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The Specialist

THE MAGAZINE OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

www.asms.org.nz

ASMS 25 YEARS OF ENGAGEMENT 1989-2014

The founders of the ASMS

Drs George Downward, Allen Fraser, James Judson and John Hawke.

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More ways to get your ASMS news!

You can find news and views relevant to your work as a specialist at **www.asms.org.nz.** We're also on Facebook and LinkedIn, and links to those are at the top of the ASMS website homepage.

We now have short videos of the ASMS National Presidents, past and present, on the website as well as the presentations given by Professor Martin McKee at our commemorative conference in August.

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The founders of the ASMS

– *creating an organisation that endures*

They were at the birth of the ASMS; the obstetricians, if you like.

As the Association of Salaried Medical Specialists (ASMS) marks 25 years since its formation, it is timely to remember the people who helped the organisation come into being.

In particular, to acknowledge the efforts of George Downward (intensive care), Allen Fraser (psychiatry), James Judson (intensive care) and John Hawke (dentistry).

These four are considered the founders of the ASMS for the leadership they provided during an intense period of debate and negotiation as senior doctors and dentists around the country grappled with the idea of establishing for the first time a union to represent their employment interests.

Quarter of a century later, the gains made by the ASMS in support of specialists and defence of the public health system are a source of pride.

"We compiled a list back then of what whole-timers [full-timers] want and I have to say that we've got almost everything on that list now," says James Judson. "So I'm really quite chuffed about what the ASMS has achieved."

George Downward spoke with feeling and humour about the birth of the ASMS and its first steps in a presentation to the 25th commemorative conference held in Wellington in August. He talked about the process of setting up a union for senior doctors and dentists, developing a set of rules, enrolling members and carrying out the first negotiations.

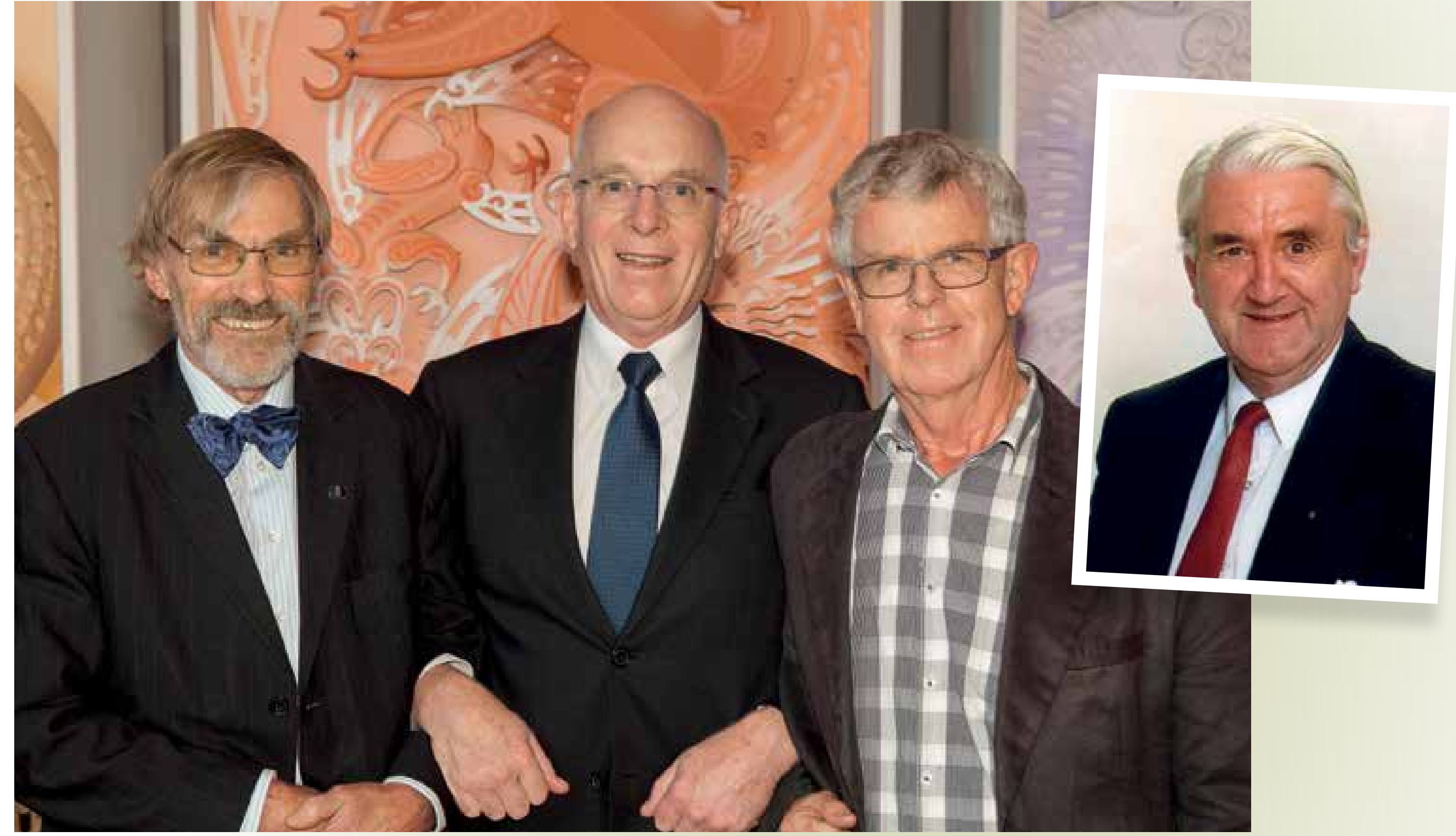
The State Sector Act 1988 removed salaried senior doctors and dentists from the state sector, placed them under the Labour Relations Act 1987 like other salaried employees, and changed their existing salaries and conditions into an industrial award. The New Zealand Medical Association could no longer negotiate for them because it could not legally register as a union. As a result, a number of specialists began the process of establishing a union.

> *"You've all grown up in it and it seems quite normal, but back then to talk about a union was something quite different."*

"It was a novel concept for us as professionals at that time," George Downward told the conference. "You've all grown up in it and it seems quite normal, but back then to talk about a union was something quite different."

James Judson says there was considerable debate over what to name the new organisation.

"I wanted it to be called the New Zealand Medical Union but was told that would upset a lot of people," he says.



Left to right, Drs Allen Fraser, George Downward and James Judson at the ASMS commemorative conference in August 2014. At far right, John Hawke.

"There was a huge amount of dissatisfaction with salaries and conditions at the time but on the other hand we were professional people and there was a view that we shouldn't be industrial and mustn't go on strike. I respected that. In the end I was more interested in what it could do than what it was going to be called."

Southland physician Andy MacFie, a member of the original ASMS interim Executive, says senior doctors and dentists were initially unsure about union membership.

"The feeling was roughly half and half, I think. Half didn't like the idea of being forced into a union, the other half realised we had no choice. But if you look at the first two or three years of the ASMS, how many people took out a subscription, whatever uncertainty they'd had initially they quickly got over it.

"I felt very strongly that we should have cohesion throughout the country, and I was a very firm supporter of establishing the ASMS."

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NOTES FROM MEETING OF INTERESTED GROUPS ON THE FORMATION OF A UNION FOR SALARIED MEDICAL OFFICERS HELD AT THE WEST PLAZA HOTEL, WELLINGTON ON 26 APRIL 1988 AT 10.00 AM

M I N U T E S

Present: Dr Tony Baird, Dr Deborah Sidebotham, Dr James Judson, Dr Allen Fraser, Mr Marsden Bell, Mr Peter Hunter, Dr Derry Seddon, Dr John Marwick, Dr Roger Ridley-Smith, Mr Rob Crozier, Dr Neil MacGregor, Dr Murray Jamieson, Ms Andie Pong Toy, Mr Philip Bartlett, Miss Lisa Holt, Mr Roger Caudwell, Mrs Lynley Smith-Pilling, Dr Rodger Hilliker, Dr George Downward, Dr Tom Marshall, Dr Richard Tyler, Dr Phillipa Hay, Dr Philip Rushmer, Dr Alan Cockburn, Dr Bill Treadwell, Dr Lewis King, Mr Rod Perkins, Mr Terry Powell, Dr Rosemary Fenwicke, Dr Roger Foote, Dr Anthony Poynter, Dr Don Palmer, Dr Robyn Hewland, Dr Karen Palmer, Dr Tony Newsome, Dr Brian Corkill, ...
Livingston, Mr H Smith, ...

Canterbury rehabilitation physician Rick Acland, who was an anaesthetist in Auckland and on the executive of the Part-Timers Association at the time (and who is currently an elected member of the Medical Council), agrees.

"We were all a bit stunned that we had to form a union," he says. "It was anathema to a lot of doctors. My fellow part-timers were all rather old school and this was a bit much for them. So we had to persuade people that this was the new world and that there would be benefits. We put out newsletters and we talked to people."

> *"We had to persuade people that this was the new world and that there would be benefits."*

George Downward says the new union came into being on 1 April 1989. It had to have 1,000 members in order to be a registered union and to the delight and relief of all involved, 1,260 people had signed up by August 1989, a 60% penetration rate at that time.

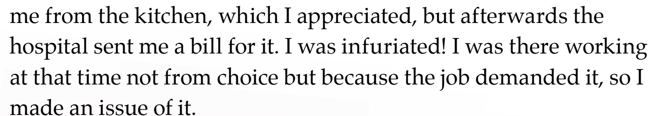
"The fact that we now have more than 4,000 members and 90% penetration is a sign of the value of the ASMS in the minds of the membership," he told the commemorative conference.

James Judson says the period spent establishing the ASMS is one of the things he is proudest of.

"The 1980s was a time of low salaries and high taxes and mortgage rates. Prior to the ASMS we didn't have an effective or truly national organisation, and we were working very long hours without recognition or proper payment. I decided that I personally wanted to do something to improve salaries and the conditions of our employment."

One issue in particular still has him riled, and he says it illustrates the type of petty issues doctors had to deal with at the time, in addition to issues over pay and conditions.

"I was on call one night and was called in at two or three in the morning. I wasn't being paid for it as it was above the 44 hours which was the maximum paid at the time. The nurses ordered a sandwich for me from the kitchen, which I appreciated, but afterwards the hospital sent me a bill for it. I was infuriated! I was there working at that time not from choice but because the job demanded it, so I made an issue of it.



"I became the squeaky wheel on a variety of issues on the grounds that it's the squeaky wheel that gets the oil," he says.

Andy MacFie and Rick Acland acknowledge the skills and commitment that James Judson, George Downward, Allen Fraser and John Hawke (now deceased) contributed to the ASMS' formation 25 years ago.

"Their combination of talent and insight made them ideal for the birth of the ASMS," says Andy MacFie.

WHAT DO WHOLE-TIMERS WANT? (May 1986)

1. Appropriate recompense for additional duties within and outside of ordinary working hours
2. Increase in numbers of SMOs, especially in shortage specialties
3. Availability of funding for CME as of right
4. Increase in annual leave entitlement
5. Maintenance of an appropriate basic salary
6. Removal of ceilings on remuneration for those on Additional Steps
7. Obligation of employer to provide funds for locums
8. Payment of interest by the employer on salary arrears if the requirements of Section 24 of the Wages Protection Act are not met
9. Realistic expenses for WTs required to use a car for their duties
10. Realistic expenses for WTs required to have a telephone
11. Pay in lieu of leave, and cessation of forfeiting of annual leave
12. Retirement gratuity as of right
13. Allowance for forgoing the right of private practice
14. A better Superannuation scheme
15. Cumulative sick leave
16. Realistic reimbursement of other income-related expenses and incidental fees
17. Increased allowances for home office
18. Recognition of service overseas in determining step on Automatic Scale
19. Insurance for accidents when on employers business
20. Hepatitis vaccination for at-risk staff
21. Provision of meals during call-out
22. Uniform conditions of service throughout the country

James Judson at the time the ASMS was founded

The 'Judson sandwich'

Advance care planning for a palliative medicine workforce crisis

Dr Anne O'Callaghan, Chair of the Palliative Medicine Training and Coordination Committee (PAMTRACC), and Clinical Director, Auckland Hospital Palliative Care Service.

Dr Jonathan Adler, Member of the Palliative Medicine Training and Coordination Committee (PAMTRACC), and Clinical Leader, Wellington Regional Hospital Palliative Care Service.

When someone is sick, a clear expression of what is important for them if they were to get sicker or die can help to ensure their future wellbeing, and provide the most appropriate treatment and care.

Such planning for the future is critical if we are to ensure people get the care that best relieves suffering, and supports them and their families.

Dr Anne O'Callaghan

As with people, so with services

Palliative medicine itself is sick, with a rapidly worsening workforce crisis.

Immediate action and careful planning for the future are needed if we are going to provide equitable high quality specialist services to New Zealand's rapidly aging population.

Current situation

There are 55 palliative medicine specialist positions in New Zealand, spread between community palliative care services (hospices) and hospital support teams. Of these posts, 22% are vacant. Within the next five years, a further 42% of the current workforce will retire[1].

> *Palliative medicine itself is sick, with a rapidly worsening workforce crisis.*

As a result, 30 new specialists are needed within five years to maintain services at existing levels.

At current training rates we may train between 5-10 new specialists during this time. An additional one third of new specialist posts are also required to address current inequities, ensure services' sustainability, and meet future need.

Dr Jonathan Adler

Factors exacerbating the crisis

Firstly, services need to expand to address current unmet need in people with non-malignant conditions. Palliative care

1. New Zealand Palliative Medicine SMO workforce projections and training capacity. August 2014. O'Callaghan A, Adler J PAMTRACC, Health Workforce New Zealand

need is as high in these people as it is in those with cancer – most services mainly care for the latter, resulting in inequitable access.

Secondly, population projections show a rapid and large increase in the elderly population living longer with chronic illness over the next decade, with almost certain implications for increase in service provision for palliative care services.

> *Services need to expand to address current unmet need.*

Thirdly, many services are not sustainable with their current workloads and levels of specialist cover. About 40% of district health boards (DHBs) either have no specialist cover, or only partial cover (hospital or hospice, but not both), and single practitioner services are not sustainable long-term, given the workload.

> *Many services are not sustainable with their current workloads and levels of specialist cover.*

Finally, recruiting from overseas is difficult – there is a shortage of specialists in many countries. Competition is fierce and in fact in the past five years, New Zealand has lost five trainees to Australia – in a period when we have only trained 10.

To ensure there are enough specialists to meet future population need and ensure services are sustainable and viable, it is estimated that the current number of positions needs to expand by 34% within the next 5–10 years. This would take the workforce to a total of 74 posts.

Addressing the crisis

To address the issue, we either need to train more specialists, attract more to New Zealand, or develop other aspects of the workforce.

In palliative care, the third approach is already underway with development of nurse practitioners and specialist roles, as well as allied health and counselling expertise. Even with expansion of these posts and new ways of working, these non-medical positions are unlikely to significantly reduce the number of specialists needed down the track. Rather, they will help enhance the breadth of service provision to a wider proportion of the population, thus helping to reduce inequalities.

Increasing registrar training positions is the most viable option in the short to medium term, given how difficult it is to recruit from overseas. There are currently nine fully-funded three-year training rotations in the country. This means that both the Health Workforce New Zealand (HWNZ) and the DHB funding have contributed to funding the rotation. If, however, we only continue to train at the current rate, the number of specialists in five years will be fewer than at present.

Maximum training capacity, were funding available, is currently 14 posts country-wide, an increase of 5 from what we have now. This could be increased even further to 19, were it not for the current workforce crisis limiting the numbers of specialists available in the regions to be supervisors.

HWNZ has clearly identified palliative medicine as a vulnerable specialty in crisis. As a result it has released enhanced funding for up to 11 posts, and is currently considering increasing to 14. Although this is encouraging, and HWNZ has written to the DHBs encouraging them to fund new rotations, as yet there has been little expansion with DHBs saying they have other priorities.

One solution would be to centrally recognise the workforce crisis, and pump prime for a six-year period the urgently needed DHB component of the rotations at a national, coordinated, strategic level through the Ministry of Health. Such targeted ring-fenced money for areas of priority has precedent and would seem to be the most effective way of rapidly and effectively driving the increase in posts needed. For example, a recent National pre-election pledge of $20 million dollars has targeted community palliative care services (hospices and aged residential care).

Either this or an alternative solution requiring creative leadership and funding from the Ministry is urgently needed.

Conclusion

Action is needed to comprehensively and effectively implement a plan for the future wellbeing of palliative medicine training and the specialist workforce. Failure to do so will mean that in five years from now, specialist palliative care services for many parts of the country will almost certainly be diminished and unable to provide appropriate medical care.

> *Urgent action is needed.*

This will happen at a time when palliative care services will be needed more than ever.

The role of clinical leadership in eHealth

Graeme Osborne, Director of the National Health IT Board, National Health Board, Ministry of Health.

Graeme Osborne

Health is a knowledge and information-based sector. The priority for the leaders of our health system must be to create an environment for the dissemination of knowledge through quality improvements and the measurement of performance.

In the 21st century, this means promoting the use of technology to drive innovation.

Yet not all our leaders have the understanding, experience and vision required to achieve this goal.

Many hospital specialists will have experienced times when poor leadership has prevented information systems from being used to improve workflow, bring efficiencies or support a better and safer integrated health care model.

> *How can we lift the sector's performance and work together to create digitally savvy health care organisations?*

Young clinicians coming into the sector are often frustrated by their leaders' inability to recognise the potential of information systems to improve patient outcomes.

The question for us all is how we can lift the sector's performance and work together to create digitally savvy health care organisations.

The importance of quality

Quality is the critical driver of a resilient, adaptable and safe health system. Key stakeholders, clinicians and consumers must be part of the co-design process.

The National Health IT Board's primary role is to provide leadership across the health and disability sector to support an improved health information model and future health care delivery models. However, everything we do is driven by quality improvement methods and the New Zealand Triple Aim.

It's tempting for health care organisations to believe they require specialist information technology systems to suit their individual needs. But having all 20 DHBs developing their own systems to meet a common need is both inefficient and a poor use of resources.

A better approach is to have one or two DHBs or other health care organisations that are furthest up the maturity curve to work on a common problem and share their innovations with others. Remaining organisations can be 'fast followers'.

eHealth in practice

One example of how this works in practice is the University of Auckland's VIEW research group's collaboration with Counties Manukau DHB, Midland DHBs and Middlemore Hospital's Department of Cardiology to develop a web-based electronic support programme called Acute PREDICT.

This programme was introduced into Auckland metropolitan hospitals and all Midland DHBs' hospitals before being expanded to include all patients admitted to New Zealand hospitals with Acute Coronary Syndrome (ACS).

The information is stored in the All New Zealand Acute Coronary Syndrome – Quality Improvement (ANZACS-QI) database, which is based on an international standard. The database is used to better predict patients' risk of heart disease and stroke, and to identify possible treatment improvements.

In addition to deciding who should lead the development of solutions to common problems, another important success factor is to ensure we consistently capture quality outcomes data.

Many senior doctors and dentists will be familiar with the *Atlas of Healthcare Variation*, which shows variation in the health care received by people in different geographic areas. The New Zealand Atlas aims not to make judgements but to stimulate debate on health care inequalities.

A new perspective on IT

Quality outcomes data is essential if we are to uncover the unwarranted variations in health care. And yet in New Zealand it's all too common for chief information officers to report to chief financial officers, and to be treated as if their work was nothing more than part of back-office operations.

> *We are facing several trends that will have a great impact on health care.*

Strong leaders are challenging this view. At Canterbury DHB, for example, Chief Medical Officer Dr Nigel Millar has the Chief Information Officer (CIO) report to him because he and his executive colleagues recognise that robust information is vital to the quality of the care delivered to the community.

And at Counties Manukau DHB, Professor Jonathan Gray was appointed by the Chief Executive to address the urgent need for transformational change in the way health care was designed and delivered for South Auckland communities.

A significant step was the launch of Ko Awatea as an educational centre where people were encouraged to meet, share ideas, carry out research and access the latest information on health care quality improvement.

How do we lead our organisations to deliver high-quality outcomes for patients? The answer is by measuring what we do. If it can't be measured, it can't be managed.

Clinicians as architects

Clinicians – working in partnership with consumers – need to be architects of the health system, and should accept the need to measure the impact they have at both a population level and at an individual level.

For example, are our intervention rates correct? Do we have the information systems we need to deliver services? Will our health system be sustainable with the changing dynamics of population demand?

Everything we do should be within the context of a quality model – high quality care for the people, by the people.

We are facing several trends that will have a great impact on health care. These trends include rising consumer expectations, an aging population, and rapid advances in science and biology that will increasingly allow personalisation of the health system.

In the future, empowered consumers will do their own research, use monitoring equipment and have access to personalised medications to maintain their own health and wellbeing. Health professionals will need to respond as part of the consumer's team.

How will the leaders of today adapt to this trend?

> *Health care professionals must take a lead in designing and building systems of care.*

I'm reminded of a keynote address given by Professor Sir Muir Gray to the Asia Pacific Forum on Quality Improvement in Health Care in Auckland in 2012.

Sir Muir, director of the National Knowledge Service and Chief Knowledge Officer to Britain's National Health Service, identified three forces driving a revolution in health care: citizens, knowledge and technology.

Health care professionals must take a lead in designing and building systems of care to support this revolution, said Sir Muir. "If you do not imagine and plan and build the future, someone else will."

Graeme Osborne

DEPUTY EXECUTIVE DIRECTOR

The annual salary survey: 1.2% increase in base salary for specialists

The ASMS has been running this survey since 1993, but the survey's purpose has changed over the years.

Originally it was used to compare salary levels within DHBs (or their predecessors) for the purposes of single employer collective bargaining. Now it provides information on the number and gender of senior doctors and dentists, and their spread over the salary scale.

This year the DHBs supplied information for 4,230 specialists (1,420 females and 2,810 males) and 527 medical and dental officers (249 females and 278 males). This is 208 more specialists since last year and an increase of seven medical officers. All of the information is current as at 1 July 2014.

The survey shows the mean salary of specialists has increased by 1.2% from 2013 and by 0.8% for medical officers. The highest average base salary for specialists is in Wairarapa and the lowest in Counties Manukau. The highest average base salary for medical officers is at Tairawhiti and the lowest is in Auckland.

For the past nine years we have had good data on the gender of senior doctors. Half (50%) of specialists on step one are now women; 20.5% of those on step 13 are female. This is probably a cohort effect as the increasing numbers of female students and registrars work their way through the system.

Also of interest is the distribution of senior doctors on the salary scale. There are 1,411 specialists on step 13, and 509 on step three as at 1 July.

> *The highest average base salary for specialists is in Wairarapa and the lowest is in Counties Manukau.*

The superannuation figures supplied by DHBs have proved to be increasingly problematic as memory of the closed NPF and GSF schemes fades. We have found it hard to get accurate figures from DHBs.

After querying some unlikely responses a few times, DHB figures show 323 senior doctors are on the NPF or GSF schemes. The bulk of our members (3,749) are receiving an employer subsidy of up to 6% for superannuation under the ASMS DHB MECA.

The full results are available on the ASMS website.

Angela Belich

Support services for doctors

MAS and the Medical Protection Society have joined forces to bring their members an important support service. The support service provides access to a free professional counselling service. **Doctors seeking help can call**

0800 225 5677
(0800 Call MPS)

The service is completely confidential.

DEPUTY EXECUTIVE DIRECTOR

The new SMO: colleagues are great, DHB management not so great

Your early experience at a district health board (DHB) probably shapes your view of the employer, your colleagues and, in the case of international medical graduates (IMGs)[1], the country.

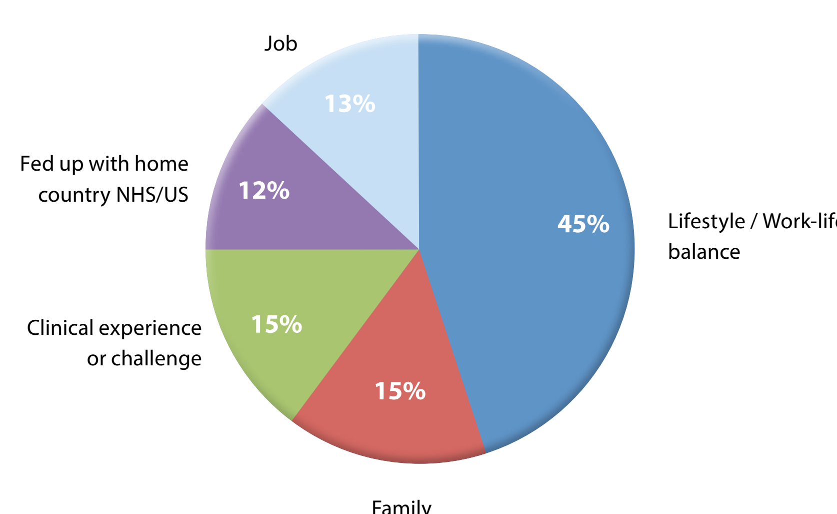
Figures for IMGs taking up jobs in New Zealand show that a disturbing number leave within a short time.

In order to investigate the experience of SMOs taking up a new appointment, ASMS ran an electronic survey of new appointees between 17 July and 15 August 2014. It was sent to 471 ASMS members who were new appointees in DHBs and had started employment in the past two years.

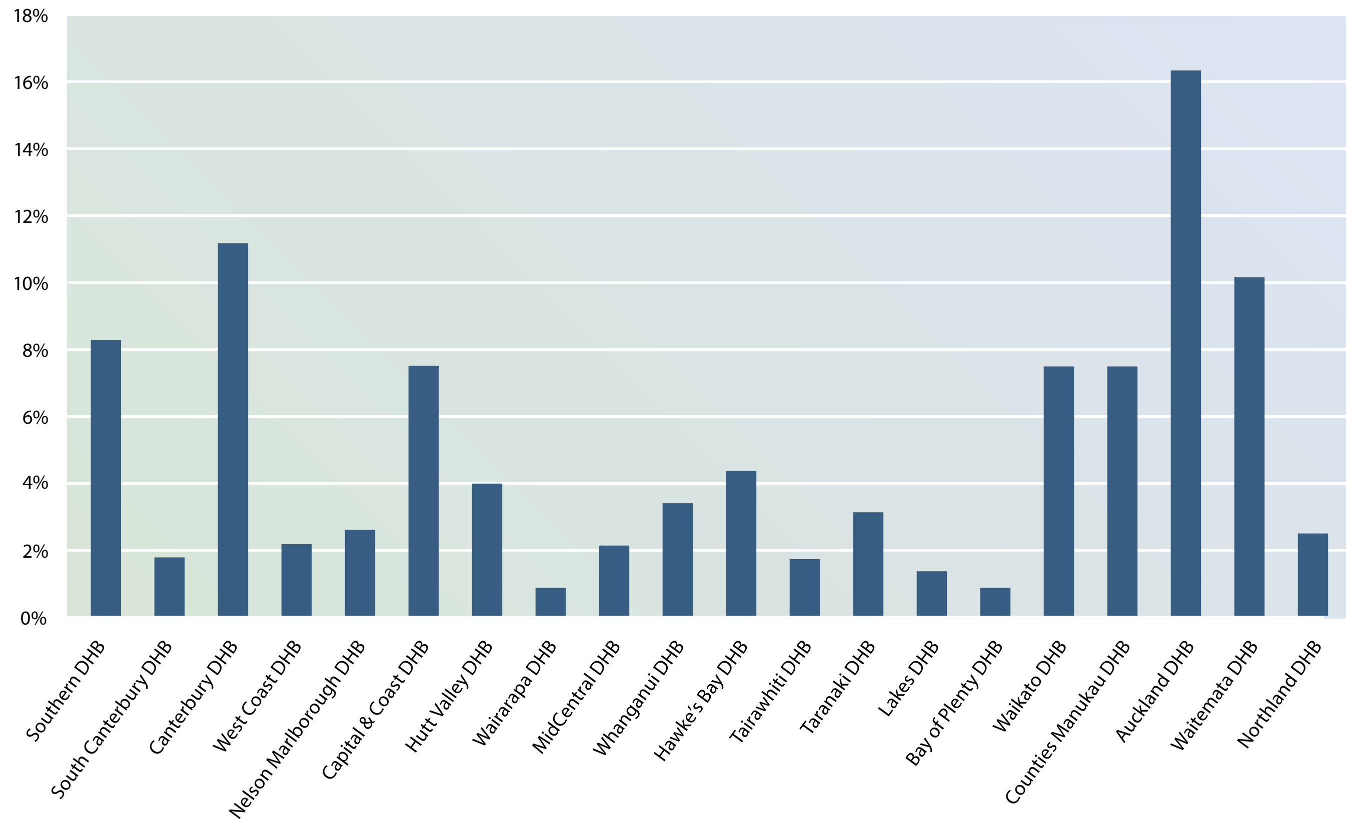
A total of 226 new appointees completed the survey – 48% of the total approached.

It was a good response rate and the spread of DHBs and specialities seem to indicate that it is representative.

Why did you choose to come to New Zealand?



Graph 1. Response by DHB



Respondents were split 50/50 between international medical graduates and New Zealand graduates. We plan to monitor this over time in order to track the proportion of IMGs that are new appointees.

We asked people why they came to New Zealand and found that 45% moved here for reasons of lifestyle or work-life balance. Comments included:

- 'Heard that work-life balance very good.'
- 'New Zealand responded within a day with five job offers as opposed to Australia and Canada which took a week.'
- 'Peaceful and high development index with multicultural and multi-ethical society and excellent human right and justice system. Good people.'
- 'The people are so honest and friendly. The country is so beautiful and has a reputation for honesty and lack of corruption, and a good quality of life.'

ASMS advice

A unique feature of the ASMS approach has been the advice we offer people who are not yet members but who are considering a job offer from a New Zealand employer.

Of those participating in the survey, 30% sought ASMS advice before taking up their appointment. The survey showed that 38% of the New Zealand-trained doctors did so but only 22% of the IMGs.

Encouragingly, nearly all of those who sought ASMS advice found it helpful.

Collegial support / DHB support

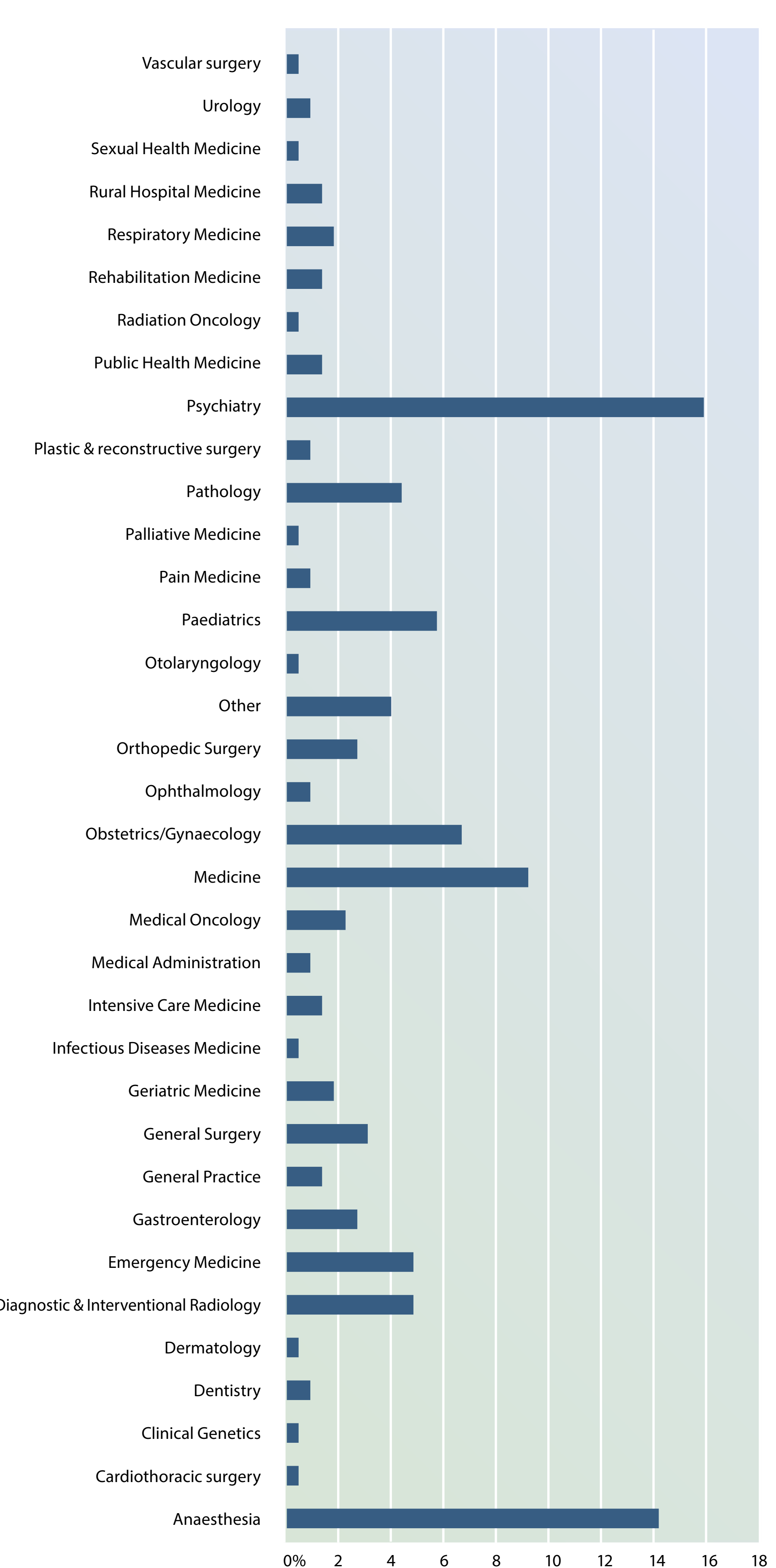
The survey found 35% of respondents rated the support they received from the DHB as excellent whereas 73% rated the support they received from their colleagues as excellent.

Just 29% of people had a DHB mentor.

Fixed-term positions

A disturbingly high proportion of respondents (20%) were appointed to fixed-term positions and some of the reasons for a fixed-term require further examination (see separate article on the legal situation).

Graph 2. Responses by Specialty



1 IMG. International Medical Graduate; someone whose primary medical degree was achieved in a country other than New Zealand or Australia.

The reasons given for a fixed-term appointment included:

- 'To be converted to permanent post on vocational registration.'
- 'Eight months MOSS, then review pending fellowship exam result.'
- 'Covering a vacant Intensivist position and a permanent staff leave.'
- 'As I had not worked for previous year as I was caring for my wife it had to be a locum, I understand.'
- 'They were taking a risk employing someone they didn't know.'
- 'I was told that this was the policy of the DHB.'

Where to from here?

ASMS members, branch officials and staff will need to monitor the use of fixed terms by DHBs. It is fine to use fixed-term appointments to cover staff leave and perfectly acceptable to use them to cover a position before a permanent appointee is in a position to take up the position. It is not acceptable to use them as a sort of trial.

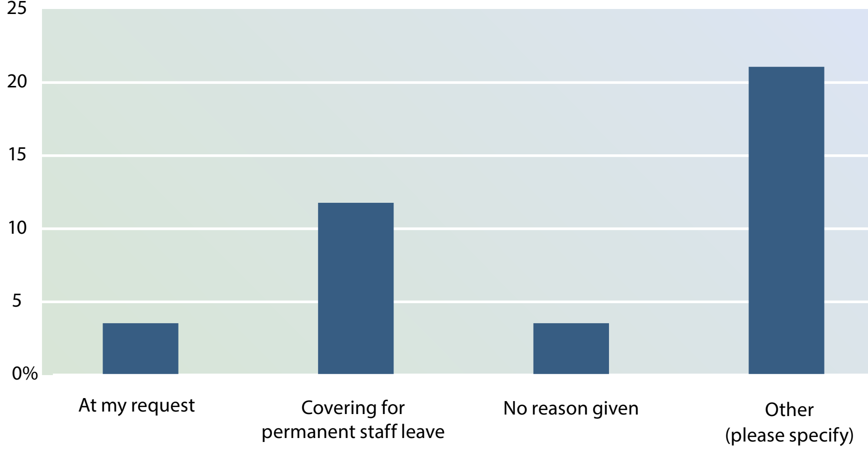
We will also need to consider methods to increase the proportion of new appointees that seek ASMS advice. This might be included as part of a small checklist for SMOs who serve on appointment panels.

Action to increase mentoring might also be useful to all new appointees, not simply part of a package for IMGs.

Finally, we will repeat this survey every two years to see if any of these initiatives have made a difference.

Angela Belich

Graph 3. Why was it a fixed-term appointment



Official recognition of prolonged specialist shortages

At last! The release of two Health Workforce New Zealand (HWNZ) reports in November provided long overdue official acknowledgement of prolonged medical specialist shortages in public hospitals.

On page 13 of one of the reports, *The Role of Health Workforce New Zealand*, is the statement that:

> *While the Taskforce initially focused on the immediate postgraduate period, it has now adopted a whole-of-career perspective. The most important issue currently is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors. Other areas under consideration, some of which are directly related, include the distribution and long-term retention, including retirement intentions, of doctors trained in New Zealand and overseas. Leadership opportunities in systems improvement and innovation, consistent with the In Good Hands report on clinical leadership, are another focus for the taskforce.*

The legal situation

Overseas-trained doctors taking up positions in New Zealand may not be familiar with important aspects of this country's employment laws.

For instance, they often do not realise that New Zealand's employment laws generally require job offers to be for permanent positions.

The exception is when an employer has a "genuine reason on reasonable grounds" to offer a non-permanent position (see s66 of the Employment Relations Act 2000).

A "genuine reason" might be that a fixed-term appointment is needed to cover for an SMO on leave, who is due to return to work on a specified date. Or perhaps a temporary appointment is needed to cover for another SMO who has been seconded to a project of finite but uncertain duration (an "event" or "project" based reason).

An employer cannot make a fixed-term appointment for vague reasons such as workflow or funding uncertainty, unless the employer has reasonable grounds for believing the position will disappear soon.

It is the employer who needs to have a reason, and the reason needs to be stated in the job offer. Employees do not need to feel pressured into signing fixed-term agreements where no reason is offered by the employer. Prospective employees should contact ASMS if no reasons for the fixed term are given.

An employer cannot use a fixed-term contract to test an employee's suitability for a position.

A genuine reason cannot be that an employee wants a fixed-term position. SMOs taking positions in New Zealand to "test the waters" can advise the employer informally of an intention to remain in New Zealand for a limited time, but shouldn't ask for a fixed-term agreement. Being on a permanent contract gives an SMO the option of remaining longer if their circumstances change. SMOs can keep the employer informed of their intentions, and give formal notice of leaving (three months' notice is required at DHBs) at the appropriate time.

A temporary work permit is not a genuine reason for a fixed term employment when it is likely that the work permit would be extended on application.

If you are unsure about any aspect of the legality of your employment contract, please contact us at ASMS.

SENIOR INDUSTRIAL OFFICER

Supporting international medical graduates

The last issue of The Specialist looked at the way Taranaki District Health Board is helping overseas-trained doctors settle into their new jobs. This article follows on from that.

The ASMS industrial team presented a challenging session to ASMS Branch Officers at their meeting in Wellington on 27 August.

Of specialists on the New Zealand medical register, 42% are international medical graduates (IMGs). Without them, many of our specialist hospital services would simply collapse and be impossible to resurrect.

When another foreign locum (or if we are lucky, permanent appointee) turns up to fill the vacancy left by the last New Zealander to retire, to work solely in private, or leave for a more lucrative or professionally supported position overseas, do we offer silent thanks that "we" may now be able to cope (or take our leave)? Or do we wonder how yet another IMG and his or her family will cope in our "foreign" country, whose culture and egalitarian ways we know so well and are so very proud of?

The industrial team is concerned that perhaps a disproportionate number of new IMGs find themselves in difficulties within the first year or two of their appointments. All too often, it seems, these IMGs are confronted and perhaps bewildered by our "kiwi" culture of directness and egalitarianism that gives rise to complaints from colleagues with low tolerance or understanding of "difference"?

> *Without IMGs, many of our specialist hospital services would simply collapse.*

The employment exit survey of IMGs and Lyndon Keene's research (reported in the September 2014 issue of *The Specialist*) suggest that IMGs are less likely to remain working in New Zealand than our local graduates (who are also leaving the country).

The surveys suggest that all too often IMGs leave New Zealand because of difficulties they or their family have experienced adjusting to a new country and culture or a lack of professional support or understanding from the Medical Council, employers and colleagues.

This is a serious problem and one that needs to be acknowledged and tackled by the different agencies that have an interest in recruiting and retaining medical graduates, in particular international medical graduates whose services our public health service will rely on for many years to come.

ASMS is now actively investigating ways in which we and employers may welcome and support IMGs and their families from the moment they arrive to take up their new appointment. We will also actively engage with the appropriate agencies, including the Medical Council and Colleges, Ministry of Health, District Health Boards and the Medical Protection Society to ensure all new IMGs receive comprehensive practical orientation followed by sympathetic mentoring and effective supervision.

In this way, we hope to ensure that fewer IMGs leave New Zealand because they have not been made to feel welcome and valued in their new (but foreign) country.

The industrial team would be very pleased to receive your thoughts and ideas about how we might all provide more effective support for recently appointed IMG members and their families.

> *We are investigating ways to ensure IMGs are welcomed and supported as they settle into their new roles.*

We are particularly keen to hear directly from our IMG members themselves about their experiences in coming to New Zealand and what we and other organisations might have done to be more supportive and assist them and their families to settle in.

Henry Stubbs

Life membership award for Canterbury doctor

Canterbury child psychiatrist Dr Brian Craig has been made a life member of the ASMS.

Conference delegates voted unanimously at the ASMS Annual Conference to recognise Dr Craig's many years of service to the Association, in both local and national roles. Delegates gave Dr Craig a standing ovation as he entered the conference hall following the vote.

He joins a small group of other life members – John Hawke, James Judson, George Downward, Allen Fraser and Peter Roberts.

Dr Craig told the Conference he was humbled by the recognition as he had gained so much personally from his association with the ASMS over the years.

A short videoed interview with Dr Craig can be viewed on the ASMS website.

NATIONAL PRESIDENT

Address to the ASMS Annual Conference

My Dad recently passed away and one of my tasks was to tidy his study, back-up his still running computer, and shut it down.

A retired psychologist, he had thrown himself into writing a book about the impact of language on our lives; in particular, how it can affect our thoughts, actions and relationships. In one chapter he explores the fact that we quite often use terms that can mean different things to different people. Pretty vs Ugly. Success vs Failure. Integration vs Separation. One person's success might be very different to another person's idea of success. The meanings of words are subjective and open to many interpretations.

This made me think about the language and concepts being used here in New Zealand to describe, influence and change our health care system. The language and words are often vague and the interpretation subjective at best. Considerable time, effort and resources are then used in an attempt to bring that subjective interpretation to life.

One thing led to another and I thought it would be interesting to construct a meeting buzz word bingo. Many of you will be familiar with the concept and I'm sure you have words of your own that could also be used.

Buzz word bingo

There are many ways to put together a jigsaw puzzle – but the result should be the same. You have a reference picture to look at, to guide you and to confirm that you have completed it correctly.

Where is the picture for our health care system? Who has it? Can we have a better look at it?

> *Where is the picture for our health care system? Who has it? Can we have a better look at it?*

Yoki Berra, a famous retired USA baseball player, said: "If you don't know where you're going, you might end up some place else". I have this nagging feeling that parts of our health care system are heading someplace else at the moment. District health boards (DHBs) interpret concepts and implement them. Most of the time they appear to be doing so without a clear "reference picture", which makes me wonder how they know if the jigsaw puzzle has been completed successfully.

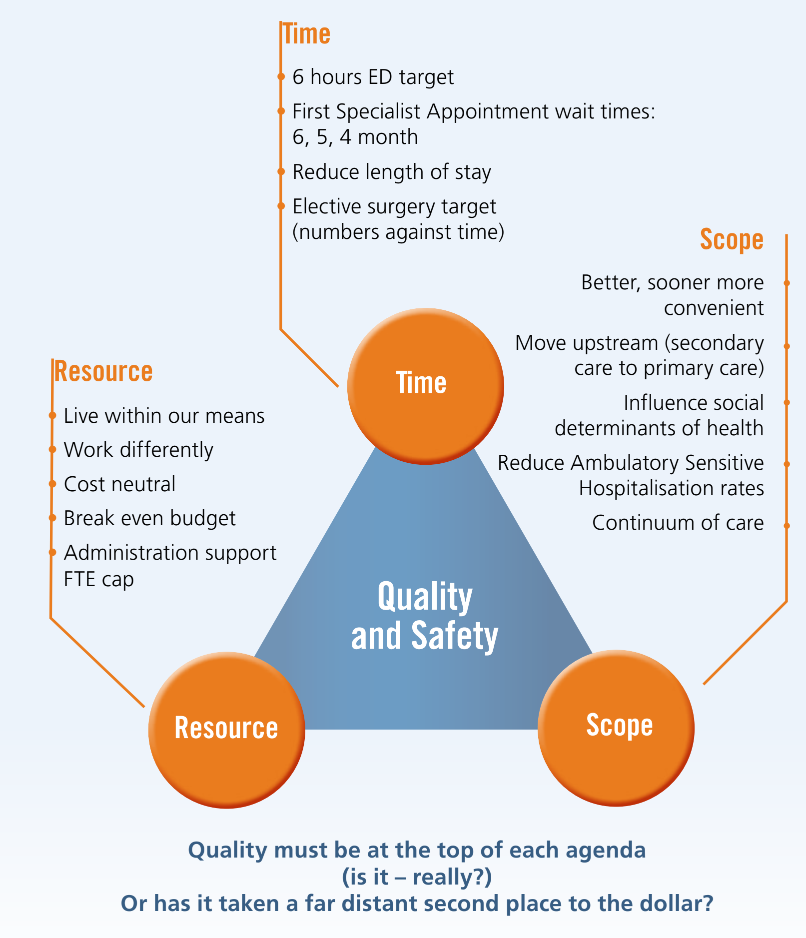
As mentioned, these concepts have an impact on resources (money, staffing levels, etc), time (working faster to achieve more in the same time frame) and they increase the scope of what we are expected to do in the public health care system. The relationship between time, scope, resource and quality are well known. In health care, we should add safety to quality.

The relationships are captured in the Triple Constraint or Iron Triangle. This is widely accepted and is self-explanatory.

If you need to complete a project in a shorter amount of time, you will need more resource or you will have to reduce the scope; otherwise quality and/or safety will be compromised. If you widen the scope, you need to increase time, resource or both, etc.

I want to take a closer look at the current drivers/targets and concepts and see how they relate to the triangle.

Currently pressure is being applied to all three aspects of the triangle in the hope this will increase efficiency and effectiveness. But will it? Up to a point the health care system can reduce waste and become more efficient but then something will have to give. Quality and safety (patient care) can begin to suffer or the system can try to cope by letting fewer patients into the system. If the hand basin is full, turn off the tap or it will overflow.



Dealing with complexity

When do we reach the point where things start to come apart? That is difficult to determine. Health care systems and delivery are complex. The effect of change or pressure on the system often do not follow a "domino effect" where the fall of one domino leads to the predictable fall of the next. It is more akin to a "butterfly effect", where you fiddle with something over here and something quite unpredictable and unforeseen happens way over there. In other words, it can lead to unintended consequences.

> *The effects of change or pressure on the system often do not follow a "domino effect" where the fall of one domino leads to the predictable fall of the next.*

I am not saying we should not try to improve the system (quite the opposite, in fact). We need to tread carefully, however, and be alert for unintended consequences. These can potentially have a significant negative impact and are more likely to occur if changes are further encouraged with 'carrots and sticks', especially if the carrot or stick is big. This can lead to gaming of the system or perhaps ignoring or not reporting the true situation, thereby avoiding the stick or alternatively being awarded the carrot. This can contribute to the creation of an environment where a "Mid-Staffordshire" type event is more likely to occur or repeat itself.

Are there early warning signs or red flags to indicate we are reaching a point where things might start to unravel? Yes, indeed – as I have mentioned, quality and safety might start to suffer and/or the system might try to cope by letting fewer patients into the system (eg, to meet the maximum waiting time target for electives).

The recently released report by the Health Quality & Safety Commission shows the number of serious adverse events reported in the year to June has again risen, more than doubling since the first report in 2007. This has been attributed to increased and better reporting by the health sector and, while this might be the case (in part at least), I think we should watch this space very carefully.

A recent article in the New Zealand Medical Journal shows that 36% of patients needing hip and knee replacements (in the two DHBs where the audit was done) are not getting them because of budget restrictions. Meeting the waiting time targets further impacts on these figures: **http://www.radionz.co.nz/national/programmes/morningreport/audio/20156313/shorter-wait-times-squeezing-patients-off-waiting-list.**

This adds further weight to the increasing concern and evidence of a growing unmet health need in New Zealand. This seems to have gone past the point of 'watch this space'. There is increasing evidence that things are starting to unravel.

We must be careful what we measure. Measuring number of units performed against time (the expectation is to do more in less time) and simultaneously putting significant pressure on resource (break even budget or else…) can lead to unintended consequences. The six hour ED target is a good example. We measure time (six hours) but not quality or safety or the compassion of service delivery. Because we are not measuring it, is it less important? As long as everybody is out the door within six hours, the target has been met.

Is putting pressure on all three aspects of the iron triangle a method of driving "disruptive innovation"? I don't think Harvard Business School professor Clayton Christensen, who invented the term and concept, would approve.

Time to change the triangle

I am proud to be working in the New Zealand public health system, one of the best in the world. The New Zealand public seems to support that view. In a recent article in the *New Zealand Herald*, Brian Gaynor explored the differences in private health insurance coverage between New Zealand and Australia: **http://www.nzherald.co.nz/brian-gaynor/news/article.cfm?a_id=14&objectid=11351424.** In it he states: "But the most frightening statistic is that only 12.5 per cent of New Zealanders aged 65 and over are covered by health insurance compared with 52 per cent across the Tasman".

I do not find that frightening at all. I find it reassuring that most people over 65

years of age in New Zealand entrust their health care to the public health system. That does not mean we can pat ourselves on the back and sit back and relax. We have an obligation to make sure their trust is not misplaced. We must continue to innovate, improve and modernise our health care system. Surely there are alternate ways of achieving this, other than trying a top-down "squeeze" on the iron triangle (it is called that for a reason) and running the risk of compromising quality and safety and increasing the unmet health need?

I recently attended the APAC 2014 meeting (highly recommended) in Melbourne. In Maureen Bisognano's (CEO of the Institute of Healthcare Improvement in the USA) keynote address **(http://vimeo.com/105695300)** she pointed out the importance and positive impact that the joy of the health workforce has on the delivery of health care. At the entrance of the Institute for Healthcare Improvement in the USA people encounter the following sign:

We will improve the lives of patients, the health of communities and the joy of the health care workforce.

Compassionate care

I touched on this topic at last year's Annual Conference and the dangers of compassion fatigue and burnout. This year we have some excellent speakers on the topic.

Have the public's perception of compassion in health care delivery changed? This is obviously difficult to determine or make a call on. I recently came across two paintings depicting doctors in their work environment. The first is the well-known and much written about painting "The Doctor" by Sir Luke Fildes (1887, The Tate, Britain, London). In 1887 the doctor could offer not much more than compassion to the dying child but in doing so inspired the painting: **http://www.tate.org.uk/art/artworks/fildes-the-doctor-n01522.** The second is a painting commissioned in 2002. The artist is Ken Currie (National Gallery, Scotland). It depicts professors in the Department of Surgery and Molecular Oncology at Ninewells Hospital and Medical School in Dundee: **https://www.nationalgalleries.org/collection/artists-a-z/c/artist/ken-currie/object/three-oncologists-professor-rj-steele-professor-sir-alfred-cuschieri-and-professor-sir-david-p-lane-of-the-department-of-surgery-and-molecular-oncology-ninewells-hospital-dundee-pg-3296.**

The artist spent a significant amount of time with the clinicians in their work environment to get insight into their daily working lives and pressures. Their facial expressions are quite gaunt and they look tired. There is no patient depicted but all three seem to have been interrupted in their clinical duties. Their clinical skill and knowledge make it possible for patients to receive individualised clinical care. It is difficult to judge from the painting if compassion is one of those things.

It is difficult to offer compassion if you yourself are constantly tired, rushed and under pressure.

> *Doctors need time to spend with their patients and to ask "what matters to you?" instead of "what is the matter?"*

Doctors need time to spend with their patients and to ask "what matters to you?" instead of "what is the matter?"

Distributive clinical leadership

The importance of distributive clinical leadership is the one aspect of our health care system where there is wide spread agreement, including the Minister of Health (current and previous) and clinicians. We do have a reference document, *In Good Hands* (picture of the jigsaw), and yet after five years the implementation across the country is still variable.

The health care system cannot innovate, improve and modernise without distributive clinical leadership. We need to urgently review this. It is very

A new triangle started to take shape in my mind

Maureen Bisognano asked a few show-of-hands questions during her APAC presentation.

In the past week have you:

- Skipped a meal due to work?
- Eaten on the run?
- Worked a full shift without a break?
- Arrived home late from work?
- Changed family or private plans due to work?
- Drank too much coffee, tea, etc. to keep going?
- Slept less than five hours a night?

In the past week did:

- HR make your life easier?
- You leave work feeling positive about your day?

Thoughts or questions that are not asked at all or often enough:

- Are you happy in your job?
- Are you okay?
- You look tired, take a break.
- Thank you.
- Is there something I can do to help?
- Great job, well done.
- And in some DHBs, isn't it time for you to take your sabbatical?

Who takes or has responsibility to encourage and promote a joyful workforce?

Do we have a measure or performance target for this important aspect of our health care system?

encouraging to hear Health Minister Jonathan Coleman emphasising the importance of clinical leadership.

Effective, efficient, appropriate

Our public health care system already compares favourably with other systems as far as efficiency and effectivity goes. Are we starting to fall behind when it comes to the appropriateness of health care delivery? Countries like Canada and the USA are currently rolling out and promoting the 'Choose wisely' programme, making best use of resources in an evidence-based way, engaging and empowering patients to make the right decisions: **http://www.choosingwiselycanada.org.**

The Doctor by Sir Luke Fildes. © Tate, London.

There are also difficult conversations to be had around frailty care and towards end-of-life care. These conversations can only be had by a clinician who has time to spend with his/her patient and their family to reach a compassionate and well informed decision.

Conclusion

Do not get me wrong, we have a very good public health care system but we should continue to improve and modernise it further.

I have obviously generalised and made some broad statements. The truth and saddest part is that there are good examples where DHBs, managers, clinicians, clinical networks, departments etc have made significant improvements and implemented successful change but their success is not shared or transferred to the more troubled DHBs or areas. We do need to actively seek out the positive deviants and duplicate their successes across the country.

Our jobs are intellectually challenging and physically demanding. We are faced with constant change and the pressure to stay within budget and to do more with relatively less. This can lead to fatigue, compassion fatigue, burnout and a less effective, more prone to mistakes, workforce.

This is not an environment that promotes joy in the workforce.

We need to look after our health care workforce, optimise the work environment and make sure we achieve and maintain joy in our workforce. Clinical leadership has a major part to play in achieving this. Investing money in health care and the health of the New Zealand population is not money wasted.

Our patients and we should expect a safe and high quality health service delivered by compassionate staff in a friendly environment.

Let us change the triangle.

Hein Stander

ASMS Annual Conference 2014

Consultant Psychiatrist at Southern District Health Board, and ASMS Otago Branch President.

Five minutes with Chris Wisely

What inspired you to become a doctor?

I used to love reading about science when I was a kid, about people who discovered things, chemistry and so on. Both of my parents were zoologists, New Zealanders who were working in Australia, which is probably why I learnt to swim in a pool of Port Jackson sharks when I was three. I remember an octopus came up and took my red ball.

My father went on expeditions and my mother did parasitology at one stage. I just thought it was normal to be given worming pills every six weeks.

So the science background was there and the interest. We moved to New Zealand when I was five and I decided early on that I was going to be a doctor, and that's what happened. As to why I didn't become a zoologist, well, I remember thinking that it was easier to talk to people than animals.

Auckland University interviewed me when I applied for medical school and beforehand I had to choose an area of interest, so I chose psychiatry without knowing much about it. I read the book Battle for the Mind by William Sargant, about the effects of shellshock, and it just so happened that the person who interviewed me had read the same book so we started talking about that and it all went very well.

> *As to why I didn't become a zoologist, well, I remember thinking that it was easier to talk to people than animals.*

After training at medical school, I did two years as a house surgeon and six months general practice. I'd intended to go overseas but the bottom fell out of the sharemarket so I had to do something else, and I spent that time in general practice. It was very good. I developed a real respect for the people who work in general practice, especially their knowledge of when to wait, when to watch, and when to send someone to hospital.

I went over to England after that, in about 1988, and fell into doing my higher training in psychiatry, then I came back to Dunedin and got a job with Paul Mullen, a Professor of Psychiatry. I remember talking to him on the phone before I got the job and for some reason I thought he was one of the managers. I was swearing and all sorts, then I asked him what his name was. He told me and I said, isn't that funny, you having the same name as the psychiatrist! There was silence on the other end of the phone. Eventually it clicked.

I told him then that I wanted to work with him and could he find me a job in Dunedin as quickly as possible, which he did.

I started at Dunedin Hospital in 1991, working in forensic psychiatry initially, before becoming a consultant.

What do you love about your job?

I love talking to people. Really, I do. You have a chance to shape a person's whole life rather than just being an ambulance at the bottom of a cliff. You can talk to them about the meaning of life, their spirituality and purpose, as well as the physical issues such as thyroid or diabetes.

> *At the end of the day it's hard to define clinical wisdom, but it's about knowing when to act and when not to act.*

You form extraordinary relationships with people and you can make a real difference. People only feel down or depressed if they feel they can't do anything about the situation they're in. Sometimes you'll say something that makes a difference, you don't know what it is but it ends up changing things for the person.

At the end of the day it's hard to define clinical wisdom, but it's about knowing when to act and when not to act.

My wife, Jubilee Rajah, is also a psychiatrist, working in student health. It really helps being with someone who works in the same field and knows what it is like.

What is the most challenging aspect of practising medicine?

It annoys me when I have someone I need to admit and they don't have the beds available. If someone needs an assessment, they shouldn't have to be at the point of suicide or homicide to be observed and assessed.

In his spare time, Chris Wisely takes photographs, swims, plays table tennis, learns Maori, and walks his dogs.

A lot of the people we see do not have a support structure. We used to get people in the hospital for a while and observe them, but now it's very much in and out in a hurry. It's still very valuable to be able to have a really in-depth clinical assessment over time.

One of the most challenging things is when we don't have a good working flow with our management or when colleagues attack each other when they feel stressed.

The future focus will certainly be nutrition in all its facets – the use of tailored diets to treat conditions and watch out for viruses (the dark matter we know little about even though almost 50% of our genetic material is viral in origin).

Why did you decide to become a branch officer for the ASMS?

An anaesthetist called David Bowie (yes, the same as the singer) asked if I could go along to a union meeting to discuss the contract because he felt bullied by the managers. That was in the mid-1990s. I went along and at one point I took exception to one of the managers' comments that doctors have no idea about budgets.

Then David Bowie told me he was going to Christchurch and could I take over the union role. So that's what I've done since then.

What have you learnt from this experience so far?

The importance of having a good long-term plan and sound principles on which to build a sustainable health system.

> *It's about making connections and supporting each other.*

What looks like union wrangling to some is actually about setting the conditions and shaping health policies. You've got to have that, without it we'd be in total chaos.

One of the things I love the most about the ASMS is the annual conference. It's the one time I get to see my colleagues from all different branches of medicine gathered together in one place. It's fantastic being able to talk to other doctors, sharing problems, and finding out the latest developments.

It's about making connections and supporting each other.

Northland DHB – investing in a culture of encouraging sabbaticals

When paediatrician Catherine Bremner was considering a sabbatical from her job at Northland District Health Board, one place stood out: a busy 300-bed private mission hospital near Nairobi in Kenya.

Northland District Health Board

She'd heard good things about it from colleagues who had spent time there, and it ticked all the right boxes for the type of professional development she was seeking. While the hospital had access to some of the technology she was used to – x-rays, basic bloods, a CT scanner – it relied more on the clinical skills of doctors than the latest technology.

"It involved a very different practice of medicine and I thought it would challenge and refresh me," she says. "I'd be working somewhere where a lot of people don't speak English and I wouldn't be familiar with the culture and the cultural backgrounds of the people I'd be dealing with."

She spent two months in 2012 working with an American paediatrician at the hospital in the province of Bomet, supervising junior staff and running two paediatric wards and a large neo-natal ward.

Two years later, she's still reaping the benefits of her sabbatical – and so is the Northland DHB.

"My time in Bomet left me with a real appreciation of the importance of our clinical skills and also how much it's possible to do when you have very little," she says.

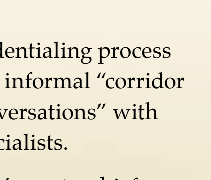
"I've always thought I had reasonable clinical skills but I learnt a lot from watching and working with the paediatrician who had been at the hospital for nine years, the nuances he picked up on and the importance of the patient's history and examination in helping us decide what investigations were needed.

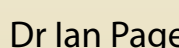
> *"I've always thought I had reasonable clinical skills but I learnt a lot."*

"I'm much more aware of these issues now as I work and the whole experience really recharged me and gave me fresh perspectives."

That will be music to the ears of Ian Page, Northland Branch President of the Association of Salaried Medical Specialists (ASMS), a doctor at Northland DHB and a strong advocate of the value of sabbaticals.

He says the DHB has been developing a culture of actively encouraging hospital specialists to take sabbaticals. It discusses sabbaticals in the Joint Consultation Committee (JCC) meetings the ASMS has with management, as well as during the DHB's credentialing process and informal "corridor conversations" with specialists.





Dr Ian Page

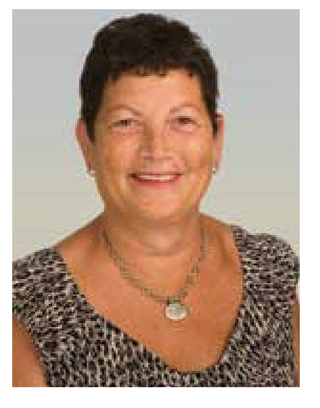
"We've got a chief executive here who recognises the value of SMOs continuing to develop professionally and who understands that improvement is continual. There's a growing awareness of the benefits to the DHB, and specialists are increasingly seeing the benefits of upskilling."

> *"People come back full of enthusiasm, ready to apply their new knowledge and insights."*

Chief Medical Officer Mike Roberts says that having time away to reflect on their work and how to improve it or develop their skills further is hugely valuable.

"People come back full of enthusiasm, ready to apply their new knowledge and insights. That alone outweighs the cost of providing

Below, Dr Catherine Bremner with two interns while on sabbatical



Jeanette Wedding

locum cover for them over the period of the sabbatical."

He says he takes every opportunity available to recommend a sabbatical to the DHB's hospital specialists.

"Sometimes they are working so hard they worry their patients will suffer if they go away for a few months," says Mike Roberts. "I understand that but I try to stress to them that they will gain a lot from the experience and in fact what they learn will actually enhance their patient care."

That's echoed by the DHB's Lead General Manager, Jeanette Wedding, who says the DHB benefits from the sabbaticals.

"People bring something back to the organisation and they share what they have learned within their own departments, and also in presentations to Grand Rounds, etc. It's a real learning experience. You might be exposed to something completely different, an improvement or a different way of working."

She says the DHB makes sure that its clinical directors, general managers and people working in the DHB's services know they can apply for a sabbatical.

"For me, as a general manager, if I was talking to some SMOs and they mentioned they were thinking of doing some study etc, I'd encourage them to apply for a sabbatical. There's a lot of that informal type of encouragement happening within the DHB."

Jeanette Wedding also noted the value of discussing issues to do with sabbaticals at the JCC meetings with ASMS. She says it can be a challenge for the DHB to provide cover for specialists to take leave but it does its best to accommodate this.

Ian Page acknowledges the difficulties of this, especially in small departments but says there are ways of dealing with these issues. For example, instead of leaving the DHB for three months to go somewhere else, the specialist might choose to spend a day a week gaining new skills, for an extended period of time.

"It's quite a thing to organise but it helps having a culture within the DHB that is more open to people taking sabbaticals," he says. "The number of people taking a sabbatical is still quite low but it's increasing.

"I think now that if the clinical head of a department signs off an application for a sabbatical, there's an expectation that management will say yes, that's fine, how can we make it happen? That's the culture shift that has occurred here."

The neonatal unit at a private mission hospital in Bomet

The keys to a successful sabbatical

Anaesthetist Helen Frith attributes the successful use of sabbatical leave in her department at Counties Manukau DHB to a combination of knowledge, encouragement, and good planning and rostering.

As the recent head of department for anaesthesia at the DHB and the ASMS Counties Manukau Branch President, she made sure her colleagues knew they could apply for a sabbatical – and also that they needed to get in early.

"I asked people to come and see me about 18 months in advance so we could talk about what they'd like to do," she says.

"I then made sure the application was taken care of in plenty of time, a year in advance, and I ensured that sabbaticals occurred sequentially within the department in order to minimise the impact on the roster. Mostly we have been able to cover the leave by employing specialists on fixed term contracts."

Helen Frith says sabbaticals are very successful within her department and provide a lot of value, both to the individual hospital specialists but also to the department and the DHB as a whole.

"The DHB needs us to be at the peak of our clinical skills, which means we need to take up opportunities for professional development.

> *"The DHB needs us to be at the peak of our clinical skills, which means we need to take up opportunities for professional development."*

"Some people use the leave for their individual learning experience but as a department we still get the benefit of that. They return from their sabbatical with a new skill or new information, and it gets shared around. It seeps in to the work we're all doing."

Sabbatical leave is generally not included in departmental job-sizing projects because it cannot be guaranteed that there will be an SMO on sabbatical all the time. In large departments like anaesthesia at Counties Manukau, with 68 anaesthetists, there will always be someone who is eligible to take a sabbatical so job-sizing for it is something to be seriously considered.

She says it would be a disincentive for SMOs to take sabbatical leave if locum cover was not obtained and one's colleagues had to take up the slack or clinical service reduced. This could be a problem in smaller departments.

In addition, having flexibility in how a sabbatical may be taken has proved very beneficial.

"Initially it was expected that people had to go away for the three months when they took a sabbatical but now the MECA states it can be split into parts, which is often more manageable. That means it doesn't interfere as much with family lives or their clinical practice."

Helen Frith

What the DHB MECA says

Under the DHB collective employment contract (the MECA), you can apply for a sabbatical for three months on full pay after six years' service.

Your sabbatical is subject to approval but this cannot be unreasonably withheld.

Employers are expected to actively encourage you and your medical colleagues to undertake professional development and education.

Where practical, the planned dates for your sabbatical must be agreed with your employer at least a year in advance.

There is no rule requiring you to take the sabbatical in a single continuous period. If you'd prefer, or if it would make sense for the sabbatical you have planned, you might choose to take a sabbatical as a series of separate periods (for example, one day a week, or as a series of fortnights).

The sabbatical needs to take place at an appropriate institution or clinical unit, and must be for the purpose of acquiring clinical knowledge, upgrading clinical skills or undertaking an approved course of study or research relevant to your clinical practice. It must be taken within six years and sabbatical leave cannot be accumulated.

You can use CME funds to support a sabbatical (Clause 36.1B of the MECA).

ASMS Deputy Executive Director Angela Belich says use of the MECA's sabbatical provision (Clause 36) has gained momentum since the ASMS negotiated the availability of CME funding for use in sabbaticals.

More information is available from the ASMS website at **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-five/clause-36/.**

The ASMS has also produced a Standpoint paper about CME which you might find helpful, and this is available from **http://www.asms.org.nz/wp-content/uploads/2014/08/ASMS-Standpoint-Professional-Development-and-Education.pdf.**

EXECUTIVE DIRECTOR

Changing of the ministerial guard

One generally assumes that when governments change it is time for a change in a number of policies and in styles and approaches. While not normally of the same scale, it is interesting that more often than not this occurs when ministers of the same government change.

Sometimes the differences are due to personal styles and approaches while at other times it is simply the fact the minister has changed that makes the difference because it gives the new incumbent an opportunity to change direction over some matter.

For those working in the justice field, when then Minister of Justice Simon Power did not stand for re-election in 2011, life under his successor from the same government, Judith Collins, must have felt like a change of government, given their chalk-and-cheese personalities.

In late 2007 Labour Prime Minister Helen Clark replaced the increasingly unpopular and polarising Pete Hodgson with David Cunliffe as Health Minister. This was also a significant change with the new Minister much more explicitly interventionist in industrial disputes (as it happened, involving ASMS and our MECA negotiations), facilitating the *Time for Quality* Agreement between ASMS and the DHBs which elevated the status of distributive clinical leadership, and recommending to Cabinet that they reinstate the right of the medical profession to elect a specified number of doctors to the Medical Council (this right had been taken away and changed to one of ministerial discretion by the same government; he was overruled by his fellow cabinet ministers but it was the attempt that was important). These were significant differences, with none imaginable under Mr Cunliffe's predecessor.

On the other hand, whereas the Health and Disability Services Act introduced by then Labour Health Minister Annette King in 2000 was a radical change from its predecessor legislation of the National Government of the 1990s, in late 2008 National's incoming Health Minister Tony Ryall wisely determined to continue this Labour-enacted legislation with only some strengthening in certain areas (for the better and with Labour support).

The new Health Minister

So what do we make of the change from Tony Ryall to Jonathan Coleman (aside from shirts and ties)? The obvious response is that it is far too early to tell but at the very least the fact that there is a change regardless of respective personalities provides opportunities. The new Minister will not openly disown his predecessor's policies and the broad direction can be expected to continue. But just as there can be a deceptively big gap between cup and lips, so there is much in the specifics of the broad direction that offers opportunities, including for the medical and dental professions.

One early sign was the message from Dr Coleman that he accepted that there would be differences between ASMS and the Government over health policies and direction, and that he was fine with that. This contrasts with his immediately predecessor who struggled with this and appeared fixated on the notion that if you were not for him, you must be against him.

Assuming the message from Dr Coleman survives the warm glow of receiving his ministerial warrant and front bench placement (and I'm perennially a glass half full kind of person), this is encouraging. Differences between governments and advocacy organisations such as ASMS are inevitable in a sector as inherently dynamic, innovative and passionate as health, whether it be over direction or pace of direction, issues at the core or around the margins. The trick is how you develop, sustain and strengthen a constructive relationship around this heart of vibrancy. A Minister of Health who views his or her critics as their best friend will be a better Health Minister because of it.

> *The fact that there is a change regardless of respective personalities provides opportunities.*

Dr Coleman has got off to an excellent start with his announcement of the winding down of Health Benefits Ltd. This caught many by surprise, including me, but this financial white elephant has been such a destabilising force in DHBs for far too long. Much of its faults have been due to what directed HBL from behind, rather than the infrastructure itself, but HBL has become damaged goods and a toxic brand. HBL was so much Tony Ryall's baby that the willingness of his successor to make such a bold move quickly sends a powerful message. I'll still stick with my 'it's too early to tell' position mentioned above but the water does seem to be a bit above the halfway mark in my cup.

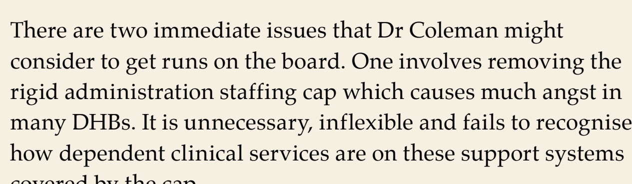
Social determinants

Another area is social determinants of health. Increasingly, not necessarily yet overwhelmingly (but presumably only a matter of time), it is recognised that if we want to make a real transformative difference for the better, then the health system has to focus much more strongly on social determinants such as obesity.

Mr Ryall struggled with this and was clearly uncomfortable and touchy over their public advocacy. It seems ironical given he was an excellent advocate by the deed of healthy lifestyles but there appeared to be a piece of ideology engrained in his belief system that this was a personal rather than collective responsibility.

Well, his successor has not come out batting with the language of social determinants of health. But he has come out with the language of the 'drivers of health' with a particular reference to obesity. Spot the difference!

> *A Minister of Health who views his or her critics as their best friend will be a better Heath Minister because of it.*



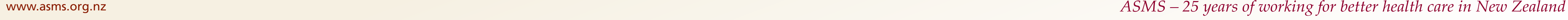
There are two immediate issues that Dr Coleman might consider to get runs on the board. One involves removing the rigid administration staffing cap which causes much angst in many DHBs. It is unnecessary, inflexible and fails to recognise how dependent clinical services are on these support systems covered by the cap.

The second involves removing the financial penalties for the electives target. Targets can have a role in improving systems performance but only in areas that are easily countable, which only constitute a minority of what DHBs do. Consequently they are not a reliable reflection of a DHB's performance. In the context of the provision of public health services, these penalties are a perverse disincentive.

Dr Coleman could make these changes without distancing himself from his predecessor. He could simply say that they have, over time, outlived their usefulness. The real test of Dr Coleman's stewardship will be how he addresses the change of entrenched specialist workshop shortages that have become the norm, but this will take time. In the meantime, there is plenty of low-hanging fruit around to get 'win-win' outcomes.

Chinese leader Chou En-lai reportedly said it was too early to tell whether the French Revolution of 1789 was a good idea or not. Clearly a few weeks are too early to tell whether the new Health Minister offers new opportunities. But we would be fools not to consider this a realistic prospect, and foolish not to explore it to its full potential.

Ian Powell



ASMS 26th Annual Conference

Inspiration, information and connections

A line-up of stimulating speakers on a range of important topics and a valued opportunity to renew connections with far-flung medical colleagues.

That's the feedback from attendees at the 26th ASMS Annual Conference at Te Papa, Wellington, in November following two days of energetic presentations, discussion and networking. A total of 134 senior doctors and dentists from around New Zealand attended this year's conference.

Photos, presentation slides and videos of the key speakers can be viewed on the ASMS website **www.asms.org.nz.**

ASMS National President Hein Stander set the scene with a thought-provoking presidential address, which can be read on page 14 of *The Specialist*. The President of the New Zealand Medical Students Association, Dr Marise Stuart, followed with a few brief comments about her transition from being a medical student to a new role as a house surgeon at Whangarei Hospital, the impact of technology on health care and some of the challenges that lay ahead.

A highlight of the formal business that followed was the decision of delegates to award life membership to Dr Brian Craig. More can be read about this on page 13 of *The Specialist*.

Speakers over the two days included:

- Dr Jeff Brown, ASMS National Secretary, on defining acceptable minimum standards in services and departments
- Dr Peter Huggard, University of Auckland, on building resilience
- Dr Tony Fernando, University of Auckland, on the science of happiness
- New Health Minister Jonathan Coleman delivered his first address to an ASMS conference and you can read more of this on page 28
- Graeme Osborne, National Health IT Board, on the importance of clinical leadership in the work of the IT Board
- Dr Charles Hornabrook, Capital & Coast DHB, on job satisfaction and stress
- Dr Erik Monasterio, Canterbury DHB, on the Trans Pacific Partnership Agreement (TPPA).

Following Dr Monasterio's presentation about the potential impact of the TPPA on health care decision-making in this country, conference delegates passed a resolution to support calls for a formal independent health assessment of the TPPA to be carried out prior to the agreement being signed.

The Conference also voted overwhelmingly in favour of the following second resolution: 'That the ASMS opposes the TPPA on the grounds that health care will suffer from the loss of national autonomy that may result.'

Another conference highlight for many was the opportunity to reconnect with medical colleagues and friends, with functions at The Boatshed in Wellington and a dinner for conference attendees at Te Papa both well attended.

Graeme Osborne

Dr Marise Stuart

Dr Tony Fernando

Dr Peter Huggard

Dr Erik Monasterio

Dr Jeff Brown

Dr Charles Hornabrook

Dr Brian Craig and Dr Hein Stander

Clinical engagement the key to good performance

"Your feedback as leaders in the health system is incredibly important to me as I shape up my approach to the portfolio."

The importance of clinical engagement and leadership in health decision-making was a recurring theme in Health Minister Jonathan Coleman's first speech to an ASMS Annual Conference in November.

He spoke of his visits to public hospitals in his first few weeks in his new role and how struck he had been by the commitment of the health workforce, and the message he had given DHB chairs and chief executives.

"I believe they need to be talking with the clinical leaders and fostering, encouraging and supporting clinical-led decision-making," he said.

"DHBs where clinicians feel engaged are performing better on a range of indicators than those where clinicians feel their views are not being heard. This isn't a coincidence. Clinician engagement makes a difference not just to the morale of a DHB but also to its efficiency and quality of the health care delivered.

"Whenever a DHB chair or chief executive wants to discuss a new idea or service change with me, I say to them: well, what do the doctors think of this?"

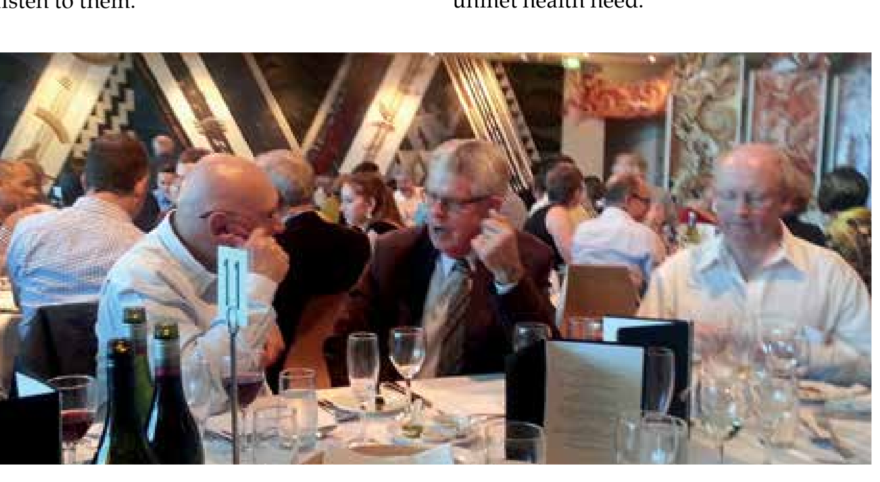
Dr Coleman talked about his concept of 'Team Health New Zealand', which involved people working together to improve health care. He told the audience the health system would continue to face pressures and he was relying on doctors, nurses and allied health professionals to come up with innovative solutions.

He told ASMS members they should never have any doubt about what he thinks on a given issue and he promised to listen to them.

Health Minister Jonathan Coleman

"The door will always be open to talk to the ASMS and to have your views reflected in conversations in the Beehive."

The Minister was put through his paces in the discussion that followed, with questions about the Government's intentions for privatisation of the Wellington region's public hospital laboratories, the training of students, issues to do with speaking out, the Trans Pacific Partnership Agreement (TPPA), business cases started under the soon-to-be-defunct Health Benefits Limited, and the possibility of a target to measure unmet health need.



MPS MEDICAL DIRECTOR

Managing patient expectations and reality

Dr Rob Hendry, MPS Medical Director, shares his thoughts on how to reduce complaints by managing the gap between patient expectations and reality.

In a hectic clinical environment, patient loads are continually increasing and practitioners can see a large number of patients in a week. While focusing on trying to see and treat them all, one is also trying to meet a multitude of expectations – those of patients and colleagues, as well as those outside of work, including family and friends.

The risk is that when we have too many demands placed upon us, it can lead to gaps between meeting expectations and what is actually possible in reality. Unfortunately, and as most of us would have found out the hard way, this can cause patient resentment if expectations are not met, that can in turn lead to complaints.

> *Doctors have the potential to reduce the risk of complaints by improving their communication skills and better managing patient expectations.*

The gap can be closed by taking the time to focus on the basics around managing patients' expectations – a process that begins and ends with good communication.

International research shows doctors have the potential to reduce the risk of complaints by improving their communication skills and better managing patient expectations. The following tips reinforce how important good communication is before, during and after treatment.

Build good relationships

While it's tempting to spend more time with 'happy' patients, it is in your best interests to make an effort to build a good rapport with patients who seem unhappy or nervous. These are the patients who are more likely to make a complaint about you if something goes wrong down the track.

Two-way communication

Shared decision making is where doctors and patients make decisions together, and is widely regarded as an effective approach to improve communication with patients. Patients are encouraged to engage with the healthcare process and consider the options to treat or manage their condition (and the likely benefits and harms of each), so that they can help select the best course of action.[1]

Most patients will have an idea about what is wrong with them and what treatment they anticipate you will provide. It is recommended that you seek to understand what the patient already knows, what is important to them and what their expectations of their proposed treatment are.

Only then should you add your view, based on your clinical assessment, as well as such information as is necessary to add to – or correct – the patient's existing knowledge.

> *The first step is to listen to your patient.*

The next step is to discuss diagnosis and treatment options and address the patient's expectations – even if this means explaining gently why they cannot be met. This is a very important step in preparing the patient for what is to come and could mean the difference between a happy patient and an unhappy patient after treatment. An excellent example is laparoscopic surgery. Patients often have high expectations and work on the assumption that a brief hospital stay and small scar implies that it is complication free.

The benefits and risks of all options available should be discussed, including the possible consequences of no treatment. Assume the patient has no background knowledge whatsoever about their options and think about what you would want to know about the procedure if you were in their position.

Certain information should also be shared, including possible side effects, complications and any considerations relating to their individual past medical and present social and occupational history.

As the discussion progresses, the range of options will narrow as the patient or the practitioner express a reluctance to proceed with some. This will usually lead to one, preferred and mutually agreed decision. Any recommendation made should take into account the preferences, values and expectations of the patient. If agreement cannot be reached, then it may be time to get a second opinion or otherwise halt the process.[2]

Be proactive when things go wrong

When we hear the words: "I wanted… but…" it can be easy to feel stressed or overwhelmed and act in a defensive manner.

If you do find yourself being questioned after an adverse clinical event, mistake, delay, system error or provision of incorrect care, there are certain things you can do to improve the patient's level of satisfaction, minimise the damage to the doctor–patient relationship and reduce the risk of a complaint.

The first step is to listen to your patient and understand why they are upset – they want their story heard and their distress acknowledged. Pay particular attention to non-verbal signs of feelings and emotions and attend to their comfort. This will go a long way in beginning to repair the emotional damage that has been caused.

Next, it is important to demonstrate an expression of regret or sorrow. You could use an apology of sympathy, for example, "I'm sorry this happened to you", or an apology of responsibility, such as "I'm sorry I/we did this to you". In some cases, an apology is all that unhappy patients seek from their practitioner.

> *Good communication and effective expectation management are now more important than ever.*

An open and truthful discussion should follow, including a factual explanation of what happened and any anticipated consequences so the patient is prepared for what to expect going forward. If required, propose a management plan for ongoing care. If you can't provide this, explain how the patient can obtain further help and assist with these arrangements by providing contacts and resources.

Finally, offer some comments on what has been learnt from the incident as well as information on how recurrences will be prevented in the future.

If the patient is still unhappy and you suspect they will make a complaint, contact MPS as soon as possible. A medicolegal adviser will be able to provide you with advice specific on your individual situation.

While these recommendations may seem basic, the current complaints environment is a reminder that good communication and effective expectation management are now more important than ever. In my opinion, they are some of the most important risk management tools a practitioner can employ.

Rob Hendry

1 Elwyn G, Laitner S, Coulter A, Walker E, Watson P, Thomson R. Implementing shared decision making in the NHS. BMJ 2010;341c5146

2 Elwyn G, Frosch D, Thomson R, Joseph-Williams N, Lloyd A, Kinnersley, Cording E, Tomson D, Dodd C, Rollnick S, Edwards A, Barry M. Shared decision making: A model for clinical practice. J Gen Intern Med 2012 27(10):1361-7

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 more than 4,000 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 Direct
In addition to *The Specialist*, the ASMS also has an email news service, *ASMS Direct*.
If you wish to receive it please advise our Membership Support Officer, Kathy Eaden, at **ke@asms.org.nz**

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Please email any changes to your contact details to:
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