ISSN 1174-9261 DECEMBER 2012 | ISSUE 93

The Specialist

The newsletter of the Association of Salaried Medical Specialists

The leaking bucket: still awaiting repair

In 2004, a report by the New Zealand Institute of Economic Research described our health workforce as a "leaking bucket". In 2009, an ASMS report found the situation unchanged for the specialist workforce. This article, which examines the latest figures on new vocational registration and retention rates, finds the specialist workforce in a continuing precarious state.

Medical Council data (2012) confirm that New Zealand's newly qualified specialists are quitting practice in this country at an increasing rate. The Medical Council's latest annual report on the medical workforce shows that of the New Zealand doctors who gained vocational registration in 2010, 13.5% were no longer practising here one year post-registration, compared to 5.5% in 2000 (see graph). Hospital (and other secondary care) specialists account for around two-thirds of new vocational registrations.

The retention trends fluctuate more in subsequent post-vocational registration years but the general direction is towards an increasing loss of doctors. For example: three years post-registration, 10% of those who registered in 2008 were not practising here compared with 5.5% of those who registered in 2000. Six years post-registration, 11.5% of those who registered in 2005 were not practising here compared with 5.5% of those who registered in 2000.

The number of New Zealand doctors gaining vocational registration is declining

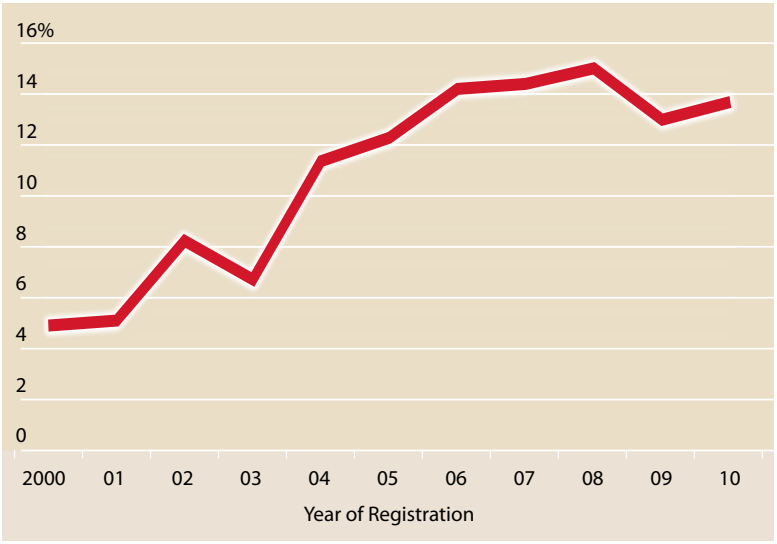
It is often argued that many doctors who leave New Zealand tend to return eventually. The data show that over recent years some specialists (but not many) have indeed returned, at least for the short to medium term. However, by eight to 10 years post-registration the numbers tend to drift away again and the eventual loss is greater than in the early post-registration years.

As well as a worsening retention rate, the actual number of New Zealand doctors gaining vocational registration in a hospital specialty, notwithstanding annual fluctuations, has not grown over the past decade and has declined on a per-population basis. In the five years 2002-06, an average of 155 New Zealand doctors gained registration in a hospital specialty annually, compared with 158 in the five years 2007-11. That equates to an average drop of 3% per head of population (18.9/100,000 to 18.3/100,000).

New Zealand has a well-documented entrenched shortage of specialists

Per head of population, the number of doctors gaining registration in the latest six-year period was just 79% of the number in the previous five-year period, on an annual average basis (5.3/100,000 compared with 6.7/100,000).

Percentage of New Zealand doctors lost one year after vocational registration



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

Researcher
Lyndon Keene

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

Ph 04 499 1271

www.asms.org.nz

The significance

Despite these trends, the medical register shows the number of doctors with vocational registration, excluding GPs and doctors in accident and medical practice, increased by an annual average of 4.4% between 2005 and 2012, so what is their significance?

There are several points.

First, New Zealand has a well-documented entrenched shortage of specialists and our growing and rapidly ageing population means that our specialist workforce needs to grow significantly to meet future health service demand. The current net growth rate (173 specialists per year on average) is about 60 specialists short of a modest minimum target agreed with the district health boards in the DHB-ASMS Business Case in 2010.

The decline in the number of New Zealand doctors gaining vocational registration reflects the poor retention rates in the resident medical officer workforce

Second, the decline in the number of New Zealand doctors gaining vocational registration reflects the poor retention rates in the resident medical officer workforce where around a third of New Zealand medical graduates are no longer practising here 10 years post-registration. There is no clear sign of this improving to any significant extent. While recently retention rates of those registered appear to have been getting better in the immediate post-graduation years, this has been at least partly offset by an increasing proportion of the final-class year that do not register after graduation. In 2010, for example, 17% of the final class year did not register after graduating – up from 6.6% in 2005.

Third, the decline in the number of New Zealand doctors gaining vocational registration, together with the declining retention rates, means New Zealand is becoming increasingly dependent on short-term locums and overseas-trained specialists (international medical graduates - IMGs) to attempt to fill the gaps.

Information on the total number of specialist positions filled by locums each year is not readily available but an indicator of trends is provided in registration information. In 2005, for example, there were 75 special purpose registrations issued for "locum tenens in a specialist post" and one for "emergencies or other unpredictable short-term situation". In 2011 those registrations had increased to 145 and 18 respectively.

The number of IMG specialists has increased from 35% of the workforce in 2000 to 42% in 2011. Such excessive reliance on IMGs increases the vulnerability of the workforce. Retention rates for IMGs are especially poor because many – as the MCNZ has noted – come here for short stays only. This "revolving door" of specialists has significant negative flow-on effects that further worsen our systemic instability.

Excessive reliance on IMGs increases the vulnerability of the workforce

Fourth, a marked improvement in recruitment and retention rates is needed to compensate for an impending flood of retirements. Again, as the Medical Council notes, the largest group of doctors (almost 20%) was aged 40-44 in the early 2000s, aged 45-49 in 2009, and aged 50-54 in 2011. Unpublished Medical Council data shows there is a sharp drop-off in specialist numbers when they reach their 50s.

Lastly, there are no signs of meaningful activity or plans to address the continuing shortcomings of specialist recruitment and retention nationally. The response of government agencies is to focus on developing new service models, but there is no evidence of any model that might mitigate the needed growth in the specialist workforce.

Ian Powell
Executive Director

EXECUTIVE DIRECTOR'S COLUMN

One trick ponies are only good for one thing – one trick only

Workforce planning and development in DHBs is characterised by 'one trick ponies'; that is, a single trick that will be the solution to all or many problems when at best it helps one thing a little and at worst does nothing at all but is a corroding distraction in the process.

Physician assistants and the mythical 800 extra hospital doctors

The government's health workforce agency, Health Workforce New Zealand (HWNZ, located in the Ministry of Health) began this with embellished claims back in 2009 over what physician assistants could do to reduce senior doctor shortages in DHBs. One ambiguous 'demonstration' and a shoddy self-promotional non-independent evaluation later, we are no further advanced on knowing whether physician assistants have a practical role in New Zealand's health system, let alone relieving specialist shortages.

Then Tony Ryall, based on knowingly misleading advice from the Health Ministry's National Health Board (NHB), found himself ridiculed at last year's ASMS Annual Conference with the false claim of 800 extra hospital doctors (including resident medical officers) since he became Health Minister. This was debunked by the ASMS based on DHB data, including in the last issue of *The Specialist*. The NHB's data ended up confirming the ASMS's analysis of senior doctor numbers while the embellished overall total was due to a mix of the NHB's deliberately misleading presentation and highly dodgy RMO numbers.

The Minister's credibility with the medical profession was compromised by this debacle leading one wit at this year's ASMS Annual Conference last month to comment that if the Minister was asked what three times three was, his answer would be 800.

The Australians are coming!

Now, if some voices are to be believed, such as within HWNZ, a significant flood of medical graduates from Australia plus specialists and other doctors from England is going to be a significant part of the solution to the specialist shortages in DHBs.

In the first instance this follows reports that Australian hospitals were unable to cope with the increased number of medical graduates following the significant expansion of medical school intakes (and medical schools) a few years ago.

Certainly Australia's investment in the capacity to train medical graduates did not match its investment in the increased numbers of medical students. But facts are important. At an Industrial Coordination Meeting convened in September by the Australian Medical Association, and attended by both the ASMS and Resident Doctors' Association, the AMA reported that contrary to previous media reports all interns are expected to get a position in Australia at the end of this year.

In the first instance all Australian domestic graduates have now got places. The picture is similar for international students. According to the AMA there were 552 international students of whom 498 have also found positions. The remainder have returned to their home countries as a condition of their scholarships.

Until 2016 the number of medical graduates will continue to increase before leveling off. At this stage there is a projected shortage of training positions for the next few years but whether this is addressed in advance remains to be seen. History, and necessity, suggests it will be addressed.

If any resident medical officers from Australia come to New Zealand next year they are likely to be a small number in their third or fourth years that can't get a position in Australia.

Aspirations of floods of Australian medical graduates coming to New Zealand to help solve our shortages remain precisely that – aspirations that are very unlikely to materialise.

Okay; if the Australian's aren't, by golly the English are!

The second instance is based on the massive marketisation restructuring of the National Health Service in England (fortunately for them devolution has meant that Scotland, Wales and Northern Ireland are able to protect themselves from this disastrous move). Certainly this restructuring, which was strongly opposed by the medical profession including the British Medical Association, is having a demoralising effect on NHS health professionals. But the claim of a flood of specialists is based on an assumption of job losses through the retrenchment that is accompanying this marketisation restructuring.

Again fortunately, the United Kingdom has some reputable health 'think tanks' one of which is the London based King's Fund, founded by Queen Victoria's oldest (and naughtiest) son Edward. The King's Fund publishes quarterly monitoring reports on 'How is the NHS Performing?' The latest report (September 2012) is revealing.

The trend in employment for all staff groups in the NHS increased by around 1.4% between September 2009 and March 2010 but has since fallen by 2.8 percentage points – a reduction of 29,223 full-time posts. So far this is consistent with the assumption.

But the changes have varied for different NHS staff groups. Following an increase of around 1.3% between September 2009 and March 2010, the number of qualified nurses, midwives and

health visitors has fallen back to a fraction under the September 2009 level – a reduction of 5,509 compared to March 2010. On the other hand, the number of scientific, therapeutic and technical staff increased by 3% per cent since September 2009.

However, of far greater significance and relevance, the number of consultants has risen continuously since September 2009 – from 34,156 to 37,693 in June 2012, a 10.4% rise.

While there are variations between specialties, a 10.4% increase in specialists in the United Kingdom is not the basis of a flood of the displaced from England to New Zealand (especially when one has to bypass the much higher remuneration opportunities in North America and Australia). England, of course, is not all of the United Kingdom but it is most of it. The combined medical populations of Scotland, Wales and Northern Island are simply too small to make a difference.

This information, along with anecdotal reports around DHBs, suggests that rather than a flood it is more like a continuation of the usual English trickle. If anything the flood (more a wave than a flood if the truth be known) of NHS managers is the real story.

'One trick pony' is an apt description of this jumpy unsystematic approach to workforce planning and development in DHBs. Perhaps another is the persistent search for a 1963 Dallas 'magic bullet'?

Ian Powell
Executive Director

Counting Senior Medical Officers

The front page article in the last specialist explained the debate between ASMS, the Minister of Health Tony Ryall and the National Health Board on the number of doctors employed by New Zealand District Health Boards. Ian Powell, Executive Director of ASMS explained that the figures from the ASMS salary survey provided the best data on the numbers of senior medical officers.

We have now analysed the figures from the 2012 salary survey. The head count of specialists provided to us by DHBs as at 1 July 2012 is 3,826, an increase of 141 on last year. The number of Medical Officers employed by DHBs decreased by 25 from 565 to 540.

Number of Specialists employed by DHBs

DHB	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002
Northland	117	117	108	101	95	87	105	106	63	64	71
Waitemata	323	307	272	289	345	245	233	243	200	182	180
Auckland	782	755	726	702	654	624	565	563	554	509	480
Counties Manukau	385	370	367	335	284	269	257	259	240	216	201
Waikato	306	284	273	268	273	261	249	235	234	221	204
Bay of Plenty	149	139	128	136	121	105	99	110	111	96	73
Lakes	66	69	67	59	55	57	48	50	50	44	49
Tairawhiti	43	47	47	51	44	31	32	30	29	24	22
Taranaki	64	59	52	54	47	39	47	49	43	40	39
Hawkes Bay	114	114	108	101	92	86	79	65	68	69	66
Wanganui	43	41	44	46	36	43	45	41	36	34	21
MidCentral	131	110	102	103	109	109	97	104	110	101	86
Wairarapa	23	24	26	26	26	24	19	15	18	17	21
Hutt Valley	124	123	117	115	106	100	101	94	88	76	84
Capital Coast	317	299	284	295	281	139	226	232	196	204	181
Nelson-Marlborough	112	106	104	106	90	91	92	82	81	79	72
West Coast	26	24	22	23	18	24	24	13	11	8	13
Canterbury	427	440	430	414	415	350	305	299	274	276	214
South Canterbury	38	37	35	29	28	30	30	25	28	27	29
Southern	236	220	221								
Otago				150	143	137	138	140	128	126	115
Southland				54	50	43	54	56	47	46	38
Total	**3,826**	**3,685**	**3,533**	**3,457**	**3,312**	**2,894**	**2,845**	**2,811**	**2,609**	**2,459**	**2,259**

Number of Medical and Dental Officers employed

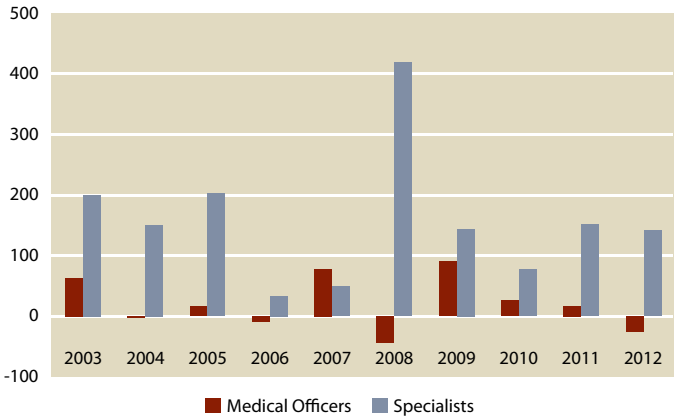
DHB	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003	2002
Northland	31	35	29	27	28	27	5	5	22	23	22
Waitemata	78	87	74	68	3	65	62	66	25	25	21
Auckland	116	107	116	100	106	87	46	75	61	54	37
Counties Manukau	39	33	26	32	18	15	21	20	14	19	17
Waikato	31	35	35	33	35	27	32	21	29	34	32
Bay of Plenty	22	24	29	28	26	23	20	20	19	23	12
Lakes	7	8	7	6	7	8	9	10	10	9	10
Tairawhiti	8	10	9	12	7	6	4	5	5	3	5
Taranaki	25	25	27	24	20	23	19	18	17	19	15
Hawkes Bay	12	11	13	14	13	12	16	11	23	20	24
Wanganui	3	4	8	1	1	5	8	8	12	7	8
MidCentral	17	13	17	19	20	16	16	20	19	19	16
Wairarapa	6	4	3	3	4	3	6	5	4	4	4
Hutt Valley	10	12	10	13	13	13	11	9	11	12	12
Capital Coast	13	9	9	19	11	28	20	19	20	12	10
Nelson-Marlborough	29	33	28	30	26	24	26	18	20	31	26
West Coast	12	11	9	11	11	8	6	5	2	2	0
Canterbury	52	65	62	52	57	56	44	46	45	46	28
South Canterbury	4	6	4	3	3	4	4	3	4	4	2
Southern	25	33	33								
Otago				9	11	11	9	12	14	13	16
Southland				18	11	13	12	8	12	10	10
Total	**540**	**565**	**548**	**522**	**431**	**474**	**396**	**404**	**388**	**389**	**327**

The picture is even clearer when it is set out in the graph (right).

Yes there has been an increase in the numbers of SMOs employed at DHBs but it is smaller than last year and does not meet the target agreed with DHBs in 2010 of 209 additional specialists employed by DHBs each year. Neither was the target reached in 2011 when the number of specialists increased by 152.

Angela Belich
Assistant Executive Director

Year-on-year change in SMOs



24th Annual Conference 2012

Conference summary

Following a well-attended pre-Conference function generously sponsored by the Medical Assurance Society the preceding evening (including delegates, politicians, Health Ministry, DHBs, medico-legal lawyers, unions and other professional bodies) the Presidential Address was given by Dr Jeff Brown on the first morning of the two day ASMS Conference. Dr Brown was himself absent officiating at the Champions Men's Hockey Trophy tournament in Melbourne. This was delivered by a pre-recording assisted by a towering, at times intimidating, cardboard cut-out of Dr Brown. In his absence the Conference was chaired by Vice President Dr Julian Fuller.

Key sessions

- The main subject matter was the forthcoming national DHB MECA negotiations beginning with a presentation from Executive Director **Ian Powell** followed by breakout groups, feed-back from these groups and a final general session. The broad consensus was to focus on retention and recruitment with particular reference to improving the competitiveness of the salary scales.
- Health & Disability Commissioner **Anthony Hill** gave a very well received address on achieving distributive clinical leadership. This presentation was for many delegates the Conference highlight.
- **Jeff Sissons**, Council of Trade Unions Legal Adviser (and former ASMS Industrial Officer), outlined the pending changes to industrial law, including the Employment Relations Act. This included the ramifications for the ASMS and our members.
- **Dr Al MacDonald**, renal physician at Capital & Coast, reported on his work on promoting clinical ethics networks.
- **Dr Robert Hendry** (Deputy Medical Director, Medical Protection Society) out from the United Kingdom discussed with delegates his insightful views on the issues and challenges in legal medicine.
- **Professor John Fraser** (Dean of Faculty of Medical & Health Sciences, Auckland University) addressed Conference on the training of the doctors of the future. Although his presentation did not focus on the theme as much as we expected, it did lead to some firmly expressed debate and challenges.
- Assistant Executive Director **Angela Belich** led discussion on the government's review of the Health Practitioners Competence Assurance Act, assisted by **Geoff Annals** (Chief Executive, NZ Nurses Organisation) and **Lesley Clarke** (Chief Executive, NZ Medical Association). This led to a unanimous resolution supporting the maintenance of the current regulatory authorities (eg, Medical and Dental Councils) in order to protect the safety of the public.

Other matters

- International guests were **Peter Somerville** (Australian Salaried Medical Officers Federation, Federal) and **Andrew Murray** (Australian Salaried Medical Officers Federation, South Australia).
- In recognition of the ASMS's healthy financial position the membership subscription remains unchanged at $750 (GST inclusive) for the financial year 1 April 2013 – 31 March 2014.
- Constitutional amendments, including meeting new statutory requirements requiring secret ballots when union members vote on strike action, were adopted.
- **Drs Clinton Pinto** and **David Galler** (Counties Manukau) gave a short presentation on 'Sustainability: a clinical question'.
- **John MacDonald,** who is retiring early next year including from the National Executive, was the guest speaker at the Conference dinner, also generously sponsored this time by the Medical Protection Society. His entertaining speech was on the theme of 'reflections' and including the Hardy-Nelson relationship and logical science.


Chris Hodson QC, Harbour Chambers


Dr Guy Rosset, Bay of Plenty DHB


Dr Judy Bent, ASMS National Executive


Dr James Judson, Auckland, and Dr Carolyn Fowler, ASMS National Executive

Dr Ruth Spearing, Canterbury DHB, Joan Crawford, Medical Council, Drs Les Snape and Martin Searle, Canterbury DHB

Angela Belich, ASMS, Dr Matthew Hills, SC DHB, and Dr Brian Craig, ASMS National Secretary

Dr Richard Tyler, MAS

Dr Julian Fuller, ASMS National Vice-President

David Gordon and Glenys Talivai of MAS, and Ian Powell, ASMS Executive Director

Dr Trevor Cook, Canterbury DHB, and Dr Brian Craig, ASMS National Executive

Dr Chris Nunn, Waikato DHB

Dr Andre Smith, Southern DHB

Heather Ann Moodie, ANZCA and Renu Borst, NZSA

Maryan Street MP, Labour Health Spokesperson, and Dr David Galler, Counties Manukau DHB

Jeff Sissons, Council of Trade Unions

Dr Campbell White, Taranaki DHB

Dr Clive Garlick, Nelson-Marlborough DHB

Dr Courtenay Kenny, Waitemata DHB

Dr Rodger Wandless, Southern DHB

Dr John Chambers, Southern DHB

Dr John Bonning, Waikato DHB

Drs David Galler and Clinton Pinto, Counties Manukau DHB

Anthony Hill, Health and Disability Commissioner

Dr Jonathan Casement, Waitemata DHB

Dr Sylvia Boys, Counties Manukau DHB

Dr Ruth Large, Waikato DHB,

Angela Belich, ASMS Assistant Executive Director

Lesley Clarke, NZMA

Dr Geoff Shaw, Canterbury DHB

Professor John Fraser, Auckland University

Geoff Annals, NZ Nurses Association

Dr John MacDonald, ASMS National Executive

Dr Seton Henderson, Canterbury DHB

Lloyd Woods, ASMS national office and
Dr Tim Frendin, ASMS National Executive

Dr Matthias Seidel, Bay of Plenty DHB

Drs Helen Moore and Brigid Connor,
Auckland DHB

Dr Andrew Darby, ASMS National Executive

Dr Robert Hendry,
Medical Protection Society

Object in the mirror

Dr Jeff Brown's Presidential Address to the 24th ASMS Annual Conference delivered on 29 November 2012

No mai, haere mai. Ko Jeff Brown tenei.

Welcome. Welcome.

This is the 24th Annual Conference of the Association of Salaried Medical Specialists. You are the representative senior doctors and dentists who have been granted favour to attend by your colleagues covering duties at home. I am recording my tenth Presidential address on Wednesday morning in the national office of your Association. I trust my projected visage and voice help frame your discussions over the next two days under the guidance of your Vice President Julian Fuller who, I am certain, will imprint his own style on your proceedings. He will be chairing sessions exploring Clinical Ethics Networks, chatting with the Minister of Health, contemplating training Doctors of the Future, sharing a visit from the head of MPS, discussing with the Health and Disability Commissioner, examining implications of changes to the Health Practitioners Competence Assurance Act, and, of course, seeking guidance for our MECA negotiations.

I look forward to hearing the outcomes of your deliberations and the direction you give your Executive for the year ahead.

Object in the Mirror

After brief reflection on a journey over a decade, I will heap praise for good deeds, examine barriers and beliefs that impinge on our best efforts, dissect demands for disruptive change, and challenge the morality of missing health care.

In 2003 I pondered the triple aim of looking after the individual, looking after each other, and looking after the system. In 2004 I aspired for us to be victims no more, but wondered whether we would grow apart, or grow up together. In 2005 I focussed on strengthening branches and leading clinical networks while supporting ourselves. In 2006 I challenged us to seize leadership. In 2007 I explored the rewards of connectedness, and the harm of disconnectedness. In 2008 I dissected leadership from power, claiming we were translational (as distinct from transactional and transformational) leaders. In 2009 I asked "are we there yet?" on the journey from competitive silos thrust upon us by Simon Upton's reforms, away from the lingering toxic legacy of fighting each other, from the poisons still leaching out under pressure, to an integrated health journey in an integrated health system. In 2010 I wondered how we defined our best, and the benefits of reducing variability, optimising the known, and addressing more cleverly the unknown. Last year after tossing and turning I reported stories of heroism, stories of endeavour, and what we could learn from other disciplines about what drives us to act the way we do. This year I have owned up to mistakes I make, and will continue to make, while trying to grasp critical thinking.

During all these addresses I have been prepared to criticise, to cajole, whilst also encouraging and engaging. Optimism outbalancing pessimism. I know no other way.

Object in the Mirror

Let me hold up the mirror of praise. Praise first to Ian Powell and his tireless fight for a high quality public health system and those who work within it, and against those who deliberately or accidentally set out to destroy it. Praise next to the industrial team of Angela, Henry, Lyn and Lloyd who try to anticipate the machinations of managerialism and support members through tough times. And praise to the team led by Yvonne, who with Kathy, Terry, and Ebony run a highly professional national office. As membership increases, so do the demands and expectations on these hard working folk, therefore your Executive has determined that we should increase the industrial team and the office staff, and the office space thus required. Praise to your National Executive who agonise before, during and after their decisions made on your behalf.

I also praise the Minister of Health. He has laid down challenges with some targets which the system and fine individuals within it have risen to achieve. Childhood immunisations are now at an all time high, and the disparity between ethnicities has disappeared in many areas. Healthier lifetime outcomes will escalate for many who previously missed out on perhaps the most effective health intervention known to science. Cancer networks are redesigning their approaches to improve access to diagnostics, confirmation, and treatment. Access to elective surgery is improved. Rheumatic fever is being tackled. Some of the factors behind our shameful record in this and other diseases of poverty and poor housing, such as pneumonia, bronchiectasis and skin infections, will require much more joined up thinking with other Ministers and Ministries. Likewise our violent society has yet to effectively address the damage to our children from accidental and non-accidental injury and death.

Some of the factors behind our shameful record in... diseases of poverty... will require much more joined up thinking

I do pause to ask, as we accelerate down the road of productivity, whether we are carefully looking in the mirror for those we might leave behind? For those whose affliction does not match a target. For those whose health is compromised when, as with Pike River, production trumps safety. When the big bag of blancmange bulges elsewhere.

Object in the Mirror

So I raise objections to some of the demands driving perverse behaviours in those aspiring to be the best at their special craft. I object to appeals to the venal, paying piece rates to incentivise. I object to the stripping of bureaucrats in the back rooms without stripping of the bureaucracy. I have not noticed a reduction in

the number of forms I have to fill in, the number of reports I have to write, the paperwork involved in any transition of health care or inpatient health care. The opposite is often true. I am finding I need to type more of my own correspondence, spend more time cleaning up messes, and grapple with increasingly archaic infrastructure. All blocks and barriers to my clinical productivity.

One of the challenges I continually grapple with as a provincial Paediatrician is the balance between the desire and time to seek the absolute best for the children and families I encounter every day, and the desire and time to improve the system we all work within so that others are eager to train and work here. To work with my colleagues at the coalface as well as those charged with the difficult but fundamental task of reverse-engineering a highly complex system whose inner workings are largely a mystery.

How can the finances of such a complex system be understood by capital city analysts who cannot forecast the nation's operating deficit from one quarter to another? The last three month deficit to September was 27% bigger than forecast, provisional tax $103 million below forecast, source deductions and GST each $166 million below forecast. Yet the offices of these same analysts proffer PPPs to salve our DHB finances, along with other nostrums such as disruptive innovation. I will dissect some of these offerings.

Object in the Mirror

One of the imperatives of integrating primary and hospital care has been to deliver services, traditionally sited in hospital campuses, in settings closer to home, in homes, and by innovative craft groups and individuals. Objective analysis of outcomes has not always matched ideology, and while I am personally enmeshed in many activities seeking to innovate, integrate and challenge tradition, I also need to keep critical thinking post-its stuck to my mirror.

A few GPs in England are said to be pocketing millions of pounds from the sale of NHS funded out-of-hours GP service Harmoni to private health care company Care UK, at the expense of NHS Direct call centres. Meanwhile a report in the Medical Journal of Australia found 52 percent of patients who had been given advice by a healthdirect registered nurse to stay put or seek treatment in a non-emergency setting nevertheless presented to an ED. The report also found 73 percent of healthdirect referrals to emergency departments to have been appropriate, compared with an almost identical number for people presenting of their own accord. An accompanying editorial piece questioned whether healthdirect is a sound use of government health dollars. "In relation to whether an ED visit is required, it appears that a phone call will not answer the question". Especially as a 17.5 percent increase in calls to June 2012 compared to the same period in 2011, will obviously drive even more referrals to EDs or doctors elsewhere. In the UK the shadow health minister Jamie Reed opined "As the private sector takes over out of hours services, it's a dangerous mix of medicine and the money motive". We need to beware of perverse outcomes from perverse incentives.

Another current fashion is to espouse the writings of Clayton Christensen, author of The Innovator's Dilemma in 1997, and more recently focusing his Harvard badged lens on education and on health. He has promoted disruptive innovation as the cure for schools (Disrupting Class, 2008) and for the American healthcare system (The Innovator's Prescription, 2009). He carries the accolade of the world's most influential business management thinker in 2011. Some of his claims may resonate or at least sound familiar to you: 50% of all health care is driven by physician and hospital supply, not by patients' needs, doctors work in a system where they are rewarded for the number and cost of the services they provide rather than by the value of those services in helping patients, fee-for-service is a runaway reactor in accelerating the rise in health-care costs, what we need is a system of new value networks that will disrupt the old business models in this industry, we need a new approach not just to insurance and reimbursement, but also to the places where medical services are delivered, the way we use technology, the way pharmaceuticals are developed, the way we educate medical professionals, and who performs what kinds of services. He also promotes electronic medical records, particularly personally held records, as a portable and proven (in sub-Saharan Africa) disruptive innovation, they can be "the connective tissue that draws and holds together the individual elements of our care". He cautions that until we make treatments and services effective and affordable, changing the way consumers pay for the services doesn't fix anything, that changing one piece, or plugging an isolated innovation into an existing framework, will not solve the larger problem. He says that only by making lower-cost venues more capable that health care becomes affordable, not by expecting large hospitals to charge less.

But before admiring the new fashion in the mirror, let's explore a few more of his mantras. Clay Christensen argues that physicians attempt to preserve incomes with dysfunctional service models, that we need "the visible hand of managerial capitalism" to "create a new business ecosystem, to get all parties to work together to bring about real change." He is a friend from church and advisor to Mitt Romney, saying that how to apply Mormon gospel in the wider world drives Mr Romney's life. Having also served as a bishop in the church, this business professor may be following the long tradition of Mormons sharing secular versions of their tenets, illustrated by Steven Covey's "The Seven Habits of Highly Effective People" which Matthew Bowman calls Latter-day Saint theology repackaged as career advice.

Beware his acolytes if their disruptive change does not fit well with your intimate insights into this noisy, messy and complicated world we share. Do not sit on the sidelines while forced dichotomies masquerade as non-alignment. Argue with energy, with passion, with desire for the best, while preserving our obligations to one another.

In the counted tale of things a rule of thumb for sound inference has always been that if it looks like a duck, swims like a duck and quacks like a duck, then it probably is a duck. But there's a corollary: if it struts around the barnyard loudly protesting that it's a duck, that it possesses the very essence of duckness, that it's more authentically a duck than all those other orange-billed, web-footed, swimming fowl, then you've got a right to be suspicious: this duck may be a quack.

Object in the Mirror

As I approach a decade serving you as President I have gained insights from wandering between the coal face and the centre. I struggle daily with the illnesses of children which should be banished from rich countries, which help frame our double jeopardy along with the silver tsunami of many living longer. We have to grapple with the health demands of the aging alongside the health demands of the destitute, and mostly, young.

I reflect on the chaos of earthquake-torn Christchurch and cringe at the advice of John Briere. This eminent psychologist, with experience of the effects of cyclones, terrorist attacks, gangs and torture, showed us last week that the worst effects on children, and adults, are three years and more after the initial disaster. We have to face very real and very present dangers.

As I pass two decades as a Consultant Paediatrician I find I am working harder in my own silo, even though I strive to integrate and regionalise my expertise. I am trying harder to do what I trained to do. The core of my clinical business is history and examination, then formulation of possible diagnoses complemented by appropriate investigations, then mutual construction of a management plan, supplemented with followup and reinforcement as necessary. How much of the first two processes, history and examination, do I conduct in the silo of my own clinic room? How much can I improve how I take a history and conduct an examination if I am not directly observed and appraised? By my peers, and more than once or twice. How can I argue for this quality control, especially when any time I might sit in a colleague's clinic, or she in mine, is unproductive in the churn of FSAs and waiting time targets? The Medical Council and others are instigating very occasional and expensive practice reviews when we could be integrating more frequent feedback and support in our everyday workloads. Which is a better reflection of our practice and competence? A better modelling for our trainees and specialists of the future? A true training as part of clinical activity, not divorced from productivity. Which object are we pursuing?

Object in the Mirror

We are implored to deliver more productivity, more patients seen and less often, more handed over to other professionals, to their families, to volunteer carers, to themselves . We are implored to train our future colleagues more collegially, more productively, more comprehensively, more compassionately, more professionally, more quickly. These are often portrayed as competing ideals which cannot be accommodated. And those who try to accommodate both get enmeshed in omnishambles – the confusion of multiple shambles.

In this omnishambles we are working harder, faster, better, sooner. And very patchily, still stuck in silos. Some of these are of our own making, forced to build an empire or amplify a squeaky wheel to be heard above the din. Replacing the rhetoric of integration with the reality of the rationing in front of us. The rationing we did not design. The rationing we did not desire. The rationing of inertia.

How can it be ethical or moral for one DHB to block or prevent another acquiring more efficient systems, for a DHB to not invest in better systems a neighbour... is using to provide best patient care?

Removing barriers to sharing the care of patients requires sharing basic information about them, trusting others to interview, examine, record, investigate, prescribe, opine, debate, reflect, and make it all as seamless and non-repetitive and non-duplicative as possible. To ease the patient journey by making them the centre of activity. And yet we allow our health system to sabotage sharing. Allow administration systems to block and prevent transitions of care. Allow non-use of proven electronic referrals, proven electronic prescribing, proven clinical portals.

How can it be ethical or moral for one DHB to block or prevent another acquiring more efficient systems, for a DHB to not invest in better systems a neighbour, near-neighbour, or another New Zealand DHB is using to provide best patient care? To waste clinician time and productivity and deny patients the care they could otherwise access if their journeys were joined up.

There is rightful indignation if proven medicines or procedures are not implemented, if complication rates vary wildly, if some patients are denied best outcomes because of antiquated medical practice, if clinicians do not keep up to date, if national targets are not met. I should expect to be criticised by my patients and my peers if I do not advise, prescribe, and advocate best practice. If I do not implement care and processes for the proven best outcomes and least variability in my actions. Yet we see behaviour in administrative silos that appears out of alignment with proven practices that can free up frontline professionals to look after patients better, sooner, and more conveniently.

Clay Christensen may not be wrong when he espouses electronic shared medical records as a disruptive means to an end. As a way to empower patients and centre care around them, rather than around us and our systems. Yet our DHBs are permitted to thwart the efforts of the National Health IT Board to implement robust clinical systems that can share vital information whenever and wherever a citizen encounters a health professional. Despite such sharing happening right now in pockets of enlightened networks. With demonstrable improvement in resource use, in patient access, and in reducing duplication. And better use of specialised and generalised care. We have to question the ethics and morality of not making these benefits available in any and all DHBs.

While needing to be careful to avoid the debacles of the MSD kiosk and the teachers' payroll, we nevertheless need to interrogate the ethics of rationing healthcare according to the whims of infrastructure investment. If it is ethically and morally acceptable to your Board, or that of your neighbour, it may not be so to you as an SMO or SDO, and most assuredly cannot be so for your patients.

Object in the Mirror

The person you see in the mirror is the one who can demand and lead the necessary improvements, but only if you strive together, not in competition with others. Lift your head up from the instance of a patient encounter. Lift your head up from the urgency of a target. Lift your head up above the parapets and risk being hung for other's crimes, drawn into conflict, courted by empire builders. Lift your head up, for others whose appreciation may only be expressed in their absence of objection. This is true clinical leadership. Leadership that is translational. That translates integrated pathways and patient desires into what might be achievable within the realms of medical miracles and funding envelopes.

This is the leader as servant, something I have strived to be for you, and for the system we dream of, together. For together we are greater than the sum of our individual ambitions.

Toi Mata Hauora

Our association, which represents the pinnacle of medical professionalism, and argues for the highest quality of our public health system, has for 24 years presented a somewhat monocultural face. I believe that a New Zealand organisation at the forefront of healthcare for Aotearoa should have an identity in te Reo. On your behalf I have sought advice and cultural counsel on how we might present ourselves. The offering we have is Toi Mata Hauora, which conveys the essence of us representing the pinnacle of healthcare. I am exploring how we can adopt this gift as part of how we represent ourselves to our members and to the wider health system we guide and lead. I propose that we arrange adoption of this addition to our name at a special gathering of the executive, branch presidents and vice-presidents early in 2013. I look to its adoption as a parting gift.

As I look to step aside from the Presidency next year, the ASMS will not recede in my mirror. I will still support and serve an organisation that is stronger and more relevant than ever. It could never be described like the Republican Party – appealing only to angry older white males. ASMS has stronger branches than it ever had, with branch officers taking local leadership. And is constantly striving to support and communicate with members through their highs and lows of specialist careers. Through the last decade we have endured tough battles and achieved much more than I or many may have expected, in fiscal matters and, even more importantly, in driving clinical leadership and other transformations in the lives of specialists, for the good of their patients.

Thank you for your engagement that enabled leadership. I respect the energy and commitment you display. I remain hopeful I can continue to help our specialist workforce strengthen their individual and collective roles in the leadership of our complex, frequently frustrating, and often brilliant, health system.

Kia kaha

Jeff Brown
National President

Enhanced functionality for ASMS job listing service

ASMS provides a vacancy listing service on our website for the benefit of health sector employers and job-seeking SMOs. This service has proven to be successful with employers as the number of job listings typically sits at around 90 and 75% of DHBs in New Zealand regularly post vacancies to the site.

It has also proved popular with Specialist and Medical/Dental Officer job-seekers with around 1,500 unique visitors to the job listing pages each month, half of whom are typically new visitors to our site.

As noted in previous issues of *The Specialist* because our job listing pages are a service provided for members rather than a business, we focus on putting the proceeds from the job advertising into growing the market and enhancing our services to both jobseekers and their prospective employers

In line with that commitment we have commissioned a totally new and more user friendly jobs portal that will allow job seekers to access full job descriptions from the prospective employer, apply directly to employers and register for job alerts.

The upgraded portal will also provide an improved service for advertisers by making the job listing process more efficient, allowing them to edit and expire their own listings and to generate reports on their current and historic usage of the service. In line with this we are also hoping to simplify the transferability of vacancy listings between DHB job portals and our own.

The new jobs portal will go live early in the new year and following that we will be launching a promotion drive to attract even broader use of the service.

The 2012 Salary Survey: a summary

Each year since 1993 the Association has surveyed DHBs on the base salary of SMOs. Initially these surveys were used in local bargaining of collectives in each DHB and their predecessors and served a useful role in comparing the impact of the different salary scales agreed to by different employers.

We have now continued to survey base salaries over the three national MECAs. Changes to the scales and progression through the scales are now the main drivers of changes to the average salary.

The survey is of full-time equivalent base salaries and does not take into account hours worked in excess of 40 hours per week (which are recognised through job sizing), the availability allowance or other special enhancements.

As at 1 July 2012:

The increase in the average salary between 2011 and 2012 was 4.3% for specialists and 5.1% for medical officers reflecting changes to the salary scale that came into force in January 2012.

The average base rate for specialists is $184,271. The average base salary for women specialists was $176,918 per year while male specialists earned a base salary of $187,661. We expect that this is because the bulk of women specialists have less seniority than the males as women have moved to more equal representation in the medical workforce relatively recently.

The average base rate for medical officers is $144,488 ($145,137 for men and $143,729 for women).

Specialists in the Wairarapa DHB on average have the highest base pay and those in Counties Manukau the lowest (just pipping Waitemata at the post for the lowest position). Medical officers have the highest average base pay in Whanganui 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 1,311 specialists (1,057 males and 254 females) on the top step (out of 3,826) and 221 (133 males and 88 females) medical officers (out of 540).

Angela Belich
Assistant Executive Director

	Specialists		Medical and Dental Officers	
	Mean Base $	Annual % Increase	Mean Base $	Annual% Increase
1993	85,658		67,457	
2001	120,942	3.6	91,9311	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
2012	184,271	4.3	144,488	5.1

Specialists							
Numbers 2012		$ Mean 2012	$ Mean 2011	$ Mean 2010	$ Mean 2009	$ Mean 2008	% change 08-12
Female	1207	176,918	168,965	164,520	163,273	153,303	15.4%
Male	2619	187,661	180,185	175,191	173,691	162,782	15.3%
TOTAL	**3826**	**184,271**	**176,705**	**171,977**	**170,578**	**159,986**	**15.2%**

Medical and Dental Officers							
Numbers 2012		$ Mean 2012	$ Mean 2011	$ Mean 2010	$ Mean 2009	$ Mean 2008	% change 08-12
Female	249	143,729	136,330	131,243	129,571	122,582	17.3%
Male	291	145,137	138,453	134,297	134,947	127,240	14.1%
TOTAL	**540**	**144,488**	**137,495**	**132,881**	**132,383**	**124,916**	**15.7%**

On the record

Dr Alan Doris, MPS medical adviser, looks at the dilemmas posed when a consultation is recorded.

Managing the situation depends greatly on who is intending to make the recording, how this is done, and for what purpose

Modern technology makes audio and video recording of dialogue and behaviour extremely easy. There have been many recent examples in the general media where supposedly private or personal material has been brought into the public domain, causing considerable distress and problems for those involved.[1,2]

Increasingly, MPS is being contacted by members who seek advice in circumstances where recordings have been made or are proposed in clinical settings. Managing the situation depends greatly on who is intending to make the recording, how this is done, and for what purpose. We will look at a range of scenarios below:

A clinician wishes to make an audio or video recording

The Health Information Privacy Code 1994 (the Code) was established to ensure that health agencies (including individual practitioners) abide by strict rules when handling information about patients. This is in recognition of the confidential and often sensitive nature of health information. If a health provider decided to record a clinical interaction then they must ensure that their actions comply with the Code.

The Code is "technology neutral" and so information in the form of an audio or video recording must be managed by the health agency in the same way as if the information was recorded in a traditional paper record or an electronic medical record.

The information collected must be necessary for a lawful purpose or function of the health agency.[3] Patients must know that information is being collected, why it is being collected and what is going to happen to the information. Patients are also entitled to request a copy of any recording that is collected or used on the basis that it is part of their health information.

Health information must not be collected by a health agency by unlawful means or by means that, in the circumstances of the case, are unfair; or intrude to an unreasonable extent upon the personal affairs of the individual concerned.[4] Making an audio or video recording without the patient's knowledge is an example of where collection would be unfair.

In some circumstances, additional safeguards require that explicit consent is gained from the patient before a video or audio recording is made, such as Section 68 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 and section 52 of the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

A successful complaint that a health agency has breached one of the rules of the Code can lead to proceedings in the Human Rights Review Tribunal, with possible penalties including an award of damages of up to $200,000.

A patient asks to make an audio or video recording

The Code only applies to health agencies and so does not have any role where a recording has been made by a patient. It is possible that the Privacy Act could apply in circumstances where some personal information of the doctor was included in the recording, though this would be unusual. Patients may ask to record a clinical interaction for a variety of reasons. When the assessment is for a medico-legal purpose, such as an insurance or ACC claim, the patient may wish to have their own record of what occurred.

The Medical Council of New Zealand (MCNZ) refers to this issue in its statement on *Non-Treating Doctors Performing Medical Assessments of Patients for Third Parties Doctors (Dec 2010):*

> ***Recording a consultation***
>
> *11. A patient may want to record the consultation by video or audio tape. You should consider such a request carefully and, if you do not consent, ask the third-party to arrange for another doctor to conduct the assessment.*

You should be clear about the reasons why you refuse to permit a patient to record a consultation

The MCNZ refers to the case of Jackson v ACC, which upheld the patient's privilege to record a consultation, though also acknowledged that doctors have a privilege in deciding what way a medical assessment should take place. The doctor must be able to reasonably justify a refusal to allow recording in these circumstances.

Therefore, you should be clear about the reasons why you refuse to permit a patient to record a consultation. The reasons should stand up to scrutiny if the patient complained about your refusal. Reasons to refuse to consent to recording might include concerns that:

- The presence of a recording device will hinder the open sharing of information and views
- A recording cannot convey relevant non-verbal cues that affect an assessment
- The recording (or a transcript) may be edited in ways that alter its significance
- The subsequent use of the recording will be outside your control and could be used to misrepresent your actions or views.

A doctor could seek the patient's agreement to make his or her own separate recording of the consultation

MPS is aware of cases involving members where each of these problems has arisen.

In situations where a doctor agrees to the recording of a consultation, it is suggested that the doctor consider making an

agreement with the patient, prior to any recording, to receive a copy of the whole recording from the patient. Alternatively, a doctor could seek the patient's agreement to make his or her own separate recording of the consultation.

A clinical assessment is covertly recorded by the patient

Occasionally clinicians discover after a consultation that the patient has made a recording without their knowledge. As it is the patient's health information that has been recorded, and it is in the possession of the patient, the doctor has very little influence over what is done with the recording.

MPS has been asked to assist members who have discovered audio recordings or transcripts of consultations that have appeared on the internet. This material is usually placed in the public arena by the patient seeking to make a particular point and may be edited or altered in some way.

As it is often impossible to know whether a consultation is being recorded it may be prudent to assume that it is, in a similar way to assuming that all your written entries in a medical record will be read by the patient.

Material recorded covertly is provided to the doctor

Investigators working for insurance companies or ACC occasionally present covertly obtained video recordings of claimants to doctors; for example, where there are concerns of fraud. The steps required on the receipt of such unsolicited information will differ depending on whether the assessment is purely about the health of the patient or whether it is required for legal proceedings.

If a health assessment, then before considering information obtained in this way, it is important to ascertain from the information provider whether the patient is aware that this information has been provided to you. If the patient is not aware of the material then it may be difficult to form a valid medical opinion on a video or audio recording that has been made without the knowledge of the patient, in non-clinical circumstances and without the opportunity to ask the patient questions arising from examining the recording.

You may decide to return such information as you may need to show why it was necessary to use it without the patient's knowledge and response, if a complaint resulted. If there are legal proceedings in existence or anticipated, different considerations apply. Please consult MPS with any queries.

A person masquerades as a patient and records the interaction

MPS is aware of cases where individuals have presented to doctors with fictitious complaints for the purpose of manipulating and covertly recording the consultation for their own purposes. A member was recently assisted by MPS after a complaint had been made to the MCNZ alleging inappropriate prescribing.

A journalist pretending to be a patient had presented to several GPs seeking to obtain medication with the potential of abuse by deception and, at least in one case, intimidation. This was done to form the basis of a newspaper article. A covert recording of one consultation was used by him in his subsequent complaint to the MCNZ. After considering the response from the doctor detailing the circumstances, the MCNZ took no further action.

The principles of the Privacy Act do not apply to news organisations and so it is unlikely that the Privacy Commissioner would receive a complaint in this type of situation. However, a complaint to the Press Council or Broadcasting Standards Authority could be considered on the basis of a possible breach of their own standards. It is also possible that a trespass order could be sought against the person masquerading as a patient in this way or an injunction preventing the use of the recording by the media.

The therapeutic alliance between patient and clinician is based on mutual trust. Recording of consultations without the knowledge or consent of one party inevitably undermines trust, damaging the relationship and the potential effectiveness of care. As the technology to make recordings is now ubiquitous, it may be best to assume that all clinical interactions are potentially being recorded.

This article was originally published in the Medical Protection Society's September 2012 issue of 'Casebook'
www.medicalprotection.org/newzealand/casebook-september-2012/on-the-record

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1 Election tea tape leaked online
2 www.levesoninquiry.org.uk
3 Health Information Privacy Code 1994, Rule 1
4 Health Information Privacy Code 1994, Rule 2

The state of palliative care

Dr Sinead Donnelly is a Palliative Medicine Consultant and Chair of ANZSPM Aotearoa.

The Australia and New Zealand Society of Palliative Medicine (ANZSPM) was established in 1993 and now represents 84 doctors with a working interest in palliative medicine in New Zealand. Thirty six of these are described as palliative medicine specialists of whom 16 work in hospitals.

In September 2001 the Medical Council in New Zealand recognised palliative medicine as a specialty preceding the Australian Medical Council by four years. Through our work over the past 12 years, health professionals and the community now understand what palliative medicine offers to patients and the benefits of incorporating palliative medicine in community and hospital based care.

Trained palliative medicine specialists work in hospitals, hospices or specialist palliative care units and in the community. There is an advanced training program to become accredited as palliative medicine specialist coordinated by the palliative medicine education Committee (PMEC) of Australasian College of Physicians. Palliative Medicine Training Co-ordination Committee (PAMTRACC) more recently established, assists PMEC in accrediting sites for training in New Zealand.

What we are training for

We have been trained specifically to care for people with advanced progressive diseases, whose death is anticipated in the near future. Palliative medicine had been associated with advanced cancer. Nowadays patients with a wide range of illnesses are referred for symptom control, end of life care, emotional, social, spiritual distress, support of their family, and bereavement support.

Care of the dying patient has also been traditionally associated with hospices. Nowadays most people die in hospital (36% in hospital, 6% in hospice). Increasing numbers of patients are initially referred to palliative care teams within the hospital. In 15 years time it is estimated that the number of adults who would benefit from palliative care will increase by 23.5% to 19,076. Patients receiving palliative care die most commonly from cancer (42.6%), but over 57% die from non-cancer conditions, such as cardiovascular and respiratory disease.

In 15 years' time it is estimated that the number of adults who would benefit from palliative care will increase by 23.5% to 19,076.

ANZSPM Aotearoa (ie ANZSPM New Zealand branch) members aim to work alongside general practitioners and hospital consultants in providing care for their patients who have advanced progressive disease and in empowering doctors through knowledge and guidance to provide that care.

Importance of education

Education in the philosophy and practice of palliative medicine is critical to achieving a high standard of care for patients who are dying. Our ideal would be that every person who is dying irrespective of where they live will receive the highest standard of care. To achieve this requires a general medical workforce with knowledge and understanding of patient and family/whanau needs at this critical time in all their lives. Equally important are sufficient numbers of a sustainable highly educated specialist palliative medicine workforce, ideally home grown.

Education will also improve doctors' confidence and satisfaction in the care they provide for patients who are dying. Doctors who care for patients for many years as GPs in primary care and in the hospital (eg, renal, respiratory physicians) want to have the skills and competence to care for these people when their condition is deteriorating and their dying and death are imminent. Through education we as palliative medicine physicians can empower and enable the other specialists to achieve this.

Increasingly combined clinics (eg, renal/palliative medicine or heart failure/palliative medicine) are spearheading the integration of specialties to the benefit of all. As palliative medicine specialists we cannot and do not need to look after everyone who is dying. The reality is that everyone will die. So every doctor needs these skills, referring to specialist palliative medicine for support in the event of physical, emotional, or social complexity in patient care.

Through education we as palliative medicine physicians can empower and enable the other specialists to achieve these skills.

Incorporation into post-graduate curriculum

Incorporation of palliative medicine knowledge into the undergraduate and early post graduate curriculum is a priority to ensure all patients in whatever setting will receive an acceptable standard of palliative care. Medical students, having been introduced to concepts of palliative care in their early learning, are requesting in clinical years to observe palliative medicine doctors with patients, to understand what a doctor offers to patients who have advanced progressive illnesses.

Incorporating this apprentice-like exposure in the medical student curriculum time is the next challenge. Doctors training as GPs would benefit from time (eg, three months)

spent with palliative medicine doctors and palliative care teams in the community and inpatient units such as a hospice. This has been successfully incorporated into GP training in other countries.

An excellent development is dual training of advanced trainees combining palliative medicine with another specialty (eg, geriatrics, renal and oncology). We have yet to hear of surgical trainees incorporating palliative medicine in their post graduate studies! The establishment of academic leadership positions in Palliative Medicine at university level would farther advance palliative medicine and serve the medical community.

Education at all levels is fundamental to the survival of palliative medicine as a respected specialty. It has been suggested that palliative medicine doctors should be so good at teaching and so committed to teaching their junior and senior colleagues that we do ourselves out of a job and become redundant! Undaunted by that risk, we are committed to our medical colleagues and all patients to work tirelessly to educate ourselves and others.

Dr Sinead Donnelly MD, FRCPI, FAChPM

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.

We welcome your feedback as it is vital in maintaining the site's professional standard.

ASMS job vacancies online *www.jobs.asms.org.nz*

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

Substantial discounts are offered for bulk and continued advertising.

ASMS email broadcast

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

Rewarding relationships are built on trust

You can trust MAS to understand your unique financial requirements. Most MAS Members are professionals and we have specialised in the professional sector for more than 90 years. Please contact us for more information on our financial products and services.

For more information
0800 800 627
Visit us online at **www.mas.co.nz**

MAS

Merry Christmas

The ASMS National Executive wish all members
and staff health and happiness over the holiday season.

The National Office will be closed from 25 December 2012 to 2 January 2013 inclusive.
During this period messages of urgency can be emailed to **lw@asms.co.nz**
Throughout much of January we will be operating with reduced staff.