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The Specialist

The newsletter of the Association of Salaried Medical Specialists

Is our health leadership in a state of kef?

Kef is an interesting noun I recently came across. It originates from the Arabic word kaif and means a state of drowsy contentment. It is also a word that seems to sum up (if a little generously) the state of leadership in the public health system at the moment. Interestingly another derivative of kaif is keef which is a substance, especially a smoking preparation of hemp leaves, used to produce this state of kef. I'm not looking to push this analogy as far as to suggest that the system's leaders are 'stoned', especially as that born again hippie Don Brash is not the Minister of Health.

Tony Ryall spent his three years as opposition health spokesperson (2005–08) very effectively seeking and comprehending the pulse of the health sector. His efforts were impressive and an excellent model for his successor opposition health spokespeople to follow. In the history of the ASMS, along with Annette King (who did something similar in the late 1990s), I can't think of another politician who became health minister so well prepared for the portfolio.

Tony Ryall spent his three years as opposition health spokesperson (2005–08) very effectively seeking and comprehending the pulse of the health sector; an excellent model for opposition health spokespeople.

Off with a hiss and a roar

While a significant number of improvements to the health system had been made by the previous government (1999–2008) including legislative reform removing the requirement for public hospitals to operate as if they were competing commercial businesses, he was able to identify some serious weaknesses. These included the precarious state of the DHB workforce (particularly senior hospital doctors), lack of progress in achieving extensive clinical leadership, the need for clinical networks, increasing inter-DHB clinical service collaboration, and enhancing primary-secondary integration.

In March 2009 Health Minister Tony Ryall forwarded to DHBs with his endorsement a document titled *In Good Hands*. This commendable document built on the *Time for Quality* agreement between the ASMS and DHBs the previous year. But *In Good Hands* took it further with a more explicit focus on 'distributive clinical leadership', of which formal positions of clinical leadership (eg, clinical directors, chief medical officers) were only a small part.

More important was the involvement of the wider mass of senior medical staff in decision-making beyond their immediate clinical practice through the lens of quality improvement and what makes good clinical sense.

This was part of a package of initiatives some of which involved legislative change although not of the magnitude that had to be introduced by Annette King back in 2000. This change largely arose out of an influential report (commissioned by the new Minister) by a committee headed by the current Chair of the National Health Board, Murray Horn, known as the Ministerial Review Group report. That report was rather weak in analysis (including a predilection towards 'market forces') but did identify a number of needed functional changes.

Arising out of this a number of sensible structural changes were introduced. The Ministry of Health was given a more operational focus in respect of DHBs with the creation within it of the NHB; a new more practically focussed health workforce body was established within the Health Ministry (Health Workforce New Zealand – HWNZ); the autonomous Health Quality & Safety Commission (separate from the Ministry and chaired by Dr Alan Merry) was established; and the functions of the National Health Committee (now chaired by Dr Anne Kolbe) were sttrenghtened.

In Good Hands was a commendable document building on the *Time for Quality* agreement but taking it further with a more explicit focus on 'distributive clinical leadership'.

It is still early days to make a call on the latter two organisations. But the NHB has got off to a good start with its influential expert panel on South Island neurosurgery and its insightful investigations into systemic issues at Dunedin Hospital and health services in Wakatipu

ASMS

Executive Director
Ian Powell

Assistant Executive Director
Angela Belich

Senior Industrial Officer
Henry Stubbs

Industrial Officer
Lyn Hughes

Industrial Officer
Lloyd Woods

Executive Officer
Yvonne Desmond

Membership Support Officer
Kathy Eaden

Admin Officer
Terry Creighton

Admin Assistant
Ebony Lamb

Level 11
Bayleys Building
Cnr Brandon St &
Lambton Quay
PO Box 10763
Wellington
New Zealand

Ph 04 499 1271

www.asms.org.nz

that have led to recommendations being adopted by the governing Southern DHB.

But regrettably in terms of health system leadership this is largely as good at it gets.

Specialist workforce crisis

Up until October 2010 Tony Ryall was still accepting that there was a hospital specialist crisis and that it was his number one priority. But, presumably because it was election year, we started hearing statements initially from HWNZ and then both the Prime Minister and Mr Ryall that there had been 500 more hospital doctors since 2008. Subsequently this increased to 800.

Up until October 2010 Tony Ryall was still accepting that there was a hospital specialist crisis and that it was his number one priority. But the claim of 800 more hospital doctors is cynically used to assert that the hospital specialist crisis had been solved. There is a problem for this politically generated narrative – it's called the truth.

This was then cynically used to, in effect, assert that because of an increase of 800 hospital doctors the hospital specialist crisis had been solved (this success was, by implication, due to government policy including the work of HWNZ). But there is a problem for this politically generated narrative – it's called the truth. For example:

- The alleged 800 extra hospital doctors include resident medical officers. Those responsible for providing the minister with this data have either not been able to differentiate or choose not to.
- The Ministry now calculates senior medical officer full-time equivalents (FTE) on the basis of what it names 'employed FTEs' in a way that inflates numbers. In summary, FTE is seen is a 40 hour week. Someone who works less than 40 hours for their DHB is pro rated under this approach (eg, someone who works 30 hours for the DHB is counted at 0.75. Someone who works more than 40 hours per week is, however, counted as 1.0 (eg, someone who works 50 hours for the DHB is counted as 1.0). This may be more robust than previous forms of calculating medical ftes but it is not a headcount. If job sizing reviews lead to increased paid hours to part-timers (eg, from 30 hours to 40 hours per week), the total fte increases but not the headcount; it is the same senior doctor. There has been a lot of job sizing over the past two to three years, including in the more populous three Auckland DHBs. Part of this is the greater recognition of time for non-clinical duties.
- Information provided by the DHBs to the ASMS shows that the number of specialists has increased by around 240 (plus another 40 or so medical officers). If the extra 800 hospital doctors' claim was correct then over 500 of them would have to have been RMOs. This seems unlikely (the Resident Doctors' Association would dispute it). Contributing to the inflated calculation may be the shift in the wider Auckland region from locum to regular salaried RMO employment (ie, same RMOs but previously not counted and now counted).

The alleged 800 extra hospital doctors include resident medical officers.

Whatever the explanation for this inflated claim the specialist workforce crisis in public hospitals and related services remains largely as it was three years ago, the systemic issues that cause it (as outlined in *Securing a Sustainable Senior Medical and Dental Workforce: the Business Case* jointly developed and agreed by the DHBs and ASMS in November 2010) remain unchanged. Despite this the government's position has shifted to the polar opposite by becoming a crisis denier.

Health Workforce New Zealand

HWNZ was a welcome creation. In the 1990s any question of workforce planning was seen as an attack on market forces which, according to the ideology of the day, were supposed to be the driver of the public health system. There was a positive change from 1999 with the encouragement to promote workforce planning but, in the main, this was largely for data collection, analysis of the issues and scene-setting. The formation of HWNZ with its more practical orientation was seen as an advance.

While there has been some interesting work in primary care and some useful things might arise out of its commissioned service reviews, increasingly HWNZ is being seen as an impediment to workforce development (exactly the opposite of what it was formed to be). The feed-back the ASMS receives from the 'clinical shop floor' is that HWNZ has been scattergun in its approach, failed to get incremental 'runs on the board', has a 'decree issuing' rather than engagement approach, produces generic communications to explain specific issues (e.g. regional training hubs), and is out-of-touch with how public hospitals work.

The specialist workforce crisis in public hospitals remains largely as it was three years ago and the systemic issues that cause it remain unchanged.

A couple of examples come to mind:

1. HWNZ has produced an alarming proposal on the prioritisation of funding for postgraduate medical training. Its text (what there is of it) and conclusions ranged from difficult to understand to incomprehensible. It has been widely criticised by the various medical professional bodies for lack of robustness. The comment was made at the ASMS Annual Conference that it would not meet the standards for publication in a respected peer reviewed medical journal. The main problem is that HWNZ is trying to use government health targets to determine the prioritisation of funding for training in the medical specialties. But the former has a short-term focus while the latter requires a much longer term approach. Further, the targets only cover a portion of the needs of the health system. On the positive side HWNZ has noted the firm critical responses and is producing a new version of the proposal which is expected to be circulated soon for further discussion. But the previous proposal caused considerable damage to HWNZ's reputation. It failed on the basic ABCs.
2. HWNZ has got overexcited over the physician assistant pilot/demonstration at Middlemore Hospital's general surgery department and consequently overstated its significance. Its public comments confuse the contributions of two outstanding and experienced American individuals with insights into the relevance and value of physician assistants in a New Zealand context. Further, there is no appreciation of the practical needs of the general surgery department in terms of the form of support for specialists and the service they provide.

HWNZ started out as a promising good idea but is increasingly seen by many at the frontline of healthcare delivery as a missionary in search of a mission. If this continues it is at risk of being seen as a fundamentalist in search of a crusade or jihad. HWNZ needs to reposition its feet on the ground, establish its street credentials with the professions, and focus on getting practical runs on the board.

Increasingly Health Workforce New Zealand is being seen as an impediment to workforce development (exactly the opposite of what it was formed to be).

Polymorphous DHBs

Sadly there has been no improvement in the ability of DHBs to work together nationally, in the experience of the ASMS, despite their express desire (and that of successive governments) to do so. Their conduct in the DHB MECA negotiations, and particularly over the jointly developed *Business Case*, has been both a betrayal of trust and disgraceful. Even on a smaller issue of developing agreed guidelines for the engagement and employment of senior medical staff in regional service collaboration between DHBs, the DHBs, through their chief executives, have overturned an agreement between the ASMS and their representatives.

Sadly there has been no improvement in the ability of DHBs to work together nationally. They are polymorphous and unreliable to work with.

At a national level DHBs are polymorphous and unreliable to work with. The calibre of chief executives is highly variable. Overwhelmingly they are competent (several are very impressive) but too many of them struggle to see beyond a short-term local lens and to be more than an able hospital manager when cast into a national context requiring a broader vision. Distributive clinical leadership is seen by some chief executives and others in positions of DHB leadership as a threat to their perceived 'right to manage'. This is behind much of the hostility towards the *Business Case* even if only from a minority of chief executives. But minorities drive down the majority.

The consequence of this is that adherence to agreements reached with their representatives can't be relied on. There is a systemic dishonesty in the way in which they work together nationally because they can't operate in an integrated and functional manner. A change of personnel in the national chief executive leadership can make the world of difference. We experienced this in our MECA negotiations. The hostile attacks on the ASMS leadership and abandonment of the principles of the previously agreed *Business Case* coincided with the changes in the key positions of the chairs of the national chief executives group and the DHBs' Employment Relations Strategy Group.

It is simply not sustainable to argue that the quality of national leadership by the DHBs has improved; in fact, it has arguably declined.

Hasn't at least clinical leadership advanced

It would be nice to believe that clinical leadership has improved. It is a flagship of Tony Ryall's; *In Good Hands* had the potential to be transformative. For a time many in the sector, including the ASMS, said the time was now right for achieving substantial clinical leadership.

Mr Ryall is not the first health minister to promote clinical leadership in DHBs. Annette King did with forthright statements in her annual letters of expectations to DHBs as did her successors Pete Hodgson and David Cunliffe. The outcome was responses from DHBs claiming that they were actioning this expectation but with little substance to back this up. Genuine comprehensive clinical leadership runs into conflict with the ideology of managerialism, which remains engrained below the radar, and a narrow approach to what chief executives see as their 'right to manage'.

Tony Ryall learnt from this and proceeded to establish a good working group to write *In Good Hands*. But, according to private comments from DHB leaders, the Minister apparently gave the ASMS and DHBs conflicting messages. To the ASMS he was explicit stating that it was government policy. But DHBs say he never explicitly said that to them. If this is correct, and even despite his support for *In Good Hands*, this gave the DHBs wiggle room to treat it in the same way as they treated the former Labour health ministers' letters of expectations.

Whatever the truth of the matter, the fact remains that *In Good Hands* required an attitudinal and cultural change by the DHBs; particularly at the top with boards, chief executives and senior management which overall has not happened.

This does not mean that there have not been success stories of distributive clinical leadership. The ASMS Annual Conference last month featured one – the remarkable performance of Counties Manukau achieving the six hour target in one of the busiest acute hospitals (Middlemore) in the southern hemisphere. But fundamentally it is no different to what has occurred for two decades. The impressive 'Canterbury Initiative' based on collaborative clinical pathways between primary and secondary care has been an incremental development over many years even before Mr Ryall became opposition health spokesperson in 2005. What we have is what we have had for two decades – oases of splendid success surrounded by a huge desert of lost opportunity. All that has changed is the location of the oases.

Lost opportunity

The government had a wonderful opportunity to turn this around by championing *the Business Case* which provided the wherewithal to deliver on the aspirations of *In Good Hands* by investing in the capacity of the senior doctor workforce in DHBs in order to deliver on these aspirations. But it made the conscious decision not to and instead rely on the mythology of 800 extra doctors and the proclamations of HWNZ. A simple case of lost opportunity.

This unfortunate state of kef means that our health leadership is characterised by obscurantism (opposition to the increase and spread of knowledge; deliberate obscurity or evasion of clarity) when we need the universal wisdom or knowledge of pansophy. If we are not careful then perhaps kef will evolve into keef.

Ian Powell
Executive Director

PRESIDENT'S COLUMN

Tossing and turning, tossing and turning

[Below is Dr Jeff Brown's Presidential Address to the 23rd ASMS Annual Conference delivered on 17 November]

Over the last 12 months and over the last few days and nights, tossing and turning has been my life, and I'm going to lead you, not on a ramble but maybe an amble, through three stories. Stories of heroism, stories of endeavour and earnest hope, and a story that tries to explore why things unravelled, how we might grasp on to the tail of what has unravelled a little more than we had hoped, and build a future out of it.

Over the course of the next couple of days we're going to spend time here in workshops trying to work out a direction forward for the thousands of senior medical and dental officers that help run this marvellous health system of ours. We have, as you know, the lowest number of specialists per head of population of any OECD country and yet we have one of the best health systems. That means you, and your colleagues that have let you come here, are working bloody hard and working very well. We may lose sight of that because botches and dramas make the front pages. The other thing that makes the front pages is disaster, and we've had a few, haven't we?

I was privileged to work with and observe some amazing human beings in an absolutely unplanned reaction to a disaster.

My first story: of other heroes

My first story of tossing and turning is a personal story but a story of other heroes.

On 22 February this year 182 people lost their lives in Christchurch. Many more were injured, some very seriously. Thousands have had their lives disrupted and will never be the same again. I had the dubious privilege of being on the 14th floor of the Grand Chancellor when it happened. I and those around me were incredibly lucky to get out without serious injury. I have subsequently seen some of the footage of where we were, it made me cry, and realise how lucky we were and how unlucky other people were.

However, over the next 20 hours I was privileged to work with and observe some amazing human beings in an absolutely unplanned reaction to a disaster. Now, if you look into the literature and read about crowds, or if you hear commentary about crowd behaviour, you get quotes like this: "crowds obliterate reason, sentience and accountability", "a crowd reduces its myriad individuals to a single dysfunctional persona", "crowds are stupider than the averaging of component minds".

But delve a bit deeper, as John Drury from Sussex University has done, searching for the evidence behind those sorts of statements, and you find they are not substantiated. Disasters in soccer crowds and people getting crushed are actually more about physics than morality. Non-linear dynamics means that if you have a little push somewhere, it's like you're encountering a sudden stop on the M6. Not due to an accident, it's just a crowding. You get people pushing up against others. And when you are against a door or a balustrade you might get crushed. It isn't a crowd going wild, it is merely physics.

What we know is that people in crowds and in disasters can do things that they normally would not do. Maybe what is happening is they're finding neglected parts of their personality. They are performing heroic acts for strangers. What I saw, and was fortunate enough to take part in, was human beings doing acts of heroism for other human beings that they had no knowledge of beforehand. They risked their own lives for others. You may say they were stupid doing so. But that was crowd behaviour that showed what we as humans can do for each other. Not just what we can do, but what we will do. I was extremely privileged to be part of that.

This story has more specific implications. I was with a bunch of medics, mainly doctors and some nurses and an ambulance officer. What I saw were amazing skills but, more importantly, amazing behaviour. The behaviour I saw and was privileged to be part of was behaviour which you do not learn by being a productive unit in a hospital, by producing more widgets, by increasing your elective surgery or churning out more patients or reducing your average length of stay.

Presidents well before me have argued for time away from patients to learn the things like leadership, like team work, like human factors that are essential to cope with the unknown in front of you. We saw in Latimer Square, and in the rest of Christchurch, people putting those skills, attitudes, behaviours into practice in the most extreme circumstances.

The skills I saw were teamwork skills, were human factor skills, were skills of leadership, were skills of ability to toss your ego out and get on and do what you could do as part of teams that formed and re-formed as the situation needed. These skills have been learned and honed, away from what some of our leaders would say is the core business of your job. These are skills that were learned on things like the Advanced Paediatric Life Support course that we were on. Three days away from the hospital, three days away from the patient, three days in a 2 to 1 student to teacher ratio environment. Honing the behaviour and skills that we then saw in action in Latimer Square.

These are the "extras" that we as ASMS have argued for in varying MECA negotiations. You also know that in our everyday SMO lives we are constantly challenged to use those things that we learn, not just by sitting down with a patient or cutting into them or prescribing for them. To use those very important things

learned in non-contact time your union has fought for you to have. These came to the fore. That's one of my stories of tossing and turning.

A second story: the MECA journey

Another story of tossing and turning is our MECA journey.

I want to wind you back a little bit to 2008. *Time for Quality* with the then Minister of Health, David Cunliffe, shaking hands on behalf of ASMS and the DHBs, endorsing a partnership between managers and SMOs. One step on a journey.

Then 2009, *In Good Hands*. The new Minister of Health, Tony Ryall, wanting to encourage clinical leadership. Having spent months exploring the health system around the country he realised that he needed clinicians to take more charge. However, he wanted something concrete, in five weeks, over Christmas. Leading a small expert group I submit we delivered a document which is still Government policy, which is still extant, *In Good Hands*. Clinical leadership from bedside to boardroom. Distributive clinical leadership. We'll have some presentations tomorrow about success stories of distributive clinical leadership.

2010, another year, *The Business Case*. I am obviously presuming that all of you have read this several times and tuck it under your pillows at night to make you feel better about the world. This business case which was developed in a new way with some honest individuals from DHBs and honest individuals from ASMS who believed in what they were doing. A business case that agreed some targets and agreed a level of investment which would be necessary. A level of investment equivalent to building a new hospital. But a level of investment that would be necessary to produce the medical workforce of specialists who could then implement changes that were necessary within our health system, to bring us up from the bottom of the table of specialists per population.

This is a process that was entered into in good faith and continued over many months. One year ago standing here I could tell you we had a business case which we had to be slightly secretive about because of certain sensitivities. It has since been broadcast and generated a degree of DHB antagonism. However, we made a further effort this year to try and stay in the same room with DHBs and develop a *Joint Quality and Patient Safety Improvement Plan* – the implementation document. A worthy document, a blueprint, not just lots of nice words. This plan has three interconnected components – quality and safety, clinical leadership and a stable SMO workforce. The point about this plan, which I emphasise has been developed in agreement between DHBs and ASMS, is that all these three things are interconnected – you cannot get one of them without the other two.

Quality and safety improvement – you all know about that. Reducing variance where you can, improving outcomes for patients and freeing up resources. Economists and accountants, including the Ministerial Review Group, state that approximately $800 million per annum is spent on error, and of that maybe $590 million per annum is avoidable error. And about 80% of that occurs in hospitals. That's a lot of money spent on fixing up error. So just by entering the health system, and especially a hospital, you have money spent on you to fix things that go wrong. If a proportion of that $590 million could be saved, it could be spent elsewhere. There is possibly more money to be reinvested from these savings than in the next great cancer drug or next great surgical technique. It's a challenge for all of us.

The challenge is to unlock that money. To find it and prevent it being wasted, we need clinical leadership and we need a stable SMO workforce. We need clinicians stepping forward and particularly SMOs stepping forward. We need time freed up for that leadership. We need SMOs being upfront and central in setting quality and safety agendas, not being dragged reluctantly into a room to be token champion of the next best thing. And to do that we need a stable and sustainable workforce. We cannot do it languishing at the bottom of the OECD table. We cannot do it by not having enough of you. We need an investment and we need a significant investment so that the people who want to be specialists want to be specialists in New Zealand and don't disappear over the ditch. And if they do disappear for some extra training, they will want to come back

So what your negotiating team and your Executive have tried to do over the last 18 months is find a way of making it more attractive for the young specialists-to-be to come here. And argued that we need to keep the older specialists whose families have grown up and are at a place in their life where they can travel the world and work where they want, to encourage them to want to stay here. Whether we have succeeded or not is yours to call over the next two days. I challenge you to help us.

Tossing and turning. I've lost sleep over unravelling. We had an agreement with DHBs about an investment. What has happened over the last few days, weeks and perhaps months for that agreement to unravel?

This plan has three interconnected components – quality and safety, clinical leadership and a stable SMO workforce... you cannot get one of them without the other two.

Last Story: something forensic

My last story to share with you is trying to do some forensic – not psychiatry – but forensic economics and try and look at behaviour and why perhaps we are where we are now and what our challenges are over the next couple of days.

One thing we started off with almost two years ago was blue sky thinking. We tried to start with a fresh approach, we tried to sit round and agree on things rather than being adversarial. When you think about blue sky thinking it sounds great, as if everything's an option.

But blue sky thinking itself does not really encourage limitless imagination. It rather embeds in its own metaphor our absolute inability to think outside our own perceptual and conceptual limitations. We as humans perceive the sky as blue only because of our peculiar physiology and the arrangement of our senses. We think we are doing blue sky thinking but we are constrained by who and what we are. We can't help but do it our way. Perhaps your negotiating team and the DHB representatives were constrained by the very people we are and the way we think.

Chicken sexers, plane spotters and being risk averse

I read a paper recently about chicken sexers and plane spotters. Chicken sexers from Japan and plane spotters from England. Trying to explain perceived wisdom, that mysterious and ineffable

expertise that some people just have. It's very difficult to sex chickens, I understand, when they're little, and decide whether they're males that should be tossed out or females that are going to produce eggs.

Experts in Japan in the 1930s could tell very quickly, by looking for a particular part of their rear end, whether it's male or female. The problem is, they couldn't say why they knew and they found it very difficult to train someone else. You can send them to a skills lab, you can send them to a simulation suite, you can send them to a course on chicken sexing – they don't know how to sex chickens. The only way to learn is by apprenticeship, by actually having the master there and the pupil or apprentice saying "male" and being told "no, female" and over a period of time learn that mysterious and ineffable expertise. A lot of what we learn in medicine is more like chicken sexing than a skills lab.

It was the same with plane spotters in England in the Second World War. There are certain people who have a personality that enabled them, before the days of sophisticated radar, to pick an enemy plane from a friendly plane as it flew over. But they couldn't explain why and when you tried to train the next plane spotters, because obviously you wanted more of them, it became very difficult. It took months and months of apprenticeship with a master. Does that sound a lot like medicine?

However, and here's the danger, we believe as SMOs, as specialists, as wise old, or not so old, heads, that we just get it right. That our instincts are right. Some of our own have shown, however, that that's not quite so. Atul Gawande has written about the dangers of doctors who place too much faith in their intuition. *The Checklist Manifesto* argues that just because you're a doctor doesn't mean you can remember everything; in fact you do better with checklists.

I was very glad the pilots who flew me here yesterday through the washing machine of cloud formations, circling round and round with no sense of horizon, had checklists so they knew whether the plane was upside down or not. Yet how many of us use checklists in our everyday medical life? Or do we just trust some of our instincts?

A very interesting physician, Donald Redelmeier from Toronto, has researched what confronts us in medicine and life. He has looked at the determinants of emergency department crowding, what makes us not achieve the 95% target. It's not about alternate primary care or patient preference or community education or the weather or the season, but it was about whether there were local rest home services. It's not about patient co-morbidities or complexities, it's not about access to labs or staff morale but it's more about the staffing characteristics, how many ED doctors and nurses you actually have and about availability of afterhours radiology.

Some of his other research is about mobile phone use. As a doctor who didn't like the fact that people were coming in dying or dead into his trauma room, he has established that mobile phone use in a car is as dangerous for producing motor vehicle accidents, or deaths in motor vehicle accidents, as being drunk. He has showed that changing lanes in busy traffic produces no actual real benefit in terms of getting to your destination quicker but increases your chances of having a collision threefold. He has also shown that over five years from 2004 to 2009, if you were an applicant to enter medical school, you were much less likely to be accepted if you were interviewed on a rainy day.

One of the reasons for recommending his research is that along with Tversky, a Nobel Laureate in Economics, he found that doctors making a decision for a single hypothetical patient favour more expensive treatments and more expensive investigations than when making a decision for a group of hypothetical patients with similar symptoms. So you and I, when faced with a patient in front of us, will make expensive decisions for that single individual. Yet if we back off and make a decision about a group of individuals, we'll be more parsimonious, we'll use the health dollar better. It's a challenge for us to try and understand why we behave one way with a patient in front of us and another way when we've got our hands on some of the purses of the health dollar. As we step into clinical leadership roles, how are we going to mix and balance those two behaviours?

When we look at our agreed MECA pathway, the tossing and turning that went on to produce a business case, to produce an implementation document with an agreed level of investment, why was there a sudden backing away. A backing away by some of the health bosses, backed by health politicians? Why did that happen?

I wonder whether some of Tversky's work with Kahneman actually gives us an answer. The idea of behavioural economics or prospect theory, which has, over a generation, managed to unravel some of the beliefs of utility theory which said that the market was open and transparent, which said that people are fully rational when they make decisions, that they are completely selfish when they make decisions, and that they have stable tastes. Tversky's work which won him the Nobel Prize undid all that, and introduced behavioural economics – how you and I assess the probability of an event. We search for memories of relevant examples, things that we can easily remember. But that leads to a completely faulty assessment of risk. If we don't have "like" events in front of us, we have nothing to absolutely compare with.

The MECA process that we've been going through, *the business case* development, the thinking of investment of the size of a new hospital in a medical workforce, was an event which no Minister, no health boss or Ian Powell had even thought of before. This was new, supposedly blue sky, thinking. It was a challenge, yet whilst it remained a theoretical undertaking, we all worked with it. When it became practical, rubber-hitting-the-road reality, all of a sudden human behaviour took over.

What we then saw, and what Tversky showed, is that human beings are risk averse when they are making a decision that has hope of a gain. Even stock market agents are usually bad at investing themselves. When there is hope of a gain, we as humans are risk averse. And yet we take risk when we're making a decision that will lead to a certain loss. I wonder whether our health bosses and those behind them, when confronted with a chance to make a real gain, to make a substantial investment in the SMO workforce for the next generation, behaved as only humans behave – risk averse. And maybe we have been led to a decision which may be a certain loss.

So your job over the next two days, as delegates representing the SMOs who have let you get away to this Annual Conference, is to help us work out how to go down a path which may be a loss or may be a gain for the health of the citizens of New Zealand. I look forward to tossing and turning with you, to having robust discussions and finding direction from you. To find wisdom in the crowd, in those you represent. And to champion a future for the people who, in their everyday lives, perform the sort of miracles and heroism which we saw in Christchurch earlier this year.

Jeff Brown
Presedent

EXECUTIVE DIRECTOR'S COLUMN

Whither national collaboration with DHBs

The ASMS has experienced a sharp learning curve in our efforts to collaborate nationally with the 20 district health boards. We have always had difficulties. The public health system was badly fragmented in the 1990s with the focus on treating public hospitals as competing commercial businesses. Although the Public Health and Disability Act 2000 ended the legislative basis for this fragmentation and required an integrated collaborative approach, it was always going to take time.

> Attitudes and behaviours don't change overnight especially with those potty trained and indoctrinated in a culture of managerialism which is the antithesis of distributive clinical leadership.

Attitudes and behaviours don't change overnight especially with those potty trained and indoctrinated in a culture of managerialism which is the antithesis of distributive clinical leadership as envisaged by the *Time for Quality* agreement between the ASMS and DHBs and the government's policy statement *In Good Hands*.

Recent past history

In our 2006–08 DHB MECA negotiations we were confronted by aggressive counter-claims from the DHBs, whose team was then led (for most of the time) by Southland chief executive Nigel Murray (unknowingly, to those employing him, also chief executive of a major health authority in Vancouver towards the end of this time). These counter claims threatened claw-backs to existing terms of employment (eg, time for non-clinical duties and sabbatical) and rights (eg, consultation). We experienced misrepresentation of our position and other questionable conduct. It was a sharply adversarial time. Several DHB chief executives expressed disquiet about this behaviour and privately distanced themselves from it but either did not try or failed to change it.

In the eventual settlement in 2008 a major feature was the establishment of a Senior Medical Officers Commission tasked with investigating terms of employment for DHB-employed specialists. This was to include including looking at Australian specialist relativities. The DHBs contribution in its representations to the Commission was to distort the situation and deny the problem. For example, they tried to argue that a discretionary provision for up to five days extra paid leave for exceptionally onerous conditions that was grand-parented to a limited number of DHBs was universal (it only applies to a handful).

Leopards, spots and such things

So, knowing this, why did the ASMS go down the *Business Case* approach when invited to by the DHBs in July 2010? Aside from the fact that it would have looked churlish and risked being used against us if we rejected it and the MECA negotiations subsequently got into difficulty, there were positive reasons.

The DHBs had new chief executives in key national leadership roles (Garry Smith, Auckland, chair of the national chief executives group, and Karen Roach, Northland, chair of the DHBs newly formed Employment Relations Strategy Group – ERSG) both of whom were genuinely committed to constructive engagement with the ASMS. In our informal discussions from December 2009 the DHBs national leadership distanced themselves from the conduct of the leadership in the 2006–08 period and expressed interest in a better way of handling the negotiations. This led to the four joint workshops in mid 2010 in which there was a high level of consensus over the state of the specialist workforce in DHBs.

The decision to proceed with the *Business Case* was a logical consequence of those joint workshops. The rest, as they say is history. The *Business Case* was jointly developed and agreed during September–November 2010; constructive discussions continued on its application through to early April 2011; the DHBs started to distance themselves from it in late April; and then the DHBs effectively rejected its principles and engaged in vitrolic deceitful attacks on the ASMS leadership from late August.

There is not a member of the National Executive (or our wider negotiating team) who does not believe they were lied to and about by the DHBs national representatives. The only debate is over when this started – when the DHBs first proposed the joint business case approach in July 2010; when the chief executives (under political pressure) decided not to seek some additional seed funding from government (as they originally envisaged) in December 2010; or when they started repudiating the principles of the *Business Case* and commenced their vitrolic attacks.

What was significant was the impact of the change of national leadership in the DHBs this year from Garry Smith to Kevin Snee (Hawke's Bay) and Karen Roach to Graham Dyer (Hutt Valley). It was only after these changes that the DHBs started repudiating the principles of the *Business Case* and attacking the ASMS. This highlights the brittleness of DHBs trying to function nationally. The only difference between the conduct of their respective spokespersons Nigel Murray in 2006–07 and Graham Dyer in 2011 was that the latter does not have a second secret job overseas.

> The decision to proceed with *the Business Case* was a logical consequence. But there is not a member of the National Executive that does not believe they were lied to and about. The only debate is over when this started.

On top of all of this the chief executives have also walked away from an agreement reached between the ASMS and DHBs over guidelines for the utilisation and employment of senior medical staff in inter-DHB service collaboration.

Were Hegel and Marx wrong

Where does this leave us? The kindest interpretation of the DHBs national leadership is that it is dysfunctional,

disproportionately influenced by the continuing culture of managerialism and the 'right to manage' (to which distributive clinical leadership as promoted by *In Good Hands* and the *Business Case* is seen as a threat), and is dragged down by the lowest common denominator. The net result is a form of systemic dishonesty in the way in which the DHBs act nationally and a complete lack of trust by the ASMS in its dealings with them.

> The damage that the DHBs have inflicted on constructive engagement is immense.

The damage that the DHBs have inflicted on confidence in constructive engagement is immense. Two of the greatest intellectual philosophers of the 19th century, Hegel and Marx, promoted the concept that there was a dialectical interaction between a thesis and its antithesis which leads to a new synthesis.

With the greatest respect to these intellectual giants of their time, it is difficult to see what the synthesis in this mess is (managerialism and distributive clinical leadership don't lead themselves to synthesis).

At best the outcome will be a focus on small tangible issues. There is nothing transformative or dialectical about this.

Ian Powell

Executive Director

IMG Supervisor Training Workshops 2012

Thank you for your commitment to providing supervision for international medical graduates (IMGs).

The Medical Council of New Zealand (Council) would like to encourage you to attend one of the free training workshops we are holding for supervisors of IMGs. This training is part of Council's ongoing work to support supervisors of IMGs in their work, and offers the chance for you to network and share ideas with colleagues. Feedback from those who have attended the training days is very positive and indicates that they have found the day very valuable.

Dr Susan Hawken and Dr Richard Fox from Connect Communications will be facilitating this training for the Council and senior Council staff will also be in attendance.

Learning objectives:

1. To learn how to deal with cultural differences and different approaches to practicing medicine.
2. To gain an understanding of maps and models of supervision and supervision tools.
3. To learn about different methods for providing feedback and dealing with difficult or poorly performing clinicians.
4. To gain an understanding of Council's processes and requirements for regulatory supervision of IMGs.

The upcoming workshops will be held:

Auckland:	Thursday 23 February 2012	9.00am - 4.00pm
Christchurch:	Thursday 8 March 2012	9.00am - 4.00pm
Wellington:	Thursday 22 March 2012	9.00am - 4.00pm

To secure your place on one of the above workshops, please email Laura Lumley at llumley@mcnz.org.nz

If you have already attended one of Council's supervisor training workshops, please kindly disregard this invitation or share it with any of your colleagues who may not yet have attended

24th Annual Conference

29–30 November 2012

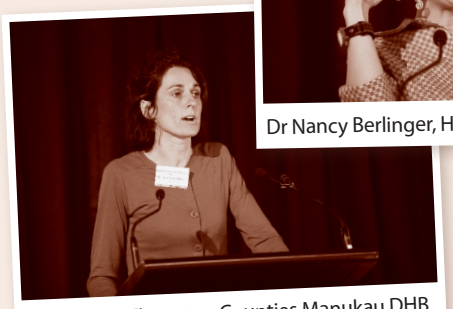
Mark it in your dairy now!

ANNUAL CONFERENCE HIGHLIGHTS

The 23rd ASMS Annual Conference had over 100 delegates and more international guests than normal. Particularly noteworthy were the Vice Chair Andreas Botzlar and Executive Director Armin Ehl of Marburger Bund, the doctors union from Germany as well as retiring Medical Protection Society Chief Executive Tony Mason. We were again also delighted to have four guests from the Australian Salaried Medical Officers Federation and Australian Medical Association.

Breakout group discussions on the proposed MECA

Dr Nancy Berlinger, Hastings Centre, New York



Dr Vanessa Thornton, Counties Manukau DHB

Opening Proceedings

The Opening Proceedings were chaired by Vice President, Dr Julian Fuller who also paid a special tribute to former Vice President David Jones. The feature of this session was the Presidential Address from Dr Jeff Brown (see page 4).

During this session the Australian Medical Association was very explicit that the increase in medical school numbers in Australia would not lead to a reduced demand to recruit specialists from New Zealand. Delegates were disabused of any such belief.

DHB MECA Negotiations

The main focus of the Conference was the DHB MECA negotiations which included a detailed presentation from Executive Director Ian Powell on why the National Executive was recommending acceptance of the provisional settlement as well as discussion of the proposed MECA in break-out groups, report-backs from these groups, and a plenary session.

The following two resolutions were then adopted (the first with one dissent and the second with 10):

1. *That this Annual Conference has lost trust in the DHB leadership and is disappointed that they and the Government have withdrawn from their responsibility to address the specialist workforce crisis. This crisis must be resolved in order to maintain a high quality health system for all New Zealanders.*

2. *That the Annual Conference endorses the proposal for settlement of the national DHB MECA as recommended by the National Executive.*

It is debatable whether the second resolution would have been adopted if the first resolution had not been put and adopted.

Political Matters

Through impeccable planning (not) the Conference was held in the week before the general election. We had hoped to have a debate between the two main political parties but this proved not to be the case. Nevertheless both Grant Robertson (Labour) and Tony Ryall (National) gave accomplished presentations and generated many questions from delegates. Mr Ryall was, however, challenged and faced low level heckling by incredulous delegates over his assertion that the specialist workforce crisis in DHBs had been solved because there were now 800 extra hospital doctors since he became Minister of Health.

Professional Subjects

Despite the predominance of the MECA negotiations the most intellectually stimulating part of the Conference was two sessions on professional matters.

The first was Dr Nancy Berlinger (Hastings Centre, New York) on the ethics of avoidance in healthcare, with particular reference to workarounds.

The second was on the theme of achieving distributive clinical leadership. This was based on presentations from Dr Vanessa Thornton (Clinical Health of Emergency Care, Counties Manukau DHB) on achieving the six hour target for emergency admissions at Middlemore Hospital and Professor Jonathon Gray (Director, Ko Awatea, Health Systems Innovation & Improvement, Counties Manukau DHB) supported by Dr David Galler.

Both sessions included lively questions, answers and general discussion between the presenters and delegates.

Other Matters

Other matters included:

- An interesting update from Tony Mason on MPS developments.
- The membership subscription was increased by $10.00 to $750.00 (GST inclusive) for the 2012–2013 financial year.
- WHK Wellington were reappointed as auditors for the 2011–2012 financial year.
- The 2012 Annual Conference was set for 29–30 November (Thursday–Friday). Members are encouraged to enter this date into their diaries now.

Twenty-third Annual Conference 2011

Grant Robertson, Labour Health Spokesperson

Hon Tony Ryall, Minister of Health

Dr Jeff Brown, ASMS National President

Dr Richard Tyler, Medical Assurance Society

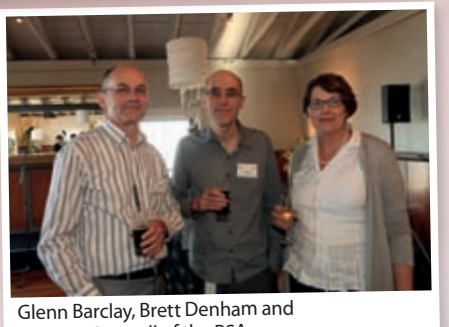
Dr Andrew Klava, Lakes DHB

Dr Rod Harpin Northland DHB, Dr Andrew Morgan Nelson-Marlborough DHB and Carolyn Fowler, ASMS National Executive

Angela Belich, ASMS national office, and Gary Waghorn, Capital and Coast DHB

Dr Chris Occleshaw, Auckland DHB

Dr Denys Court, Medical Protection Society and Dr Richard Tyler, Medical Assurance Society



Glenn Barclay, Brett Denham and Christine Ross, all of the PSA

Dr Brigid Connor, Auckland DHB

Warwick Hough AMA Federal, Dr Chris Occleshaw Auckland DHB and Geoff O'Kearney AMA Victoria

Dr Hein Stander ASMS National Executive, Nicola and partner Dr Rick Cirolli Tairawhiti DHB, and Lloyd Woods, ASMS National Office

Dr Sarah Burling, Taranaki DHB, Dr Felisa Roldan, Hutt Valley DHB and Dr Clinto Pinto, Counties Manukau DHB

Dr Ian Esson, Canterbury DHB and Dr David Peddie, Canterbury DHB

Tony Mason, Chief Executive Medical Protection Society

Dr Martin Thomas, Lakes DHB

Dr Clive Garlick, Nelson-Marlborough DHB

Dr Anna Ranta, Mid-Central DHB

Breakout group discussion on the proposed MECA

Dr John Chambers, Southern DHB

Dr David Galler, Counties Manukau DHB, and Dr Al MacDonald, Capital and Coast DHB

Dr Nancy Berlinger, Hastings Centre, New York

Dr David Grayson, Counties Manukau DHB

Dr Sarah Burling, Taranaki DHB

Dr Askar Kukkady, Waikato DHB, and Dr Sohail Sheikh, Hawkes Bay DHB

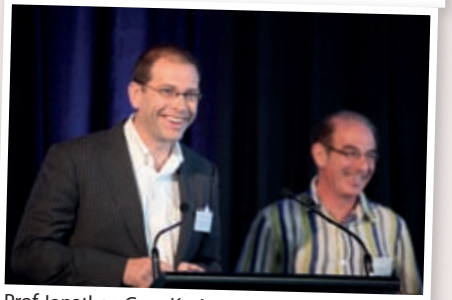
Dr Vanessa Thornton, Counties Manukau DHB

Dr Andre Smith, Southern DHB

Dr Guy Rosset, Bay of Plenty DHB

Dr Andrew Darby, ASMS National Executive

Dr John MacDonald, ASMS national Executive, Lyn Hughes and Kathy Eaden, ASMS national office



Prof Jonathan Gray, Ko Awatea Health Systems Innovation and Improvement, and Dr David Galler, Counties Manukau DHB

ASSISTANT EXECUTIVE DIRECTOR'S COLUMN

Prioritisation of Funding by Health Workforce New Zealand: Third Time Lucky

Health Workforce New Zealand has replaced the Clinical Training Agency as the funder of RMO training positions and has been attempting to find a way to shape the future clinical workforce by giving a priority to the positions it funds at DHBs. Funding will then be available more readily to the higher priority disciplines than the low priority ones. It is fair to say that throughout this process it has always been made clear that they will continue to fund RMOs already in training schemes though potential impacts on the number of registrars available to provide services don't seem to have been considered.

Poor consultation process

Initially Health Workforce New Zealand sought feed back on a paper proposing priorities for its investment in clinical graduate training for **all** clinical disciplines giving a time frame for feedback from 1 June (when the Association received the request) until 8 June. This approach posed particular dangers to funding for RMO training positions because it is likely that any priority given to funding clinical disciplines other than medicine would be taken from the funding available to medical training. This approach seems now to have been put on the back burner. As well the paper was very difficult to follow and did not follow any credible methodology.

In September a further template for investment by Health Workforce New Zealand was put out for consultation. This time the attempt was limited to medical disciplines. The paper was still very difficult to follow. It was based on giving a weighting to various medical disciplines according to their 'vulnerability' and their contribution to the governments current health targets (the full paper is available on our website *www.asms.org.nz*). We discussed the paper with our members through our electronic publications and have discussed it at meetings (JCCs) with our members and DHB managers at many, if not most, DHBs.

Membership feed-back

Feed-back from our members included these comments:

"I have doubts as to whether this is going to fix our shortage of specialists and am not sure of the robustness of the data and assumptions on which this has been based... I question how we can meet the health target of 4 weeks FSA to treatment and not value the RMOs."

"I find it obviously a difficult document to understand, and does not drill down into sub-specialties where the vulnerabilities, particularly at a local level, become much more obvious. It does not seem to take into account current shortages or shortfalls in level of care. In my own area of practice… does not get its own analysis ... This does not come across as a sophisticated way to plan, as it does not take into account factors other than the health targets listed. !"

"I have tried quite hard to read and understand this document and I am still confounded by it. Even when you add the data up you get to a different score from the numbers quoted! I don't understand how relying on general registration makes a service more vulnerable. I am concerned as to the validity of the process involved and I am also concerned as to what this document is going to be used for and how that may be done."

"My specialty is listed, but with such a small workforce I think it is ridiculous to give us a relatively low priority rating effectively on the back of a staff of about 5!"

",[Our specialty] has been ranked the second most vulnerable specialty in terms of workforce, however as it has not been included in the government's list of health targets it ranks very low on the contribution score. The society has major concerns regarding the health status of the New Zealand population….. New Zealand has significantly worse... statistics than other OECD countries."

Specific criticisms

Overall the feeling was the document lacked rigour and did not drill down into the non-surgical sub–specialities. A number of people commented that the maths was wrong. Managers at DHBs with a training focus said that they spent considerably more than they received from HWNZ on training and that therefore the impact of a change in HWNZ funding would not be definitive. Comment was also made that the funding now dispensed by HWNZ had been taken from DHBs or their predecessors in the first place

The consensus was that the paper was

- difficult to understand, poorly conceived and lacked rigour
- used short term targets to assess long-term needs (specialty training commenced in 2012 would often not be complete until a decade later) and therefore assumed , implicitly, that the current health targets would not be reached for a decade
- ignored current shortfalls in the specialist workforce due to unfilled vacancies, shortages that are so long standing that they haven't been conceptualised as vacancies and unmet need that would be met in most of the developed world
- ignored non-surgical sub specialities
- dealt cavalierly with very small specialties

Finally the process does not address the question posed by *"Securing a Sustainable Senior Medical and Dental Officer Workforce in New Zealand: The Business Case"* – even if this process gets the

training in medical specialities to exactly match the future needs of New Zealand it becomes pointless if the new specialists then leave the country. The voluntary bonding system is unlikely to perform this task.

Should use the *Business Case* approach

A far more fine-grained approach would be better perhaps based on the medical workforce needed in 10 to 20 years to match the estimation of health needs in the long-term that has been done by the Ministry of Health's National Health Board. The approach agreed by the DHBs and ASMS and set out in the *Business Case* (especially Appendix One) which compares the numbers in each speciality in New Zealand to the number we needed to reach Australian levels offers the beginnings of a better approach. Health Workforce New Zealand's own workforce service reviews sometimes strayed into this area though most recommendations made by these on the specialist workforce seem to have been ignored.

Decisions of this magnitude need to be made after marshalling the best data available and after careful discussion with local College leaders mindful that, in a country New Zealand's size, a bad decision can quickly lurch into catastrophe. Recently it's been suggested that Health Workforce New Zealand will be looking at a more clinically driven process. If that's the case it should be welcomed.

Angela Belich
Assistant Executive Director

The 2011 DHB Salary Survey

Since 1993 the Association has been surveying the salaries of Senior Medical and Dental Officers employed by DHBs and their predecessors. Originally the purpose of the survey was to compare the salaries between the different DHBs to help with negotiating the collective agreements at each DHB. Since the first MECA in 2003 the purpose has been more academic in that differences between DHBs have pertained largely to placement of SMOs on the salary scale.

The survey is essentially a head count of the number of SMOs at each DHB on each salary step. In the early years of the survey some DHBs were reluctant to give us the information and some had trouble generating the information. For the last ten years or so it has been relatively straightforward.

For the last six years all of the DHBs have been able to supply us with a gender breakdown. This has allowed us to monitor a small but worrying difference between the base salary of women SMOs and the base salary of their male colleagues. We have theorised that this is because women tend to form a larger proportion of the younger age cohorts and that this should lessen over time.

Table 1: Summary of National Mean Full Time Equivalent Base Salary

	Specialists		Medical and Dental Officers	
	Mean Base $	Annual % Increase	Mean Base $	Annual % Increase
1993	85,658		67,457	
2001	120,942	3.6	91,931[1]	2.4
2002	125,289	3.6	96,207	4.7
2003	129,743	3.6	100,002	3.9
2004	131,740	1.5	101,640	1.6
2005	140,583	6.7	111,088	9.3
2006	143,310	1.9	114,664	3.2
2007	145,044	1.2	114,380	-0.2
2008	159,986	10.2	124,916	9.3
2009	170,578	6.6	132,383	6.0
2010	171,977	0.8	132,881	0.4
2011	176,705	2.7	137,495	3.5

1 This figure has been amended from the 2001 salary survey

A side benefit of this survey is that we have a DHB supplied head count since 1993 of what DHBs (or their predecessors) say is the number of SMOs that they employ. This should allow us to ascertain the number of specialists and medical officers that are currently employed and, more importantly, the trend.

Those of you who have followed DHB generated information on their workforce will view with some scepticism DHB supplied information. We hope that the data they have supplied to us is accurate as far as it goes. At least when produced the DHBs have to make sure that the number on each step add up to the total.

The data is a head count and doesn't include any estimate of job size, part-time or fulltime or any assessment of remuneration other than base salary step.

It shows a pattern of a significant increase in base salary at the time a MECA settlement feeds into the scale and a falling off after that.

The annual increase between 2010 and 2011 was 2.7% for specialists and 3.5% for medical officers. The previous year the increase was only 0.8 % for specialists and 0.4% for medical officers so we are seeing the effects of the 2% increase in January this year.

The average base rate has increased for specialists by 2.7% to $176,705 ($168,965 for women and $180,185 for men) between 1 July 2010 and 1 July 2011. The average base rate for medical officers has increased by 3.5% to $137,495 ($138,453 for men and $136,330 for women).

Specialists in the Wairarapa DHB on average have the highest base pay and those in Waitemata the lowest. Medical officers have the highest average base pay in South Canterbury DHB (albeit with only 6 in total) while those in Auckland have the lowest average base pay.

The top step of both scales has the greatest number of doctors on it of any step with 1,145 specialists on the top step (out of 3,685) and 201 (out of 565) medical officers. Last year 885 specialists were on the top step as were 164 medical officers.

Angela Belich
Assistant Executive Director

Table 2: Change in Mean Salary by Gender 2007/11

	Specialists							Medical and Dental Officers						
	Numbers 2011	Mean 2011 $	Mean 2010 $	Mean 2009 $	Mean 2008 $	Mean 2007 $	% change 07–11	Numbers 2011	Mean 2011 $	Mean 2010 $	Mean 2009 $	Mean 2008 $	Mean 2007 $	% change 07–11
Females	1143	168,965	164,520	163,273	153,303	139,741	20.9%	255	136,330	131,243	129,571	122,582	112,878	20.8%
Males	2542	180,185	175,191	173,691	162,782	147,084	22.5%	310	138,453	134,297	134,947	127,240	115,702	19.7%
Total	3685	176,705	171,977	170,578	159,986	145,044	21.8%	565	137,495	132,881	132,383	124,916	114,380	20.2%

The Bargaining Fee Ballot: Your chance to vote again

Democracy is a wonderful thing. First the general election; then the national DHB MECA ballot and now, if the MECA is ratified, the bargaining fee ballot. Those of you who remember the last MECA may also remember the ballot on the bargaining fee. If the MECA is ratified by the ASMS Executive such a ballot has to be held at each DHB.

What is the bargaining fee?

The Employment Relations Act makes it possible for a union and an employer to agree that a collective agreement includes a clause which requires non-union members who choose to be covered by the collective agreement (the MECA) to pay a bargaining fee to the union to compensate union members for the costs that they have borne throughout the negotiation.

At the ASMS conference in 2005 it was resolved that ASMS should include a claim for a bargaining fee in our MECA claims and we have done so for both the MECA that expired in 2010 and for the proposed new MECA.

In the negotiations the DHBs agreed with the claim by ASMS for a bargaining fee. The MECA that you are currently voting on includes clauses (31.2 to 31.6) which set out the conditions for the bargaining fee.

If the MECA is ratified and SMOs at your DHB vote in favour of having a bargaining fee then non-ASMS members at your DHB will have to pay a fee equivalent to the ASMS membership fee in order to be covered by the MECA. They will also have the option of opting out of the MECA coverage.

What is the bargaining fee ballot?

Beginning on 16 January your DHB will run a voting process where each SMO (ASMS members and non-members alike) will get the opportunity to vote on whether you will have a bargaining fee at your DHB.

The ballot will be run by someone from your DHB administration (we will be given the names over the next few weeks) and ASMS will appoint scrutineers. These will be either branch Presidents or Vice Presidents if they are available or someone that they delegate to perform the task, if they are not.

When will the bargaining fee ballot take place?

The law requires that the bargaining fee ballot take place after the MECA is ratified. Because of the timing (around Christmas) of the ratification ballot we have agreed with the DHBs that the bargaining fee ballot will take place in the second half of January from 16 January and will close on 3 February.

What should I do?

Vote in the ballot held between 16 January and 3 February at your DHB.

The ASMS conference voted to claim a bargaining fee because they were concerned at non members 'freeloading' on members yet getting all the benefits of the MECA. ASMS urges you to vote in favour of the bargaining fee. Non ASMS members who are SMOs can vote in this ballot so it is important that ASMS members vote and vote in favour of having a bargaining fee.

What happens then?

If the majority of SMOs in your DHB vote in favour of having a bargaining fee then the clause will be activated in your DHB. As an ASMS member you don't have to do anything else.

Non-member SMOs will be given the option of opting out of the MECA in which case their terms and conditions will remain as they are. If they don't opt out they will receive the MECA but will have the equivalent of the ASMS annual fee deducted in four separate amounts from their four pays after 28 February. This will then be sent by the DHBs to the Association.

These "bargaining fee payers" will not have any of the other benefits of ASMS membership such as enforcement of the MECA or advocacy and advice.

What if the bargaining fee ballot is lost?

Then non member SMOs will not pay a fee to ASMS. It will be up to them and DHBs as to what their conditions of employment are in their individual employment agreements (IEAs).

VOTE FOR THE BARGAINING FEE

If the MECA is ratified, a ballot will be held in each DHB to determine whether you will have a bargaining fee at your DHB. The ballot will run between 16 January and 3 February. Vote for the bargaing fee to ensure that all those who receive the benefits of the MECA, share the cost of negotiating it.

Helping Doctors or Physician Assistants?

The two charming Americans who took part in the physician assistant pilot at Middlemoore got rave reviews from nearly everyone. They were helpful, skilled, worked hard and worked long hours. There the consensus ends.

Physician Assistants

In 2010, Health Workforce New Zealand set out to trial the occupation of physician assistant in a New Zealand setting. The physician assistant is a health profession originating from the United States (initially in the armed forces). It differs from nursing in that the physician assistant works under the direction of a doctor. This difference is not quite what it seems in that it appears that physician assistants can work in very remote areas to doctors who are some hundreds of miles away.

Pilot or demonstration?

The pilot was set up in the general surgical department at Middlemore Hospital in Counties Manukau DHB. Initially there was some dispute over whether they would work with the surgeons on acutes or on electives. This was settled to the general surgeons satisfaction with the physician assistants working on acutes.

At this stage there was a change in the way the project was described. From being a pilot or trial, which implies a careful evaluation with future decisions being based on a weighing up of evidence, it began to be referred to as a demonstration, which implies showing a sceptical audience what a great idea it is.

There is a lot of speculation that for some minds at Health Workforce New Zealand it was definitely intended to be at least part of the magic bullet that they think will solve New Zealand's specialist workforce shortages. They have referred to physician assistants as a role that 'potentially offers a solution to New Zealand's ongoing doctor shortage through providing an extra pair of skilled hands with the flexibility to work under a doctor's delegation according to the doctor s requirements.' [1]

Changing the Evaluators

If the pilot or trial was to provide a sound evidential basis for the future of the role then an evaluation was a critical component. Initially Pam Oliver Ltd was employed to do the evaluation. The evaluation was to be in two parts; a formative evaluation which was to evaluate the way in which the pilot was set up and a summative evaluation (the name of this morphed as well into an 'Impact' evaluation) which was to look at the trial after its conclusion. The formative evaluation was completed and the executive summary is available on the Health Workforce New Zealand website. ASMS obtained the full evaluation under the Official Information Act and that is available on the ASMS website.[2]

Clearly something happened as Health Workforce New Zealand then changed evaluators. The Association asked why the change had occurred but the National Health Board (of which HWNZ is part) refused the information on the grounds that the information was either personal or would unreasonably prejudice the commercial position of the person who is the subject of the information. The impact/summative evaluation is now to be done by an Australian Consultancy, Siggins Miller, and has been promised by the end of this year. There is not much of the year left so it should be available any day!

Verdict at Counties Manukau

Through a robust discussion over email our members who worked with the physician assistants across several specialities reached pretty much a consensus in their feedback to us on the physician assistant (PA) trial at Counties Manukau DHB.

- The PAs in the trial were very experienced individuals and operated at a high level. It is doubtful that someone who had just completed physician assistant training could have performed at the same level. They worked long hours and neither these hours nor the remuneration that they received appears to be regarded as sustainable (the physician assistants got $130,000 per year).
- The positions, if proceeded with, would need to be regulated under the HPCA as it was too onerous on supervising SMOs if they were not.
- The PAs had had the effect of freeing house officers and registrars from paper work and thus considerably enhancing the training of the RMOs but this could be done by people with other clinical backgrounds who were recruited to do these tasks more cheaply and without the expense of another regulated profession.

Counties Manukau management is widely reported as having been so pleased with the outcome of the project that they made funding available to keep the physician assistants working for them after the end of the trial. However, the physician assistants had to return to the United States to retain their registration. Some SMOs add that this was because the work they were doing at Counties did not utilise their skills thus placing their registration at risk.

Interestingly, at the last Counties Manukau JCC, a slightly different story emerged with Chief Executive Geraint Martin calling for a conversation among the clinicians as to the future

role of physician assistants if any at the DHB. Even at Counties the role of the physician assistant has not been made completely clear as the result of the trial

The Future of Physician Assistants in New Zealand: No magic bullets

There is a perception that the pilot was intended to demonstrate the workings of a decision already made by the Ministry to proceed with introducing a new profession.

The University of Auckland is believed to be ready to proceed with a physician assistant training course irrespective of the outcome of the impact or summative evaluation.

Health Workforce New Zealand says that senior clinicians throughout the country are talking about using physician assistants in emergency care and general practice and HWNZ will be supporting further demonstration sites. These will be selected from areas with a doctor shortage and where there is readiness to contribute to the costs of the project. They will be seeking more information on the extent to which the physician assistants enable the freeing up of senior (rather than junior) doctor time hoping that will allow senior doctors to practice 'at the top of [their] scope'. They hope for "increased teaching and learning opportunities; improved recruitment and retention of both senior and junior medical staff; reduced dependence on short term locums and international medical graduates; improved working conditions, working environment and employment opportunities". This is a lot to expect of the role.

SMOs assessment of the role was that they freed up RMO time and therefore had some impact on teaching and learning. It would be surprising if the rest of the hoped for impacts were found.

However the position was summed up by one Counties Manukau SMO (not one involved in the pilot) who said that the pilot was set up so it would not be allowed to fail no matter what – the antithesis of the testable hypothesis.

Angela Belich
Assistant Executive Director

1. Letter from Brenda Wraight , Director Health Workforce New Zealand to ASMS

2. ASMS homepage (www.asms.org.nz), *In Depth* section

ASMS services to members

As a professional association we promote:

- 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 district health boards which ensures minimum terms and conditions for around 3,000 doctors and dentists, over 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

Other services

www.asms.org.nz

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

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In addition to The Specialist the ASMS also has an email news service, ASMS Direct. This is proving to be a very convenient and efficient method of communication with members.

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at ***ke@asms.org.nz***

How to contact the ASMS

Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
Cnr Brandon St & Lambton Quay, Wellington

Telephone	04 499-1271
Facsimile	04 499-4500
Email	asms@asms.org.nz
Website	www.asms.org.nz
Post	PO Box 10763, Wellington 6143

MEDICAL PROTECTION SOCIETY

Resuscitation orders: an overview of issues in New Zealand

Dr Garry Clearwater, Medical Adviser at the Medical Protection Society (MPS) looks at current issues in New Zealand relating to Resuscitation Orders.

Resuscitation Orders are known by various names (such as "Do Not Resuscitate" – DNR – directives). They are prepared in advance to assist health professionals who must make urgent decisions about an unconscious patient with cardio-respiratory collapse. Is it appropriate to start resuscitation? If so, how far should they pursue the effort with resuscitation technology?

A resuscitation decision must balance three imperatives:

- The default legal and ethical position, that health practitioners should provide emergency treatment and that witholding such treatment could be illegal if it leads to a patient's death.
- It is appropriate to withhold treatment if it is deemed to be futile or otherwise "not in the patient's best interests."
- The obligation to act within the constraints of patient consent. A well-informed competent patient has the right to refuse (in advance) consent for resuscitation. It could be illegal to act against such a directive.

A Resuscitation Order should be readily available to staff at the scene of a collapse in time to effect a decision. Clinicians at the scene need to be confident that the Resuscitation Order was made by a valid process and that the order is relevant to the situation that faces them.

There is no proscribed format. The decision-making process must be robust and defensible. It can be a positive clinical exercise, requiring professional judgment and skill. Elements include:

- A sensitive discussion with key parties in a non-threatening environment and with adequate time.
- A careful evaluation of the patient's mental and physical condition and prognosis.
- If the patient is competent, a thorough discussion to explain the issues, evaluate the patient's wishes and to be sure that the patient is fully informed and that their consent is valid.
- Carefully documenting the discussions, rationale and decision.
- Communicating decisions in a clear and fair manner to the patient, their representatives and clinicians.
- There is an option to specify one or more specific interventions, such as basic CPR, limited attempts at defibrillation, assisted ventilation, and/or intubation.
- A Resuscitation Order needs to be routinely reviewed and updated to incorporate changes in a patient's condition or views.

Challenges arise when the patient is not legally competent because of cognitive impairment. The wishes and philosophy of the patient may be determined from the patient's agent (if there is one), family and staff. Points to note include:

- An advance directive, made by the patient when fully competent and adequately informed, is a very relevant indicator of the patient's views.
- Welfare Guardians or individuals who have been granted an Enduring Power of Attorney (EPOA) for personal care and welfare matters under the Protection of Personal and Property Rights Act 1988 are excluded – in section 18(1) – from being able to refuse life-saving measures for the person in their care. For example, they cannot sign a "Do not resuscitate" order on behalf of the patient. However, their knowledge of the patient's prior preferences could still be very influential in a resuscitation decision.

Resuscitation Orders carry risks:

- Validity (and defensibility) is compromised if they are undertaken hastily, under duress, or with inadequate consultation. This is a concern in busy acute hospital services, for example.
- They may be misused beyond their scope – at worst, for inappropriate withholding of basic humane care (such as pain relief, comfort cares) in situations apart from emergency collapse.
- Patients and/or their family may complain if they are not kept informed about, or disagree with, the decisions made in a Resuscitation Order.

As with so many other aspects of clinical practice, Resuscitation Orders require thorough discussion, clear documentation and good communication. There is always the option to consult more widely with colleagues and medico-legal advisers. The references below are recommended for a fuller discussion of the issues.

References:

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Merry Christmas

THE NATIONAL EXECUTIVE AND STAFF OF THE ASSOCIATION WISH ALL MEMBERS HEALTH AND HAPPINESS OVER THE HOLIDAY SEASON.

The national office will be closed from 23 December 2011 to 4 January 2012 inclusive.
During this period messages of urgency can be left on the office answerphone which will be cleared regularly.
Throughout much of January we will be operating with reduced staff.