihautū Tuarua/Deputy Chairperson Te Ohu Rata o Aotearoa - Māori Medical Practitioners Association (Te ORA). He has a long-standing commitment to improving Māori health and is a strong advocate for health equity.

ASMS NATIONAL EXECUTIVE ROLL CALL
ASMS has put together a list of members who have sat on the National Executive since the Association was formed 30 years ago. If you’re interested you can find it on the ASMS website www.asms.org.nz and search ‘roll call’.
SPECIAL HONOUR FOR DOCTOR KILLED IN CHRISTCHURCH MOSQUE ATTACKS

T he memory of ASMS member Dr Amjad Hamid is to be honoured with a special medal developed by the Royal New Zealand College of GPs.

Dr Hamid was one of the 51 people killed in the Christchurch mosque attacks just over a year ago.

He was a heart doctor and a rural hospital consultant.

He lived in Christchurch with his family but travelled to Hāwera Hospital where he worked for Taranaki DHB.

Dr Hamid had worked as a registered doctor in New Zealand since 1998.

The Amjad Hamid medal will be awarded for the first time this year to the top student of the University of Otago’s OENA 728 paper, which is Cardiorespiratory Medicine in Rural Hospitals.

Lynne Hayman, CEO of the College says, “It is a fitting tribute to Dr Hamid to honour him in this way and to associate him with the highest achievers in cardiorespiratory medicine.”

ASMS Executive Director Sarah Dalton says the medal is a tangible way of acknowledging the contribution Dr Hamid made.

“It’s also a poignant time to stop and reflect on all those who died, along with the work of emergency workers and hospital staff who gave everything at the time to save lives,” she says.

DID YOU KNOW

ABOUT MECA ADVICE AND JOB OFFER ADVICE?

Bargaining is an important component to improving your terms and conditions. Another important component of securing fair terms and conditions is ensuring you are getting your existing entitlements in the MECA. ASMS is here to offer members advice on their MECA entitlements and advise on how relevant clauses apply in your specific circumstances.

In addition, ASMS offers free advice on job offers to anybody being offered employment as a senior doctor or dentist. This is a membership service we offer to existing SMOs moving between DHBs. We also offer advice to registrars looking at their first consultant position, or doctors coming from overseas, and they do not need to be members at that point in order to access this service.

Having an ASMS check on a job offer is a very good way to ensure new doctors in DHBs get fair and equitable conditions. It also allows us to check how conditions are being applied equitably to those already employed. Unfair salary step placement and inequitable starting conditions can be an important contributor to the gender pay gap.

If you are aware of an RMO or someone from overseas getting a job offer from a DHB, please remind them of the opportunity (without having to be an ASMS member) to access our advice. If you are moving between DHBs yourself, we also recommend getting in touch. There are regional variations that you may not be aware of and we can help with.
Q & A Covid-19

Employment, CME & other travel advice for SMOs/SDOs

If I’m required to self-quarantine because of potential exposure to Covid-19 how will I be paid?
- If your employer agrees that you may work from home, you should receive your full pay.
- If you’re otherwise healthy and available for work and your employer has insufficient work for you to do from home or in quarantine, DHBs have agreed that the balance of your quarantine will be paid as special leave on full pay.

Do I have to pick up additional duties because of a colleague needing to self-quarantine? How should this be paid?
- The usual rules apply. Where applicable, locum rates should apply, or new rates agreed.
- If it is safe for you to do so, you may be required to pick up the additional work/duties, but you should not do so at the risk of your own health and welfare.
- Picking up the complete workload of one or more colleagues for 14 days will risk excessive fatigue.
- If you’re covering for a colleague and temporary or locum help is not available (which is likely to be the case), clause 47 of the MECA – Vacancies and Locums - will apply.

Can my DHB cancel or delay previously approved CME because of Covid-19?
- Yes. Some DHBs have already done so and others are in the process of doing so.
- DHBs have also agreed to reimburse all properly incurred pre-booked and paid CME expenses that may be lost through cancellation, and are not otherwise covered by applicable travel insurance.
- DHBs have also agreed CME days will not be forfeited, if they were about to be lost for exceeding the three-year accumulation limit.

What if my approved CME event is cancelled (by the event organiser) because of Covid-19?
- Any fees or costs not refundable by the event organiser will be reimbursed by your DHB (as above).
- Your CME leave balance should not change, but any days at risk of forfeiture, by exceeding the three-year accumulation limit will be protected, as above.

What happens if you choose to undertake or continue personal travel overseas during this period?
- DHBs’ advice is that if you’re required to self-quarantine on your return, you will not be entitled to special leave on full pay and you will be expected to take annual or unpaid leave, or work from home if that is appropriate and agreed with your employer.
- ASMS has a less rigid approach: each case should be considered on its merits including the known or likely risks at the time your travel was commenced.

Where can I get advice if my circumstances are not covered by the above?
- Our advice may change as circumstances change, so if you have any questions or concerns, please contact the ASMS national office, or your regional ASMS Industrial Officer.

PLEASE BE AWARE THIS ADVICE WAS DRAFTED EARLIER THIS MONTH AND WHILE IT IS STILL CURRENT THERE COULD BE FURTHER UPDATES DEPENDING ON DEVELOPMENTS WITH THE COVID-19 PANDEMIC.
COMING UP IN THE NEXT EDITION OF THE SPECIALIST

This camp stretcher which is available for use in a training room is the “overnight accommodation” provided for O&G staff at Whangarei Hospital. It was brought along to the recent JCC meeting by ASMS members to highlight the inadequacy of accommodation provision. Access to appropriate sleeping accommodation is a MECA entitlement. We know lots of you are battling the same problem.

The next issue of The Specialist will be taking a look at overnight hospital accommodation for SMOs. If you have any photos or information to share, please get in contact liz.brown@asms.org.nz

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.org.nz

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

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

ASMS job vacancies online
jobs.asms.org.nz

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

Substantial discounts are offered for bulk and continued advertising.

ASMS Direct

In addition to The Specialist, the ASMS also has an email news service, ASMS Direct.

How to contact the ASMS

Association of Salaried Medical Specialists Level 11, The Bayleys Building, 36 Brandon St, Wellington
Postal address: PO Box 10763, The Terrace, Wellington 6143
P: 04 499 1271
F: 04 499 4500
E: asms@asms.org.nz
W: www.asms.org.nz
www.facebook.com/asms.nz

Have you changed address or phone number recently?
Please email any changes to your contact details to: asms@asms.org.nz

www.asms.org.nz | THE SPECIALIST 27
“They’ve been insuring New Zealand families like mine for nearly 100 years.”

Katherine Reinhold (and Rosa)
Lawyer and MAS Member

MAS is 100% New Zealand owned and we’ve been serving our Members, like Katherine, for nearly 100 years now. Not only have we established a foundation to fund health initiatives, we have been awarded Consumer NZ People’s Choice across four categories* for three years running.

* House, contents, car and life insurance

mas.co.nz
0800 800 627