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A new MECA round and final words

Professor Murray Barclay | ASMS President

Last month we launched into a new round of MECA contract negotiations, with only a 12-month gap between the last negotiations, which ended prematurely due to Covid-19 disruption. From a general member point of view, this is the most important activity for ASMS.

Many things have happened in the world over the last year. There have been more than 2.5 million deaths from Covid - many of them health care workers. The global economy has taken huge hits, and there has been hardship for so many.

The worst effects of Covid on New Zealand’s health care workers have been avoided due to our border closures and elimination policy. But some risk remains, as we are reminded each time there is community transmission and altered lockdown levels.

What hasn’t changed for ASMS members are the work pressures and threats to well-being that were present at our last MECA negotiations. If anything, those pressures have risen, notably in the mental health area, but also in areas where SMOs have had increased workload in an attempt to catch up with waiting times that stretched out during our Covid lockdowns. There is still an average 24% shortage of SMOs, and our most recent member survey shows no improvement since 2015 in burnout rates. (see p7)

It is clear that DHB attempts to improve burnout, such as focused discussions, mindfulness training and peer support, have made no difference. What we need are more colleagues to share workload and respond to patient need.

Other important features of the negotiating environment include the following:

• Recruitment difficulty is reported in 79% of hospital departments throughout New Zealand.

So, the main areas of focus for our MECA negotiations are, and must be, the ability to recruit and retain SMOs/SDOs, along with well-being. Within this there is a particular focus on after-hours and shift work, which are becoming increasingly onerous and were not well-recognised in the previous two MECA negotiations.

It is clear that DHB attempts to improve burnout, such as focused discussions, mindfulness training and peer support, have made no difference.

Another very important factor to consider is the state of the New Zealand economy and the ability to afford health care. During 2020, there was well-founded pessimism regarding the effects of Covid-19 on unemployment and GDP. New Zealand, like the rest of the world, had been preparing for a long and difficult period for its economy. Rightly, ASMS needed to reassess our ability to claim for substantial salary increases. Surprisingly, however, our economy bounced back more strongly than expected in the September quarter, with unemployment rates dropping and an increase in GDP to a level comparable to or better than it was before Covid. The latest GDP data has not been quite as positive, but the Finance Minister Grant Robertson has said the economy remains ‘resilient’. Therefore, New Zealand is still in a reasonable position to invest in its health care system and improve salaries and conditions for SMOs so we can improve recruitment and retention and provide New Zealanders with the level of health care they deserve.

We have a large and enthusiastic ASMS MECA negotiating team, and while it’s always hard to predict how long negotiations will take or what the final result might be, your representatives will do their best to get a good result for members.

Finally, this is my last President’s article for The Specialist. Over the last three years, I have enjoyed working with a very supportive Executive, and the dedicated and hard-working team at the ASMS Wellington office. The industrial, research, comms and support teams all go the extra mile to get the best outcomes for members. It is almost time to hand over to Dr Julian Vyas, paediatric respiratory physician from Auckland, as our President for the next three years. The current Executive has done well to have ASMS in good shape for Julian, who will no doubt bring his own special qualities to the role.
Congratulations to the new ASMS National Executive.

After several weeks of voting, members elected their representatives to serve on the National Executive for the next three years. The Executive is made up of a President, a Vice President, and two members from each region, along with the immediate past President.

The new National Executive is:

- **Dr Julian Vyas** (respiratory paediatrician, Auckland) – President
- **Dr Andrew Ewens** (emergency medicine, Waitematā) – Vice President
- **Professor Murray Barclay** (gastroenterologist, Canterbury) – immediate past President

**Region 1 - Northland, Waitematā, Auckland, Counties-Manukau**
- Dr Julian Fuller (anaesthetist, Waitematā), Dr Sylvia Boys (emergency medicine, Counties-Manukau)

**Region 2 - Waikato, Bay of Plenty, Lakes, Taranaki**
- Dr Annette van Zeist-Jongman (psychiatrist, Waikato), Dr Andrew Robinson (anaesthetist, Lakes)

**Region 3: Tairawhiti, Hawkes Bay, Whanganui, MidCentral, Wairarapa, Hutt Valley, Capital & Coast**
- Dr Nathalie de Vries (paediatrician, MidCentral), Dr Kai Haidekker (radiologist, Hawkes Bay)

**Region 4: Nelson-Marlborough, West Coast, Canterbury, South Canterbury, Southern**
- Dr Katie Ben (anaesthetist, Nelson-Marlborough), Dr Seton Henderson (intensivist, Canterbury)

We want to acknowledge the contribution of outgoing National Executive member Dr Paul Wilson, and his years of service in the role of National Secretary.

The new National Executive will take office in April and a new National Secretary will be appointed.

Your new President

A very warm congratulations to new ASMS President Dr Julian Vyas.

Dr Vyas is a respiratory paediatrician at Auckland’s Starship Hospital and has been on the National Executive since 2018.

He stood unopposed for the President’s role in the National Executive elections.

Dr Vyas grew up in Lancashire in the UK, went to medical school in London and did his training in Birmingham, Leicester, and Melbourne. He was a consultant in respiratory paediatrics in Manchester for six years before coming to New Zealand in 2006.

His goals as ASMS President include engaging as much as possible with all members and encourage increasing diversity of member representation at branch and national leadership level.

“I want to ensure that members receive fair pay for all work done, are valued in the development and provision of service delivery and are not exposed to harmful workloads or service models,” he says.

Overall, he believes in promoting a fair, safe, and sustainable public health system, which is responsive to each patient’s clinical and cultural needs.
I am just off a phone-call with one of our members. Someone who will soon resign. They do not particularly want to stop being an ASMS member, but they do want to stop working in the public health system.

The burden of their clinical load is overwhelming them. They do not want or feel able to do on-call work anymore and call frequency is sometimes not safe. They do not have access to clinical debrief after traumatic events and are just expected to crack on with the next case.

Now they are taking some overdue time out. Thinking about the pros and cons of work in the public system, they’ve realised that all of the items on the ‘cons’ side of the ledger are things they have no control over, and no matter what they think, or say, or do, they have no power to change those things.

"Why is our system continuing to chew through its most valuable people?"

Because they are a proceduralist, they have the option to work in private. They will not have to work at night or on weekends and they will have a predictable work pattern. While there are lots of things they will miss about caring for people in the public system, it is not enough to keep them in a DHB.

Why is our system continuing to chew through its most valuable people? Our updated burnout data tells the same miserable story through the numbers. Fatigue and burnout are creeping steadily up. In some specialties it is really bad. But across the system we find that nearly half our senior medical workforce is flaming out, and the key drivers are occupational factors. It is not an individual issue, it's systemic.

I made this point when I launched our MECA negotiations. Here is some of what I said:

We know that key MECA terms and conditions are signposts of the value placed on the work SMOs do, and of the care shown to this critical and highly skilled workforce group by the system they serve.

Throughout the pandemic and economic bounce back, and irrespective of whatever happens over the next year or so, our senior medical and dental workforce have, and will continue to lead and deliver services above and beyond the demands of keeping our hospitals ticking over and will keep our health system functioning.

It is not ok to look the other way while our highly trained workforce slides backwards.

We know our senior doctors and dentists are hugely valuable to our health system – but how do we show them that they are valued? This is the place where we expect that value to be recognised - and there is no doubt that the agreements reached through the MECA discussion will give a clear steer to the senior medical and dental workforce about how they are valued by the DHBs and by the Ministry.

We are here to negotiate safe, sustainable work for senior doctors so they can continue to give best care to patients. We want a health system that sustains all its people, and which cares for those who care for the patients. We need SMOs to be supported over the whole course of their careers, with time and space to continue to learn and to lead. We must provide conditions that help SMOs to remain rested and healthy throughout their working lives.

On a final note, I want to acknowledge Murray Barclay’s fine work as our President for the past three years. He has made notable contributions to our research, to MECA bargaining, and continuity of leadership over his term of office.

I would like to offer my personal thanks to Murray and his wife, Bindy, for their contribution to ASMS, and for the time the Barclay family has given up in favour of his leadership role.

I am grateful and glad that he will continue as the immediate past-President on the Executive, and I know he will continue to be a great support to me and our incoming President, Julian Vyas.

For now, I want to thank Murray for his impressive contribution to our union, and to welcome Julian as he picks up this new challenge.

Ngaro atu he tētēkura, whakaete mai he tētēkura.

When one chief disappears, another is ready to appear.
The hidden cost of health care

One in two
New Zealand medical and dental specialists experience high levels of fatigue and exhaustion, resulting in burnout.

Chronic workplace stress
Burnout is an occupational syndrome – it means our doctors and dentists are suffering from chronic workplace stress.

Burnout rates
- Work related burnout is creeping up
  - 44% in 2020
  - 42% in 2015
- Burnout affects female doctors more than male doctors
  - 57% Female
  - 42% Male
- Male doctors with children are more burned out
  - 47% With children
  - 33% Without children

"I love my work. I love dealing with the patients. I wish I had more time to do my job properly."
"I might not be providing the best care to the patients because I have too many things to do."
"The burnout I feel is more from the system than the actual patients."

Rates of burnout are on the rise in our hospitals

If DHBs don’t look after our doctors and dentists, they can’t look after us
Let’s build a system that supports all its people
In 2015 ASMS conducted the first nationwide survey of the senior medical workforce using the Copenhagen Burnout Inventory (CBI). The results were stark – one in two New Zealand medical and dental specialists were found to be suffering high levels of fatigue and exhaustion, with many blaming their working conditions and experiences. In August 2020, we repeated the study to see if anything had changed.

An occupational syndrome

The 2015 report provided a critical lens on the consequences of short staffing, growing patient demand and clinical creep. At the time, there had been no nationwide studies on burnout levels among senior doctors and dentists using the CBI. Burnout is now established as a key indicator of their health and wellbeing and the duty of care facing their employers.

In 2019, the definition of burnout was changed by the World Health Organisation to that of an occupational syndrome. The International Classification of Diseases diagnostic manual now defines burnout as “resulting from chronic workplace stress that has not been successfully managed”. This change signals an important shift in understanding burnout as the result of stressors in the workplace and therefore requires a shift in strategies to address it. While mindfulness techniques, stress management and personal resilience strategies have their place, fixing burnout requires addressing the conditions of work that are creating stress and looking at how they can be modified.

Survey results

Of the 4,653 members invited to participate in the survey, 2,102 responded, giving us a healthy 45% response rate. There were no statistically significant differences between the 2015 and 2020 burnout scores.

Gender differences

There was a significant decrease in the proportion of women in their 30s scoring with burnout when compared with the 2015 data (p=0.003). In the 2020 survey, 57% of women in their 30s scored with burnout whereas 71% of this age cohort scored with burnout in the 2015 survey. This is a significant improvement for this group. However, women still record significantly higher burnout scores overall than their male counterparts (Figure 2). There were no other significant differences in the rates of burnout by gender between 2015 and 2020.

“Just wish my job was containable within the hours I am given to do it. That is probably the single biggest stressor – the constant feeling that I have forgotten something really important and the to-do list is never completely done, and that I might not be providing the best care to the patients because I have too many things to do.”
The impact of children

In the 2020 survey we looked at whether having dependants, defined as children still living in the home, had any association with burnout. Overall, we found that mean scores for personal burnout increased slightly with number of children ($p=0.015$). There was no statistical relationship between either work-related or patient-related burnout in relation to whether respondents had dependants. When the data was cut by gender, there was negligible difference in the proportion of female respondents experiencing either work-related burnout or personal burnout and whether they had dependants. For men, however, having one or more children resulted in higher rates of personal and work-related burnout as well as a slight increase in the proportion experiencing patient-related burnout. This is an interesting result. It runs contrary to the wider literature, which has found that men who are either married or in a committed relationship and have children can reduce their likelihood of experiencing emotional exhaustion.1

Interestingly, the highest proportion experiencing personal burnout were women in their 30s and 40s without children (65.3% and 64.4% respectively). Just over 50% of men experiencing personal burnout were in their 50s with children (50.4%). These trends were explored by cutting the data by hours of work, gender, and dependants. Figure 3 suggests there is little difference in hours of work by gender, although men with one or more children represented over half of those who worked more than 50 hours a week.

As in 2015, work-related and personal burnout correlated with increasing numbers of hours worked in a week. We again found that working more than 14 consecutive hours as well as not having a 24-hour break, free of any scheduled work, positively correlated with scoring with personal and work-related burnout.

Places of work

The frequency of work-related and personal burnout differed significantly according to DHB. Eleven of the 20 DHBs had over half of their respondents scoring as likely to be suffering from personal burnout. Eight had over half of their respondents likely to be suffering from work-related burnout. Eight had over half of their respondents likely to be suffering from work-related burnout. As displayed in Figure 4, just over 60% of respondents at Southern DHB were experiencing work-related burnout, and 62% were experiencing personal burnout. This was the only DHB to experience a statistically significant increase in their burnout scores over the five-year period.

“I LOVE MY WORK, I LOVE DEALING WITH THE PATIENTS. I WISH I HAD MORE TIME TO DO MY JOB PROPERLY. BUT I AND MY COLLEAGUES ARE FRUSTRATED BY THE UNREALISTIC EXPECTATIONS OF THE MANAGEMENT TEAMS OF OUR CAPABILITY WITHIN THE CONSTRAINTS OF TIME AND BUDGETS.”

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“When I see what is available in private, it’s very demoralising for those of us committed to public practice and meeting the needs of all of our patients, not just those with means.”
Burnout by specialty
Due to the more robust numbers of respondents in the 2020 survey, we were able to take a closer look at specialty burnout scores. The high scores for radiation oncologists (n=20) in this current research (Figure 5) are of concern, as are the high levels of burnout for rural hospital specialists (n=22) and those working in respiratory medicine (n=20) and emergency departments (n=164). The low scores for those in public health medicine (n=26) were queried by some at the 2020 ASMS conference. It was suggested that rates of burnout may be higher than what is reported, but those worst affected by burnout were perhaps least likely to respond to the survey.

Conclusions
Overall, and despite the efforts to raise the profile of burnout as an issue of concern for medical professionals in New Zealand, this survey suggests little has changed in five years. Analysis of the qualitative data suggests that similar pressures raised in the first survey persist.

Respondents continue to emphasise burgeoning patient demand, frustrations with the system, clinical creep, and a sense of growing moral distress at not being able to provide patients with the level of care that is required.

The full report of the burnout survey will be available to members in April.

REFERENCES

“Our hospital is old and five times too small, our emergency department is heaving with volumes commonly exceeding capacity, patients boarding for hours, inadequate access to outpatient services to help keep patients out of hospital. The burnout I feel is more from the system than the actual patients.”

Glossary

Personal burnout: the degree of physical and psychological fatigue and exhaustion experienced by the person overall, including work-related burnout, patient-related burnout, and non-work-related factors.

Work-related burnout: the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to their work.

Patient-related burnout: the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to their interactions with patients.
It may not seem long since you last read an article about ASMS-DHB-MECA negotiations, but after last year’s Covid-interrupted talks and swift settlement, we find ourselves back at the table, less than a year later.

Negotiations kicked off on February 10th. Like 2020, we have a large ASMS team with a representative from every DHB that can provide one.

The DHBs are represented by Gretchen Dean and Aaron Crawford from TAS (Central Region Technical Advisory Services, which negotiates on behalf of the DHBs), Sam Bartram (consultant), Kieran McConn (Chief Operating Officer, Wairarapa DHB) and Kate Coley (Executive Director Organisational Support, Waikato DHB).

Our claims were formulated following feedback from the Annual Conference, branch officer meetings, the shift work working group, our National Executive and from members more generally. We have used our own research (particularly related to burnout, fatigue and presenteeism) and our claims all relate in some way to the wellbeing of our members and the overall functioning of the health system.

This year we have based our claims around Sir Mason Durie’s model for health – Te Whare Tapa Whā.

They are focused around the four dimensions of wellbeing - Taha Tinana, Taha Hinengaro, Taha Wairua and Taha Whānau – plus the foundation of Whenua. The claims fall into one of these five dimensions.

We have now had the first four days of talks and have started getting down to business. We have tabled and had a response to all our claims and have also received two claims from the DHBs. Both sides have found the Te Whare Tapa Whā model useful in explaining the strong link between our claims and SMO/SDO wellbeing.

Notably, as an old colleague of mine used to say, “claiming is not getting”, and we have a difficult job ahead of us but one that the ASMS team has already embraced and feels strongly about.

Look out for our ‘MECA Matters’ newsletters for updates on how negotiations are going. You can always give feedback to your local representatives on the negotiation team or email us at asms@asms.org.nz.

Also, you can help us by checking that your colleagues are ASMS members and, if they aren’t, encouraging them to join.
Dr Andrew Laurenson is a rural medicine specialist on the West Coast and is one of several new faces on the ASMS negotiating team. We asked him some quick questions after the first round of negotiations:

**Have you ever done anything like this before?**
Never! Probably about the closest that I’ve come would be attending JCC meetings in our DHB, which are much lower stakes and generally fairly congenial.

**Why did you want to get involved?**
The opportunity to see a different aspect of the broader health care system. We are trying to do some innovative things on the West Coast and being exposed to different approaches and ideas around managing competing tensions within health should be a great learning opportunity.

**Were there any issues you were particularly keen to push?**
I work in a rural area so I’m keen to see that the MECA helps support recruitment, retention and training for those of us working in settings that aren’t the norm for most of our specialist colleagues.

**What were your impressions after day one of talks?**
The first day was fairly dry, which I didn’t expect prior. The procedural aspect to the opening of negotiations took longer that I’d expected. However, the range of interesting opinion and experience in our negotiating team is impressive, and I look forward to this being put to the test as the debate around the claim starts in earnest.
Comings and goings – workforce implications of Covid

Eileen Goodwin | Senior Communications Advisor

Travelling the world to practise and train has been a rite of passage in medicine for decades, but Covid-19 has moved the goalposts. Senior communications advisor Eileen Goodwin looks at how the pandemic has changed medical migration.

Many of our aspiring specialists are unable to gain crucial overseas experience due to the current travel restrictions.

Doctors continue to immigrate to New Zealand, and there are anecdotal reports of a surge in interest from overseas, but this is not yet reflected in the numbers of international medical graduates (IMGs) granted registration by the Medical Council of New Zealand (see Table 1).

Doctors can enter the country under the critical health worker border exemption, but there are frustrations.

Professor Des Gorman, former head of Health Workforce New Zealand, says he expects travel restrictions to lift within a year or so, and he doesn’t see Covid as a huge gamechanger for the medical workforce. The highly unsatisfactory reliance on IMGs is likely to continue, he says, as the country is not training enough doctors or providing career planning to encourage specialists to practise in New Zealand.

“The question is, over the next year, how quickly we get back to pre-Covid migratory flux.

“Anyone who thinks they know with certainty what the impact of Covid is dreaming”.

While it’s impossible to make predictions, he suspects that “at some stage next year we go back to our previous situation of just leaking graduates”.

Covid restrictions have created a burgeoning training “log-jam”, with New Zealanders currently finding it more difficult to obtain overseas experience.

He says many specialists go overseas for fellowships and don’t come back because appointments in New Zealand are random and there is no career path planning.

DHBs have resisted attempts to foster this, he says. ASMS also makes this point in our Building the Workforce Pipeline, Stopping the Drain report.

New Zealand Orthopaedic Association (NZOA) Chief Executive Andrea Pettett is also assuming international travel will resume within a couple of years, allowing a resumption of overseas fellowships.

If restrictions remained in place significantly longer, a rethink would be needed, she says.

“This is a global blip. Whilst I don’t think everything will be exactly the same, I think international travel will re-commence.”
It is a disappointing situation for surgeons who have missed out on valuable overseas experience due to the pandemic. New Zealand trains about a dozen orthopaedic surgeons each year – NZOA is aiming for 15. She says too few orthopaedic surgeons are being trained in New Zealand due to a lack of trainee places, funding, and ultimately, workforce planning.

After graduating as surgeons, most go overseas to pursue their chosen subspecialty. These tend not to be lucrative and can be financially costly for the trainee but are considered a rite of passage and a great way to travel.

“They are quite concerned about their international opportunities,” Ms Pettett says of specialists who have missed out on overseas training due to Covid.

Opportunities to subspecialise in New Zealand are limited, and there has traditionally been competition from overseas-trained surgeons for these.

“You cannot do the complex procedures without doing the fellowship. It is the expected standard.”

She believes it will be relatively easy to clear any training bottleneck once travel resumes.

“If it becomes more than a short-term problem, then I think we will have to think about it.”

The question is, over the next year, how quickly we get back to pre-Covid migratory flux.

Ms Pettett says she has heard anecdotally about a surge in applications from surgeons wanting to move to New Zealand. She says where applicants are suitable this could be positive, but there is a strong preference for New Zealand-trained surgeons.

And it all comes back to New Zealand’s lack of health workforce planning.

“We need co-ordinated and consistent longer-term plan across the workforce ecosystem, giving us a competent, sustainable and representative workforce that meets the current and future needs of people in New Zealand,” Mr Little said.

**Immigration woes**

Royal New Zealand College of General Practitioners chief executive Lynne Hayman says “substantial delays and frustrations in the process” have made it difficult for doctors moving to New Zealand.

The essential worker classification had been given on a short-term basis, to 31 March, making it difficult logistically to take the necessary steps and enter the country in time to start their jobs, she says in a statement. “This short-term cycle is negatively impacting the ability for general practices to plan and be able to confirm their GP resourcing.” This meant the flow of GPs had “materially slowed”, worsening New Zealand’s serious GP shortage.

However, just as The Specialist went to print, Immigration Minister Kris Faafoi confirmed the rules had been reviewed and the expiry date will be lifted.

On a positive note, Ms Hayman notes the number of GP trainees has increased in recent years, with 214 registrars entering the College’s specialist General Practice Education Programme in 2021, up from 194 in 2017 and 69 in 2007.

Table 1 shows the number of doctors being granted registration in the relevant scope of practice in the given periods. Registration is granted shortly before the doctor starts practising medicine in New Zealand.

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<tr>
<td>General (Australian medical graduates who have completed their internship)</td>
<td>33</td>
<td>41</td>
<td>27</td>
<td>18</td>
<td>13</td>
<td>6</td>
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<tr>
<td>Provisional general (UK/Irish medical graduates, doctors working recently in a comparable health system and NZREX pathways)</td>
<td>137</td>
<td>108</td>
<td>79</td>
<td>66</td>
<td>272</td>
<td>180</td>
<td>232</td>
<td>103</td>
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<tr>
<td>Vocational (VOC1) doctors holding a general scope who have gained an approved New Zealand or Australasian postgraduate qualification</td>
<td>132</td>
<td>144</td>
<td>87</td>
<td>95</td>
<td>139</td>
<td>107</td>
<td>103</td>
<td>141</td>
</tr>
<tr>
<td>Vocational (VOC2) IMGs holding the approved New Zealand or Australasian postgraduate qualification</td>
<td>14</td>
<td>17</td>
<td>21</td>
<td>17</td>
<td>23</td>
<td>25</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>Provisional vocational (IMGs with a non-New Zealand/Australasian specialist medical qualification)</td>
<td>28</td>
<td>40</td>
<td>21</td>
<td>17</td>
<td>28</td>
<td>35</td>
<td>26</td>
<td>38</td>
</tr>
<tr>
<td>Special purpose (IMGs: locum tenens working in a specialist post, teleradiology, postgraduate training, research, teaching, pandemic)</td>
<td>49</td>
<td>58</td>
<td>32</td>
<td>19</td>
<td>43</td>
<td>27</td>
<td>58</td>
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Table 1: Doctors granted registration in relevant scope of practice

Source: Medical Council
Dr Ryan Radecki moved to New Zealand last year from the United States to work as an emergency medicine specialist at Canterbury DHB.

The biggest factor in the move was enabling his children, aged 4 and 6, to attend school and preschool.

“Coming to New Zealand allowed our children to start up in school again, whereas many schools in the United States have been limited to online-only or minimal in-person settings,” Dr Radecki said.

“The pandemic has been handled quite poorly, overall, by the United States federal government in 2020, and the effect on physicians working in hospitals has been quite depressing.

“The working conditions have quite deteriorated, and many physicians have died from Covid-19, in part due to lack of protective equipment and a cultural failure to prevent the country from becoming overrun.”

Before coming to New Zealand, Dr Radecki worked at Kaiser Permanente in Portland, Oregon.

He arrived in July last year and completed isolation in an Auckland hotel. He says overall the move was not that difficult.

“It’s rather straightforward to become registered and begin practising down here – certainly the easiest foreign country.

“Flying when we travelled was dicey, as Air New Zealand was cutting flights somewhat unpredictably. But things like getting movers and getting our house sold was surprisingly not terribly more difficult than usual.

“Even with limitations and restrictions in movement in the United States, most of the work soldiers on.”

Asked how border restrictions and changes worldwide would affect medical migration long term, Dr Radecki says it’s not clear. He suggests that when free movement returns, the same pressures will apply.

“There may be a chance the pandemic attracted a slightly different demographic of physician to New Zealand, but it’s too soon to tell.

“Improving retention is probably best affected by addressing the same modifiable factors: remuneration, contract structure, and work–life balance,” he says.

He says New Zealand is a “refreshing change” after working in the United States health care system.

“I definitely come from the slice of the United States that thinks the current health care delivery model is reaching a critical tipping point into being a colossal failure for the average citizen, and needs to be blown up to create a national health system.”

Dr Radecki has an active Twitter presence (@emlitofnote) and co-hosts the Annals of Emergency Medicine podcast.
Two years after the mental health inquiry: the crisis continues

Lyndon Keene | Health Policy Analyst

The international shortage of psychiatrists is well recognised, as are the common causes – under-investment in mental health services, growing service needs, an ageing workforce, high rates of burnout, and difficulties attracting young doctors into the psychiatric specialties.

A 2019 survey by the Royal College of Psychiatrists in the United Kingdom found 1 in 10 consultant psychiatrist posts were unfilled, leading to increasingly lengthy waiting times for treatment. Pre-Covid reports from Australia describe psychiatry as in crisis and ‘under siege’. And in Canada, again pre-Covid, the ‘critical shortage’ of psychiatrists has led to jam-packed emergency departments, long wait lists, stressed-out families, and burned-out doctors.

While caution is always needed in interpreting international comparisons, the available evidence shows that New Zealanders face even tougher barriers to accessing psychiatrist services. Matched with 10 comparable countries (including the above), New Zealand has the lowest number of practising psychiatrists per capita (Figure 1).

Figure 1: Practising psychiatrists per 100,000 population

This is despite New Zealand’s level of need for mental health services being one of the highest in industrially developed countries, based on the estimated prevalence of depressive disorders and anxiety disorders published by the WHO in 2017. On those combined measures, New Zealand has the second-highest prevalence (12.7% of the population), behind Australia (12.9%) and ahead of the United States (12.2%).

While New Zealand’s psychiatrist workforce is growing, thanks largely to recruitment from overseas, Ministry of Health data shows the growth rate is well below the growth in service use, including inpatient and outpatient services and the growth in the number of clients being seen by DHBs. Addressing this gap will require a continued heavy reliance on overseas recruitment as there are currently fewer trainee psychiatrists than there are psychiatrists aged 60 plus—an issue facing most specialties in New Zealand.

**Workforce planning and development woeful**

Aside from the critical need for big improvements in the wide range of social and economic determinants supporting good mental health, addressing the gap also requires a quantum leap in resources for workforce planning and development. This has been woefully poor over many years, along with the lack of monitoring and public accountability for the developing service crisis revealed in the 2018 mental health inquiry. The re-establishment of a Mental Health Commission, with its role of independent watchdog, is a potential game-changer in ensuring improvements are made in practice, as recommended by the inquiry.

However, while the inquiry acknowledged workforce shortages were contributing to growing pressures on acute specialist services and difficulties getting timely access to them, it made no specific recommendation on addressing the shortage. The solutions, according to the inquiry, were to focus on improving prevention and early intervention in the community, and: “We expect demand for specialist services will reduce as issues are dealt with earlier, before they escalate…”

No one would argue with emphasising better prevention and early intervention, but the effectiveness of this is by no means a given. Use of primary care and other community services for mental health and addiction needs have already been increasing well above population growth rates; this hasn’t stemmed the flow of hospital admission rates for mental health, which have also risen well above population growth rates.

The effectiveness of early intervention policies depends on a lot of things, not least continuing adequate resourcing of services and making real progress in improving the economic and social conditions for good mental health. These are long-term goals. In the meantime, the absence of any recommendation to address the immediate needs of specialist services, including the psychiatrist workforce, risks continuing neglect.

The messages coming from the service ‘frontline’ are clear on this. Table 1 provides just a few examples that illustrate how things were before the inquiry and how they are today.

In the absence of any signs of government plans to draw more attention to what is happening in specialist mental health and addiction services, and what’s needed to address them urgently, ASMS is currently compiling an in-depth report to fill the void.

**Table 1: Comments from mental health staff and service users**

<table>
<thead>
<tr>
<th>Year</th>
<th>Comments from People’s Mental Health Report</th>
<th>Comments from ASMS psychiatrist members</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>I’ve promised friends that if things get really bad, I will call the crisis team. But I’m not sure I can keep that promise, because I know what a crisis is to the system, and unless I’m actually putting the rope round my neck, I’m not having one. – Client</td>
<td>We haven’t increased inpatient beds in 20 years … A lot of our beds are blocked by people because there is no accommodation and then we can’t get crisis patients in or they come in later and so they’re sicker.</td>
</tr>
<tr>
<td>2019</td>
<td>Now they’d never put me in hospital, the system has always been an ambulance at the bottom of the cliff, but now the cliff is higher, and the ambulance has three flat tyres. You have to be really F*****d up to get any help. – Client</td>
<td>It’s become a 24-hour service, lots of after-hours, lots of police callouts, lots of 109s overnight. Then there’s a lot of paperwork and follow up. We are running the same number of consultants on call as we were 20 years ago, but the workload has increased along with population and needs.</td>
</tr>
<tr>
<td></td>
<td>[The] inpatient unit … requires a person to be at their very worst point and of some risk to themselves or others before an admission is even considered and then spits them out too soon. – Community mental health worker</td>
<td>Increasingly we are seeing people turning up later into the course of their illness, or patients who were already on the waiting list to be seen by mental health services turn up at ED, because the wait list is months long. We are seeing things reaching a crisis point for people more often.</td>
</tr>
<tr>
<td></td>
<td>WE DON’T HAVE ENOUGH ACUTE BEDS, THERE IS REALLY HIGH OCCUPANCY AND TURNOVER RATES, AND WE CAN’T GET PEOPLE IN.</td>
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**2018 mental health inquiry**

The developing service crisis revealed in the 2018 mental health inquiry. The re-establishment of a Mental Health Commission, with its role of independent watchdog, is a potential game-changer in ensuring improvements are made in practice, as recommended by the inquiry.

**Shortage of psychiatrists**

Psychiatrists aged 60 plus — an issue facing most specialties in New Zealand. Psychiatrists aged 60 plus – an issue facing most specialties in New Zealand.

**Community mental health worker**

WE DON’T HAVE ENOUGH ACUTE BEDS, THERE IS REALLY HIGH OCCUPANCY AND TURNOVER RATES, AND WE CAN’T GET PEOPLE IN.
Rowing their own waka

Eileen Goodwin | Senior Communications Advisor

Senior Communications Advisor Eileen Goodwin recently visited Ora Toa Cannons Creek Medical Centre, and also the headquarters of Te Rūnanga o Toa Rangatira, to check up on progress two years on from an unprecedented industrial dispute.

A new operating model planned at Ngāti Toa’s five Wellington region GP practices will see doctors, nurses, and practice staff make key decisions about pay, operating hours, and the services they provide for Wellington’s most deprived communities.

This is the goal of Helmut Modlik, Chief Executive of the iwi’s Porirua-based NGO, Te Rūnanga o Toa Rangatira, whose Ora Toa PHO oversees five practices – Waitangirua (currently co-located with Cannons Creek), Cannons Creek, Mungavin, Takapūwāhia, and Pōneke. The practices, which provide low-cost access to health care, have just over 18,000 enrolled patients. ASMS represents 24 members, all GPs, at the practices.

Mr Modlik emphasises the ambitious nature of self-determining practices, which will take time to implement. In the meantime, a one-year collective agreement will keep things ticking over – with a 2% pay rise – while a working party is established to make decisions on the new operating model. Next year is expected to bring “significant change”.

“We’re going to make happen what needs to happen for our people”

It’s a far cry from the situation a little over two years ago when GPs – in what’s believed to be a first in New Zealand – went on strike when negotiations broke down.

Mr Modlik, who has been in the job for a year, says the breakdown of the 2018 negotiations reflected the financial pressure from Ngāti Toa effectively being forced to subsidise the inadequately funded practices.

“My understanding is that it was hard for everybody.”

He says progress has been made with Capital & Coast DHB in providing funding that recognises the deprivation of the communities served by the five practices. However, Ngāti Toa continues to fund a shortfall.

Innovative goals

“We are and will continue to grow our ability to row our own waka. In saying that we won’t let them off the hook. We’re
going to make happen what needs to happen for our people," says Mr Modlik.

"From most people’s point of view it isn’t an appropriate use of our iwi’s intergenerational equity to subsidise public health services.”

Nearly 70% of the practices’ patients are Māori and Pasifika, and they are younger than the New Zealand population average. Over a third of the patients have a long-term condition.

One of the goals is offering longer appointments, and home visits where required. He says there is limited potential in remote consultations because many patients do not have access to generous quantities of data. Also, many patients stated a preference for face-to-face consultations when these were limited by the Covid-19 lockdown.

He acknowledges GPs want to see longer consultation times become the norm. However, while some patients need 20 minutes or so, others do not, he says, and it would be unsustainable to offer all patients that long. He wants to find innovative ways to help the “worried well” make fewer visits while encouraging those who tend to put off visiting to do so before their condition becomes serious.

The PHO has been growing its patient roll, acquiring a new practice, Waitangirua. Because the building had proven to be "a dog", the clinic is being delivered out of the Cannons Creek practice. A new building will open in May.

Management style shift

As part of changes introduced by Mr Modlik, practice managers have been hired to provide stronger management at each site.

His vision for the medical practices is a move away from an “orthodox top-down” management style. “We are making a fundamental shift,” he says.

This will see the practices become as autonomous as possible, including staff determining their own pay rates and opening hours. He says this could lead to some interesting discussions between the professional groups within practices, but it will be positive, he believes.

“They are the best people, they are heroes,” he says of the staff.

“I have no agenda. All I’m after is for my staff to be happy and to be paid as well as they can be.

She is pleased with the progress made in negotiations with the Rūnanga, but “we need to see detail behind it to keep the momentum going”. Dr Todd says there is a need for longer appointments. English was often a second language, and patients tended to have more than one item to discuss.

“It’s been 15 minutes traditionally, but it’s not long enough.”

Her patients are “great” and make the job what it is, she says.

An innovative approach – an industrial officer’s view

Lloyd Woods | Senior Industrial Officer

A

SMS has been negotiating a collective employment agreement for members employed by Te Rūnanga o Toa Rangatira for many years, and it has not always been easy.

The collective agreement expired in June last year, but due to the Covid situation we rolled it over a few months. Negotiations took place in November.

Te Rūnanga o Toa Rangatira Chief Executive Helmut Modlik gave a presentation on behalf of the new management team, noting the planned review of its health services. This involved the culture of the organisation and how to best deliver health services.

The ASMS representatives found it interesting, showing an authentic passion for the future of health services.

The outcome of the negotiations was a one-year deal which includes a 2% salary increase, with all other claims put aside for discussion as part of the iwi-wide health service review.

ASMS agreed with this innovative approach with some important caveats.

Crucially, ASMS has negotiated input into the review of health services, including consideration of longer appointment times to ensure patients receive the best care, best practice administrative time for maintenance of patient records, pay rates that foster retention and recruitment, inclusion of the Cannons Creek dental team into the GPs’ collective agreement, and other matters involving conditions and entitlements.

It’s a very innovative approach to negotiating, relying heavily on the good faith relationship between the parties. The ASMS team felt it was worthwhile, and this was backed by members when terms of settlement were formally agreed.

Notably, the review will cover conditions for all staff, and our Nurses Organisation union partners were also very happy with the agreement.

We are looking forward to starting the review process.
After a tempestuous past year, the Canterbury DHB has a new Chief Executive, but there are concerns that not enough has changed.

The new Chief Executive is Dr Peter Bramley, formerly head of Nelson Marlborough DHB. He comes to the job with the DHB facing a deficit thought to be over $200 million.

Last year Canterbury DHB management’s troubled relationship with the Ministry of Health and the Board culminated in the departure of Chief Executive David Meates, the first in a series of senior leadership resignations.

That led to protests by DHB staff and the public in support of the management team, and over concerns that Board plans to implement a severe cost-cutting programme to bring down the deficit would result in significant service and staffing cuts.

The Government’s reappointment of Crown monitor Lester Levy last month has raised eyebrows as it suggests to some the hard-line approach to the DHB’s deficit position will continue. Last year ASMS member and then Chief Medical Officer Sue Nightingale cited Mr Levy’s attitude to deficit reduction as a key reason for her resignation.

Stress and uncertainty

The Christchurch Hospitals’ Medical Staff Association, in a statement for this article, says medical staff have been through significant stress and uncertainty.

“We do have several departments that are in crisis with SMOs who are unable to deliver the care to patients that they deserve due to a variety of staff shortages.

“Having said that, the most important thing we need from our chief executive is to move forward with a plan that delivers high quality healthcare to the people of Canterbury.

“While we recognise that this has to be within the budget set by the Government, savings need to be made in a way that limits impact on frontline services that in some cases already have inappropriate waiting times.

“We remain concerned that the issues that led to the resignation of the previous management team hang over us with no easy solutions,” the statement says.

The statement goes on to emphasise the willingness to engage with Dr Bramley to determine where savings can be made without adversely affecting health outcomes.

We remain concerned that the issues that led to the resignation of the previous management team hang over us with no easy solutions.”

Dr Bramley declined to be interviewed for this article but provided written answers to questions shortly before he took up the role in February.

Asked about deficit reduction, Dr Bramley says there is “no question” the DHB needs to get on to a sustainable pathway.

“My role is to support and enable the staff of Canterbury DHB to ensure Canterbury people have access to the best possible care.”

Asked about the DHB’s issues with the Ministry of Health, Dr Bramley says he offers a “history of a good relationship” in that quarter.

Asked about SMO shortages, he said there will always be challenges deciding where resources are deployed and in recruiting to specialties.

“The executive team and our clinical leaders need to work together to prioritise those investments, so we expect there will be savings in some areas and investments in others.”

He was upbeat when asked about Christchurch general surgeon Dr Phil Bagshaw’s description of the role as a “poisoned chalice”.

“The role certainly comes with challenges but also presents phenomenal opportunities.”

Dr Bramley has a Bachelor of Science in biochemistry and physics. He worked for the Wellcome Medical Research Institute in Dunedin and has a PhD in Medicine. He lectured in Biochemistry and Medical Physiology, first in Dunedin and then at the University of Canterbury in Christchurch.
Fighting the good fight

Elizabeth Brown | Senior Communications Advisor

Dr Rob Beaglehole is no stranger to the frontline of the public health battle. Late last year the dentist and public health specialist led the charge against Coca-Cola, forcing the company to stop putting the words ‘bub’ and ‘mum’ on its ‘Share a Coke’ packaging.

It is the kind of campaigning and advocacy which sits well with his role as the head of the new National Public Health Advocacy Team for DHBs.

The team has been established by DHB leaders. They were looking for smarter, more consistent approaches to public health policy that could be applied nationally. The overarching goal is to help eliminate health inequities, improve the sustainability of the health system, and make it easy to make healthy choices.

New Zealand ranks as the third most obese population of the 36 countries in the OECD, and about 10,000 people die prematurely each year from unhealthy diet and weight. That all adds up to unnecessary strain and pressure on our health services.

“It’s a unique role. I am employed collectively by DHB chief executives. My remit is to reduce obesity and alcohol-related harm from an advocacy perspective from within the DHB structures.”

“We’ll be encouraging all DHBs to adopt a position statement and move towards implementing an action plan.”

“He says that means helping DHB leaders ensure their organisations are adopting best practice in terms of policies and advocating outside the health system for policies that will reduce obesity and alcohol-related harm.

His first priority is to look at what DHBs are currently doing. He points to the fact that while 17 of the 20 DHBs have a position statement on alcohol-related harm, only three have a strategy about how to deal with it.

“It was a unique role. I am employed collectively by DHB chief executives. My remit is to reduce obesity and alcohol-related harm from an advocacy perspective from within the DHB structures,” Dr Beaglehole says.

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“We’ll be encouraging all DHBs to adopt a position statement and move towards implementing an action plan.”

He will also be putting pressure on DHBs themselves to improve and update their own healthy food and beverage policies.

“We should not be selling sugary drinks. These are the things that make people sick,” he says.

Dr Beaglehole brings a wealth of experience to the role. He is the spokesperson for the New Zealand Dental Association and has worked for the WHO and the FDI World Dental Federation in the areas of oral health, tobacco control and sugar consumption. He is also familiar with parliament and political processes, having been a senior political advisor to government ministers Damien O’Connor and David Clark.

In his view, “Health is politics and politics is health. If we really want to improve the health of the population and initiate policies, we really need to go down the regulatory and legislative route.”

That means working to address the wider social determinants of health, such as child poverty, housing, and economic status.

Dr Beaglehole started his new job in earnest in November. He plans regular visits to DHBs up and down the country. He is keen to talk with other ASMS members to help build, inform, and support the work he is doing, both within DHBs and with wider public advocacy.
Whangārei anaesthetist Dr Sarah Preissler-Hunt is a keen sewer who regularly makes clothes for her children, but recently her colleagues have been reaping the rewards of her handiwork.

In a project which has taken on a life of its own, Dr Preissler-Hunt volunteered to make personalised theatre caps for her fellow anaesthetists.

The idea came out of a team simulation exercise around patient safety. It is widely accepted that knowing and recognising team members by name reduces the risk of adverse outcomes and builds trust among teams.

Also, while many of the staff often work together, names can be hard to remember in busy environments and emergency situations.

Dr Preissler-Hunt began by designing a few prototypes based on her own personal preference.

“I get headaches from the normal theatre hats when there’s something banded around my head. The only ones I tolerate are the big fluffy ones – like a big circle with elastic around.”

She went about creating a pattern and came up with five variations, based on feedback from her colleagues.

“I thought there’s only 12 anaesthetists, so I’ll do 24 hats – two for each person.”

Her head of department offered to cover the costs from a social fund. The project grew and Dr Preissler-Hunt soon found herself sewing 72 caps to cover the heads of the intensivists, anaesthetists, and anaesthetic registrars, which added up to about 35 hours of sewing.

She decided on purple caps for her fellow anaesthetists, but after a bit of pushback from some of the men, she tracked down a few prints to cater for different tastes. Individual names and job titles have been embroidered by a local company.

There is also a silver lining in terms of sustainability.

She points out, “It was never meant to be a sustainability thing, but it is indirectly because throwing a disposable hat away at the end of every day is a lot of waste.”

The hats have been a runaway success and are now being rolled out to all theatre staff.

Sewing another 300 hats was too big a commitment for Sarah, so one of the nurses has organised to get them made.

“Everyone really likes wearing them and we’ve had really positive feedback, not just in the theatre environment, but from patients as well,” Dr Preissler-Hunt says.

“When you introduce yourself to a patient and say ‘Hi, I’m your anaesthetist’, it can be an overwhelming time, names get forgotten and it’s embarrassing for the patient to ask again. Having our names and jobs on our caps makes it easy.”
Covid-19 – up close and personal

Dr Julian Fuller | ASMS National Executive

A SMS National Executive member Dr Julian Fuller left New Zealand late last year to visit his dying brother in South Africa and contracted Covid-19. He returned to New Zealand last month and used some of his time in managed isolation to write about his experience.

I am an anaesthetist at North Shore Hospital, and in December I undertook a compassionate trip to Durban to visit my 63-year-old younger brother, who was dying from amyloidosis of the heart and kidneys.

When I booked my flight in early November, Covid-19 in South Africa was relatively stable. There were roughly 1,500 new cases a day, with 55 deaths. There were 4,800 cases in hospital, with 500 in ICU and 250 being ventilated.

Five weeks later when I touched down in Durban on December 19th, it was a different story. Daily cases had risen to 8,500, with 8,500 in hospital, 1,100 in ICU, and 430 on ventilators.

By the time I myself developed symptoms on January 6th, the numbers were even grimmer, and when I finally managed to fly out on January 21st, daily cases were peaking at 20,000, with 17,000 in hospital, 2,500 in ICU, and 1,400 on ventilators.

Looking back, it was almost inevitable that I would get Covid, despite taking all the usual precautions, including masking up, hand sanitising, and social distancing. I rarely ‘went out’ apart from visiting my sick brother at his home every day.

I am pleased to say that before I got sick, I did have ten wonderful, quality days with my brother before he passed away on December 29th.

It was the undertakers who described Durban to me as being like a ‘war zone’ with so many dead. The mortuaries were all full, as were the morgues, hospitals, undertakers, and crematoria.

A former anaesthetist colleague told me there were no hospital beds left in the city.

Private hospitals had stopped elective work and were treating Covid patients in the wards and in ICUs. Patients were being ventilated with makeshift ventilators.

Durban was now so full of Covid that if you suffered a heart attack or some other medical emergency, you were on your own.

I also heard story after story of fit and well young people succumbing to Covid, including physiotherapists, doctors, and nurses – just anyone.

How did I know I had Covid?

To begin with, I developed fevers and rigors which lasted two to three days, and then the worst myalgia I have ever had – muscle aches and pains all over my back and shoulders, along with chronic persistent headaches. Add to that extreme lethargy, loss of appetite, and
an upset stomach. It was remarkably debilitating. Five of our bubble all had similar symptoms and tested positive. None of us had marked respiratory symptoms, just a mild productive cough. These chronic symptoms lasted around 10-12 days.

With my symptoms starting on January 6th, I self-isolated in my hotel room. My PCR swab test came back positive on the 13th.

“Durban was now so full of Covid that if you suffered a heart attack or some other medical emergency, you were on your own.”

South Africa’s President had announced strict lockdown conditions with immediate effect on December 28th. I lived in trepidation that he could also close the borders again.

I had flown to South Africa with Singapore Airlines, arriving in Johannesburg only to find they had cancelled my return flight! I then re-booked with Emirates, but they went on to cancel all flights out of South Africa, six days before I was due to fly out. The last major airline flying out of the country going east was Qatar Airways.

After catching Covid, I’d had to delay my return in order that I could have a full 14 days of self-isolation in Durban before flying.

I then had to make an application for an ‘Emergency Allocation’ of an MIQ slot back in New Zealand, but even with the support of my DHB, this was turned down.

I applied again, with further support from my DHB, just two days before my intended departure. You cannot imagine my relief when at around 6:30 am, after being up all night checking, emailing, phoning and worrying, I saw an emailed MIQ voucher arrive. It came just three hours before I was due at Durban Airport.

The last couple of weeks in Durban, I had only survived by being an eternal optimist, always positive, but also always a realist. I’d had so many ups and downs – emotionally with my brother, contracting Covid, cancelled flights, and chasing MIQ vouchers – I knew I could only relax once I was actually on board the plane home.

By this time, I was also quite an expert in all the rules for PCR Covid testing, such as who required it, airline requirements and the average course of Covid infection.

Wisely I’d decided to obtain a medical certificate from the hotel doctor in Durban, simply stating that I had tested positive on the 13th, been symptomatic since the 6th, and was now asymptomatic and not contagious. Most information at this stage suggested a person was infectious for 10 days after symptoms began, but that the PCR test would remain positive for at least another two weeks.

You can imagine my utter frustration when I checked in at Durban Airport and was asked to provide a negative PCR test! Qatar Airways phoned New Zealand, but still insisted on a negative test, even though I’d informed airline staff that it was not a legal requirement. I then produced my medical certificate, which was sent to New Zealand. I was kept waiting 90 minutes before a rather apologetic Qatar Airways staff member walked over and gave me my boarding pass!

I have never felt such relief or happiness as I did when we touched down in Auckland. I was then sent to the Jet Park Hotel to do my two weeks of quarantine.

“My age was against me, and it was like playing Russian roulette because you really have no idea if you are going to draw the short straw.”

Final thoughts

I don’t regret the time spent with my brother, but if I knew what I know today, there is some doubt in my mind as to whether I would have made the trip.

When I got Covid, I lived day by day, hoping that it was just a ‘mild’ version, but never quite knowing. My age was against me, and it was like playing Russian roulette because you really have no idea if you are going to draw the short straw. Managing my illness, coupled with the fluid lockdown levels, multiple cancelled flights, and the need to change MIQ dates, was incredibly difficult. If my MIQ voucher had not come through when it did, I would have been looking at a minimum of three to four months marooned in South Africa.

I cannot for the life of me see any reason to leave New Zealand at present, except on compassionate grounds, and even then, the decision needs to be taken seriously with ‘eyes wide open’.
As the first vaccinations are received here in Aotearoa New Zealand, billions of people across the world face a long wait for theirs. A mere 10 countries have administered 75% of available Covid-19 vaccines, while in more than 113 countries, not a single person has received a dose. At current rates of distribution, 80% of people in the poorest countries will not receive a vaccination in 2021. This is neither morally right nor scientifically safe. When we remove the artificial boundaries of nation states, there is no reason why a health professional, frontline worker or older person in a low-income country should not get the vaccine at the same time people are being vaccinated in a high-income country. Further, the longer the virus circulates anywhere, the greater the opportunity to mutate and potentially spread more rapidly.

The situation stems from long-standing global inequities, alongside a global pharmaceutical industry that does not always place human welfare ahead of private profit. Wealthy countries have been able to negotiate bilateral deals directly with pharmaceutical companies, pre-purchasing enough supplies to vaccinate their populations several times over. The poorest countries are at the mercy of donations to COVAX’s Advanced Market Commitment mechanism, which was created to purchase and distribute the vaccine to the 92 least developed countries. But this situation was not unforeseen. Millions of people with HIV lost their lives while waiting for anti-retroviral treatment they could not get because pharmaceutical companies would not share their patents.

So even before there were any Covid-19 vaccine candidates, groups like the People’s Vaccine Alliance began calling for any vaccine to be free to all, and fairly distributed across the world based on need. Countries too called for solutions, such as South Africa and India, who were the initial co-sponsors on a proposal to the World Trade Organization (WTO) to temporarily waive some intellectual property rights for coronavirus tests, treatments and vaccines until the pandemic is declared over. This proposal continues to work its way through the WTO’s negotiating process, far slower than the pace at which the coronavirus spread across the globe.

A new study commissioned by the ICC Research Foundation found that the global economy could lose up to US$9.2 trillion if developing economies are denied access to Covid-19 vaccines. Where is Aotearoa New Zealand in all this? We have contributed $27 million to COVAX to secure doses for Aotearoa, and $17 million to the Advanced Market Commitment mechanism for low-income countries. We have pledged $65 million through our Aid Programme to purchase vaccines for the Cook Islands, Niue, Tokelau, Samoa, Tonga and Tuvalu, and to support them with the vaccine roll-out. Yet, we’ve also pre-purchased enough vaccine to cover our population and these six Pacific states almost three times over, and we have not given our COVAX vaccine allocation to countries in much greater need than us. We currently neither support nor oppose the WTO waiver proposal.

What can be done? The Government can engage with pharmaceutical companies to encourage them to openly share their vaccine manufacturing technology, intellectual property and know-how through the Covid-19 Technology Access Pool. We can come out in support of the proposal to temporarily waive some intellectual property rights, even if only for the Covid-19 vaccine. We can state openly that we will not take what is offered to us through COVAX, instead allowing the allocation to go to countries where there is greater need than here. We can lead by example, much as we did in controlling the virus in our country. Only then will we be able to live up to our Prime Minister’s words in an open letter alongside South Africa’s President Ramaphosa, saying that “where you live should not determine whether you live”. ASMS is supporting efforts to try and secure a People’s Vaccine. We promoted a petition, signed by almost 6,000 people, calling on the Government to support the proposed temporary relaxation of WTO intellectual property rules on Covid-19 vaccines. We also joined 41 other organisations in signing an open letter to the Government calling on it to uphold New Zealand’s reputation as a good global citizen by championing a People’s Vaccine.
Have you ever considered what your professional vulnerability is when a colleague asks you for a second opinion? Whether you are the SMO on call at the end of the telephone providing advice to a registrar or being consulted by a colleague for a second opinion, your opinion needs to be provided with reasonable care and skill.

In 2019 the Office of the Health and Disability Commissioner reported on a case of a radiologist who had sought the second opinion of a colleague.1 Both failed to diagnose a colonic tumour, yet it was the second radiologist – the one providing the second opinion – who was deemed to have breached the Code of Health and Disability Services Consumers’ Rights. How could this be?

Case in point
Dr D had performed a CT colonography for a man with a family history of bowel cancer. He had difficulty deciding whether or not the appearance in the caecum was abnormal. Specifically, he couldn’t decide whether a mass was faecal residue. He sought the opinion of his colleague, Dr C. Dr C performed a second read of the study and concluded that the abnormality was retained faecal material. The basis of his opinion was that the abnormality moved from one side of the colon to the other as the patient moved between prone and supine scans. Dr D reviewed the scan again and accepted Dr C’s conclusions and reported the examination as normal. Several years later the patient re-presented with metastatic bowel cancer. An expert opinion found that the approach to differentiating between lesion and artefact should involve consideration of whether the mass had soft tissue density, its morphology (including shape and structure) and whether it was fixed with change in position.

Although subject to an adverse comment, Dr D was not found in breach because he had proceeded correctly. He appropriately sought a second opinion when he was unsure how to interpret the detected abnormality.

The departure from the accepted standard of care primarily applied to Dr C, as his opinion was the main reason for the final report. Dr C considered the possibility of the mass being a lesion; however, his final opinion given to Dr D did not reflect this, including that he did not provide a differential diagnosis for Dr D to consider. This error of interpretation led to a lack of further investigation, which the expert considered should be standard practice if there were reasonable doubts.

On first appearance, it may seem unfair that the person who gave the second opinion was found in breach and not the individual who provided the final documented opinion. It is up to the person giving the second opinion to qualify their answer if there is any uncertainty, as their opinion may be definitively relied upon, as occurred here.

‘Corridor consultations’
When you are asked for an opinion from a colleague, even the notorious ‘corridor consultation’, your opinion needs to be provided with high care and skill, however informal. You need to give that opinion as if you were the doctor primarily responsible, so you need to make sure that you have sufficient information to draw your conclusions. If you too are uncertain, this should be expressed – for example, by way of differential diagnoses. If you need further information – for example, by way of further investigations – then these should be sought. Similarly, when on call and giving an opinion to a registrar over the phone, again you need to make sure that you have sufficient information to provide an opinion.

When giving a second opinion, it is worthwhile keeping a record of the crucial information provided to you on which you base your opinion, and what your advice has been. This information can be stored safely to be referred to in the future if necessary or can be entered into the patient clinical notes when possible.

1 Case 17HDC02239: https://www.hdc.org.nz/decisions/search-decisions/2019/17hdc02239/
What inspired career in medicine?
At school careers day I went to a lecture on architecture as I was interested, and the lecturer was so boring that my dad said he ‘uninspired’ a room full of potential architects. My grandad was an ‘old school’ GP - the kind that delivered the entire village - so you could say there was ‘medical blood’ in the family. I wasn’t sure if I was capable of getting into med school (starting ‘imposter syndrome’ early!), but my friends and family encouraged me, so here we are!

What do you love about your job?
I’m an ED SMO in Auckland. I love ED because every day is different. Your job is to take chaos and attempt to create order - take an undifferentiated patient and make same sense of the situation, for yourself and for the patient. Obviously there is the drama and adrenaline of a resus situation, but my favourite are the elderly patients, chatting to them, making them feel valued and heard, and loving their stories. Also, there are NO ward rounds!

What are some of the challenging aspects of practising medicine in the current health environment?
A pandemic is a difficult time to be an ED practitioner. At the beginning of the pandemic I often talked about ‘the tendrils of Covid’, as those tendrils get everywhere. Covid would be an intrusive differential diagnosis, an understandable phobia for patients, a decision on bedspace utilisation and on hospital disposition, a disrupter of training programs, or a wall isolating people from families overseas. It appeared there was nothing Covid couldn’t reach. As a profession, and a country, we have stood strong in what will be a historic moment, and of that I am proud.

What keeps your happy outside of work?
I’m a bit of a collector of hobbies - apparently it’s a family trait to be incapable of sitting still! I’ve loved photography since being a child, learning from my dad on an old unautomated SLR and spending hours in the darkroom. I was ill as a child and in bed for a month, so my mum bought me paper, pencils and a ‘learn to draw’ book. I’ve loved drawing since that time, although now I mostly do digital art. My mum also ensured I learned to play piano as a kid. I didn’t enjoy the hours of practice, but now I’m extremely grateful to be able to relax at the piano and even manage to get my toddler to join in!
When you are on leave you should be paid the same as normal. When you take certain types of leave you must be paid on "full pay".

The types of leave that must be paid on full pay are:

• Annual Leave (MECA cl. 23)
• Public Holidays (MECA cl. 24)
• Leave for Illness, Accident and Bereavement (MECA cl. 27)
• Paid Parental Leave (MECA cl. 28)
• Professional Meetings Leave (MECA cl. 29)
• Sabbaticals (MECA cl. 36.5)

By extension some other types of leave are also paid on full pay, for example, long service leave, onerous duties leave, etc.

Some MECA clauses allow breaks without loss of pay - which has the same effect. For example, the recovery time clause (MECA cl. 13.6) allows an employee to have an adequate break without deduction from full pay before commencing work following periods of on call related work where the employee is too fatigued to safely undertake their next scheduled activity.

What is full pay?

The MECA defines “full pay” as:

"the employee's usual gross fortnightly earnings (based on their agreed job size and current remuneration schedule)." (MECA cl. 11.6)

Clause 13.2 of the MECA defines 'job size' as the average weekly number of hours the employee is required to undertake their various duties including “rostered after hours’ on-call duties.....”.

It follows that full pay is not just base salary. It also includes allowances and average after-hours call remuneration.

Where SMOs have event-based arrangements for the payment of call, full pay includes these payments where they arise out of rostered call, as these arrangements are still part of your job size.

The only payments that would not be included in full pay would be one-off payments for unusual or extra duties.

Please contact your industrial officer if you have any problems over the payment of full pay.

Did you know?

Welcome to our new industrial officer

David Kettley has joined ASMS as a new industrial officer. David has a strong history in industrial relations, having worked as a union organiser for the Engineers Union (now E tu) before moving into employment and industrial relations in different agencies within the government sector. He will be a familiar face to some, as he comes to ASMS from his role as an HR project manager with the Nelson Marlborough DHB. He says he is looking forward to working for ASMS and supporting members in the face of the ongoing challenges in the health sector. David will be working in our southern team, with members in the South Island.
ASMS and the Canterbury Charity Hospital Trust are joining together to co-host a virtual conference on July 2-3. The Creating Solutions conference will aim to define some solutions to the chronic health disparities that affect the people of Aotearoa New Zealand. This will not be a chalk and talk fest. It will generate an outcomes document, which will include conference papers, along with a practical change agenda which will go to government. Details about the conference and how to register will be available in the next few weeks.

Creating Solutions conference
Save the date

Creating Solutions
Towards health equity outcomes for all

Calling arty members

We have had considerable interest in our proposed art exhibition featuring the work of senior doctors and dentists. The “Artists who Doctor” exhibition would coincide with the ASMS Annual Conference in November and would be curated and held at the New Zealand Academy of Fine Arts in Wellington. We are trying to get an idea of final numbers and are still calling for expressions of interest from any member who would like to be involved. Artwork can include ceramics, sculpture, paintings, photography, or jewellery.

If you’d like to take part or want to find out more, please contact our senior industrial officer Lloyd Woods at lloyd.woods@asms.org.nz asap.
Noticeboard

Clinical Mentoring Programme

The New Zealand Medical Students’ Association and the Association of Salaried Medical Specialists are proud to launch the ASMS-NZMSA Year 4 Clinical Mentoring Programme for 2021.

The programme pairs fourth year students in one-on-one mentoring partnerships with ASMS members. The key aims are:

• To develop and foster wellbeing and resilience, not career coaching or specialty-specific advice
• To reduce isolation and confusion for medical students throughout their medical training
• To empower medical students through having access to mentors who can provide wisdom and advice
• To upskill clinicians in communication and mentoring.

This programme is informal, with those paired up simply recommended to meet three or more times during the year, where students can share experiences, seek advice and gain further insight into medicine.

If you would like to be a part of the programme, please sign up via the QR code.

If you have any questions please email wellbeing@nzmsa.org.nz

ASMS rural health research

Look out for our upcoming Research Brief on rural health which looks at how to provide medical care in isolated areas.

The paper highlights disparities in healthcare access between rural and urban areas, staff shortages in rural hospitals and general practices, and rural generalism as a scope of practice.

The Research Brief will be distributed to members and will be available on our website.

Māori Health Authority

ASMS and the New Zealand Medical Association have issued a joint statement backing a fully empowered Māori Health Authority with full commissioning rights as a new pathway to deliver health equity for Māori.

The final report of the Health and Disability System Review included a recommendation for a Māori Health Authority. However, Review members were split on whether it should have the power to commission and fund services. An “alternative view” in the report called for these greater powers.
Noticeboard

Covid vaccine rollout

ASMS is actively supporting the rollout of the Covid-19 vaccine to health workers and is encouraging everyone to take the opportunity to get vaccinated. We have also been involved in cross-union and government talks about supporting the public rollout of the vaccine. We are asking any members who would like to, to send in a photo of themselves receiving the vaccine to be used as part of the wider public health campaign to promote the vaccination programme. You can send your photos to liz.brown@asms.org.nz. If any member has employment issues or concerns related to the Covid vaccination rollout, please contact your industrial officer.

CTU work-life survey

New data from the CTU’s annual work life survey shows a snapshot of working people’s experiences and outlook for the year. Concerningly, 42% of respondents cite workplace bullying as an issue in their workplace - a number only marginally down on last year - and 49% say they have had their work and/or income adversely affected by the Covid-19 pandemic. However, there is massive support from working people for the Government’s planned increase in minimum sick leave from five days to ten days with 94.3% in support.

PPE stocks

The Ministry of Health says it has more than nine months’ worth of personal protective equipment (PPE) in stock at current usage rates, or over a month’s worth at “high pandemic” use rates. It has been stocking up on PPE over the past six months in preparation for any future outbreaks of Covid-19.

In a statement, it said it now had more than 600 million items of PPE in stock, including 1.4 million N95 masks, more than 275 million procedure masks, more than 190 million nitrile gloves, more than 1 million face shields, more than 14 million isolation gowns and more than 10 million aprons.
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 5,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

Other services

ASMS job vacancies online

Check out jobs.asms.org.nz a comprehensive source of job vacancies for senior medical and dental specialists/consultants within New Zealand hospitals and health services.

Contact us

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Rossi Holloway
Doctor and MAS Member