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ASMS
TOI MATA HAUORA

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E-grade for DHBs over support for distributive clinical leadership

In opposition Tony Ryall actively promoted clinical leadership in DHBs as a central part of the National Party's election health policy and hammered the then Labour led government for what he argued was lack of progress in this area.

Labours of love not enough

There was some truth (but also some qualification) in Mr Ryall's hammering. Annette King, Labour's first Health Minister in nine years on the Treasury benches, made efforts in her six years towards enhancing clinical leadership through her annual 'Letters of Expectations' to DHBs. She also enabled her Health Ministry to co-host with the ASMS a national conference on professionalism. Her efforts proved to be insufficient largely because of the resilience of the culture of managerialism inherited from the 1990s by the DHBs and her belief that directives such as the Ministerial 'Letter of Understanding' should be sufficient. Unfortunately, the DHB focus was more on formal positions of clinical leadership rather than the more extensive and 'shop floor' based distributive clinical leadership.

> *Annette King made efforts in her six years as Health Minister towards enhancing clinical leadership … her efforts proved to be insufficient largely because of the resilience of the culture of managerialism inherited from the 1990s by the DHBs …*

Her successor Pete Hodgson failed to demonstrate any substantive interest in progressing the issue and, if anything, during his two years in office set the cause back. In response to increasing angst and anger in the health sector, Prime Minister Helen Clark replaced him with current Labour Party leader David Cunliffe. Mr Cunliffe hit the road running and facilitated the *Time for Quality* national agreement (2008) between the ASMS and DHBs.

This agreement was based on the principle of distributive clinical leadership including, at a specific departmental service level, senior doctors and dentists providing the leadership role, supported by management, in service design, configuration and delivery.

Time for Quality included five engagement principles all of which were subsequently incorporated into the national multi-employer collective agreement covering ASMS members employed by DHBs. However, the energetic Cunliffe had barely 12 months before National's election victory in November 2008.

Along comes Tony

The also energetic new Minister of Health Tony Ryall was quickly off the mark pulling together a working group chaired by then ASMS President Jeff Brown. They prepared the commendable document known as *In Good Hands* which Mr Ryall then released in early 2009 as his official policy advice to DHBs. *In Good Hands* advised DHBs to promote and support distributive clinical leadership. Much wider than formal clinical leadership, it involves (as part of non-clinical duties) the wider mass of the senior medical staff workforce being involved in leadership activities, initiatives and projects.

In 2010 Associate Professor Robin Gauld (University of Otago), in collaboration with the ASMS, conducted a survey of ASMS members on the implementation of *In Good Hands* which revealed a disappointing outcome but at least at that time it could be put down to early days and work in progress.

After four years: E grade and DNS

So what is the situation over four years after the release of *In Good Hands*? Quite simply; very poor! In an electronic ballot of members employed by DHBs (conducted late August and September 2013), the ASMS asked the question "Do you feel that you have enough time for non-clinical duties to participate in 'distributive clinical leadership' activities?" 1,503 DHB employed members responded (a 43% response rate) with only 37% saying yes. Using the grading system of Victoria University's School of Governance this is an E grade.

ASMS PERSONNEL

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Ian Powell

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Senior Industrial Officer
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Industrial Officer
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Industrial Officer
Lloyd Woods

Industrial Officer
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Executive Officer
Yvonne Desmond

Membership Support Officer
Kathy Eaden

Admin Officer
Terry Creighton

Assistant Executive Officer
Lauren Keegan

Admin Assistant
Ebony Lamb

Researcher
Lyndon Keene

PO Box 10763
Wellington
New Zealand
+64 4 499 1271
asms@asms.org.nz

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This is further evidence that entrenched senior doctor shortages in DHBs have become the norm. The opportunity for DHBs to use their most highly vulnerable but enormously skilled professional workforce in improving quality of care, organisational efficiency and financial effectiveness is being wasted by a failure to invest in this workforce. As a consequence one of the government's laudable policy flagships, *Time for Quality*, has become sacrificed in this directionless sea.

What about the differences between DHBs?

Entrenched shortages and consequential lack of senior doctor time does not explain the differences between the 20 DHBs, from Lakes at B to over half of the other DHBs at E. If we had adopted a harsher grading system then Wairarapa, Hutt Valley and South Canterbury may have deserved an F while Hawke's Bay and Whanganui may have deserved DNS (Did Not Sit). In some DHBs the reason will be leadership and organisational culture and in others particular circumstances. In some cases it may be that with a supportive DHB culture, the level of distributive clinical leadership is very high but due to insufficient time this is being done in senior doctors and dentists own time and is un-remunerated.

It is clear that entrenched shortages are a major obstacle in all DHBs. The answer to the lack of time available for clinical leadership is more senior doctors in order to improve capacity and achieve the improved quality, systems and cost effectiveness performance that are sitting there waiting to be plucked. The ASMS needs to continue its efforts to expose existing failures and to encourage the government to return to the principles of *Time for Quality* and *In Good Hands*.

The ASMS also needs to get a better understanding of the obstacles over and above entrenched shortages. Our further membership surveys should provide at least some of the answers beginning with the survey undertaken in November-December this year.

Ian Powell
Executive Director

Is there a gender issue?

Of the 563 female members who completed the survey 70% felt that they did not receive enough non-clinical time compared with 59% of the 940 male members surveyed who also felt this way.

Is this gender discrimination or is it demography? Is this result shaped by the increasing proportion of younger female specialists, as younger specialists may have relatively less non-clinical time than their older more experienced colleagues who are more likely to be male.

ASMS Survey: Time for Non-Clinical Duties

"Do you feel that you have enough time for non-clinical duties to participate in 'distributive clinical leadership' activities?"

Survey responses: Specific DHB breakdown and ranking

Ranking	DHB	Yes	No	Grade
1	Lakes	68%	32%	B-
2	Tairawhiti	60%	40%	C+
3	Nelson Marlborough	54%	46%	C-
4	Taranaki	47%	53%	D
5	West Coast	45%	55%	D
6	Waikato	44%	56%	D
7	Waitemata	42%	58%	D
8	Bay of Plenty	41%	59%	D
9	Canterbury	38%	62%	E
10	Northland	38%	62%	E
11	MidCentral	33%	67%	E
12	Counties Manukau	33%	67%	E
13	Capital & Coast	33%	67%	E
14	Auckland	31%	69%	E
15	Southern	31%	69%	E
16	Wairarapa	30%	70%	E
17	Hutt Valley	30%	70%	E
18	South Canterbury	30%	70%	E
19	Hawke's Bay	26%	74%	E
20	Whanganui	21%	79%	E

Survey responses: Total responses and response rate by DHB

DHB	Response Count	Response Percent of Total Sent
Northland	45	35.4%
Waitemata	108	31.3%
Auckland	274	38.9%
Counties Manukau	147	39.0%
Waikato	124	43.5%
Lakes	31	44.3%
Bay of Plenty	59	45.4%
Tairawhiti	20	40.0%
Hawke's Bay	46	45.1%
Taranaki	34	48.6%
Whanganui	14	36.8%
MidCentral	57	46.7%
Wairarapa	10	40.0%
Hutt Valley	47	42.7%
Capital & Coast	119	41.8%
Nelson Marlborough	57	45.2%
West Coast	11	33.3%
Canterbury	175	43.1%
South Canterbury	20	66.7%
Southern	105	47.9%
Total responses	**1503**	**43.0%**

When did you last remember why you became a doctor?

What I want to share with you today all started with a text message I received late one evening from a good friend of mine. We were both in a philosophical mood, relaxing with a glass of wine and exchanging a few text messages. He then sent me this question:

When did you last remember why you became a doctor?

When did you last remember why you became a doctor?

The question stuck in my mind for a few days but then got relegated to my subconscious due to the very same reasons I have not remembered why I became a doctor for a good few years now.

From cleaner to doctor

More recently I read a newspaper article on the Stuff news website that reminded me of that text message. The article's heading was: "Cleaner swaps mop for stethoscope" and was written by Georgia Weaver. It relates the life story of Dr Jane Nugent.

She struggled at school. Was bullied. Never passed a single maths test, ever. At age 15 she left school. Her first job was cleaning hospital toilets. Not keen to do this for the next 50 years, she became a nursing aide. At times while making beds she dreamed of becoming a doctor but she really had no idea what that actually meant or what she had to do to become a doctor. At the age of 18 her mum encouraged her to become an enrolled nurse.

Years later, an experience with a patient made her reconsider her career options again. The patient was in a lot of pain and Jane asked the registered nurse on the shift if she could give the patient morphine. The nurse said that Jane needed to wait and in the interim she could give her patient some paracetamol.

Jane then decided that she wanted to be a registered nurse. She didn't ever again want anyone telling her that she couldn't give her patient pain relief.

So she trained as a registered nurse, studying during the day and working as an enrolled nurse part-time at night.

Her drive to better herself led her to complete a Bachelor of Science at Otago University, majoring in pharmacology.

Later, while working as a charge nurse on a ward, an elderly woman had a fall. The medical consultant believed the woman was too sedated, but Jane's working diagnosis was that the patient had nephrogenic diabetes insipidus and she set out to prove it.

Initially, the patient's consultant was not convinced. However, two weeks later Jane was contacted by her to say she had made an appointment for Jane with the dean of the medical school to discuss becoming a doctor. Jane graduated from medical school in 2008, and went on to become a registrar in psychiatry but in the end missed hands-on medicine so she changed tack and became a GP.

After reading the article, the question that my friend, Joe Diver, texted me months before resurfaced from my subconscious.

When did you last remember why you became a doctor?

Driven by compassion

It is clear that some of Jane's career choices were driven by her desire to help patients. She had more than sympathy, which constitutes sharing in a person's emotions, and more than empathy, whereby you have an understanding what a person is going through. She was driven by compassion, which adds a third dimension to sympathy and empathy. Compassion drives you to want to do something about the other person's suffering or problem, to step in and help.

> *Compassion drives you to want to do something about the other person's suffering or problem, to step in and help.*

So what role and how big a role does compassion have within health care?

Compassion is a core requirement as stipulated by the New Zealand Medical Council. The publication, Cole's Medical Practice in New Zealand, refers to compassion, or being compassionate, several times. The most direct call to compassion is captured in the following statement: "Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity."

> *The lack of compassionate care was clearly identified as a contributing factor to the events at Mid-Staffordshire.*

The lack of compassion is frequently mentioned in complaints by patients to the Health and Disability Commissioner. The lack of compassionate care was clearly identified as a contributing factor to the events at Mid-Staffordshire.

Humans are finely tuned to the presence or lack of compassion. It is not something we have to think about. We feel it instinctively.

So to practice with compassion is a requirement and an expectation from the Medical Council and our patients, and the lack thereof can lead to patient harm and complaints.

Is there any evidence that providing compassionate care can actually influence the outcome of care in a positive way, or does it just prevent harm and give everyone a warm fuzzy feeling?

The power of compassion

Well, Dr Tony Fernando, an Auckland psychiatrist, experienced first-hand how being sympathetic and compassionate can save a life. In a recent newspaper article (Stuff.co.nz), written by Andrew Dudding, Tony describes how a patient's psychosis was returning. At the time, the patient still had enough insight to know what

was happening and what the return of the voices in his head meant. His partner was well aware of what the implications were and they were crying during the consultation. Tony was sympathetic and he himself became quite emotional. He was desperate to help his patient.

Later on his patient told him that Tony's sympathy and tears stopped him from going home and ending his own life. He trusted that Tony and the health care system would help him and get him through this.

A recent study done in Italy of 20,000 diabetic patients showed that those who rated their doctor as being empathetic had 40 percent fewer hospital admissions.

So compassion can be very powerful and produce positive outcomes for our patients.

If compassion is such an important part of providing health care, why does it sometimes falter or disappear? How can Mid-Staffordshire have happened? Can Mid-Staffordshire happen here in New Zealand?

It is difficult to answer that unless you find the answer to the question: "How or why do health care providers lose their compassion or don't engage in a compassionate way with patients?"

The more I read about compassion and learn about it the more some of the current challenges and failures we face and experience in health care start to make sense to me.

Coping under pressure

The underlying reasons for the lack of compassion are quite complex. Some are circumstantial or systemic.

Examples of how easily compassion can falter are not difficult to find.

A consultation or patient interaction is interrupted by a pager, phone call, knock on the door, or text message. This can prevent you from listening and really getting "into" the consultation.

Patients who are abusive or swearing challenge our ability to be compassionate towards them.

There are language and cultural barriers.

Time pressure; the next patient is waiting.

There are complex patients with complex clinical conditions. Doctors tend to switch to being scientists with a pure clinical thinking mode and risk forgetting the patient behind the health problem.

I am sure you can think of more examples.

These factors or circumstances need to be recognised and addressed and we need to be mindful of how they influence our own practice and the care we provide to our patients. How do patients experience and perceive such contacts where compassion has taken a back seat? Unfortunately recurrent circumstantial lack of compassion can become the norm. "That is just the way we do things around here."

A debilitating occupational hazard

There is a much more difficult condition to identify. It can affect any one of you in this room and in fact research would suggest that around 20 percent of you are at risk or are already having symptoms.

Compassion fatigue or secondary traumatic stress disorder is a well-recognised condition.

Who is at risk of developing this? What are the characteristics of the condition? How does it impact on the individual? Is there treatment for it and more importantly can it be prevented?

Frontline care-givers and helpers from all walks of life are at risk: care-givers in aged-care facilities, nuns, lawyers, nursing staff and doctors, to name but a few.

This condition has a far slower and more insidious onset. It is not the same as burnout but can co-exist with burnout.

Compassion fatigue manifests itself as physical, emotional and spiritual exhaustion. Sufferers experience acute emotional pain. While doctors with burnout tend to adapt to their condition by becoming less empathetic and more withdrawn, doctors with compassion fatigue tend to continue to give themselves fully to their patients but lose the satisfaction and pleasure from interacting with patients and in fact can become increasingly annoyed with their patients.

> *Compassion fatigue manifests itself as physical, emotional and spiritual exhaustion. Sufferers experience acute emotional pain.*

Symptoms can vary widely and red flags include:

- Abusing drugs, alcohol or food
- Anger and blaming
- Depression and less ability to feel joy
- Diminished sense of personal accomplishment
- Exhaustion (physical or emotional) and hopelessness
- Inability to maintain balance of empathy and objectivity
- Increased irritability
- Low self-esteem
- Sleep disturbances
- Workaholism
- Recovering a healthy balance

Quite often recovery is slow, the sufferer needing a month or two off from work, receiving treatment and a realignment of priorities, followed by a staged return to work.

- Help includes:
- Developing interests outside of medicine
- Taking time for yourself
- Getting enough sleep
- Exercising and eating properly
- Identifying what's important to you
- Learning to reflect on a daily basis how you helped patients, and "banking" that feeling; and
- Mindful meditation

What not to do:

- Blame others
- Look for a new job, buy a new car, get a divorce or have an affair
- Fall into the habit of complaining with your colleagues
- Hire a lawyer
- Work harder and longer
- Self-medicate; or
- Neglect your own needs and interests

> *It is clear that we do not have unlimited supplies of compassion to give. It is a bit like a bank account. You cannot keep withdrawing from it without making regular deposits into the account.*

A number of years back Mother Teresa wrote to her superiors that it was mandatory for her nuns to take an entire year off from their duties every 4-5 years to allow them to heal from the effects of their care-giving work.

She clearly had insight into compassion fatigue and took steps to prevent it.

It is clear that we do not have unlimited supplies of compassion to give.

It is a bit like a bank account. You cannot keep withdrawing from it without making regular deposits into the account. Otherwise sooner or later you will end up with a zero balance. If you run out of compassion you cannot give something to your patients you do not have anymore. There are not a lot of compassion billionaires out there and we need to manage our accounts carefully, seeing that an overdraft is not well tolerated. When you make a withdrawal be sure to make a deposit again.

We have all seen the airline safety videos. When the oxygen mask drops from the ceiling put it on your face first. Help yourself first so you can then help others fit their masks. Quite often we are not very good at looking after our own needs first.

When did you last remember why you became a doctor?

My mind wandered further.

Stepping into a manager's shoes

What role does compassion play from a health care manager's perspective? What if I put myself in their shoes?

They have fiscal responsibility to make sure their budgets all add up and that the health care system lives within its means. They receive letters of expectation and contracts to deliver on and comply with. They deal with targets that need to be met, annual plans, regional plans and they need to implement and change systems to achieve all of this.

Reams of data come across their desks that need processing and interpreting. The problem is the spreadsheet for the laundry and salaries look no different to the spreadsheet for patient waiting times or unexpected clinical outcomes. The patient data have been completely stripped of any human factor, entirely dehumanised. You cannot feel compassion towards a spreadsheet full of dehumanised data.

To state the obvious, managers do not receive data on things that are not measured. How many patients are turned away from getting the health care they need and never make it on to a waiting list? How does that impact on that person's life? Decisions are often made based on what is best for the system, but is it best for an individual whose health needs do not meet the criteria the system demands?

It is extremely difficult or near impossible for health care managers to have compassion towards patients. They are not given the time to think about it and they are not exposed to the frontline often enough to experience it.

So what role can we as clinicians play to compensate for this? How do we add value to management?

It is our responsibility to take the compassion we have for our patients into the meeting rooms and boardroom. It is more than that; it is our duty to take the compassion we have for our patients to the boardroom. If we don't do it nobody else will.

Another thought crossed my mind. Does this perhaps give me an answer to something that has puzzled me for a long time? From time to time doctors label a clinical leader, clinical director, or CMO as having "moved to the dark side" or having become "one of them". Although the "us and them" way of thinking is slowly being eroded, it still happens from time to time. But what triggers the labelling? There are no clear criteria for when a clinician has seemingly crossed that invisible line. We tend to have a "dark-side-mometer" built in and it suddenly, as if by magic, starts to register a signal. Is it possible that as soon as we perceive that a clinician has left their compassion by the bedside and not taken it to the boardroom, they get labelled?

> *We have a duty not only to look after our patients but also to look after ourselves and our colleagues' health and well-being and guard against compassion fatigue setting in.*

Guarding against compassion fatigue

To summarise: compassion is one of the pillars that health care and humanity is built on. Unfortunately we are experiencing an increasing demand on our time and compassion. It is becoming increasingly difficult to maintain our levels of compassion at the bedside as well as the boardroom. We are running an increasing risk of accepting that that is just the way we work around here and a lack of compassion becomes the norm.

The ASMS has a duty to make sure the MECA is adhered to and thereby provide us with every opportunity to practice in a companionate way and guard against working conditions that do not foster or encourage compassionate care. We need time to spend with our patients. An over-stretched medical workforce that is continually chasing targets in an environment of increasing fiscal constraint is not conducive to compassionate care.

On an individual level, we have a duty not only to look after our patients but also to look after ourselves and our colleagues' health and well-being and guard against compassion fatigue setting in. We sometimes need to heal the healer. Put the oxygen mask on your face first. We need to be able to pause every now and then and reflect and remember why we became doctors.

> *Our patients deserve and expect to receive compassionate care. It is an expectation our health care system can ill afford not to meet.*

Our patients deserve and expect to receive compassionate care. It is an expectation our health care system can ill afford not to meet.

When did you last remember why you became a doctor?

Hein Stander
National President

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EXECUTIVE DIRECTORS COLUMN

Intense government financial pressures exposing DHB management weaknesses

At the beginning of December the ASMS received good media coverage over our strong criticism of Southern DHB (Otago and Southland) for doubling over the past three years (almost trebling in fact) its expenditure on its communications office. At the same time, it is cutting bed numbers, cutting nurse training and privatising its fertility service for financial reasons.

Southern, one among many

But while not in a good space and suffering from serious leadership weaknesses, Southern is not an outlier DHB. Instead it is one among many. It is difficult to recall a time when the public health system has been threatened by such a level of financial constraint. At the same time the government continues to:

- reduce its funding increases to DHBs below the cost of providing services;
- increase its expectations of what DHBs deliver on (while these same DHBs have to also cope with the increasing demands of an aging population and growing poverty);
- fail to invest in the capacity of the workforce (especially senior medical staff) to deliver on these increased expectations; and
- walk away from its commitment to enhancing distributive clinical leadership (In Good Hands), thereby abandoning the most effective means of achieving quality, systems and cost effectiveness, and instead revert to tokenism.

> *It is difficult to recall a time when the public health system has been threatened by such a level of financial constraint.*

Deficiencies exposed

The effect of this vice like pressure is exposing serious deficiencies in the calibre of senior DHB management. To some extent this is to be expected but the ASMS is now experiencing many more of these deficiencies then we had expected. This is being picked up and reported by our branch presidents and vice presidents (along with Joint Consultation Committee delegates and other members) and our industrial officers.

While doctors, nurses and other health professionals have demonstrated extraordinary ability to cope well in this severe environment, too many managers are not matching their performance (or the performance of their managerial colleagues who are coping).

There are increasing examples of erratic decision-making, failure to see wood from trees, petty decision-making and increased authoritarianism. Examples include:

- breaches of consultation obligations under the MECA.
- exiting or getting rid of services that have particular problems or challenges rather than fixing them.
- indications of increased bullying of senior doctors.
- excessively restrictive practices over eligibility for continuing medical education leave, reimbursement of actual and reasonable expenses, and travel policies (including changing the policy in order to decline an application).
- preventing (or trying to prevent) members from attending professional and college conferences that they are entitled to under the MECA.
- preventing senior doctors taking annual leave until they ensure locum coverage (the MECA requires that this is an employer responsibility).
- failure to resolve issues arising out of job sizing reviews and ducking their responsibility to use job sizing to address understaffed and overworked services.
- some clinical leaders morphing into 'managerialist' managers who happen to have a medical qualification rather than bringing the insights of clinical leadership into DHB decision-making.
- explicit and implicit threats against senior doctors participating in public debate and dialogue relevant to their professional expertise and experience where it might be at variance with senior management's position (despite the MECA requiring DHBs to encourage this participation).

What we are not seeing enough of is a culture of ongoing grassroots clinical engagement and leadership in quality and process improvement that makes good clinical sense and is sustainable for the medium and long-term. Instead we continue to see a focus on the short-term which is often counterproductive further down the track.

Why, why, why?

To use the jargon that apparently comes from the NHS in the United Kingdom, you achieve 'dark green' dollar savings from the former and 'light green' dollar savings for the latter. Why does senior management mouth the former but practice the latter? Is this a rhetorical question?

Since 2008 DHBs have either signed up to or been expected to adhere to various documents focussed on medium to long-term sustainability; witness *Time for Quality* (2008), *In Good Hands* (2009), *The Business Case: Securing a Sustainable Senior Medical and Dental Officer Workforce in New Zealand* (2010), and the *Quality and Patient Safety Improvement Plan* (2011).

Again, why don't we have a pervasive management culture that practices the principles and directions of these fine documents rather than lip service? Is this another rhetorical question?

Ian Powell
Executive Director

DR STEPHEN PARNIS, AMA COUNCIL OF SALARIED DOCTORS

Queensland health contracts: radical, unfair, unhealthy

The Queensland Government, based largely on the recommendations of a Commission of Audit led by Peter Costello, is implementing an outrageous policy of forcing Senior Medical Officers in the Queensland public health system onto individual contracts.

The policy, as outlined in the Queensland Health document Blueprint for better healthcare in Queensland. Broadly, will see Senior Medical Officers (SMOs) removed from award coverage, stripped of collective rights and denied access to the Queensland Industrial Relations Commission.

The whole proposal is being underpinned by legislative amendments being rushed through Parliament. It is, as far as I am aware, unprecedented in Australia, and is the result of absolutely no consultation with stakeholders.

> *This law will see Senior Medical Officers (SMOs) removed from award coverage, stripped of collective rights and denied access to the Queensland Industrial Relations Commission.*

The proposal, which has been identified as a priority by Queensland Government, is for existing conditions and protections embedded in awards and agreements to be removed by transferring senior medical staff on to contracts.

The AMA Council of Salaried Doctors has unanimously condemned the approach of the Queensland Government.

AMA Queensland has been working with the Australian Salaried Medical Officers Federation (ASMOF) (Qld) to analyse the proposal and respond to it. They have identified a range of concerns with the proposed contracts, which include:

- the lack of a dispute resolution clause, which is unusual for an employment contract;
- the denial of access to the Queensland Industrial Relations Commission;
- the contract does not reference ASMOF or any union;
- salary and tiered arrangements for payment are completely discretionary for the employer;
- Rights of Private Practice will be removed. Private practice will only be allowed if agreed to by the employer;
- rates and allowances will be set by a governance committee, with no guarantee of annual indexation;
- individual contracts will reduce remuneration and rights, especially regarding overtime, on-call and hours of work provisions;
- the employer can impose a roster on salaried and visiting medical officers without reasonable consideration being given to hours of work or fatigue; and
- there is no means of collective renegotiation, or a mechanism to oversee the implementation of contracts.

These are just the issues specific to the contract itself.

Of course, more broadly, the concern is that the contracts diminish the collective bargaining rights of the doctors involved and create an imbalance in the power between the parties.

This is totally inconsistent with fair work practices, and leaves employees vulnerable, confused and with less time to devote to their core duty of patient care.

This duty of care will suffer even further as unpredictable rostering and overall dissatisfaction pervade the system.

What this means is that individuals will have to negotiate with the State, if indeed there is any room for negotiation at all. This is not only inefficient and daunting, but costly as well. Anyone who has negotiated with State entities will tell you that it can be a frustrating process.

ASMOFQ and AMAQ are currently considering their options in responding to the contract.

The Government wants the system to be implemented by mid-2014, leaving little time for doctors to consider their options, given the major cultural shift involved.

To date, there has been no meaningful engagement by the State Government with AMA Queensland or the ASMOFQ on the contracts, the enabling legislation or changes to private practice.

I cannot say it loudly or clearly enough: these contracts are unfair from a legal, industrial and health care point of view. They threaten the wellbeing of doctors in the public health system, as well as that of their patients.

I doubt whether the supposed short term gains will be sustainable or worthwhile, as many doctors are likely to leave the Queensland public health system when faced with a deal like this.

> *The Bill threatens the wellbeing of doctors in the public health system, as well as that of their patients.*

The Newman Government has an overwhelming majority in Parliament, and these proposals reflect what appears to be a take-it-or-leave-it approach which, unfortunately, is likely to damage the provision of health care in Queensland for years to come.

Dr Stephen Parnis
Chair, AMA Council of Salaried Doctors

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25th Annual Conference 2013

Life membership

Annual Conference voted by acclamation that Dr Peter Roberts become the Association's next life member. Dr Roberts spoke briefly in appreciation to Conference and also spoke at the Conference dinner where he was presented with the award.

Dr Roberts has an extensive background in the leadership of the Association which includes:

- National Executive Region 3 representative, 1991-1993.
- Vice President, 1993-1997.
- National President, 1997-2003.

In addition Dr Roberts:

- Was the Association's first Wellington branch president.
- Received the Prime Minister's prize for being top in the Master of Public Policy course in 2002.
- Received the Sir Frank and Lady Holmes Prize in 2003 for his MPP thesis which was subsequently published as part of the prize as Snakes and Ladders-- the Pursuit of a Safety Culture in New Zealand Public Hospitals.
- Has continued to be a source of advice on professional issues to the Association, including most recently the Medical Council's work on increasing prevocational training requirements.

The other life members are Drs John Hawke (deceased), James Judson, George Downward and Allen Fraser.

Strategic direction for the Association

The strategic direction of the ASMS following the settlement of the national DHB MECA earlier this year was the main focus of the Conference. It commenced on the first day with Executive Director Ian Powell giving a presentation on the strategic direction developed by the National Executive. This included greater focus on the utilisation of Joint Consultation Committees, publications, application of the MECA, hosting 'events' and membership surveys. The intent is to enhance our visibility, relevance and contribution to the narrative on important issues.

Dr Richard Tyler, MAS

The presentation was followed by eight breakout groups convened by Executive members. These groups reported back the following day with a wide range of suggestions. Discussion concluded with plenary debate which led to further suggestions. The various ideas that emerged will be considered by the National Executive in February.

Drs Jeff Brown, ASMS National Secretary, Hein Stander, ASMS National President and Guy Rosset, Bay of Plenty DHB

Helen Kelly, CTU President, and Greg Wood, Employment Relations Authority

Drs Ian Page and Neil Croucher, Northland DHB, and Lyn Hughes, ASMS national office

Debbie Chin, Capital and Coast DHB, Dr Richard Tyler, MAS, and Dr Peter Robinson, Medical Council of New Zealand

Drs Chris Wisely, Southern DHB, and Vijay Vijayasenan, Hutt Valley DHB

Drs Jubilee Rajiah and Lisa Turner, both of Southern DHB

Keynote speakers

The keynote speakers were:
Dr Andrew Connolly, Clinical Director Surgery (Counties Manukau DHB) on what is a generalist. This was a particularly riveting presentation leading to much debate on an issue that deserves more discussion than is presently happening.

Hon Tony Ryall, Minister of Health gave a presentation described neutrally by many delegates as slick. Significantly he chose not to repeat his oft stated misleading extra hospital doctor numbers claim.

Dr Les Toop, Professor of General Practice (University of Otago, Christchurch) spoke on the experiences and benefits of primary-secondary integration (including acute demand) and suggestions for the future. This was a substantial presentation.

Also substantial and attracting many questions and comments (despite being disrupted by a power cut) was the address by **Dr Bill Rosenberg,** Economist & Policy Director (Council of Trade Unions) on private public partnerships and the health sector.

Drs Russell Tregonning (Wellington orthopaedic surgeon) and **David Galler** (intensivist and Clinical Director, Ko Awatea, Counties Manukau DHB) both spoke about what's good for the environment is good for health – sustainable healthcare. This session was unfortunately too brief as it generated much discussion and also a resolution later in the Conference.

Dr Robert Hendry (Deputy Medical Director, Medical Protection Society) addressed Conference on life after Francis – can the lawmakers improve patient care? This was a timely shorter presentation that engaged attendees.

Environmental sustainability

Arising out of the earlier session on climate change and environmental sustainability the Conference adopted, by a large majority, the following resolution:

That the Association urges immediate action by government to mitigate the detrimental effects of climate change on the health of New Zealanders by ensuring that government policies and actions support environmentally sustainable practices.

Other matters

- Conference delegates voted in favour of two constitutional amendments proposed by the National Executive (with the required 70% majority) to increase the terms of the Executive and Branch Officers from two to three years from 2015.
- The Conference accepted the recommendation of the National Executive that the membership subscription not be increased for the 2014-15 financial year. Instead the subscription will remain unchanged at $750.00 (GST inclusive).
- The next Annual Conference will be held on Thursday-Friday 27-28 November 2014 in Wellington.

Ian Powell, ASMS Executive Director

Dr Andrew Connolly, Counties-Manukau DHB

Dr Kai Haidekker, Hawke's Bay DHB

Dr Jeannette McFarlane, Auckland DHB

Dr John MacDonald, retired ASMS National Executive

Dr Andrew Munro, Waikato DHB

Breakout Group

Dr Joe Harris, South Canterbury DHB

Dr Graham Martin, ACC Wellington

Hon Tony Ryall, Minister of Health

Dr Geoff Shaw, Canterbury DHB

Dr Rick Cirolli, Tairawhiti DHB

Dr Tim Frendin, Hawke's Bay DHB

Dr Peter Roberts, Capital & Coast DHB

Dr Julian Fuller, ASMS Vice President

Ian Powell, ASMS Executive Director & Dr Sally Vogel, Auckland DHB

Dr Sylvia Boys, Counties-Manukau DHB

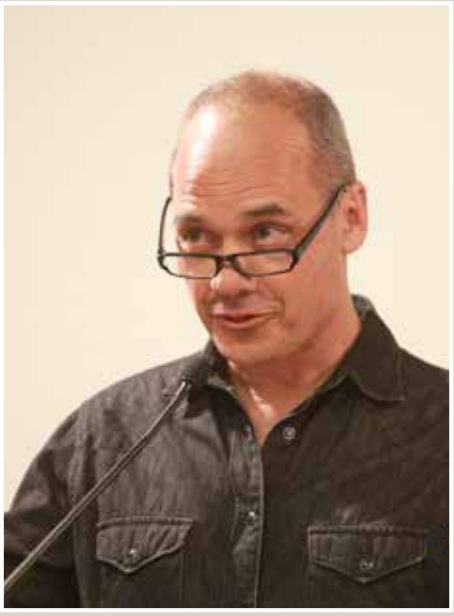
Dr Lynsay Hayward, Counties Manukau DHB

Professor Les Toop, University of Otago (Christchurch)

Dr Justin Barry-Walsh, Capital & Coast DHB

Dr Jeannette McFarlane, Auckland DHB

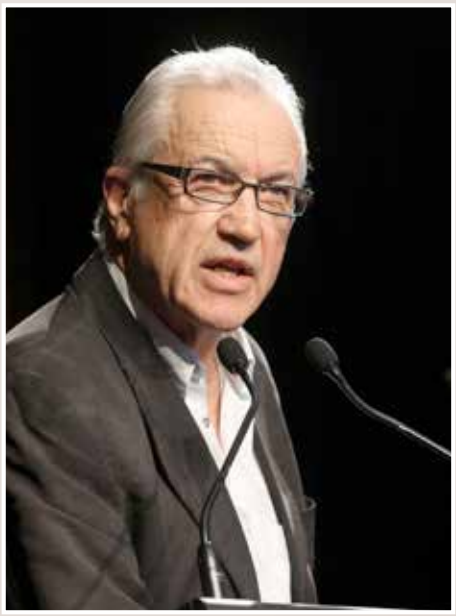
Drs Nagarajah Vijayapalan, Bay of Plenty DHB, Jega Pasupati, Waikato DHB, and Siva Govender, Waikato DHB



Dr Glen Colquhoun, Poet, General Practitioner

Dr David Galler, Counties-Manukau DHB

Dinner at Te Wharewaka



Dr Russell Tregonning, Capital & Coast DHB

Drs Chris Hirling, Bay of Plenty DHB, and his wife Michelle Hunt, Matthias Seidel, Bay of Plenty DHB, and Prieur du Plessis, NMDHB.

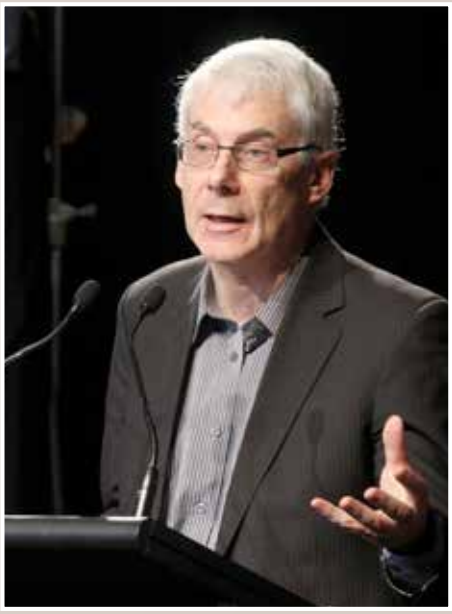
Drs Brigid Connor, Auckland DHB, Michael Jameson, Waikato DHB, Jeff Hoskins, ASMS National Executive, and Sally Vogel, ADHB.

Dr Alex Browne, Nelson Marlborough DHB

Drs Trevor Cook, John MacDonald, Brian Craig, Ruth Spearing and Les Snape of Canterbury DHB

Drs Sheila Gordon and John Grigor both of Hutt Valley DHB

Drs Lynsey Hayward, CMDHB, Alex Browne, NMDHB, David Galler, CMDHB and Jeff Brown, ASMS National Secretary



Dr Bill Rosenberg, NZCTU Economist

Dr Rod Gouldson, Bay of Plenty DHB

Dr Anja Werno, Canterbury DHB

Dr Robert Hendry, Medical Protection Society (UK)

Dr Roger Wandless, Southern DHB

Dr Peter Roberts receiving his ASMS Life Member certificate from President Hein Stander

Community water fluoridation in New Zealand: Is winning Lotto a better bet?

Community Water Fluoridation (CWF) in New Zealand needs a clear, consistent and regulated approach with central government stepping up and taking responsibility (NZ Dental Association, 2012).

With Hamilton now non- fluoridated, less than 50% of New Zealanders have access to fluoridated water. This leaves a large proportion of the population without access to optimum levels of fluoride. A situation which is contributing to inequalities between regions and ethnic groups (Ministry of Health, 2010).

The recent farcical situation that occurred in Hamilton is an example of how Territorial Local Authorities (TLA's) may be ill equipped to make intelligent and well-considered decisions regarding their communities' health. Although a prime example, Hamilton is not the only TLA to fail its community with regard to CWF, New Plymouth is another example and there are others.

The Hamilton experience

Hamilton City had been fluoridated for the last 47 years. In 2006, following a binding referendum, the people of Hamilton voted overwhelmingly to retain fluoridation despite a campaign to remove it initiated by the anti- fluoridation lobby group. However, during the 2011-2012 planning process, the Hamilton TLA received further submissions to remove CWF. The positive result from the community referendum in 2006 should have been all the endorsement the TLA required.

> *Less than 50% of New Zealanders have access to fluoridated water. This leaves a large proportion of the population without access to optimum levels of fluoride.*

However, the councillors chose to ignore this and decided once more to re-litigate fluoridation by setting up a council CWF tribunal in 2013. This tribunal comprising of the TLA councillors, heard submissions from all parties and at the completion of this process, the vote was 7:1 against CWF. Clearly these councillors believed they understood the issues involved and chose to accept the arguments of the anti-fluoride lobby group.

You may well ask how the tribunal rejected submissions as to the safety and effectiveness of CWF presented by the Waikato District Health Board, the Ministry of Health (MOH) and members of the New Zealand Dental Association (NZDA). Amongst their evidence was systematic reviews of research conducted over the past sixty years which reported that water fluoridation is a safe, cost effective and equitable public health intervention for the prevention of dental decay (FDI, 2008). The prestigious US based Center for Disease Control and Prevention describes water fluoridation as one of the most important public health advances and disease prevention of the twentieth century.

A systematic review carried out by the National Health and Medical Research Council in 2007 confirmed that water fluoridation is safe and effective at optimum levels. Further, in 2012, the Royal Society of New Zealand released a statement supporting the MOH endorsement of water fluoridation as a safe and effective measure for reducing dental caries. New Zealand studies have shown children who are continuously exposed to fluoride during their lifetime have up to half the dental caries experience of those who do not (New Zealand Guidelines Group, 2009). These studies are supported by the 2009 New Zealand oral health survey which found adolescents and adults living in fluoridated areas had significantly less lifetime decay than those living in non-fluoridated areas.

Did the members of the tribunal reject CWF because they actually believed the emotive pseudoscience of the anti-fluoridation lobby?

This pseudoscience suggests CWF is not effective and that it actually causes a range of health issues including heart and kidney disease, increased lead uptake, neurotoxicity, osteosarcoma, pineal gland accumulation, skeletal fluorosis and thyroid damage. These claims have been investigated and dismissed by public health authorities and researchers over many years. However, the anti-fluoridation lobby group, continue to publish statements to newspapers and online, as well as make submissions to LTA's, dressing up this misinformation with emotional rhetoric, and providing misleading statements to the public.

Two frequently raised objections to CWF

There are two frequently raised objections that do merit further comment. One is that an ingested excess of fluoride may contribute to dental fluorosis and the other the question of freedom of choice against mass medication.

The anti-fluoridation group, in their Hamilton submissions, used the results of the 2009 New Zealand oral health survey to claim 44% of New Zealand children had some degree of dental fluorosis. However, this claim is incorrect; findings from the study showed no significant differences in the proportion of children who have fluorosis like diffuse opacities of the dental enamel in fluoridated versus un-fluoridated areas (45.5 % and 43.1 % respectively). According to the results of the 2009 New Zealand oral health survey, the vast majority of defects quantified in the study were "questionable" fluorosis (not a definitive diagnosis). Dental fluorosis is frequently misdiagnosed, even by dentists, because more than one condition can cause diffuse defects in dental enamel.

The second objection relates to freedom of choice and the accusation of mass medication. The addition of fluoride to community water supplies is merely an artificial adjustment of fluoride levels to water supplies that already contain a percentage of naturally occurring fluoride. The Human Rights

Commission in 1980 (as cited in NZDA News, 2013) stated that "in all circumstances it is considered that the question of fluoridation of water supplies by public health authorities does not constitute a denial of human rights." The Privy Council, in 1964 also considered water fluoridation and stated "the addition of fluoride adds no impurity and the water remains not only as water but pure water and becomes greatly improved and still natural water containing no foreign elements" (MOH,2010).

> *The Human Rights Commission in 1980 stated that "in all circumstances it is considered that the question of fluoridation of water supplies by public health authorities does not constitute a denial of human rights."*

Water fluoridation is perhaps one of the most effective public health interventions that can benefit the community and reduce inequalities without requiring them to change the way they live (Broadbent, 2013).

Given this, and the weight of evidence that water fluoridation is safe and a cost effective means of reducing dental caries, it is argued that it is irresponsible of TLAs not to fluoridate community water supplies.

Winston Churchill once said "Healthy citizens are the greatest asset any country can have." However, according to the 2009 national oral health survey, dental caries is the most prevalent chronic (and irreversible) disease in New Zealand. Yet, it is preventable.

> *Dental caries is the most prevalent chronic (and irreversible) disease in New Zealand. Yet, it is preventable.*

The survey found 1:3 adults has untreated coronal decay, 1:10 had root decay and there was evidence of active decay in all age groups including older age groups. 51% of 12-13 year olds are caries free and while this is an improvement over the last 20 years (29% in 1988), there are almost half of our children today who have experienced dental caries. This disease, while universal, has a greater impact on those who live in areas of high socioeconomic deprivation, Maori and Pacific populations. Dental caries is a disease that is no respecter of age, afflicts young and old alike and the less fortunate.

Is there an alternative to CWF?

While there are topical oral health preventative measures available that can reduce the impact of dental caries such as fluoridated toothpastes, fluoride mouth rinses and fluoride varnishes, these are in addition to CWF. The most effective measure from a public health perspective is the fluoridation of our community water supplies. New Zealand has low levels of naturally occurring fluoride, approximately 0.15mg/L. However, by adjusting the level to between 0.8 and 0.9 mg/L or 0.7 and 1 ppm, a decrease in dental caries between 15-30% can be achieved. While this benefits all the population, it is most dramatic in the young.

Argument for fluoridating water supplies over the alternatives

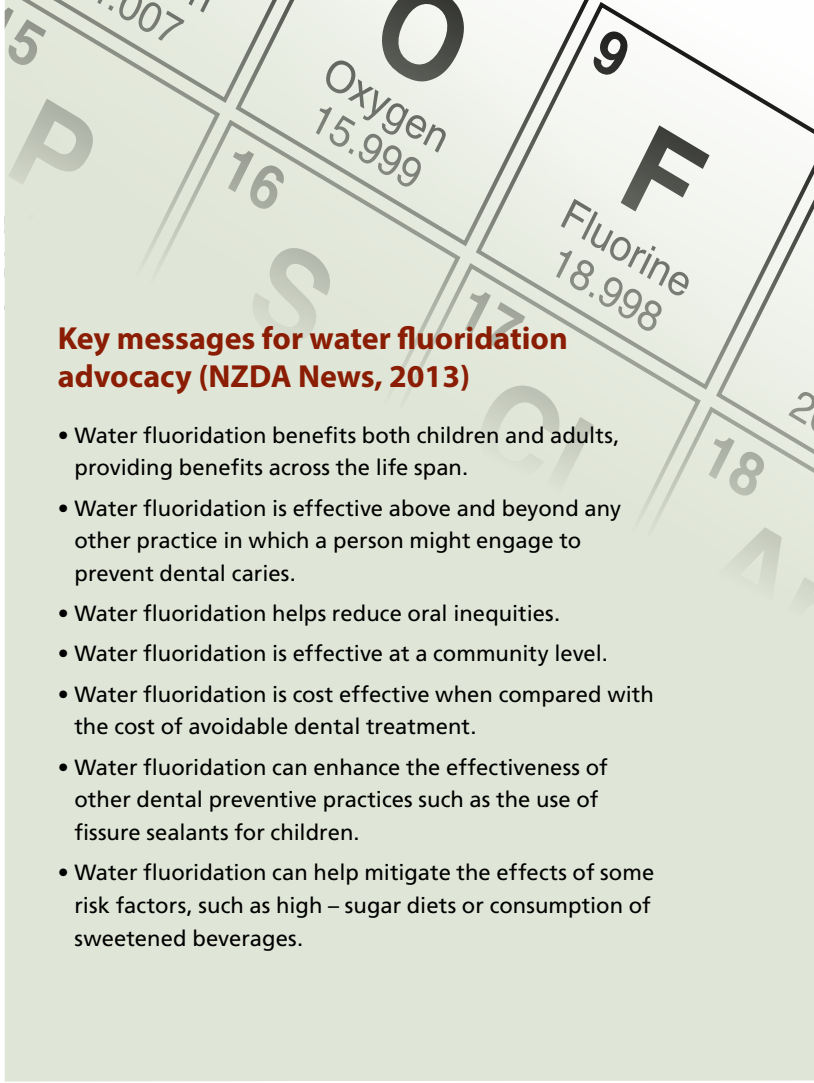
To understand the benefit of drinking fluoridated water, as opposed to other delivery systems for communities, requires a brief description of its action. Tooth enamel comprises of hydroxyapatite crystals, a highly mineralised substance containing calcium and phosphates bound together by an inorganic matrix. Bacteria capable of producing acids colonise the tooth surface via the enamel biofilm and through an acid attack, demineralise the enamel surface causing cavitation.

Fluoride either incorporated into the enamel during amelogenesis or into the surface layer of enamel during the demineralisation-remineralisation cycle alters the formation of the hydroxyapatite crystals to form fluorapatite. This remineralised enamel is more resistant to acid attack than the original enamel. The constant background exposure to fluoride through water fluoridation is one of the most effective and also cost efficient means of protecting tooth enamel and thus reducing the incidence of dental caries.

> *The constant background exposure to fluoride through water fluoridation is one of the most effective and also cost efficient means of protecting tooth enamel and thus reducing the incidence of dental caries.*

The never ending cycle of litigation and re-litigation

To return to the Hamilton experience, following the Hamilton LTA decision to remove CWF, a petition was circulated requesting a further community referendum. It was interesting that while only 1,000 signatures were required to force this referendum, 2,700 were achieved. A non binding referendum was held in



Key messages for water fluoridation advocacy (NZDA News, 2013)

- Water fluoridation benefits both children and adults, providing benefits across the life span.
- Water fluoridation is effective above and beyond any other practice in which a person might engage to prevent dental caries.
- Water fluoridation helps reduce oral inequities.
- Water fluoridation is effective at a community level.
- Water fluoridation is cost effective when compared with the cost of avoidable dental treatment.
- Water fluoridation can enhance the effectiveness of other dental preventive practices such as the use of fissure sealants for children.
- Water fluoridation can help mitigate the effects of some risk factors, such as high – sugar diets or consumption of sweetened beverages.

conjunction with the October local body elections. The result was an overwhelming support for CWF. The Mayor of Hamilton has now publically agreed to take this back to council and support the reintroduction of fluoridation.

Waikato DHB Medical Officer of Health, Dr Felicity Dumble, is quoted by the NZ Herald (2013) urging the Council to learn from the results. Ultimately, the results and those from 2006 should be used as an "example as to why it's not a good idea to use tribunals which grossly over-represent the position of small interest groups, when it comes to making public health decisions for the whole city," she said.

In researching CWF in New Zealand, the NZDA recently identified the following issues:

- The decision to fluoridate water supplies can be continually re-litigated by TLAs. Examples of this are Dunedin (2007), Kaitaia and Kaikohe (2007), Waipukurau (2009), New Plymouth (2012), Hastings (2013), Whakatane (2013) and Hamilton (2013).
- The TLA process is resource intensive for health authorities and a process of attrition is used by opponents.
- The current role of health authorities in the decision making process fails to recognize their responsibility to manage the consequences of higher disease levels.
- Central government cannot use water fluoridation to effectively address public health concerns on a national basis.

Further to this, the current decision making process for water fluoridation is flawed due to:

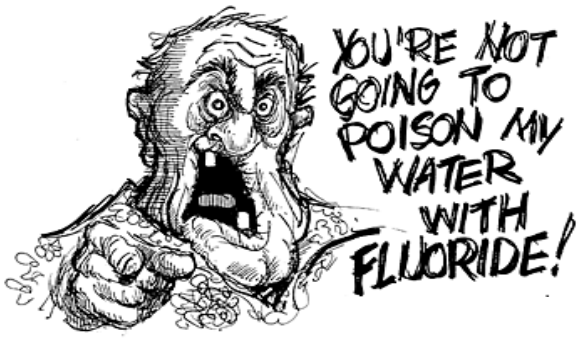
- The decision-making role of TLA is not specifically set out in current regulations.
- The decision-making role is assumed by TLA based on the requirements set out in the Local Government Act 2002 and the Health Act 1956.

In view of the declining CWF in New Zealand and the risk to oral health, the NZDA is calling for a decision process that:

- Is based on a clear, consistent and regulated approach.
- Recognises that water fluoridation is a public health issue.
- Aligns with responsibilities of health authorities and the Director-General of Health.
- Clarifies the responsibilities of TLAs.
- Has sensible time frames for review - reduces the frequency of campaigns.
- Allows for public input but does not depend on referenda.
- Puts the onus on individuals to opt out of fluoridated water, if that is their choice.

To achieve these goals, the NZDA has committed to a long term process of working with TLAs, and central government and welcomes the continued support of our senior medical colleagues.

Dr Geoff Lingard
Past President, New Zealand Dental Association



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NZDA News. (2013). 165: 25- 42

NZDA. Information pamphlet (2012). NZDA Water Fluoridation Project Group. NZDA House, Auckland. 2012.

Royal Society of New Zealand, October, 2012 Statement on Fluoridation of Water by Professor Sir David Skegg, President of the Royal Society of New Zealand.

New Zealand Herald: Hamilton votes for fluoridation, 12 October; 2013

Ministry of Health: World fluoride situation

About 60 countries have water fluoridation covering hundreds of millions of people.

For various reasons, some political, some logistical, many countries do not have fluoridation. Many countries are without public water supplies, many have more life-threatening health needs and many lack the funds to set up fluoridation systems.

There are also countries that do not have water fluoridation but provide fluoride through other means, for example, in salt (this is not as effective as water fluoridation and is not being recommended for New Zealand).

In 1994, the World Health Organization (WHO) published a report reaffirming its support of fluoridation as safe and effective in preventing tooth decay.

In line with the WHO report countries are introducing and extending fluoridation. In September 2000, South Africa introduced regulations requiring every water provider to practise fluoridation unless exempted in writing by the Director-General. As of December 1999, it is mandatory in Israel for communities of more than 5000 people to fluoridate (already more than half of Israel is fluoridated).

The US continues to introduce fluoridation to new communities and California has made it compulsory for communities of 100,000 or greater. The US is also producing fluoridated bottled water because of the demand for it.

No country has discontinued or refused to adopt fluoridation because it was proven harmful in any way.

The American Dental Association stated in 1999 that 'no European country has specifically imposed a"ban" on fluoridation, it has simply not been implemented for a variety of technical or political reasons'. In some European countries fluoride is added to salt to help prevent dental decay rather than adding it to water (for example, France, Germany and Switzerland). Other parts of Europe fluoridate their water (for example, Ireland and the United Kingdom). Fluoridation is not practical in some European countries because of the complexity of their water systems.

Countries with drinking-water supplies available with fluoride levels adjusted, or naturally, at 0.7 ppm or above include:

Australia
Bulgaria
Canada
Cyprus
Czechoslovakia
Denmark
Federation of Russian States
Finland
Hungary
Ireland
Israel
Italy
Kazakhstan
New Zealand
Norway
Poland
Romania
Spain
South Africa
Sweden
Switzerland
Turkey
United Kingdom
United States
Uruguay
Venezuela.

New Communications Director position established

At its meeting immediately preceding Annual Conference the National Executive accepted a recommendation from Executive Director Ian Powell to establish a new senior ASMS position of Director of Communications.

This followed the earlier Executive decision to embark on a strategy of raising the profile of the ASMS in the health sector and in the community at large and developing a 'Know Your MECA' campaign among the membership. This strategy is more a sharpening and deepening of our focus rather than a radical departure from what we currently do.

As the ASMS has grown so has the communications work done by the Executive Director to the extent where it is now less and less sustainable. It has become clear that the Association has now grown to the point where we need to establish a communications position at a senior level.

The skills needed are:

- expert knowledge of news media, social media and other online processes,
- knowledge of publication management processes (this will not necessarily be hands-on),
- expert writing and editing skills to publication standard,
- at least 5-10 years in managing communications or equivalent,
- professional qualification or equivalent experience,
- experience in contracting communication services and managing contractors and temporary staff,
- ability to present to a very high professional standard, gaining the trust of the highly intelligent experts in our membership who are often themselves expert communicators and users of media.

The intention is to give more teeth to our strategic direction which is becoming increasingly important due to the compounding pressures on our members of demographic change, increased government expectations on DHBs, decreased relative funding, and increased managerialism.

Not much more money but more women specialists as at 1 July 2013

Since 1993 the Association has done a survey of salaries of specialists and medical officers at DHBs and their predecessors. The survey is a head count and is taken at 1 July so the recent MECA increases which took effect on 1 October are not included. The increase reported reflects movement through the scale and, perhaps, to a lesser extent movement of SMOs in and out of employment at different points on the scale.

The survey is of base salary so doesn't include any hours over or under 40, payments for call, availability or any other payments. It is just a measure of where senior medical officers are situated on the salary scale.

The highlights are:

- An increase from 3,826 specialists to 4,022 specialists employed at New Zealand DHBs. Nearly all DHBs have had an increase; the exceptions are Canterbury and South Canterbury with a small decrease and Hutt Valley where numbers have remained static (numbers are small so this may be just an artefact of timing).
- There has been a decrease in medical officers for two years now which may be the beginning of a trend (520 this year, 540 in 2012 and 565 in 2011).
- The average salary for specialists between 1 July 2012 and 1 July 2013 went up by 0.7% from $184,271 to $185,529.
- The average salary for medical and dental officers went up by 0.4% to $145,117 from $144,488 last year.
- The average annual salary for specialists was highest in Wairarapa DHB ($200, 854) and lowest in Counties Manukau ($179,896). The average annual salary for medical and dental officers was highest in Lakes ($162,250) and lowest in Auckland ($133, 864)
- The average annual salary of female specialists was $178,342 and the average salary of males was $189,119. For medical officers the figures are $144,610 annual salary for females and $145,559 for males. A third of specialists were female while 47% of medical and dental officers were female.
- As at 1 July 1,219 male specialists and 320 female specialists were on the then top step (step 12). Numbers on the other steps were more evenly spread with the next most populous step being step two with 241 females and 224 males. The bottom step had virtually identical numbers of males and females.

This suggests that the gender balance of the specialist workforce is changing with women comprising around half of more recently qualified specialists. The next ten years will probably see a more female specialist workforce.

The full survey is available on our website at **asms.org.nz**

	Specialists		Medical And Dental Officers	
	Mean Base $	Annual % Increase	Mean Base $	Annual % Increase
1993	85,658		67,457	
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
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
2013	185,529	0.7	145,117	0.4

Specialists							
Numbers 2013		$ Mean 2013	$ Mean 2012	$ Mean 2011	$ Mean 2010	$ Mean 2009	% change 09-13
Female	1,340	178,342	176,918	168,965	164,520	163,273	9.20%
Male	2,682	189,119	187,661	180,185	175,191	173,691	8.90%
TOTAL	**4,022**	**185,529**	**184,271**	**176,705**	**171,977**	**170,578**	**8.80%**

Medical and Dental Officers							
Numbers 2013		$ Mean 2013	$ Mean 2012	$ Mean 2011	$ Mean 2010	$ Mean 2009	% change 09-13
Female	242	144,610	143,729	136,330	131,243	129,571	11.60%
Male	278	145,559	145,137	138,453	134,297	134,947	7.90%
TOTAL	**520**	**145,117**	**144,488**	**137,495**	**132,881**	**132,383**	**9.60%**

DR ANDREW STACEY, MEDICAL PROTECTION SOCIETY

Managing the media

Media scrutiny of you and your practice of medicine could put your personal and professional reputation at risk, but there are steps you can take to help minimise this.

The media may contact you by phone, email, or through social media (such as Facebook). They may arrive at your home or place of work, or make contact through friends, family, or colleagues. All these approaches may catch you off guard. Avoid responding straight away, and instead find out the journalist's name, the name of the publication/programme, exactly what they want a comment on, and their deadline. Ask the journalist if they are able to put this information in an email, as this will help you maintain a record of the conversation. Advise them that you will contact them in due course.

We recommend you contact MPS for advice, particularly if the query relates to an ongoing investigation or litigation. We can advise on how you can respond without prejudicing proceedings or patient confidentiality. If you can contact us when you think there may be upcoming media scrutiny, or immediately after you get a media query, we will have more time to prepare for media activity and build good relations with any journalists working to strict deadlines.

Always assume that anything you say to a journalist could be published, nothing is "off the record." If you don't want to see it in print, don't say it. We can liaise with the journalist on your behalf, agree a statement with you, if one is needed, and issue it to the journalist(s).

Photographers and camera crews

If photographers or camera crews appear outside your hospital or practice make sure you alert your management team. This way they can be prepared and take appropriate steps to make sure that patients' privacy is respected, by informing patients of the situation and warning photographers to ensure patients are not identifiable.

When the photographer or camera crew are filming or taking photographs of you, maintain your composure and make sure you convey a professional image. Do not cover your face or react angrily; smiling may also convey the wrong message.

Reporters at legal proceedings

Evidence presented in open court or at inquests can be reported in the media, as can unproven allegations, unless reporting restrictions are specifically imposed. As long as the journalist reports proceedings accurately, it is unlikely there would be scope for redress.

When in court or at a hearing avoid discussing the case until you have the privacy of a room from which you can be sure you will not be overheard.

If approached by a journalist while the hearing is ongoing, don't respond immediately – take time to consider your response and seek advice from MPS. You may also need to liaise with your employer. Avoid saying "no comment", as this may sound defensive.

What you can say to the media

It is important to be aware of the obligations that you have to your employer before becoming involved in any public debate or dialogue. Clause 40 of the MECA recognises the right of a doctor to comment publicly on matters related to their professional expertise and experience. However, when the matters are relevant to your employer you should first inform or discuss the issues with your employer.

Doctors are expected to protect patients' confidentiality. Breaking confidentiality, whether inadvertently or not, could lead to a complaint, disciplinary action or regulatory sanction. However, there are ways in which you can respond to media enquiries without breaching patient confidentiality. You may not be able to comment about the specifics of a particular case, but you can explain why - because of your ongoing duty to maintain patient confidentiality, or because the case is the subject of ongoing legal proceedings.

There may be occasions where it is appropriate for you to make a specific comment. For instance, if a patient has died, expressing your condolences or regrets to the family may be the right thing to do.

It is wise to keep statements succinct and factual. You should liaise with others involved, such as your employer or colleagues, to agree on the key messages. Assistance with this can be obtained via MPS or a District Health Board press officer.

Undercover journalism

If you are the target of an undercover investigation, for example, a journalist posing as a patient, it does not automatically release you from your duty to maintain patient confidentiality. Any response to the media should be handled in the same way as a query that arose from a genuine patient consultation.

In some cases it might be appropriate to ask the 'patient' to give consent for the details of the consultation to be commented on in the media, but take advice first from MPS, or others who may need to be involved, such as your employer.

Social media and discussion sites

The Medical Council document, Good Medical Practice, states that when sharing information in any public forum (including, for example, chatting in a hospital cafeteria or posting to a social networking site), you must not disclose information about yourself that might undermine your relationship with patients. Posting inappropriate comments or photographs, or describing

a patient's care on a social media site, can damage your reputation and lead to disciplinary action, as well as unwanted media attention. The same standards of professionalism and confidentiality apply, no matter what the medium of communication.

Patients posting damaging and negative comments about you on patient feedback sites could test your professionalism, but you can discuss the situation with MPS and decide the best way forward.

The assistance we offer will depend on the circumstances; but generally we can:

- Provide experienced and expert advice on handling the media
- Speak to the journalist on your behalf
- Liaise with the relevant press offices involved in your case, e.g, your hospital's press office
- Prepare press statements
- Monitor coverage and assist with any follow-up actions.

Despite the short attention span of a public fed by the mass media, being in the spotlight can be uncomfortable, and sometimes damaging for professionals. It is important to be careful in any dealings with the media and to contact MPS for advice at a very early stage to help mitigate risks.

Dr Andrew Stacey
Medicolegal Advisor at MPS, advises doctors on dealing with the media

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 3,900 doctors and dentists, nearly 90% of this workforce;
- advise and represent members when necessary;
- support workplace empowerment and clinical leadership.

Other services

www.asms.org.nz

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

We welcome your feedback 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

T 04 499-1271
F 04 499-4500
E asms@asms.org.nz
W www.asms.org.nz
P PO Box 10763, Wellington 6143

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Season's Greetings

National Executive (from left to right) Back row: Murray Barclay, Tim Frendin, Jeff Hoskins, Seton Henderson, Jeff Brown, Julian Fuller, Paul Wilson. Front Row: Carolyn Fowler, Hein Stander, Judy Bent

The ASMS National Executive wish all members and staff a safe and happy holiday season.

The national office will be closed from 25 December 2013 to 3 January 2014 inclusive.

During this period messages of urgency can be emailed to support@asms.org.nz.

Throughout much of January we will be operating with reduced staff.

www.asms.org.nz