

THE SPECIALIST

THE MAGAZINE OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

ISSUE 107 | JULY 2016

**BUILDING A SUSTAINABLE FUTURE
MEDICAL WORKFORCE | P16**

**UPDATE ON DHB MECA
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The Specialist is produced with the generous support of MAS.

ISSN (Print) 1174-9261
ISSN (Online) 2324-2787

The Specialist is printed on Forestry Stewardship Council approved paper

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SO MUCH HAPPENING AND SO LITTLE ACHIEVED (YET!)

IAN POWELL | ASMS EXECUTIVE DIRECTOR

Negotiations for collective agreements are generally characterised by a beginning, a rather long and at times irritating middle, and then an end. Sometimes the tone of the middle affects the tone of the end even where the settlement is reasonable. What is certain is that there will be a settlement (there always is); what is uncertain is whether the settlement will be satisfactory or not.

What has characterised these negotiations for the fifth multi-employer collective agreement (MECA) covering ASMS members employed by the 20 district health boards (DHBs) is that after five days the DHBs' negotiating team has yet to come out of the corner. It is refusing to negotiate in any substantive way until ASMS accepts the financial priority the DHBs have allocated for this settlement. DHBs have options; they could budget more or they could budget less. What this means is that in essence there are no negotiations; ASMS gets to have some say in the allocation of what the chief executives determine they will fund (which is not the same as what they can afford; there is a difference) but that is as good as they get.

It is akin to ASMS refusing to budge at all on what we claimed for on day one of negotiations. DHBs would quite correctly conclude that we were being inflexible and not negotiating in good faith, but when they adopt the same approach from the other end of the spectrum they are puzzled by our objection.

ASMS - PATIENT CENTRED CARE AT THE CORE

ASMS has come into these negotiations on the premise that the new MECA should significantly enable the achievement of patient centred care beyond pockets of success and sound bites.

While DHBs parrot low levels of formal vacancies in senior medical staff positions, these are what they approve for advertising. The true vacancies (ie, shortages) are covered by specialists and other senior doctors and dentists working excessive hours and compromising on their time for non-clinical duties. These entrenched hidden shortages have become the norm and are reflected in high levels of burnout and presenteeism.

DHBs therefore need to increase their specialist workforce capacity (more numbers and full-time equivalence) in order to free up more time to be involved in systems and other improvements necessary to deliver on patient centred care. But there is a demographic



FROM LEFT TO RIGHT: WILLEM VAN DER MERWE, JULIAN FULLER, JEANNETTE MCFARLANE, JEFF HOSKINS, JUSTIN BARRY-WALSH, NEIL STEPHEN, KAI HAIDEKKER, BARCLAY, MATTHEW HILLS, BRIGID CONNOR, IAN PAGE, TIM FRENDIN, IAN POWELL, TIM MACKAY, ANDREW MUNRO, PAUL WILSON AND ANGELA BELICH.

JULIE PRIOR, ANGELA FRESCHINI, HELEN FRITH, HEIN STANDER, JULIAN VYAS, SINEAD DONNELLY, MURRAY

challenge. Around 38% of those on the specialist scale are on the top step and can go no further. These are people who are in their early 50s or older. Many are at a stage of their lives with less family dependency, they are potentially more mobile than their younger colleagues and they still have a number of years in the medical workforce in front of them. The MECA needs to incentivise their retention. There is also a growing bulge in their early to mid-60s who will soon retire, at least from their public work, and this includes a large number who no longer feel able or willing to do acute rosters or shifts.

The MECA needs enhancements to better retain those we need to retain and to recruit to an expanded specialist workforce capacity in DHBs. To help address this vulnerable situation, the ASMS claim includes:

- enhancing basic salaries by improving the salary scales
- improving the enhanced rates paid for working on after-hours call rosters and shifts from time-and-a-half to double-time
- improving professional development and education by increasing the level of CME expenses reimbursement (unchanged since 2009) and strengthening the secondment provision
- improving the superannuation subsidy
- requiring the development of minimum standards necessary for providing

patient safety care in services and departments

- an express acknowledgement by the DHBs that the emotional, physical, psychological and spiritual well-being of senior doctors may affect patient care and standards
- establishing a mandatory but non-prescriptive negotiating capacity for those working after-hours rosters and shifts for agreed breaks and rest periods
- retention leave based on the current long service leave available in about half the DHBs
- extending the onerous duties provision for extra leave from about half to all the DHBs.
- increasing paid parental leave from 6 to 18 weeks
- addressing unsatisfactory existing shift working agreements, bringing forward by two hours the commencement time for after-hours shifts to 5pm, and providing one week's additional leave for those working on shifts.

DHBs' MAJOR THEMES TO DATE

The current DHBs' position in these negotiations, to date at least, is on another planet somewhere in the solar system where sufficient oxygen for distributive clinical leadership is unavailable.

What has been noticeable to the ASMS team is the attitude of the DHBs' team that they were not interested in anything that might encroach upon managerial prerogative. This included dismissing our specific claims on minimum standards for patient centred care, wellbeing, recovery time and shift work.

Further, if their approach is representative of the chief executives to whom they are ultimately accountable, senior medical staff are no different from the rest of the DHBs' workforce.

They are oblivious or indifferent to the principle DHBs previously agreed with ASMS about the importance of investing in the senior medical staff workforce to improve quality and financial performance. Now this workforce is considered a balance sheet liability.

THE BIG TRY-ON

In response to our claim, the DHBs coined the term 'industry standard', which appeared to be whatever the DHBs believed it was. It could just as aptly be called the lowest possible denominator. In contrast, for ASMS the MECA is the 'industry standard' for DHB-employed senior doctors.

The 'industry standard' then became the basis of a 'try-on' that risked ASMS being led down a path that would remove job sizing from the MECA and reduce annual leave by one week (and would arguably

also remove the relatively open-ended form of sick leave for senior doctors).

ASMS gave the DHBs a firm message along the line of 'over our dead bodies', and within a fortnight they had withdrawn this proposal. The greater concern for us was that they tried it on in the first place.

WHERE WE ARE AT

Much has happened but little has been achieved - that's a reasonable summation after the first five days of negotiations. But, although there has been no formal progress to date, there are some limited indications of movement such as:

- The DHBs have advised that there is no philosophic opposition to increasing the T1.5 rate for after-hours call rosters and shifts to T2. However, at this stage it would be from within their funding allocation for the settlement, and consequently less would be paid on base salaries. But it is helpful that ideology should not be an obstacle.
- Both parties are closely looking at whether the MECA is consistent with some of the recent changes to the Parental Leave Act (this is separate from the paid leave entitlement).
- The DHBs have proposed changes to the investigation of clinical practice clause in the MECA. Some are sensible and these are being quietly worked through by ASMS and the DHBs. This may lead to an improved clause.

These are a start at least.

Nevertheless, the nub of the issue is the DHBs' continuing position of trying to pre-determine how much they are prepared to spend on the MECA settlement and then luring ASMS into accepting this and modifying our claim to fit in with this (in effect, slashing the claim). Their tactic when negotiations resume on 14-15 July will be to promote the 'benefits' of a quick settlement (under their approach a quick settlement will only equate with a poor settlement) and to stare us down to acceptance. Members of the ASMS are purchasing their sunglasses in preparation. In recognition that the shades will have an effect, we have also agreed on further negotiations in August and September.

At some point the DHBs will realise they have to start negotiating.

Already ASMS has made several changes to our claim, largely around the area of delayed impact of those claims which carry a financial cost.

ASMS has come out of the corner; now the DHBs need to.



Regular ASMS updates on the DHB MECA negotiations are posted at <http://www.asms.org.nz/publications/bargaining-bulletin/>

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WORKING UNTIL YOU FALL APART - THE HIGH COST OF BURNOUT ON THE SENIOR MEDICAL WORKFORCE



DR CHARLOTTE CHAMBERS | PRINCIPAL ANALYST (POLICY & RESEARCH)

ASMS has conducted ground-breaking research into burnout that will shed fresh light on the high toll of fatigue and exhaustion on the senior medical workforce in New Zealand.

Our survey of members looks at the prevalence of burnout among ASMS members employed by DHBs. It also explores the links between burnout and hours of work, along with other variables

such as gender, age, and length of time in the workforce.

We will bring you the full results of this research in the next issue of *The Specialist*, but in this edition of the magazine we look at how burnout is measured and why it matters.

Burnout is an issue of concern for doctors and other medical professionals alike. The medical workforce is deemed particularly

prone to burnout due to the stressful and emotionally demanding nature of health care provision and typically unrelenting high workloads.

Existing research suggests that doctors and health care workers in general are more susceptible to burnout than other professions and have higher rates of burnout compared with the general public.¹

Connections have also been made between burnout and long hours of work, presenteeism,² shift work and on-call duties.³⁻⁵ Other contributing factors include feelings of low control and frustrations with poor quality leadership.^{6,7}

Burnout is formally defined in the International Classification of Diseases (ICD) as a state of “vital exhaustion” encompassing both physical and emotional dimensions. In the wider literature, burnout is variously described as “a particular type of prolonged occupational stress” or “psychological strain representing a process of depleting personal coping resources”.⁵ Additional symptoms may include physical tiredness, sleep disturbances,⁴ cynicism, disengagement and low reported job satisfaction.^{3,8}

WHY DOES IT MATTER?

Burnout poses a risk to the health of those suffering from it¹⁰ but also concerns the medical workforce because of known correlations between burnout and the quality of care^{11,12} and the risk of medical errors.^{13,14} A strong correlation has been found, for instance, between the likelihood of surgeons reporting a major medical error and screening positively for any of the three measures of burnout as determined by the Maslach Burnout Inventory.¹⁵ There also appears to be a strong correlation between burnout and turnover intentions of hospital physicians.¹⁶

Understanding and addressing levels of burnout in the medical workforce is therefore likely to provide significant benefits for the general well-being of this workforce, preventing high turnover, as well

as improving the quality of patient care.

HOW TO TEST FOR BURNOUT

There are different tools to screen for burnout. The Maslach Burnout Inventory, a 22-item test developed by Maslach and Jackson in 1981, remains the most commonly used test.

According to the Maslach Burnout Inventory (MBI), burnout is the consequence of emotional exhaustion, depersonalisation and a sense of reduced personal accomplishment.

There have been a number of criticisms of the MBI, including the relationship between emotional exhaustion, depersonalisation and personal accomplishment, the fact that it is only available commercially, and its applicability to different cultural and workplace contexts.^{9,17,18}

In the more recent Copenhagen Burnout Inventory (CBI), the core of burnout is fatigue and exhaustion. This tool was developed by Borritz and Kristensen for a five-year prospective intervention study on burnout in the human service sector in Denmark (the PUMA study). In contrast to the MBI, the CBI attempts to simplify the concept of burnout to a state of emotional and physical exhaustion which can be secondarily ascribed to either work-related factors or specifically work with clients, including patients.⁹

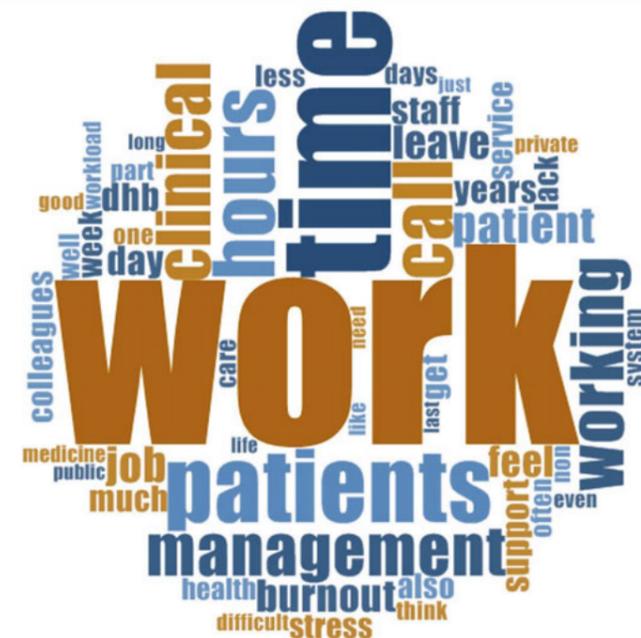
The generic part of the inventory assesses personal burnout, which can be understood as the primary state of emotional and physical exhaustion. Questions in this regard assess the frequency of how often respondents feel tired, worn out, and

physically and emotionally exhausted. The other sub-scales examine the “degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to their work”.^{9 p197}

Comparisons between the scores of personal and work-related burnout enable an assessment of how much burnout can be attributed to work-related factors as opposed to non-work factors, including health issues.

Finally, the inventory assesses “the degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to their work with clients”.⁹ In the context of the ASMS survey, patients were substituted for clients, and only those ASMS members who work face to face with patients were asked to respond to this question. There is now a considerable body of research confirming the validity of the CBI as a screening measure for burnout as well as its applicability in different countries²⁰ including New Zealand.²¹

To date, no studies have screened for burnout using the CBI in a cross-vocational, nationwide survey of a particular cohort of the medical workforce. There have been calls for burnout research that is multi-centre and preferably conducted at a national level using a validated instrument so as to facilitate comparisons of burnout scores.²² The research conducted by ASMS in November 2015 meets this challenge, and along with our research on presenteeism, holds a mirror up to the senior medical workforce in New Zealand.





WHAT PEOPLE ARE SAYING

Without giving away too much about the survey findings, as they are still being analysed, here's a quick preview of some of the comments ASMS has received about experiences of burnout and fatigue on the job:

- Burnout seems prevalent in my workplace. On call is particularly onerous and poorly remunerated, and could potentially be the reason for me to leave public hospital work.
- It's important to get the message out that if you are thinking (burnout) might be a risk for you, you are probably already suffering from it.
- Burnout is happening in the other members of the team and the SMOs mop up. I'm not ready to retire but am seriously considering moving on.
- My patients and colleagues get the happy, cheerful, helpful, collaborative me, my family get the shitty, ratty, exhausted, emotionally drained me with very little left to give. The people who love me the most get the worst of me because I'm too drained to give anymore.



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IT'S BEEN A HARD DAY'S NIGHT

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

His foot lifts off the accelerator the moment he sees the 50 km/h road sign in his headlights. This is a 'no engine brakes' zone so he starts to slow down well in advance. He glances at the time. He has 30 minutes to get to the depot, park, lock up and complete his log book. There is no time left today to unload the truck.

He knows the work-time and log book requirements. He knows breaching them can lead to a fine of up to \$2000 for him and \$25,000 for his employer, as well as disqualification from driving for at least a month for possibly all license classes (<https://www.nzta.govt.nz/assets/resources/factsheets/O2/docs/O2-work-time-and-logbook-guide.pdf>).

Across the city at the hospital, nurse Jackie Pointer is busy with handover at the end of her shift. It has been a busy day and the ward remains very busy. A nurse has phoned in sick so will not be on duty. The duty nurse manager has been called and she is meeting with the nurses to see how they can cover the shift at

short notice. The NZNO MECA gives clear guidance regarding working hours (clause 6) and rest periods that they must follow. Jackie will be in breach if she stays on and she is quite relieved that her MECA protects her from having to do another shift. She desperately needs a break after the day she has had (<http://www.nzno.org.nz/Portals/O/Files/Documents/Support/CA/DHB%20MECA%2024%20Aug%202015%20-%2031%20July%202017WEB.pdf>).

Sam Jones is an obstetrician working in a small department with no registrars. She has been asked to review a patient who is being induced for pre-eclampsia at 34 weeks' gestation. There are some concerns

regarding her blood pressure control and the CTG tracing. She drives in from home and assesses the patient. Sam is able to reassure the patient and midwifery staff that things are satisfactory and she leaves clear instructions to be called again should there be any deterioration in the CTG or in the patient's condition.

At 11pm she heads home again. It has been a fairly busy day and she hopes to get some sleep before what promises to be another busy day tomorrow.

Just after midnight her mobile phone rings. "We are concerned about the CTG tracing," she's told, and she responds immediately: "I'm on my way." Half an

hour later the on-call paediatrician's phone rings. "Can you please come in, we are doing an emergency section on a 34 weeks' gestation mother who has pre-eclampsia and a deteriorating CTG tracing?" He gets dressed and drives the five minutes to hospital. He has a brief opportunity to talk to the expectant parents and explained that the newborn will need to be admitted to the neonatal unit but pending the baby's condition, they might be able to hold their baby for a few minutes prior to the transfer to the neonatal unit. If the baby needs assistance with breathing, then obviously that will not be possible. The baby cries as she is delivered, and the paediatrician smiles. On the resuscitaire the baby is active with minimal respiratory distress and is quickly wrapped and given to her parents for a cuddle. She is then transferred and admitted to the neonatal unit and following the initial examination, cannulation and paperwork, the paediatrician heads home. He quietly enters the bedroom trying to not disturb his sleeping partner. She stirs but does not wake. He thinks: "30 years of living with an on call doctor". He notices the time on the bedside clock: 2.30am. That will give him about 4 and a half hours sleep.

8:30am. The paediatrician is handing over in the neonatal unit to his colleague when Sam Jones walks in, enquiring about the well-being of the baby born in the early morning hours. She's still in theatre scrubs. The paediatrician tells her the baby is doing well but that she looks washed out. She replies: "Yes, I am tired. Mum had complications and we had to take her to ICU. She's doing fine now but I didn't get any sleep, or breakfast for that matter. As soon as the cafeteria opens I'll grab a sandwich and some coffee, and I should be okay after that." The paediatrician replies: "Why don't you head home and get some rest and sleep?" Sam shakes her head. "I can't do that. I've got a busy day ahead with a fully booked clinic this afternoon" The paediatrician expresses concern. "You're in no state to make clinical decisions today after a night with no sleep."

Sam acknowledges this but tells him she has no choice as she cannot cancel her clinic.

THE NEED FOR RECOVERY TIME

While that is a fictional case, it will be a familiar scenario for ASMS members. During our last round of DHB MECA negotiations, ASMS put in a claim to recognise the need for senior medical officers to have recovery time. This was strongly opposed by the DHB negotiating team. Their reasoning was that the current New Zealand labour law already makes provision for this, and SMOs are responsible people who should be able to

recognise when they are too tired to work and make the necessary arrangements to get some rest. Although we argued that the more tired you are, the less insight you have into your own level of functioning, the DHBs did not budge, and as of today there is still no provision for recovery time in our MECA.

My generation of SMOs has 'grown up' in the health service working long hours. It was not uncommon as a house surgeon or registrar to get by with very little sleep, and at that time it was the accepted norm. We now know that this is not safe, and it certainly is no longer the norm.

Let me review the clinical scenario I described above. The theatre staff called back for the caesarean section will not be expected to work without a recovery break. The laboratory staff called in to process the blood specimens from the mother and baby will similarly not be expected to work and should be entitled to a nine-hour break (clause 7.5) (<http://nzmlwu.org.nz/wp-content/uploads/DHB-MECA-8-August-2014-to-4-September-2016-variation-FINAL.pdf>). The house surgeon that assisted at the C-section will have a recovery break as described in the RDA MECA.

However, the obstetrician, anaesthetist and paediatrician are expected to do a 'self-assessment' and decide whether they are fit to work that day. I am aware that a lot of anaesthetic departments have come to an arrangement that non-clinical time is rostered after a night on call. That is what I would call a workaround rather than a solution, and it compares poorly to the truck drivers of New Zealand where administration, maintenance and cleaning of the vehicle is counted as work and cannot be performed during a period of rest. Rest means rest. Further, if a truck driver breaches the work-time requirements, both the driver and his or her employer could be held responsible.

THE RISKS OF SOLDIERING ON

The public (including SMOs) understands the logic of not having a tired truck driver behind the wheel, sharing the road with other motorists. We understand that mistakes and poor reaction time or decision-making can lead to more deaths on our roads. Everybody accepts and welcomes the fact that the aviation industry addressed this years ago. We all want rested pilots in the cockpit. Yet it seems this logic does not extend to the SMO workforce.

In the scenario I've outlined, it is left entirely up to the individual obstetrician and paediatrician to use their judgment (despite their lack of sleep) to make a

complex decision about whether to soldier on and potentially risk patient safety, or cancel the clinic/theatre list/day ahead.

We are torn between a high level of commitment to patients, our colleagues and the health service.

We fully understand the disappointment a patient experiences on receiving notice of a cancellation. Added to that is the effort it will take to reschedule the cancelled theatre list or clinic in an already stretched health service, not to mention the 'please explain' conversation that will follow with management, trying to defend your decision to cancel.

Given the current system (or lack of one), it is quite often easier (but with much higher risk) to just get on with it and work the day as if you had a full night's rest.

From the New Zealand Transport Agency website:

"A breach of work-time rules is serious. If convicted, a driver can be fined up to \$2000 for each breach. In addition, you will be disqualified from driving, possibly from all license classes, for at least one month. If you employ a driver who breaches work- or rest-time limits and you're held responsible for this, you could be fined up to \$25,000 upon conviction. This is known as the chain of responsibility."

Are DHBs aware of, or accept, such a chain of responsibility? For instance, if an SMO is known to work long hours with insufficient rest periods, does the DHB have a responsibility to address this and improve patient safety and also show that they value the SMO workforce?

ASMS has once again put a claim forward for recovery time to be recognised in our DHB MECA.

Until we find a negotiated solution, I implore you to be sensible about your abilities after you have had a night of interrupted or non-existent sleep. You might think you are bulletproof or have an obligation to do that clinic or theatre list etc, but your patients might feel differently about it if they knew you are sleep deprived.

Judging by the results of the ASMS surveys on presenteeism and burnout, SMOs are not good at taking time off when they need to. We need to look after ourselves and our colleagues, and only then can we safely look after our patients.

In the words of the Beatles:

**It's been a hard day's night and I've been working like a dog
It's been a hard day's night I should be sleeping like a log.**



SHIFT WORK, SCHEDULING AND RISK FACTORS

DR CHARLOTTE CHAMBERS | PRINCIPAL ANALYST (POLICY & RESEARCH)

There are increasing expectations that Senior Medical Officers (SMOs) spend more time out of hours in hospitals - through shifts, long periods of call, extended working days or weekend work.

The ASMS has produced a research brief to summarise the literature on shift work, with a particular focus on issues arising from doctors working at night in hospital emergency departments. This paper is available on the ASMS website at http://www.asms.org.nz/wp-content/uploads/2016/07/Shift-work-research-brief_166090.2.pdf

Preventing and dealing with fatigue is a reality for medical specialists working in New Zealand's public health system. There is more and more pressure to deliver optimal health care with fewer resources, high expectations, 'presenteeism', stress

and burnout. Working night shifts and the resultant fatigue can impair a person's ability to work safely and efficiently, as well as having an effect on individual and workforce morale.

The ASMS research brief presents findings from a review of literature on shift work, looking particularly at issues arising from physicians working night shifts in hospital emergency departments (EDs). These issues are relevant to senior doctors and dentists working in New Zealand's public health system, and merit further discussion.

The goal for the ASMS is to identify best practice recommendations that are supported by the literature. These can then be used to develop a shift work clause for ASMS members under clause 19 of the multi-employer collective agreement (MECA) that covers DHBs. This will assist with the health and well-being

of the physicians involved in ED shift work as well as the patients they attend to.

For the purposes of the research brief, shift work is defined as a "method of staffing in which different employees work at different times during the day, including times outside the classic 0800-1800 hours. The 'shift' is the unit of work time scheduled per day".

The paper begins with a brief review of the impact of night shift work in physiological terms. It briefly describes the significance of night shift work for ED workers before moving on to discussing

recommendations that are raised in the literature. It concludes by raising specific points for discussion and feedback.





DR JOANNA GLENGARRY

STAFFING SHORTAGES PUSH FORENSIC PATHOLOGY SERVICE TO THE BRINK



CUSHLA MANAGH | ASMS DIRECTOR OF COMMUNICATIONS

The national forensic pathology service would struggle to cope if another earthquake as lethal as the Christchurch shakes occurred today, says the clinical leader of the service.

Clinical Director Simon Stables says the country's small team of forensic pathologists is so stretched already that shouldering the extra workload associated with a natural disaster is almost unthinkable.

"We don't have the numbers," he says.

Fellow forensic pathologist Paul Morrow agrees.

"One of the things we always have hanging over our heads is the potential for something like a plane or bus crash, or an earthquake," he says. "Frankly, it could be a real embarrassment for the Government if a disaster should happen because they would find out very quickly that the resources are not available in New Zealand to deal with it.

"We're managing at the moment, but our ability to do so is razor thin."

Another forensic pathologist, Joanna Glengarry, says the national service is very vulnerable.

"All it would take is for someone to get sick while someone else is away, and we'd have just one forensic pathologist covering the

whole upper half of New Zealand. The shortage we're dealing with could quickly become catastrophic."

Forensic pathology hit the headlines earlier this year when media reported that the national service was on the brink of a "catastrophic unravelling", with the prospect that some autopsies might not get done and inquests would be put off (<http://www.radionz.co.nz/news/national/300667/crisis-time-for-forensic-pathology-doctor-warns>). That might sound dramatic but forensic pathologists say it's an accurate assessment of the situation. There simply aren't enough of them to do the work with enough stretch within the team to handle anything unexpected that arises.

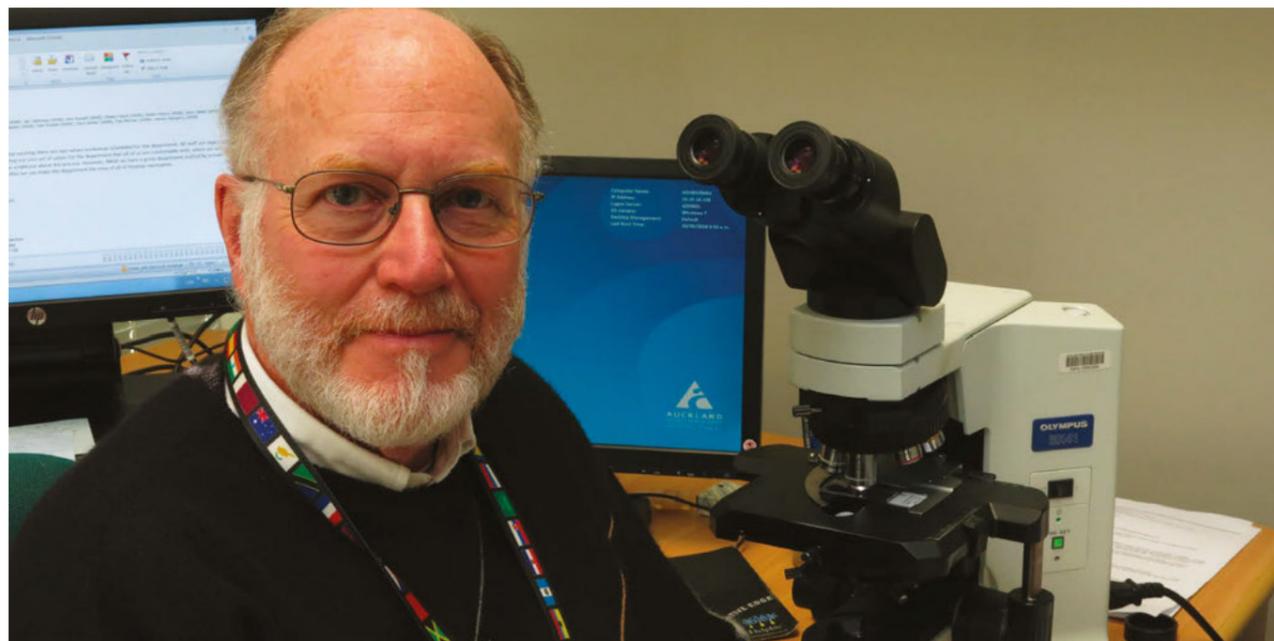
Drs Simon Stables, Paul Morrow and Joanna Glengarry are based at LabPlus at Auckland Hospital, and provide forensic pathology for the upper half of the North Island. The remaining forensic pathologists are based in Palmerston North, Wellington and Christchurch. Together, the six of them form the National Forensic Pathology Service administered by Auckland DHB under contract

to the Ministry of Justice. That contract is currently being renegotiated.

The national service came into existence in 2005 after years of negotiations, replacing an ad hoc system that Simon Stables says lacked structure, resourcing, governance, adequate succession planning, career advancement or ongoing training programmes. It provides a round-the-clock service to police, coroners and the public, and carries out about 1600 post mortems each year. According to Auckland DHB, between 170 and 190 post mortems are associated with homicides or suspicious deaths.

The service used to provide post mortem support to Samoa, Rarotonga and Tonga, but Simon Stables says it is not in a position to do so now unless it has more forensic pathologists. In the meantime, those countries are turning to Australia for assistance.

Like other specialties, to become a forensic pathologist involves years of additional training following medical graduation and experience as a house surgeon. There are a couple of pathways into the specialty. Some doctors choose



DR PAUL MORROW

to do a forensic fellowship involving five years of study with the Royal College of Pathologists Australasia, while others opt to train first as an anatomic pathologist before completing a Diploma in Forensic Pathology, which means an extra six years of study at a minimum.

Those years of specialty training are still very fresh in the mind of Joanna Glengarry, who, at 37, is one of the service's two most recently qualified specialists. Initially she wanted to be a surgeon but was drawn instead to anatomic and then forensic pathology.

"It was clear to me in my third year during my mortuary rotation that forensic pathology was the career for me," she says. "It was that brilliant mix of surgery and pathology, as well as the medico legal side and the opportunities to interact with the coroners and courts. It was just so fascinating, and a great intellectual challenge."

She completed the Diploma in Forensic Pathology in Melbourne two years ago, and has been back working in New Zealand since the start of 2015.

So, is she enjoying it?

She hesitates. The work is so varied, she says. It's interesting and rewarding, and the medical side of things is wonderful. She has great colleagues, and there's no other job she would rather be doing.

"Unfortunately, however, that comes with a big 'but', which is to do with the frustrations of workforce resourcing.

"I'm exhausted. I've accrued 77 days of leave and I'm trying to work out how I can

take it. The only way I can reliably take leave is to attend a work conference and then tack on a week's leave afterwards. So far this year I've worked out that I've been on call nearly every second week. My phone is always on in case I need to go into work. It would be great to just spend the weekend in the garden and know that I'm not going to be called in."

In a small specialised team like forensic pathology, doing work that is critical to families and to the justice system, being short by even one person can mean the difference between staying on top of the workload and scrambling to keep up. Simon Stables says the national service really needs at least three more forensic pathologists if the pressure on existing staff is to ease to more manageable levels.

And there are consequences of the shortage: delays for families, hold-ups with processing cases moving through the justice system, the personal toll of too much work and constantly being on-call for the doctors themselves.

"I got an email this morning about a family that can't get access to an insurance payout because there's no cause of death yet," says Simon Stables. "They have my sympathies and I'm trying to get that case prioritised. In situations like this, families can be living day-to-day while they're awaiting the release of funds, or they need the body of their loved one for a tangi. It can be very difficult."

At the same time, says Paul Morrow, forensic pathologists have to proceed with caution and thought because if they get it wrong, the consequences can be severe.

"The more stressed you are, the more likely you are to make a mistake. A homicide could end up being missed, a finding could be misinterpreted that could result in someone either being charged with a crime or not being charged."

It can take up to 100 hours to complete all of the work required for a single case in the justice system.

"People think that once you've done the post mortem, you have the answer, but the post mortem is just the beginning," says Simon Stables.

"Forensic pathology is like any other branch of medicine. We take a history - what the person has been doing in the lead up to their death, their social context, any symptoms and so on. We examine the person and get extra tests done as needed, and then we integrate all of that information. With living people, doctors come up with a diagnosis. In our case, we determine the cause of death."

Joanna Glengarry says the amount of time involved is poorly understood. The Auckland team, for instance, covers the area from Taupo to Northland. If the police ask a forensic pathologist to attend a scene of death, that person may need to travel a long way.

"It might just be one case in the justice system but it might have involved an eight-hour round trip for one of us, and then we have to perform the autopsy, prepare for court, many hours of consultation and review, and then there's the court testimony itself," she says.



DR SIMON STABLES

"Even when a case is closed by a coroner, it's still an ongoing case for us as we need to continue liaising with families and the courts, etc."

And the stress of being on call so often shouldn't be under-estimated, says Paul Morrow.

Originally from Vermont in the United States, he moved to New Zealand in 2009 after a long career as a medical examiner and chief medical examiner. He says the national forensic service here was in better shape back then, with a fully staffed office and a one-in-four call. The new Coroners Act had come into being a few years earlier, and coroners and forensic pathologists were in the process of redefining their roles.

"Since then I'm struggling to think of a time when we haven't been short of staff."

He decided to retire last year when he turned 66, and says he felt guilty about leaving his colleagues. He's now back working half-time, but says he has been very careful to protect himself from some of the big stresses of the work - in particular, the requirement to be on call.

"It's an inherent part of medical work but it's a big cause of stress," he says. "It's driven me from every job I've had because even if you're not actually working all of the time, you can't go to a movie without having your beeper on and knowing that you might have to sneak out. It really begins to wear on you and can burn you out. I'm too old for that now so I have ensured that I am no longer on call."

Addressing the forensic pathology shortage requires far-sighted decision-

making, adequate resourcing, and effective recruitment and retention. Without sufficient trainees the service has relied upon overseas trained forensic pathologists to maintain the service, which has left little opportunity for service development and succession planning. Recruiting from overseas has become extremely difficult as other countries, such as the United States, now recognise the importance of keeping their own forensic pathologists and are doing so by enhancing local working conditions and salaries.

There is no doubt that the demand and capacity for forensic pathologists will only increase as the population, and thus the workload, increases. Coupled with this is the diminishing desire and availability of laboratory pathologists to become involved with coronial autopsy work, which means that forensic pathologists are expected to undertake additional and responsive work for the Coroner, which is difficult to do when they are struggling to maintain their own service.

At least one part of the picture, the three forensic pathologists believe, involves getting medical students excited about the possibilities of pathology.

"Everyone knows what surgeons or anaesthetists do," says Joanna Glengarry. "Pathology, not so much. It's more removed from clinical practice on the wards, and forensic pathology is even more removed because the only time other doctors interact with us is when their patients die.

"At the moment I'm teaching first year house surgeons how to certify death. Everything in their medical training is focused on the new and fantastic ways to keep people

alive, which is great, but it means that death is now seen as a failure so there's a lot of mystery around the process of death and why it occurs. Autopsies, though, are just like any other medical procedure. It's still surgery - the only difference is that my patients are deceased."

As forensic pathologists await the results of the contract negotiations between Auckland DHB and the Ministry of Justice, they are focusing on staying on top of the work, trying to recruit into the workforce, and hoping that an earthquake or other disaster does not strike until there are more of them to deal with it.

Discussions are also underway to secure a solution to these issues and develop a long-term strategy.

But for one of the forensic pathologists, the gloss is wearing off.

"I'm supposed to be the ridiculously enthusiastic young person in the department, but that's not how it is," says Joanna Glengarry.

She was bonded to return to New Zealand following her Diploma training in Melbourne but is struggling to see why she should stay here when that bonding period ends early next year.

"It feels extraordinarily disloyal to be thinking about going back to Australia. I have the utmost respect and fondness for my colleagues, so the idea of leaving is very very hard and is not a decision I'll make lightly - but there's just so much more I could achieve in a place that is better resourced."



BUILDING A SUSTAINABLE FUTURE MEDICAL WORKFORCE

The Association of Salaried Medical Specialists and the New Zealand Medical Students Association (NZMSA) held a joint conference on the challenges facing the future medical workforce in Wellington on 1 April 2016.

It was the first time the two organisations had come together in this formal way, representing both senior doctors and many of the medical students who will become the hospital specialists of the future. Representing different ends of the career spectrum, the two organisations sought to lever off each other's attributes and experiences for the benefit of patients and the profession.

Both ASMS and the NZMSA saw the one-day conference as an opportunity to discuss issues of shared concern and to further build a collaborative relationship.

ASMS National President Dr Hein Stander set the scene for the discussion, pointing to the twin challenges of an aging medical workforce and high public expectations of the health system.

The conference was well attended by ASMS members, medical students and other invited guests. It was facilitated by Drs Curtis Walker, MidCentral DHB, and Marise Stuart, Northland DHB, and featured the following speakers:

- Medical Council of New Zealand (MCNZ) Chair Dr Andrew Connolly on the type of specialists needed in 2025 and the challenges facing the workforce: <https://www.youtube.com/watch?v=j3mk1ONjgtg>

- University of Otago Medical School Dean Professor Peter Crampton on how medical education may contribute to the future specialist workforce, including questions around increasing specialisation and the need for more generalist specialists: <https://www.youtube.com/watch?v=4iuEeLz7Jks>

- ASMS Policy and Research Director Lyndon Keene on what the health system might look like in 2025 based on current policies and policy proposals: <https://www.youtube.com/watch?v=lc5MCSY-RaO>

The starting point for discussion was the need to both improve and sustain New Zealand's current position of having a high quality public health system and an expert medical workforce committed to providing the best possible health care. To do that, the public health system needs to be adequately resourced and invested in, with an ongoing focus on quality care.

While international trends are toward further specialisation within medicine, in New Zealand we actually need *more generalists*. This is not an argument against sub-specialism but it is an argument for rebalancing the composition of the medical workforce in a country with a dispersed small critical population mass of just over four million. Medical training

and education needs to produce doctors who have skills in the breadth of medicine as well as in leadership, communication, teamwork and creative thinking.

Quality of care is a critical factor for addressing the challenges ahead. High quality health care is not only good for patients and more satisfying for health professionals to provide, it also contributes to a sustainable, cost-effective health system.

In order for that to occur, *greater investment* in the current and future medical workforce is required. Every level of the health system needs to work together to achieve accessible care for all New Zealanders.

Providing patient centred care will not only result in better clinical outcomes for patients, but will also, as research indicates, prove cost-effective. Focusing on quality in health care makes both sense and cents. However, it requires time to implement - doctors need time to build 'partnerships' with patients and, where appropriate, their families. Time requires workforce capacity, which means more doctors.

Time is also needed to develop and maintain strong clinical teams and integration and alignment between services. All of this requires clinical leadership, which again draws on doctors' time.





UDDAKA WIJESINGHE

A BROADER PERSPECTIVE ON HEALTH CARE

UDDAKA WIJESINGHE | TRAINEE INTERN - CHRISTCHURCH

Five-hundred pluripotential medical graduates are produced each year from the two medical schools in New Zealand.

We are an eclectic mix of different cultures, influences, and upbringings representative of the New Zealand of tomorrow. Despite our differences, we have in common the backing of a world-class medical education which gives us the potential to become champions of change and the health care leaders of the future.

As a medical student fast approaching the end of my medical student career, I have started to take stock of the path ahead. For me this path is misted by uncertainties which stem from a lack of awareness. Many of my concerns up until this point have been around learning clinical content. But understanding health care in New Zealand and the wider clinical context are also important in informing future decisions.

The inaugural joint ASMS-NZMSA conference was therefore an eye opener for many of the students who attended.

A core issue discussed throughout the day was the changing health care needs in New Zealand and the growing disparities. This struck a chord with many of us as often we do not take this into account when making our career choices. The interaction between career aspirations and actual health care needs is a difficult conversation, but it is an important one.

Career autonomy is indeed valued, but we joined medicine to make a difference. Why not make a difference where it's needed the most?

It's important for medical students to be aware of the future health needs of New Zealand in informing their career decisions.

The importance of clinical leadership

was also stressed. For many of us, clinical leadership had been a buzzword that we did not fully understand. Unpacking the term in our breakout sessions made the concept more tangible. Leadership is a key quality for any doctor, and extending that leadership role to management of the system itself will allow for change and improvement.

Many of the students in attendance will no doubt become the clinical leaders of the future, and getting the chance to interact with the clinical leaders of today was a useful learning experience. The consultants were all approachable, valued our opinions, and spoke to us as colleagues. Events such as these are important for students as they broaden perspective. However, perhaps the most valuable aspect is interacting with the role models who we aspire to become.



DOING THINGS DIFFERENTLY; INVOLVING SENIOR DOCTORS IN STRATEGIC PLANNING



IAN POWELL | ASMS EXECUTIVE DIRECTOR

The *Health Sector Relationship Agreement* (2008) between the DHBs and health unions affiliated to the Council of Trade Unions (primarily ASMS, NZ Nurses Organisation, Public Service Association and Service & Food Workers Union - now part of the larger merged union Etū) and the *Time for Quality Agreement* of the same year (between the DHBs and ASMS only) heralded a new era of constructive engagement broadly, and clinical leadership in particular. This clinical leadership took a distributed and relational form rather than a hierarchical and structural one.

This direction was strengthened by the government's policy statement on clinical leadership the following year called *In Good Hands*. This document was developed with significant involvement from the then ASMS President Jeff Brown.

LOVE TRAIN GOING OFF THE RAILS

For a while it seemed DHBs were at the dawn of a new era. Love (aka distributive clinical leadership) was in the air! However, ASMS has become increasingly frustrated with the derailing of the love train - possibly due to the way financial retrenchment constrains the thought processes of senior management and incentivises many to focus on the short term rather than the long term, and the tactical rather than what is strategic.

This was highlighted by the marginalising of pathologists and other affected specialists in the top-down determination of the strategic direction of hospital laboratories in the lower North Island DHBs and risks being repeated in the strategic direction of radiology services in radiology by Nelson Marlborough DHB this year.

DHBs have lapsed into habits of excluding their wider senior medical workforce from their strategic planning even where their expertise is directly applicable. This often springs from the artificial split between those involved in the planning functions of DHBs and those who know the most about clinical services and deliver those clinical services. This split is based on historical dogma of the 1990s business market era and still exists in many DHBs to one degree or another. Some DHBs have sensibly ditched this demarcation but others still cling to their old divisive ideology.

TAKING THE INITIATIVE

ASMS is raising these concerns with the DHBs through our Joint Consultation Committees. We are spelling out senior doctors' expectations of involvement in the shape of clinical services.

This is based on a number of express

rights and obligations under the national DHB MECA covering senior medical and dental officers who are members of ASMS, including but not restricted to:

- **PREAMBLE** Requires significant influence, constructive engagement with, and empowerment of SMOs.
- **CLAUSE 1.1** Requires the promotion and establishment of clinical leadership within workplaces.
- **CLAUSE 1.2** Requires collegial and collective responses to workplace challenges and issues.
- **CLAUSE 2** Expects managers supporting SMOs in the leadership of service design, configuration and delivery.
- **CLAUSE 9.2** Maintaining and strengthening trust and confidence between the parties.
- **CLAUSE 41** Dispute resolution process required for actual or potential serious patient safety concerns.
- **CLAUSE 43.2** SMOs to have opportunity to participate in reviews at earliest practical opportunity.
- **CLAUSE 43.3** Requires DHBs to seek endorsement of ASMS over purpose, extent, process and terms of reference of reviews.
- **CLAUSE 43.4** Dispute resolution process required to resolve serious professional or clinical concerns.

RAISING, ASSESSING AND GUIDING STRATEGIC DIRECTIONS

Specialists and other senior doctors and dentists are trained to weigh evidence and be aware of new developments in their

speciality and elsewhere that might affect their clinical practice. As a result, they are well equipped to raise, assess and guide the strategic direction of clinical services at DHBs, including ownership models and future models of care.

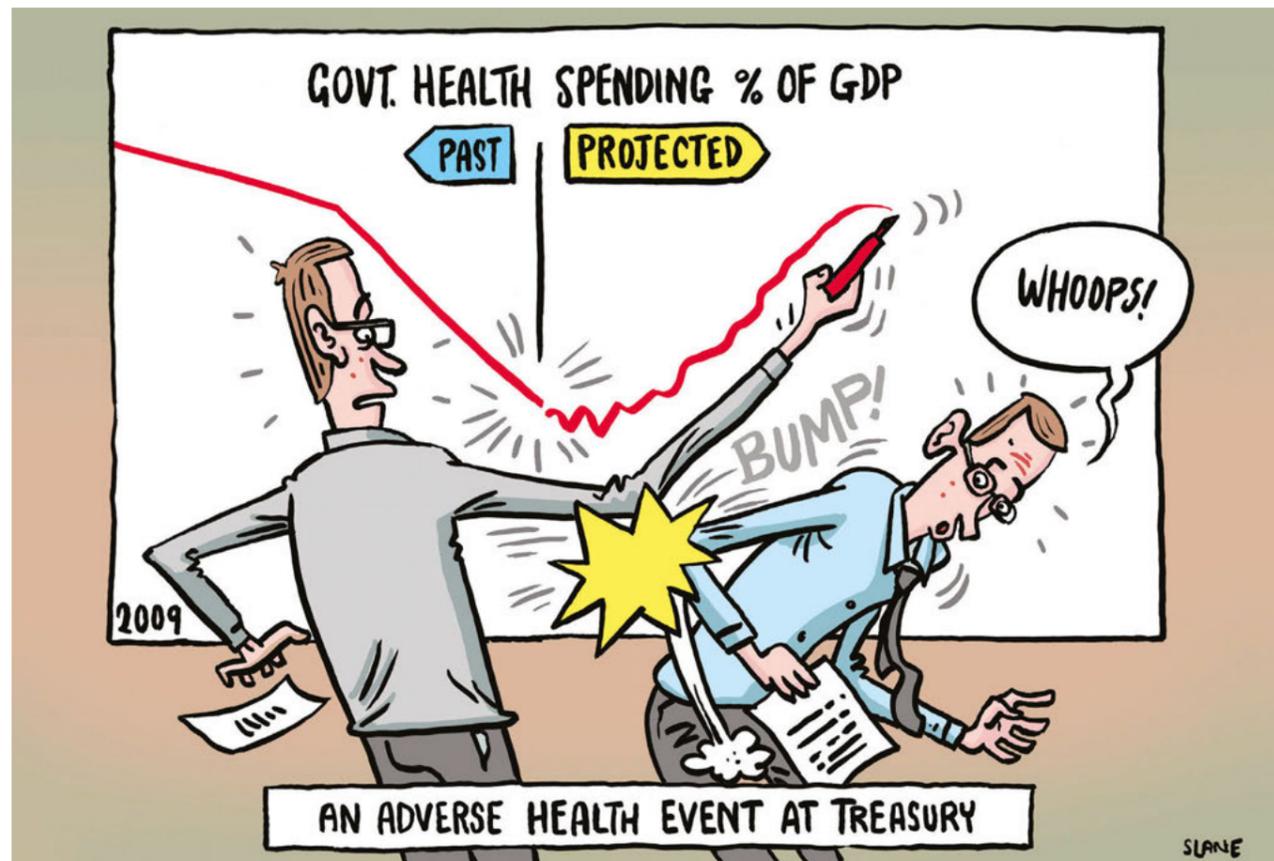
The cornerstone of senior doctors' involvement is distributive clinical leadership. DHBs must give all senior doctors the opportunity to be involved in decisions. This doesn't mean just a few selected formal clinical leaders or involving random doctors from the speciality from another geographical area, but that the doctors involved in delivering the service must be involved in setting the direction of the service. Strategic planning should be based on robust evidence subject to the appropriate critical evaluation.

Further, the initiative for changes in the design of clinical services, the configuration of clinical services, and best practice service delivery should normally come from senior doctors.

Rat holes and false diversionary assertions should be disregarded. For example, resource constraints should not be manufactured by governments and DHBs in order to create or bolster a perception that a particular service suffers from some form of 'systemic unsustainability' leading to purported inefficiency and clinically inappropriate systems. This construct originates from an ideological opposition to publicly provided healthcare.

'Commercial sensitivity' and perceived or actual 'conflicts of interest' are also diversionary justifications for negating genuine distributive clinical leadership in these processes. The expectations around distributive clinical leadership expressly include procurement and potentially contracting out decision-making processes.

It falls to ASMS, then, to rattle the cage of re-emerging managerialism and to yet again propose the alternative of distributive clinical leadership.



WHY NEW ZEALAND CAN - AND SHOULD - SPEND MORE ON HEALTH



LYNDON KEENE | DIRECTOR OF POLICY AND RESEARCH

Health systems across many countries are under pressure to meet increasing needs while governments attempt to keep a lid on health expenditure. Not surprisingly, the question “what is the right amount for a country to spend on health?” often arises in national health policy debates.

A World Health Organization (WHO) paper¹ suggests the question cannot be answered without addressing these five basic questions together:

- What health status do we aspire to?
- What health problems do we face?
- How effective are our health services, activities and policies?
- How much do health services cost?
- Are there better uses of funds for other ends?

It is reasonable to assume the short answer to the first question is that we aspire to remain in good health and that when we are ill or injured the health system is there to meet our needs. There is plenty of evidence, however, that current health services lack the capacity to meet current health needs.

WHAT HEALTH PROBLEMS DO WE FACE?

High level health status indicators show New Zealand faces some significant health service and illness prevention challenges compared with other OECD countries (Table 1).

While health status indicators are of course influenced by a number of factors, access to an effective health system is also a key factor, the importance of which has tended to be understated.² For example, an analysis exploring the effects of health care on mortality across OECD countries found the number of doctors is the second most important variable (after occupation) in terms of explaining variations in premature mortality (deaths under the age of 70) across countries and over time.³ The positive impact of health services on a population’s health status has also been found in recent studies which indicate

that around half the gains in life expectancy in recent decades stem from improved health care.⁴

Indicators such as high suicide rates, high prevalence of diabetes and obesity, high mortality amenable to health care indicate unmet need in both preventive and treatment services.

HOW EFFECTIVE ARE OUR HEALTH SERVICES, ACTIVITIES AND POLICIES?

To put it another way: are we getting the best value out of each health dollar? Treasury’s assessment is that, “New Zealand’s health system as a whole is not obviously underperforming those of other developed economies.”⁵ This in fact may be an understatement. A Commonwealth Fund report comparing health system performance indicators across 11 countries shows New Zealand’s performance on efficiency and quality of care is among the best, being ranked 3rd and 4th respectively. This has been achieved despite New Zealand being ranked bottom on health expenditure per capita. However, New Zealand’s performance falls down on access to services (7th), and equity (10th), and on a measure of ‘healthy lives’ (mortality amenable to health care, infant mortality, and healthy life expectancy) New Zealand was placed 9th.⁶

Part of the reason for our poor access figures – including long waits for treatment after diagnosis (10th), long waits to see a specialist (9th), and long waits for elective surgery (8th) – is that New Zealand has one of the lowest numbers of hospital specialists per population in the OECD.

All of this indicates New Zealand’s health system is coping comparatively well on what it actually does, but there are significant issues with what it does not do due to a lack of service capacity.

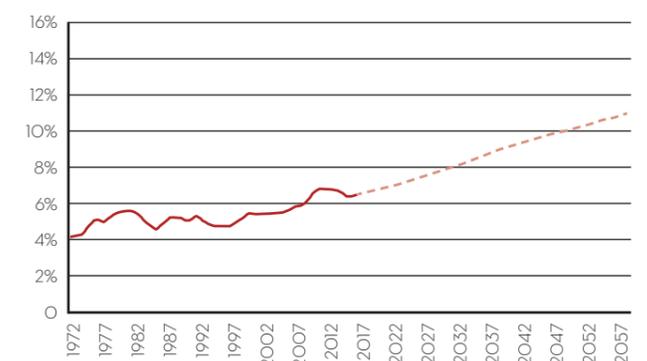
HOW MUCH DO HEALTH SERVICES COST?

New Zealand’s total health expenditure per capita, when converted to common currency, was below the OECD average (\$3,328 versus \$3,453) in 2013, placing this country 20th out of 34 countries.⁷ New Zealand’s total health expenditure (this includes private care and all government bodies, such as ACC and local government) was 9.5% of GDP, which was above the OECD average of 8.9%. However, it is down from 9.8% in the previous year. The CTU/ASMS analysis of the latest health budget shows government health expenditure per GDP has in fact been falling since 2009/10 and is continuing to fall.

Further, it should be noted that the OECD membership has a growing tail of relatively poor countries, thereby lowering average rates. Of the 11 comparable countries discussed above, OECD data show New Zealand’s total public and private health spending has been, and remains, one of the lowest.

The subtext of this question is the further question: What can we afford? Governments have always claimed – and continue to claim – that not only can we not afford to spend more, but our current spending trends are ‘unsustainable’. Graphs such as that produced by the Treasury in the recently updated New Zealand Health Strategy are used to reinforce this message (Figure 1). Leaving aside the tea-leaf reading that goes into such projections, the graph is four years old and therefore does not reflect the trend of falling health expenditure per GDP of the past six years and the Government’s fiscal policies signalling a likely continuation of this trend in the coming years.

PROJECTED GOVERNMENT HEALTH SPENDING AS % GDP



Further, if government health expenditure were 11% of GDP in 2060 we would most probably be among the low-to-modest spenders in the OECD, and the assertion in the New Zealand Health Strategy that such a level of spending would be ‘unsustainable’ has no economic basis. A number of OECD countries are already spending 11% or more of GDP on health but there is no evidence it has harmed their economies. On the contrary, the evidence shows investment in an efficient health system has a positive impact on the economy. If an illness is not treated, or treatment is delayed, the cost of that illness does not disappear. It still has to be borne by the economy. It remains a hidden and unacknowledged cost in New Zealand but international studies on the cost of illness and delayed treatment indicate a substantial burden on the economy.

New Zealand in fact is in an increasingly stronger economic position to invest more in health services. In simple sums, Budget 2016 data show core government health spending increased by \$1.9 billion (nominal) from June 2010 to June 2015, while GDP increased by \$45.2 billion over the same period.

ARE THERE BETTER USES OF FUNDS FOR OTHER ENDS?

A common argument for constraining health spending is that the Government has only so much to spend, which must be shared around all public services. As a journalist recently commented: "Health saps up a significant portion of the budget." However, the high value that societies place on health is reflected in the fact that health spending is the next highest public spending priority after social protection (welfare) among OECD countries, including New Zealand. Health is not only seen as essential for quality of life but also for a country's economic performance.⁸

The share of spending on core health services in fact has barely changed since 2009/10, when it comprised 20.7% of core government spending compared with 20.8% in 2014/15. The fact that other public services are experiencing increasing funding pressures is not because health funding is squeezing them out. It is because core government spending overall is being constrained under fiscal policies where the priorities are debt repayments and building budget surpluses (with hints of tax cuts on the horizon). Core government spending overall has dropped from a peak of 34% of GDP in 2008/09 to 30% in 2014/15.

CONCLUSION

It is reasonable to assume New Zealanders want access to a high quality health system that is on a par with comparable countries such as Australia, but the available evidence shows we are lagging behind. While the quality and performance of New Zealand's health services rank highly internationally, access to services is relatively poor, due to inadequate service capacity. Partly as a result, our health status is poorer than comparable countries in key areas.

Despite New Zealand's poor health status record, and the challenges of a growing and aging population, government health funding is falling as a proportion of GDP.

There are opportunities to meet these health challenges, as well as achieving significant health and economic gains, but they require upfront investment in health services to enable more effective illness prevention policies and better access.

Consideration of the five questions posed by the WHO discussion paper points clearly to an immediate need for a higher, sustained level of health funding if New Zealanders are to achieve the same levels of good health as is recorded in other comparable countries. New Zealand's economic and public spending indicators show clearly that a higher and sustainable level of health funding is well within the country's means.

TABLE 1: NEW ZEALAND'S POSITION IN THE OECD'S HEALTH STATUS INDICATORS, 2013

Health Status Indicator	Position among 33 OECD countries (1 being best)	NZ position relative to Australia, Canada, UK (1 being best)
Life expectancy at birth	13=	3 (above UK)
Premature mortality	26 (females) 19 (males)	4 4
Mortality from ischemic heart disease	26 (females) 25 (males)	4 4
Mortality from cerebrovascular disease	24 (females) 18 (males)	4 4
Mortality from all cancers	28 (females) 12 (males)	3 (above UK) 3 (above UK)
Youth suicides	33	4
Infant mortality	30	4
Obesity prevalence (adults)	27	2= (behind UK)
Diabetes prevalence (adults aged 20-79 years)	24	3 (above Canada)

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ASSOCIATE PROF PHIL BAGSHAW

ILL AND OVERLOOKED - A FIRST GLIMPSE AT THE RESEARCH ON UNMET HEALTH NEED

A research project to understand the extent of unmet health need among New Zealand adults is shining fresh light on the problem.

Project lead Phil Bagshaw, a Christchurch surgeon and Chair of the Canterbury Charity Hospital Trust, says it looks as if the situation is as serious as other studies have indicated.

"The findings from our research project support the notion that there is a massive level of unmet and unrecorded secondary health need," he says.

"We talking about nearly 300,000 people who have been told they need treatment but then find they can't access it."

ASMS contributed \$10,000 toward the project, which began last year. The first stage involved working out how best to measure unmet health need, in the absence of any agreed international standard. To do that, the project team carried out three types of population sampling - face-to-face, telephone and web-based interviews - and also embarked on a study of GPs in Auckland and Christchurch.

These studies found that approximately 9% of the public had an unmet secondary health need. The research also highlighted some of the work pressure on GPs.

"For example, we gave GPs in Auckland and Christchurch the easiest ways possible to record unmet need but even so it was a real struggle for them because they're so busy."

The results have been analysed and written up, with a view to publication and dissemination to a wider audience. Phil Bagshaw says the aim is to initiate a regular, independent national study of unmet health need in order to better understand and monitor the issues.

"It's very important that it be carried out independently," he says.

"If the Ministry of Health did it, then it would be like them setting their exam paper and then marking their own results."

He recorded his appreciation for the funding provided by the ASMS, the Canterbury Medical Research Foundation, and four medical trusts.

ASMS Executive Director Ian Powell says the research project will provide the health sector with valuable information that it needs to act on.

"Having a high level of unmet health

need simply defers the cost of health care, rather than removing it," he says.

"It's not a sustainable solution for health decision-makers to stick their heads in the sand like ostriches and pretend that people with unmet health needs will get better. What really happens is that people just get sicker if they don't get the treatment they need, and this affects their health and quality of life, and eventually places even more pressure on the public health system."

Phil Bagshaw was one of several authors of an article about health funding which appeared in the *New Zealand Medical Journal* in May 2016 and highlighted unmet health need. The other authors were Ian Powell and Lyndon Keene (ASMS), Bill Rosenberg (Council of Trade Unions), M Gary Nicholls (University of Otago - Christchurch) and Christopher M Frampton (University of Otago - Christchurch).

ASMS will bring you a fuller report of the research findings on unmet need when these become available.

VITAL STATISTICS

NO, MINISTER...

WHAT THE MINISTER OF HEALTH, HON JONATHAN COLEMAN, SAID:

In New Zealand we have one doctor per bed compared with the OECD average of 0.7!

WHAT HE DIDN'T SAY:

In New Zealand we have one of the lowest numbers of beds per population in the OECD: 2.8 per 1000 population compared to the OECD average of 4.8.

In New Zealand we have one of the lowest numbers of hospital specialists*

per population in the OECD: 1.3 per 1000 population compared to the OECD average of 2.0.

REFERENCES

- ** Speech to the New Zealand Healthcare Congress, Auckland, 21 June 2016.
** OECD definition includes registrars.



DR KYLE PERRIN

TACKLING PRESENTEEISM AT WELLINGTON HOSPITAL

ASMS' research into presenteeism among New Zealand's senior medical workforce is helping a group of specialists at Wellington Hospital improve the way they manage cover during times of illness.

The research last year by Dr Charlotte Chambers, ASMS Principal Analyst (Policy & Research), found that senior doctors and dentists in public hospitals were routinely going to work while sick, including when they were unwell with an infectious illness (<http://www.asms.org.nz/news/asms-news/2015/11/19/superheroes-dont-take-sick-leave-presenteeism-in-the-senior-medical-workforce/>). In addition, comments from ASMS members taking part in the survey highlighted a culture of acceptance of presenteeism, a strong sense of duty to patients and colleagues, uncertainty about when to take time off work, and a lack of workplace cover while ill.

Dr Kyle Perrin, a general physician and the clinical leader of general medicine at Wellington Hospital, says the findings came as no surprise to the doctors in his department. When they discussed

the survey results at one of their regular SMO meetings, it turned out they had all worked at one time or another when they were sick and should have been at home.

"Everyone feels an almost overwhelming responsibility to their patients and their colleagues, and we just don't want to let them down."

The survey findings prompted them to address presenteeism by formalising a protocol to manage when an SMO phoned in sick.

"We plotted out the various scenarios about how the department would respond if we were sick, and then I wrote the protocol, with others contributing," says Kyle Perrin.

"A lot of it was about documenting the things we would do anyway, but now that it's written down, everyone knows how

it works. It's a real advantage having something documented and agreed to by everyone. If SMOs are aware that covering for sickness is actually a systems issue, then it's easier for them to stay home when they are unwell."

He says he works in a large general medical department in a large hospital without a lot of outpatient commitments, and he acknowledges it may be harder to address presenteeism as effectively in other departments, hospitals and locations.

The need for formalised sick-leave protocols was a theme that came across strongly in the research conducted by Dr Chambers. She found that very few departments had clear written guidelines for the threshold for staying away when unwell, yet there was a strong association between levels of presenteeism and the absence of thresholds or guidelines.



GENDER DIFFERENCES IN THE GP WORKFORCE

Female GPs earn less than male GPs, are less likely to own a practice and more likely to work part-time and as employees.

Those are some of the findings of a survey of GPs carried out last year by the Royal New Zealand College of General Practitioners (RNZCGP).

The survey uncovered a number of interesting and potentially significant gender differences between male and female GPs.

- Female GPs earned less than male GPs, even when variables such as the difference in hours worked, employment status and age were taken into account.
- Older GPs were mostly male and younger GPs mostly female.
- 65% of female survey respondents worked part-time in general practice compared with 31% of male respondents.
- Male GPs worked between 7.2 and 8.6 more hours on average per week than female respondents.

- Family and whānau responsibilities were given as a reason by 53% of respondents who provided a reason for working part-time, and 89% of these were female.

"It appears possible that in 20 years' time around two thirds of the GP workforce will be female," says the survey report. "Hence the hours worked by female GPs will have an increasingly important effect on the availability of GP services."

Questions raised by the author of the report, Frances Townsend, include whether this pay discrepancy reflects time out of the workforce. Is it a proxy for having children under 10 years of age? Or perhaps are women less assertive negotiators of employment agreements?

The full RNZCGP report of the survey, including responses to questions about income, employment status and ethnicity, is available online at https://www.rnzcgp.org.nz/RNZCGP/Publications/The_GP_workforce/RNZCGP/Publications/GP%20workforce.aspx?hkey=a7341975-3f92-4d84-98ec-8c72f7c8e151

Other research by Dr Isabelle Sin, Fellow, Motu Economic and Public Policy Research, has also found that women in New Zealand earn on average 18-25% less than comparable men.

Based on the analysis of a decade of annual wage and productivity data from New Zealand's Linked Employer-Employee Database, which covers nearly the entire economy, the researchers used firm production functions and wage bill equations to evaluate whether differences in worker productivity explain why women get paid, on average, less than statistically similar men and, if not, whether the pay gap is indicative that women are discriminated against in the labour market.

Their research found that when differences in productivity were excluded, a significant gender-based pay gap remained, suggesting that there is active discrimination against women workers.

Older women and those working in industries with high profitability, low competition and low numbers of lower skilled workers were found to be particularly affected by the gender pay gap.



DESPERATELY SEEKING DATA?

LYNDON KEENE | DIRECTOR OF POLICY AND RESEARCH

Once again the ASMS has been approached to provide feedback on a proposal requiring a considerable amount of work with just four weeks in which to do it (see 'Consultation' or public relations? *The Specialist*, March 2016).

This time it's from Health Workforce New Zealand (HWNZ) seeking information to determine the most hard-to-staff specialties and locations (eg, hospitals) across the country for next year's Voluntary Bonding Scheme.

HWNZ suggests submissions should consider:

- Are there specialties or communities that should be, or should no longer be, considered hard-to-staff for doctors? If so, why?
- Low numbers of doctors per head of population
- High vacancy rates
- Poor match to the population demography
- The age distribution of the existing workforce
- High use of casual staff
- High use of locums
- Numbers of and need to recruit overseas trained staff
- Workforce projected demand
- Workforce implications of Health and Disability Strategy objectives.

We agree it is important this information is gathered at a local level - and gathered regularly - as well as additional information on unmet health need in local communities. But it is well beyond ASMS's capacity to do this, and we doubt whether most other organisations consulted are in any better position.

The request begs the question: why isn't HWNZ gathering this information as a matter of course?

One might reasonably expect the government agency responsible for leading the country's health workforce development to be able to provide such local information to clinical leaders for verification and comment. A combination of government agency data complemented by on-the-ground clinical intelligence would seem a sensible approach to identifying the extent of workforce pressures in each of our hospitals.

While ASMS cannot do HWNZ's work for it, we value opportunities to comment on proposed policies and initiatives at a national level and on specific proposals effecting a particular DHB or service.

With regard to the Voluntary Bonding Scheme, we believe in theory at least

that in the long-to-medium term it could potentially alleviate medical specialist shortages in hard-to-staff specialties and locations, but only marginally. Based on the available information its effectiveness remains largely unknown, and a thorough evaluation of the scheme is needed urgently to determine whether it needs an overhaul, including to what extent it should be resourced.

At best, the scheme may play only a relatively small part in addressing future medical specialist workforce shortages.

HWNZ has acknowledged the mounting pressures of "a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors". More extensive and wide-ranging policies are urgently needed to address these shortages. The ASMS has offered to work with HWNZ to develop such policies.

The ASMS submission on the Voluntary Bonding Scheme is available at: <http://www.asms.org.nz/wp-content/uploads/2016/06/Submission-to-the-Ministry-of-Health-on-Voluntary-Bonding-Scheme.pdf>

2016 NOVEMBER

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ASMS 28TH ANNUAL CONFERENCE

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

DINNER AND PRE-CONFERENCE FUNCTION

A pre-conference function will be held at The Boatshed on the evening of Wednesday 16 November, and a conference dinner will be held on Thursday 17 November at Te Marae, Te Papa.

These are a great opportunity to mingle with conference delegates and others in a relaxed social setting - and, of course, to enjoy some of Wellington's fine hospitality!

LEAVE

Clause 29.1 of the MECA includes provision for members to attend Association meetings and conferences

on full pay. Members are encouraged to make leave arrangements and register for the conference by 5 October 2016.

REGISTRATION OF INTEREST

Please help us plan for another great Annual Conference and assist us to organise travel and accommodation by emailing our Membership Support Officer, Kathy Eaden, at ke@asms.nz.

Your interest in registration will be noted and confirmed closer to the date with your local branch officers, as each branch is allocated a set number of delegates. Extra members are welcome to attend the conference as observers.

DELEGATES REQUIRED

The ASMS makes all travel and accommodation arrangements for ASMS delegates to attend its 28th Annual Conference.

Register your interest today to ke@asms.nz.



www.asms.nz



WITH TONY HAYCOCK

TONY HAYCOCK IS A FORMER GP WITH POST-GRADUATE TRAINING IN OCCUPATIONAL MEDICINE. HE NOW WORKS PART-TIME AS AN ACC CLINICAL ADVISOR BASED IN HAMILTON.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

I was surrounded by medical and allied medical people while growing up. My mother was a nurse, my father was a pharmacist and I had two uncles who were specialists. One was Professor John Hunter, who was a professor of medicine at Otago University and then became Dean of Otago's medical school. My other uncle, Tony Hunter, was a surgeon.

I grew up in Waipu, a small country town, and we had quite a lot to do with the local GP. The GP's son was my age and I spent a lot of time at their home. I was quite interested in what being a GP was like.

My mother was very keen for her sons to be doctors, and two of us are - myself, and my older brother, who's a GP in Auckland. I was driven by my mother's interest but I was inclined that way anyway, much more than the arts. As a teenager I spent a lot of my time around farms and riding horses and so Vet science interested me, but I ended up doing medicine and I graduated in 1976 from Otago.

Looking back, I don't really know why medicine appealed. It was probably the intellectual challenge - I was never scared of being pushed hard. I think it was that feeling of wanting to do something that was both challenging and worthwhile.

WHAT DO YOU ENJOY ABOUT MEDICINE AND WHAT ARE THE MOST CHALLENGING ASPECTS?

I like the diagnostic challenge, trying to work out the pieces of the jigsaw and fitting

them together. There's still a lot of art in medicine, as well as the science. I've been lucky to have diversity within my roles. Having a medical degree has given me an opportunity to do lots of different things.

Probably the most difficult thing has been keeping up-to-date and the ongoing medical education requirements. You have to be self-motivated and disciplined. I try to maintain a high standard.

YOU WERE PRESIDENT OF THE RESIDENT MEDICAL OFFICERS ASSOCIATION (RMOA) FROM 1978 TO 1979 - WHAT WAS THAT LIKE?

One of the things I learnt very quickly as RMOA President was that doctors are a hard group of professionals to lead! The term 'herding cats' comes to mind.

I became a local representative on the national executive of the RMOA while a house surgeon at Waikato Hospital in 1977. At that time the national president was Gordon Howie, who is now an orthopaedic surgeon in Auckland, and he influenced me greatly. I learned a lot from him in terms of leadership, how to get our colleagues to work as a united group, and I ended up taking over from him as president.

In 1979 when our RMOA negotiations for better working conditions and overtime pay stalled, it got to the point where I had a meeting with Health Minister George Gair in his Beehive office, and I went in there with an ultimatum that we would strike if we didn't get what we needed. At that time, however, the more senior house officers and registrars were not

inclined to be militant as there were concerns this would affect entry into, or progress in their training programmes, so I was unsure of my mandate! George Gair and I talked for a couple of hours. I had organised for a television crew to turn up at a certain time outside his office to put some pressure on. Anyway, at the end of our meeting, George Gair wasn't forthcoming, so I went out and spoke to the press about possible strike action. The Minister and I met again before I left the building, and he I felt reluctantly agreed to put in place a working party to look at the issues I had raised.

WHAT HAS BEEN YOUR INVOLVEMENT WITH ASMS?

I've represented ACC branch medical advisers for three years, and I'm also a regular member of the ASMS negotiating team for the ACC agreement.

I'm not someone who is inclined to complain about stuff unless I can do something about it. I like to take an active role rather than a back-seat role.

One thing I feel strongly about is the lack of doctors in health management leadership roles. In the days when a doctor and a nurse pretty much ran our hospitals, things were looking good for health professionals in terms of the health sector hierarchy, and the hospitals seemed to run okay. Now we have a wave of accountants, lawyers and business people with MBAs who have moved in to seize control of management in the sector - are we any better off?



DOCTOR UNIONS GATHER IN BERLIN

ASMS Executive Director Ian Powell (front, fourth from left) at the first international conference of doctor unions. This was convened by the German doctors' union Marburger Bund in Berlin in June, and was attended by representatives of 24 countries (including Germany and New Zealand).

MEDICAL CONTRIBUTIONS RECOGNISED IN HONOURS LISTS

It is always heartening to see the work of ASMS members (and doctors in general, along with other health professionals) recognised in the honours lists published each year. It's a fitting acknowledgement of the dedication, training and long hours our members have dedicated to improving the health of New Zealanders. Of course, there are many others who have also made significant contributions to the practice of medicine, and we salute you also.

The full list of New Year Honours can be found at <http://www.dpmc.govt.nz/honours/lists/ny2016-list>

The Queen's 90th Birthday Honours is online at <http://www.dpmc.govt.nz/honours/lists/qb2016-list>.

The following current and former members were acknowledged in the two honours lists (former members have an asterisk by their names):

NEW YEAR HONOURS LIST

ONZM
Dr Simon Allan, MidCentral DHB and

Arohanui Hospice Trust - for services to palliative care

Dr Joanne Dixon, Capital & Coast DHB - for services to clinical genetics

QSM

Dr Cecilia Smith-Hamel, South Canterbury DHB - for services to mental health

THE QUEEN'S 90TH BIRTHDAY HONOURS LIST

ONZM

Dr Trevor FitzJohn*, Capital & Coast DHB - for services to radiology

Dr Patrick Kelly, Auckland DHB - for services to children's health

Emeritus Professor Bryan Parry, Auckland DHB - for services to colorectal surgery

MNZM

Dr Patrick Alley*, Waitemata DHB - for services to health

Dr Garry Nixon, Central Otago Health Services - for services to rural health

Dr Nadarajah Manoharan*, MidCentral DHB - for services to health

Mr Garnet Tregonning*, Counties Manukau DHB - for services to orthopaedics

PATH TO PATIENT CENTRED CARE



The phrase 'patient centred care' has been around for some decades but not until relatively recently has it attracted much attention from policymakers around the world, including New Zealand. For politicians and DHB senior management, the phrase has an attractive, feel-good ring - and because there is no universally accepted definition for patient centred care, its meaning is malleable.

Patient centred care, however, is at the heart of what ASMS members do. It's about providing the best possible medical care within a supportive, clinically led and well-resourced environment.

ASMS is producing a series of discussion papers to promote the patient centred care approach and to examine the policies and conditions that support high quality interaction between patient and clinician, or in this case the senior doctor.

The first of these papers outlines the generally accepted meaning of patient centred care and is available on the ASMS website at http://www.asms.org.nz/wp-content/uploads/2016/06/Patient-centred-care-improving-quality-and-safety-issue-1_165837.4-2.pdf.



We will be adding more discussion papers and other content to this web page: <http://www.asms.org.nz/path-patient-centred-care/>



LYNDON KEENE

NATIONAL OFFICE STAFF

LYDIA SCHUMACHER | ADMINISTRATION OFFICER (COMMUNICATIONS)

Welcome to a new feature in The Specialist where we'll put faces to some of the people you interact with at the ASMS national office.

Lyndon Keene is the Director of Policy and Research at ASMS.

Shedding light on members' issues, providing evidence for change and improvement is the focus of his role.

"There are obviously a lot of challenges in the health and specialist workforce that need solutions, and often the policy makers use quick fixes to attempt to solve these problems," he says.

He believes there is a need for more evidence-based policy and a more rigorous policy development procedure.

At the moment he is focusing on patient centred care - what it means and what it might look like, along with the barriers specialists face in putting it into practice. He prepares ASMS submissions to the Government and government agencies on current policies and proposals. Most recently this has involved writing about the Trans Pacific Partnership Agreement, our responses to the draft update of the New Zealand Health Strategy and

to the draft Mental Health Workforce Strategy. He has co-written an article in the *New Zealand Medical Journal* about health funding and regularly analyses the Government's figures and messages about the public health spend and whether this is sustainable.

He wants to shine a spotlight on longstanding issues in the senior medical workforce to support positive evidence-based changes. He also researches local issues to support the ASMS industrial team and each May works with Council of Trade Unions economist Dr Bill Rosenberg to co-author an analysis of the Government's Budget allocations for public health services. In addition, he works closely with his colleague Dr Charlotte Chambers, who has been carrying out research into issues such as presenteeism and burnout among ASMS members.

Lyndon Keene moved to Sydney last year but says he still feels very much part of the ASMS family. He works 30 hours a week, keeps in touch with colleagues by Skype

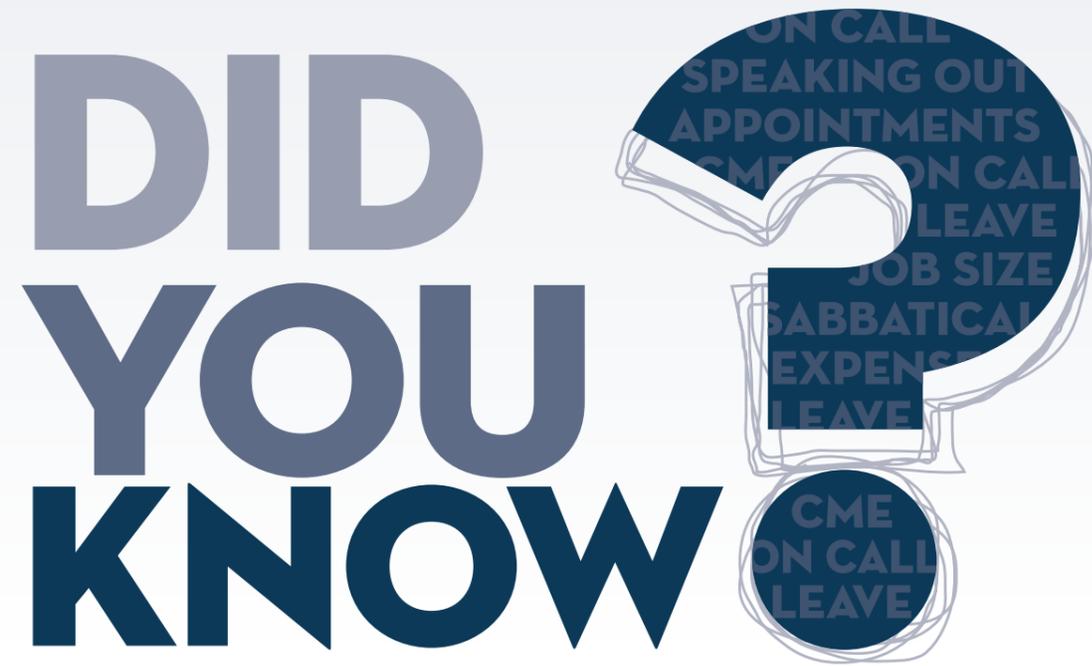
and manages to visit the office in person every three or four months.

"Working from home is not very social, and I especially miss the office morning teas, but it has the benefit of being able to get a lot of work done without interruptions, which is especially useful when you have a knotty topic to analyse."

Executive Director Ian Powell says ASMS values his work highly and is very happy with the new arrangement.

"I rate Lyndon as the best medical workforce researcher in New Zealand. He carries out solid investigative analysis of health funding and other issues relevant for our members."

Lyndon Keene studied art in England before moving to New Zealand and becoming a journalist and later developing a career in policy and research. He continues to paint, and his work has been exhibited in shows across New Zealand.



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

DID YOU KNOW THAT...

When you take annual leave your holiday pay may be different from your regular fortnightly pay? That's because the employer must pay you the greater of either your ordinary weekly pay at the time the holiday is taken, or your average weekly earnings over the 12-month period before the annual holiday is taken.

If you'd like to read more about holiday pay you can do so at <https://employment.govt.nz/leave-and-holidays/calculating-payments-for-leave-and-holidays/>



DID YOU KNOW THAT...

You should check your payslip on a regular basis? Are you being paid at the correct step? Did you get your annual increment? Are there allowances missing, or items that you do not understand? Even though your employer has a responsibility to pay you correctly and on time, employees also have a responsibility to check their pay - and alert the employer if there may be errors or omissions.

DID YOU KNOW THAT...

If you decide to reduce your hours of work it's a good idea to find out what effect that will have on annual leave owing, any long service leave you may have accrued, your superannuation contributions (and entitlements), and so on. If you are thinking about reducing your FTE you are



welcome to contact your ASMS industrial officer for advice: <http://www.asms.org.nz/employment-advice/agreement-info/>



PRESCRIBING 'OFF-LABEL' IN THE PRESENCE OF A SECOND MEDICAL USE PATENT



DR ANDREW STACEY | MEDICAL ADVISER, MEDICAL PROTECTION

Health practitioners can prescribe medications for an unapproved purpose – off-label prescribing – and Medical Protection receives calls from practitioners about this. This article explores the expectations of doctors when prescribing off-label and potential vulnerabilities when prescribing a generic drug for an unapproved purpose for which another manufacturer is the patent holder.

MEDICAL COUNCIL GUIDELINES

According to the Medical Council of New Zealand's core guidance *Good Medical Practice*, practitioners may prescribe unapproved medicines (such as melatonin prior to 2011) or medicines for an unapproved purpose (such as prescribing

ketamine for the treatment of depression).¹

However, practitioners should take responsibility for overseeing the patient's care, including monitoring and any follow-up treatment as required. It may also be worthwhile discussing the patient's

treatment with a senior colleague to get a second opinion.

The patient should also be informed:

- whether there are any other options available,
- of any risks, side effects, costs or benefits,

- that the medicine being prescribed is for an unapproved use, and
- that where the medicine is unapproved, details relating to the supply of the medicine will be supplied to the Director-General of Health.²

The prescription of unapproved medicines and off-label prescribing has been investigated by the Health and Disability Commissioner (HDC) on a number of occasions.³ The HDC frequently refers to College guidelines, the New Zealand Medical Association's Code of Ethics, and guidance from MedSafe when evaluating the care provided by practitioners. Before prescribing off-label, always consult this guidance. By adhering to the guidance you will protect yourself against future scrutiny.

SECOND MEDICAL USE PATENTS

With second medical use patents (also known as Swiss type claims) the patent holder has claimed a discovery as to how a known compound or formulation can be used for a new and previously unknown therapeutic use. A typical second medical use patent will restrict the use of that compound or formulation in the treatment of a specified condition to the patent-holder.

As an example, the pharmaceutical company Novartis is the holder of a second medical use patent, which claims the use of imatinib (brand name Glivec) for the manufacture of pharmaceutical compositions to treat gastrointestinal stromal tumours (GIST). Because there is no patent applicable to the manufacture of imatinib, other generic manufacturers are free to make and supply a therapeutic drug containing imatinib for any use other than the treatment of GIST. AFT Pharmaceuticals Ltd manufactures and supplies imatinib (brand name Imatinib-AFT), which in New Zealand is approved for the treatment of various leukaemias and certain patients with myelodysplastic/myeloproliferative diseases, systemic mastocytosis, hypereosinophilic syndrome, or dermatofibrosarcoma protuberans.⁴ It is not approved for the treatment of GIST.

The question then arises whether a

medical practitioner who prescribes a generic form of the compound for a use to which a second medical use patent applies would be infringing the patent, if, for example, a medical practitioner prescribes Imatinib-AFT 'off-label' for the treatment of GIST.

PHARMACEUTICAL MANAGEMENT AGENCY LIMITED V COMMISSIONER OF PATENTS

Secondary medical use patents have been discussed in a New Zealand Court of Appeal decision, in *Pharmaceutical Management Agency Limited v Commissioner of Patents*, which authorised the granting of patents of this type.⁵

This case was about whether, in principle, such patents could be granted in New Zealand. It does not deal clearly and definitively with the position of prescribers, and it is not possible to say definitively that no claim of infringement against a prescriber could succeed. However, the case suggests that would not be the policy of the law.

The Court of Appeal observed that there should be no interference with a medical practitioner's diagnosis and treatment of patients. It is suggested that if there is an allegation of infringement, the providers of the product for the purpose of the treatment (ie, the generic supplier) should be targeted. This is reinforced by the general principle of patent law that methods of medical treatment are not patentable.⁶

PATENT LAW POLICY

Generally, the policy of patent law supports the proposition that the prescriber of a generic medication is not infringing a second medical use patent, if the manufacturer was not promoting it, or facilitating or encouraging its use for the patented use.

Indications for the use of the generic as set out in the data sheet, or other manufacturer's literature, are important. If the manufacturer/supplier of the generic lists only indications which restrict use of the compound to uses other than the patented use, then the manufacturer/supplier will not, on the face of it, be infringing the patent.

If a prescriber then prescribes for an 'off-label use', the manufacturer or supplier would not be infringing. However, if it has knowledge that there is an actual and, to some degree, widespread practice of prescribers prescribing the generic off-label for the patented use, there may be an infringement. In this case there would be a significant risk of a second medical use patent holder succeeding with an argument that the generic supplier now has reason to believe that it is supplying a substance which will be put to an infringing use.

In particular, if prescribers were to be told by a sales representative of a generic manufacturer/supplier that the product can be put to use for indications which are the subject of a second medical use patent claim, that would raise a clear risk of the manufacturer/supplier being found to have infringed if prescribing took place.

CONCLUSION

Medical practitioners should be cognisant of their obligations when prescribing 'off-label'. The first target for litigation of the second medical use patent holder would be the manufacturer/supplier of the generic. As a matter of practicality, it is unlikely that prescribers would be pursued. However, it is inadvisable for prescribers to share knowledge or encourage one another to engage in off-label prescribing of generics for conditions where there is an applicable second medical use patent.

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2. Section 29, Medicines Act (1981) Requires that certain details relating to the supply of unapproved medicines be passed to the Director-General of Health
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4. <http://www.medsafe.govt.nz/profs/datasheet/i/imatinibaftcap100mg.pdf>
5. Pharmaceutical Management Agency Ltd v Commissioner of Patents [2000] 2 NZLR 529
6. s16(2) Patents Act 2013

HISTORIC MOMENTS

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

PRESENT WHEREABOUTS OF MEDICAL GRADUATES (1952-1961)

A study of 1013 consecutive graduates from Otago University between 1952 and 1961 inclusive has been carried out. The reasons for choosing this group are:-

1. It follows the previous follow-up study of Professor E.G. Sayers. (A and D report page 23) with only minimal overlap.
2. 1961 is the last year which can usefully be studied as it is not until 8 years after qualification that the majority of doctors have settled in their final appointment.
3. 1952 was the first year in which provisional registration came into force.

The study was made by extracting from the Medical Register of each year from 1952 onwards, the names of new registrations and then comparing these names with the names on the 1968 register, (and consequent additions to June 1969) who held current practising certificates. Enquiry was then made from contemporaries in New Zealand and the following is a summary of these findings. The figures in brackets are Professor Sayers figures for comparison.

Of 1013, 923 were male	91%	(89.4%)
90 were female	9%	(10.6%)
208 of all graduates (male and female) are overseas still.	20.5%	(14%)
8 returned to their Native country to practise.	0.8%	
2 Whereabouts uncertain)		
4 Almost certainly coming back)	4.2%	(4%)
37 Probably coming back)		
157 Are thought to be permanently overseas.	15.5%	
7 Have died	0.7%	(2%)

Women Graduates 90

1 Dead		
22 Overseas	24%	(26%)
52 Hold practising certificates	58%	
15 Have addresses in N.Z. and are not practising	17%	

Of the 157 doctors permanently overseas at least 88 (and probably many more) are Specialists.

Conclusion

The present investigation compares in all details with that of Professor Sayers for the previous 10 years except that there has been an increase of 5% in those who are remaining abroad permanently.

30 October 1969

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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.

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