THE SPECIALIST

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ISSUE 105 | DECEMBER 2015

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EXAMINING THE CULTURE OF PRESENTEEISM IN NEW ZEALAND'S PUBLIC HOSPITALS

DR CHARLOTTE CHAMBERS | PRINCIPAL ANALYST (POLICY & RESEARCH)

Senior doctors are going to work when they should be taking sick leave and this behaviour, known as 'presenteeism', is prevalent in New Zealand's DHBs.

A recent survey of ASMS members into self-reported rates of coming to work unwell and amounts of sick leave taken found that 88% of all respondents had turned up to work while ill at least once over the past two years (figure 1).

Respondents variously reported stories of working through extreme episodes of illness, 'never' taking sick leave and feeling unable to take sick leave for themselves as well as for dependents. One respondent recounted having "a very bad pneumonia last winter – but managed to do a full outpatient clinic, while being seen myself in ED!" and another stated: "I have not taken a day off sick in 30 years. Possibly should have on a few occasions, but if you are only SMO in speciality, you feel unable to do so."

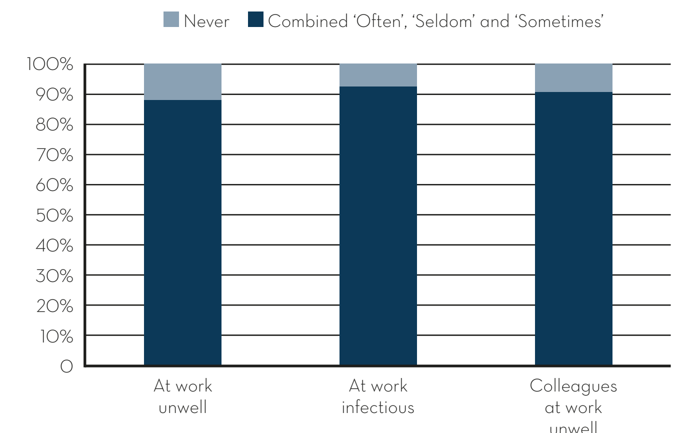


FIGURE 1: LIKERT SCALE RESPONSES FOR PRESENTEEISM OVER A TWO-YEAR PERIOD

Turning up to work with illness is a decision that can have serious consequences for practitioners and patients alike. Senior doctors are well aware of this risk and yet 75% of respondents reported coming to work when ill with an infectious illness over the past two years. This suggests that senior doctors are under enormous pressure to 'present', as for severely immunocompromised patients, exposure to even mild infectious illnesses can be fatal. Presenteeism can also lead to an increase in the number of errors made while at work. While the risk to patients can be considerable, this behaviour can negatively affect the health and wellbeing of senior doctors too. Research has found that people who are unwell but take no sick leave are twice as likely to experience significant coronary events compared to those who take sick leave. There is also a clear relationship between high rates of presenteeism and symptoms of burnout in doctors.

Doctors are renowned for taking very little sick leave and appear to work through illness at a higher rate than other professional groups. Fifty-four percent of respondents reported taking one or fewer days of sick leave over the past year (table 1). Female and younger senior doctors were more likely to come to work unwell than their older male counterparts. Those working in larger departments were more likely to take sick leave than those with few SMOs. Length of time worked in the profession had no influence on coming to work infectious but the greater the number of years worked meant that respondents were less likely to display presenteeism than their younger colleagues. These patterns were consistent with findings from other research into doctors' presenteeism in New Zealand and internationally.

TABLE 1: GROUPED ESTIMATES OF SICK DAYS AND DAYS WHEN SICK LEAVE SHOULD HAVE BEEN TAKEN OVER THE PAST 12 MONTHS

Days	Number of days sick leave taken n/1,816(%):	Number of days present at work when sick leave should have been taken n/1,816(%):
0	660 (36)	390 (21)
1	333 (18)	218 (12)
2	296 (16)	367 (20)
3 to 5	328 (18)	630 (35)
6 or more	199 (11)	211 (12)

So why do ASMS members turn up to work despite serious illness, and what can be done about it? Respondents ranked 'feelings of duty to patients' as the single most important reason influencing their presenteeism behaviour (35%). Having clinics or theatre sessions already booked and not wanting to burden colleagues were two other top reasons ranked (27% and 24% respectively). Figure 2 summarises these trends.

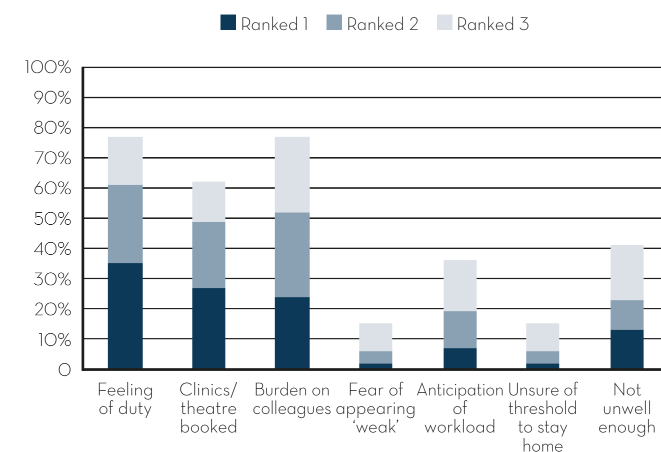


FIGURE 2: GROUPED RANKED REASONS CITED BY RESPONDENTS AS REASONS THEY WOULD TURN UP TO WORK WHEN UNWELL

Anecdotes and statements provided by nearly 40% of respondents gave additional insight into why senior doctors work when unwell. Many discussed their presenteeism with reference to the barriers they perceived around taking sick leave, with sick leave and presenteeism described as two sides of the same decision-making process. Sixty-six percent of respondents emphasised lack of cover as a core issue affecting their ability to take sick leave as illustrated by the following comment:

> *"There is no redundancy in our senior roster for sick leave cover. SMOs are not only expected to cover for other SMOs' sick leave, but also RMO and MOSS staff groups too. We routinely have 1–2 sick calls per shift, more on weekends. This sick cover is on top of a massive amount of extra locum cover the department currently needs and senior staff are getting 'locum fatigue'. Shifts go under-staffed on a daily basis."*

Comments like this suggest that senior doctors are keenly affected and aware of the pressures on New Zealand's public health system, and feel particularly vulnerable due to the limited scope for short-term sick leave cover. It suggests that under-resourcing of DHBs has served to create workplaces where legitimate sick leave is viewed as an additional burden on top of existing heavy workloads. These insights into presenteeism strongly suggest the need to devise practical solutions to assist with enabling senior doctors to feel able to take leave. Investing in the senior medical workforce to enable DHBs to 'staff up' and have better buffers for short-term sick leave is likely to pay dividends in the long term.

Presenteeism behaviour, however, is unlikely to decrease if individuals are operating in environments where working through illness is viewed as 'normal' or, at worst, 'necessary' behaviour. As another respondent stated:

> *"I have overheard my work colleagues criticise another colleague for taking sick leave many times. This is because in medicine there is never enough staff available and if someone is off sick your work load becomes ridiculous."*

Another shared a story of receiving criticism for taking too much sick leave:

> *"About five years back when my GP asked me to take 2 weeks off work because of work related stress, AND I only took one week off, I received a letter from top management at [DHB] noting that I had taken a week off and how important it was to reduce the number of sick days. I felt very unsupported by that letter and it still stings when I think of it."*

Comments like these suggest that management pressures as well as collegial expectations play an important role in encouraging presenteeism. Nevertheless, this also reflects the high value placed on the support of colleagues where senior doctors will work through illness in order to avoid overburdening their peers. Thirty- eight percent of respondents made connections between the 'culture' of senior doctors and expectations about working through illness. As one respondent noted:

> *"Recently I tried to challenge our culture of working despite being sick, and was told by my colleagues that if the SMOs stayed at home when they were sick there would be no one to look after the patients. Our unit has a strong 'SMO superhero' culture where SMOs are expected to work when sick, and not thought to need sleep."*

Another comment stated simply: "Taking sick leave when not dead is generally seen as 'letting the side down'."

Creating an environment that fosters work-life balance, including greater recognition of the challenges faced by working parents who have ongoing responsibilities for dependents, needs more explicit support. Management and those in leadership positions need to lead the way in changing the view that sick leave represents weakness. Taking legitimate sick leave must be reframed as responsible and healthy behaviour. Nevertheless, finding a middle ground where it is 'ok' to take leave without being seen to be 'letting the side down' will require better cover arrangements as well as a shift in attitude and culture.

The research also suggests that notions of wellness need to be expanded to encompass the significance of psychological illness as well as fatigue and burnout. Encouraging a culture within the medical workforce that recognises the impact of having workers who are struggling as a consequence of depression, fatigue and emotional exhaustion would be an important step in recognising these factors as legitimate reasons to take time off work. As one respondent summarised:

> *"Short staffing with pressure to keep sessions going puts pressure on individuals to turn up despite being unwell. Management [are] not encouraging of appropriate sick leave taking. [There is a] culture in medicine of being bullet proof. Psychological stress or personal crises [are] not seen as valid reasons for being absent."*

It is clear from this research that the senior medical workforce is under stress. Solutions to this clear and present issue must prioritise patient health and safety while continuing to find strategies to improve staffing levels and morale. Presenteeism poses clear risks to patients and practitioners alike. Turning up to work while unwell highlights the value placed on medical professionals' duty of care, but also the tensions in defining responsible behaviour.

SUMMARY OF RESEARCH FACTS

Definition of presenteeism used: Attending work when an individual is too unwell, fatigued or stressed to be productive.

Response rate: 1,989/3,740 (53.2%) responded to at least two questions in the survey, 1,806/3,740 (48.2%) completed the survey in its entirety and 660/3,740 (17.6%) left comments for qualitative analysis.

Respondent characteristics: 41% female and 59% male.

Measures of presenteeism: Likert scale answers over a two-year period and quantitative counts over a one-year period.

Variables: Age (according to five categories), gender, length of time in the profession (four categories), primary DHB and number of senior medical officers in the respondent's department.

Quantitative data: Non-parametric Spearman's rank correlation coefficients and Kruskal-Wallis tests as appropriate. A two-tailed p-value <.05 was taken to indicate statistical significance.

Qualitative data: Iterative process with codes generated from emergent themes until theoretical saturation point reached. Additional quantification of themes per total number of comments.

A full copy of the report on this research, including details of the methodology and references, is available as a *Health Dialogue* from the ASMS website at **http://www.asms.org.nz/?p=4007**

DELEGATES AT THE ASMS ANNUAL CONFERENCE 2015

THE ASMS ANNUAL CONFERENCE – SHINING LIGHT ON ISSUES THAT MATTER

CUSHLA MANAGH | ASMS DIRECTOR OF COMMUNICATIONS

Superheroes, preparing for next year's national DHB MECA negotiations, international trade deals, bullying and unmet health need – just some of the topics on the agenda at this year's ASMS 27th Annual Conference.

More than 120 delegates attended the two-day conference in Wellington in November. The capital obliged in typical fashion: one day of perfect weather, one day of wind strong enough to strip the enamel from your teeth.

As always, the conference featured a line-up of stimulating presentations about a wide range of issues relevant to the work of New Zealand's medical specialists. There were also plenty of opportunities to network with colleagues from other parts of the country, with a cocktail function the night before and a dinner for delegates at the end of the first day of the conference.

In his opening address to the conference, ASMS National President Dr Hein Stander talked about the increasingly toxic environment that doctors were working in. DHBs were under pressure to do more with fewer resources, and this pressure was being transferred onto the workforce. The challenge for the ASMS, he said, was to actively seek to shape the environment so that patients were at the centre of the health system.

Elizabeth Berryman, the immediate past president of the New Zealand Medical Students Association, spoke next, focusing on the results of surveys on bullying within the medical profession. She described her own experience of being bullied daily for a period earlier this year. This resulted in nightmares, tears and worry, and she questioned whether she was good enough to be a doctor. The situation changed when she bumped into ASMS National Secretary Dr Jeff Brown and told him what was happening.

"He said: you don't need to do this alone, we can support you," Elizabeth Berryman told the Conference. "That was the best thing I could hear. I didn't need him to do anything but just needed to know that the support was available."

Superheroes don't take sick leave – that was the title of an address by Dr Charlotte Chambers, ASMS Principal Analyst (Policy & Research), on the results of a survey into presenteeism. This revealing survey of ASMS members employed by DHBs found that senior medical staff were routinely going to work when they were ill. The results are described in more detail in a separate article in this issue of *The Specialist*.

Canterbury forensic psychiatrist Dr Erik Monasterio discussed the implications of the Trans Pacific Partnership Agreement (TPPA) for New Zealand's health system. This followed up his conference presentation last year in which he spoke eloquently about the risks for health care and sovereignty. He was critical of the Government's ongoing lack of engagement with people concerned about the TPPA.

"Democracy is not a toy to be roughly handled or broken just because it doesn't suit an incumbent government's agenda," he told delegates, and he thanked the ASMS for its involvement in a wider campaign for greater transparency around the TPPA.

Executive Director Ian Powell gave an address outlining the ASMS's strategic

DR JONATHAN COLEMAN

DR ERIK MONASTERIO

DR SYLVIA BOYS, INTENT DURING A PRESENTATION

DR HEIN STANDER

DR KEN CLARK

ELIZABETH BERRYMAN

ASSOCIATE PROF PHIL BAGSHAW

DR JEFF BROWN

DR ZARKO KAMENICA

DR RUTH SPEARING, CANTERBURY

MATTHEW MCCLELLAND

HELEN KELLY

DR CHARLOTTE CHAMBERS

DR STEPHEN CHILD

direction towards next year's national DHB MECA negotiations, including linking the objective of the approach to strengthening patient-centred care. Following breakout groups and report backs, the Conference voted unanimously to endorse this approach.

HEALTH MINISTER'S ADDRESS

Health Minister Dr Jonathan Coleman acknowledged the work of senior doctors and dentists in the health system, saying he knows that it was not an easy job and that everyone worked extremely hard. He outlined his priorities in the portfolio (eg, childhood obesity, non-communicable diseases, health IT, and primary care), and reiterated the importance of clinical engagement in health decision-making.

> *"I tell every DHB Chair and CEO that you have to be talking to your doctors," he said.*

Questions from the conference floor included the need for a sugar tax as part of initiatives to combat childhood obesity (the Minister argued there wasn't enough evidence to support this), the lack of engagement on the TPPA (they would have to agree to disagree, he said) and the cap on further loans for medical school students who already have a degree (a case of "watch this space, we know we need to address this issue").

The next session began with a few poignant words by ASMS West Coast Branch President Dr Paul Holt (which included the sense of abandonment of the families by government, including over the failure to address accountability and the watering down of the new health and safety legislation) and a minute's silence to remember the people who died in the Pike River disaster five years ago that day. Council of Trade Unions Economist and Director of Policy, Dr Bill Rosenberg, discussed the Pike River disaster in more detail and outlined the need for a strong system of workplace health and safety.

Dr Ken Clark, the Chief Medical Officer of MidCentral DHB and Chair of the national group of CMOs, talked about the challenges involved in addressing bullying, sexual harassment and other inappropriate behaviour in the medical profession. Effective support, empowered bystanders, good leadership and accountability were needed, he told delegates.

Former Council of Trade Unions President Helen Kelly, with much eloquence, humour and passion, spoke of the need for unions to be seen as public institutions doing valuable and valued work. Unions provided a voice for working people and were influential in getting people to think about work-related issues. They had had a number of successes and were securing pay rises, winning cases, and pushing back on issues like health and safety. She was given a standing ovation at the end of her address.

OTHER PRESENTATIONS INCLUDED:

- Canterbury general surgeon Associate Professor Phil Bagshaw on a research project (partly sponsored by ASMS) into unmet health need (see separate article)
- ASMS National Secretary Dr Jeff Brown on the medicine stories project (see separate article)
- Dr Zarko Kamenica from the Medical Protection Society and Matthew McClelland, QC, on dealing with the Coroners Court
- New Zealand Medical Association Chair Dr Stephen Child on issues of professionalism, leadership and trust.

More conference photos are on page 34.

More information about the conference, including videos of the presentations, is at **http://www.asms.org.nz/news/asms-news/2015/11/06/asms-27th-annual-conference-wellington/**

DR GEOFF SHAW SPEAKS TO A TOPIC

TIME FOR SOCIALISING AFTER DAY ONE OF THE CONFERENCE

THE IMPROVISORS

ANGELA BELICH

WARWICK HOUGH

DR BILL ROSENBERG

ONE OF THE BREAKOUT GROUPS IN DISCUSSION

DR PAUL WILSON, ASMS NATIONAL EXECUTIVE

IAN POWELL

BETWEEN TWO MECAS

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

Seven years ago I had what seemed to be a severe allergic reaction. I was in a meeting when clinicians were told: "that will have to change". My throat started to close up, I found it difficult to breathe and I became extremely agitated. Was I having an extreme reaction to change? We have all been exposed to change throughout our careers. In health care nothing stands still and things are forever changing. I had never reacted to change in this way before. Had I perhaps developed an acute case of tropophobia (the fear of change)?

Fortunately, around the same time, the word 'change' became unfashionable in the health sector and was replaced by integration, regionalisation, transformation and the more euphemistic term 'new models of care'.

So did I have tropophobia? In retrospect; no, I did not. I did not fear change as such but I had reacted to the hidden allergen of clinicians being told to change without being asked for our thoughts or input. The 'In Good Hands' document saw the light not too long after and brought with it the promise of a new era of clinical engagement in decision-making and change.

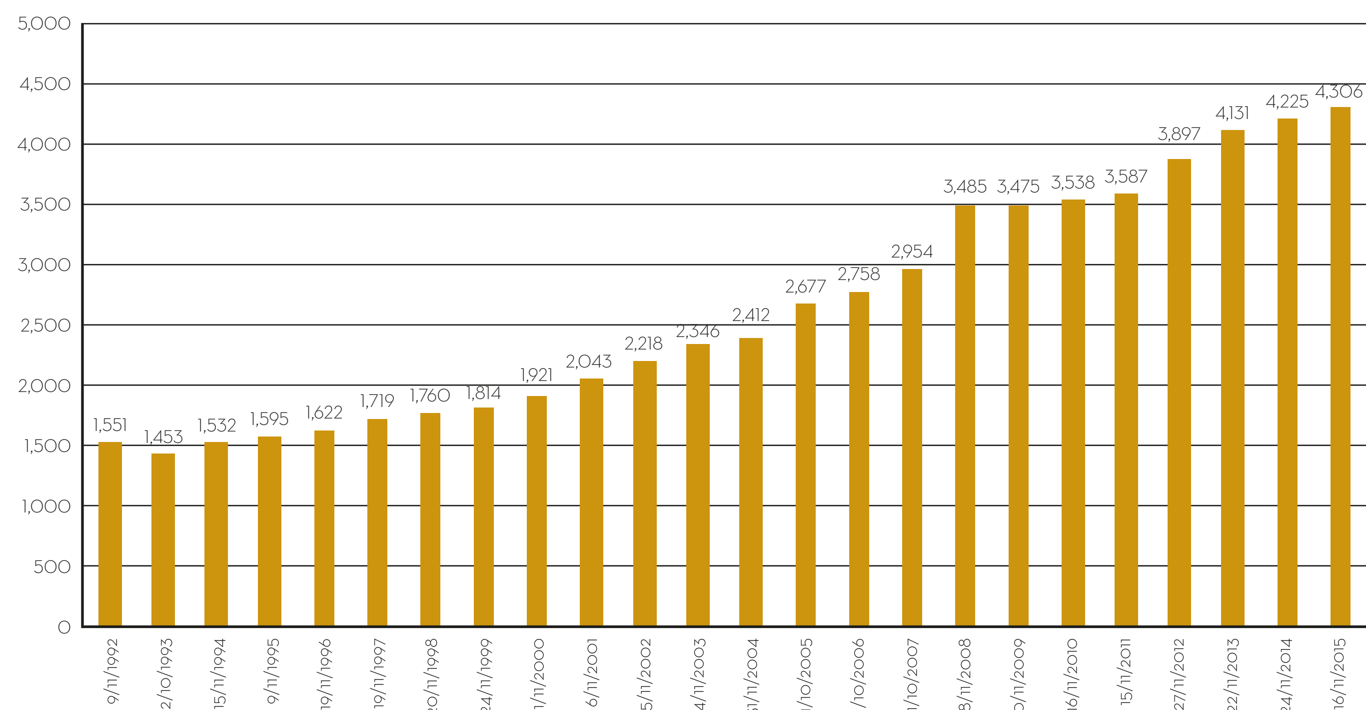
I agree with Nido Qubein, a businessman and motivational speaker, that: "change brings opportunity". As ASMS members, you have opportunities to bring about change and your thoughts and participation are much appreciated.

As you are aware, the ASMS finds itself in the unusual situation of having three years between DHB MECA negotiations. This has given us the opportunity to shift our emphasis and concentrate more on some of the other aspects and functions of the organisation (other than MECA negotiations).

I want to look at some of the changes that have occurred over the past two to three years, and introduce some potential areas of change for the future.

MEMBERSHIP

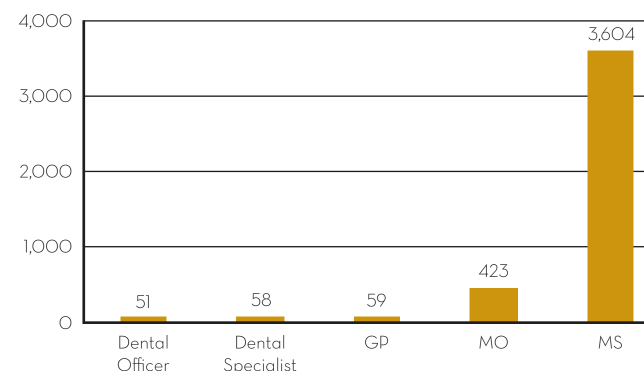
As an organisation, we are going from strength to strength. Our membership numbers have been steadily climbing over the years and the past three years have been no exception.



MEMBERSHIP AT COMPARABLE PERIODS IN PREVIOUS YEARS

YEAR	TENANCY	PERIOD	STAFFING	BREAKDOWN: INDUSTRIAL + SUPPORT	MEMBERSHIP	GROWTH
1998/9	THE TERRACE	9 YEARS	6	3 + 3	1,751–2,833	1,082
2007/8	BRANDON STREET 3/4 FLOOR	6 YEARS	9	5 + 4	2,833–3,901	1,058
2013/4	WHOLE FLOOR (9 YEAR LEASE)	2 YEARS	12	7 + 5	3,901–4,167	266
2014/5		1 YEAR	13	8 + 5	4,167–4,271	104
2015/6		7 MONTHS	15	10 + 5	4,271–4,306	35

The non-DHB sector is a growing area of membership, with 204 members currently. According to our membership rules, we may represent any doctor who is salaried and requires an annual practising certificate to perform their salaried job, aside from those who work in universities, or government departments (excluding ACC). There is a significant scope for recruitment across the sector.



PRACTICE TYPE

Industrial staff have been actively involved in negotiating non-DHB agreements for 16 organisations. (**http://www.asms.org.nz/employment-advice/advice/**)

SUPPORT FOR MEMBERS

INDUSTRIAL SUPPORT

The increase in our membership has also led to an increased need for support. The increase is due to more than what can be explained by the additional numbers in members. There has been a noticeable change in 'attitude' in the DHBs, with a shift in the approach of management and human resource departments, even in those DHBs we have had very good relationships with. Some DHBs have moved to 'zero tolerance' approaches even for quite minor alleged misdemeanours and are more inclined to escalate matters to formal disciplinary action rather than trying to sort it out at the lowest level possible. This has meant additional travel and additional demands on the team as these processes cannot usually be dealt with entirely by phone or email. For the members involved this is an extremely stressful time, they need ASMS help, and they require prompt, reliable and knowledgeable support.

YEAR	STAFFING	MEMBERSHIP	RATIO
2007/8	9	2,833	315
2013/4	12	4,167	347
2014/5	13	4,271	329
2015/6	15	4,306	287

The ASMS responded to the increase in demand and created extra positions, and successfully recruited Steve Hurring and Sarah Dalton. The bigger team also meant we had to restructure to keep the team as efficient as possible.

Having said that we tend to still operate in 'fighting fires' mode and continue to not have much, if any, capacity to be more proactive in our approach.

The 'Know your MECA' workshops have been well received and successful and will continue. Further expansion of our Industrial Officer workforce is envisaged for 2016.

COMMUNICATION

In 2013 the National Executive established the position of Director of Communications and Cushla Managh was appointed from a strong field of applicants.

Communication in its broadest sense has improved dramatically. We have a from-the-ground-up redesigned website that is also mobile friendly and easily searchable. Additionally we now have a Facebook, Twitter and LinkedIn presence and following. *The Specialist* and all our publications have been refreshed and improved to also include our gifted name, Toi Mata Hauora.

RESEARCH

We are all well aware of the big contribution Lyndon Keene has made since his appointment. During National Executive discussions it become clear that the ASMS, in its professional and policy role, lacks capacity for independent research.

ASMS NATIONAL OFFICE STAFF

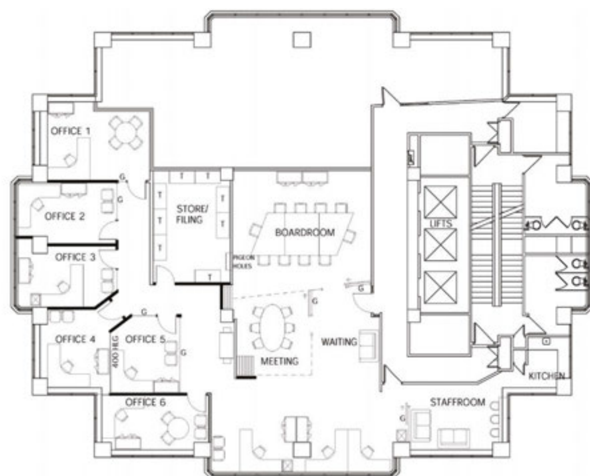
This makes it difficult to comment, promote or influence health policy. Further, we clearly need more data and information on the state of the ASMS workforce and to enhance our ability to 'measure' members' opinions and communicate with ASMS members via electronic surveys, etc. A further research position was created for a Principal Analyst and Lyndon was promoted to Director of Policy and research. Dr Charlotte Chambers came on board in June 2015 and hit the ground running.

Membership surveys have become a very useful and powerful tool.

THE OFFICE

More staff inevitably means more physical office space is required. Previously the ASMS National Office occupied part of the 11th floor of a central Wellington building but, following our expanded staff numbers, we now occupy the entire floor. Yvonne Desmond and her team expertly redesigned and redecorated the whole area.

BEFORE



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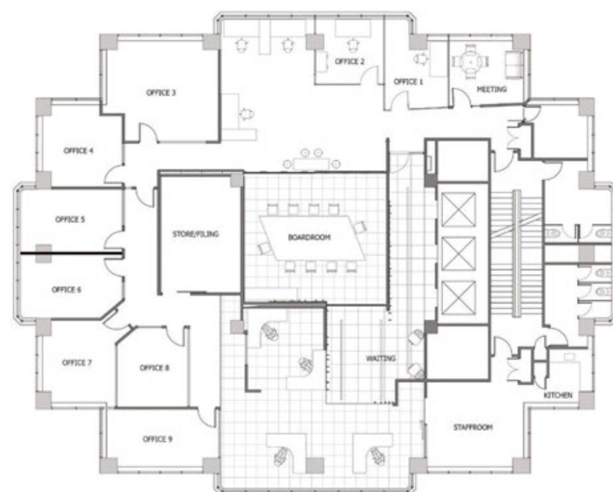


ENTRANCE

BOARDROOM

RELATIONSHIPS AND INFLUENCE

We have welcomed a new Minister of Health, Jonathan Coleman, and a new Director General of Health, Chai Chuah. We have met with Dr Coleman in his office and also welcomed him to the ASMS premises for a meeting. Similarly, the National Executive has met with Chai Chuah in our board room and Ian Powell continues to have regular scheduled meetings with him.

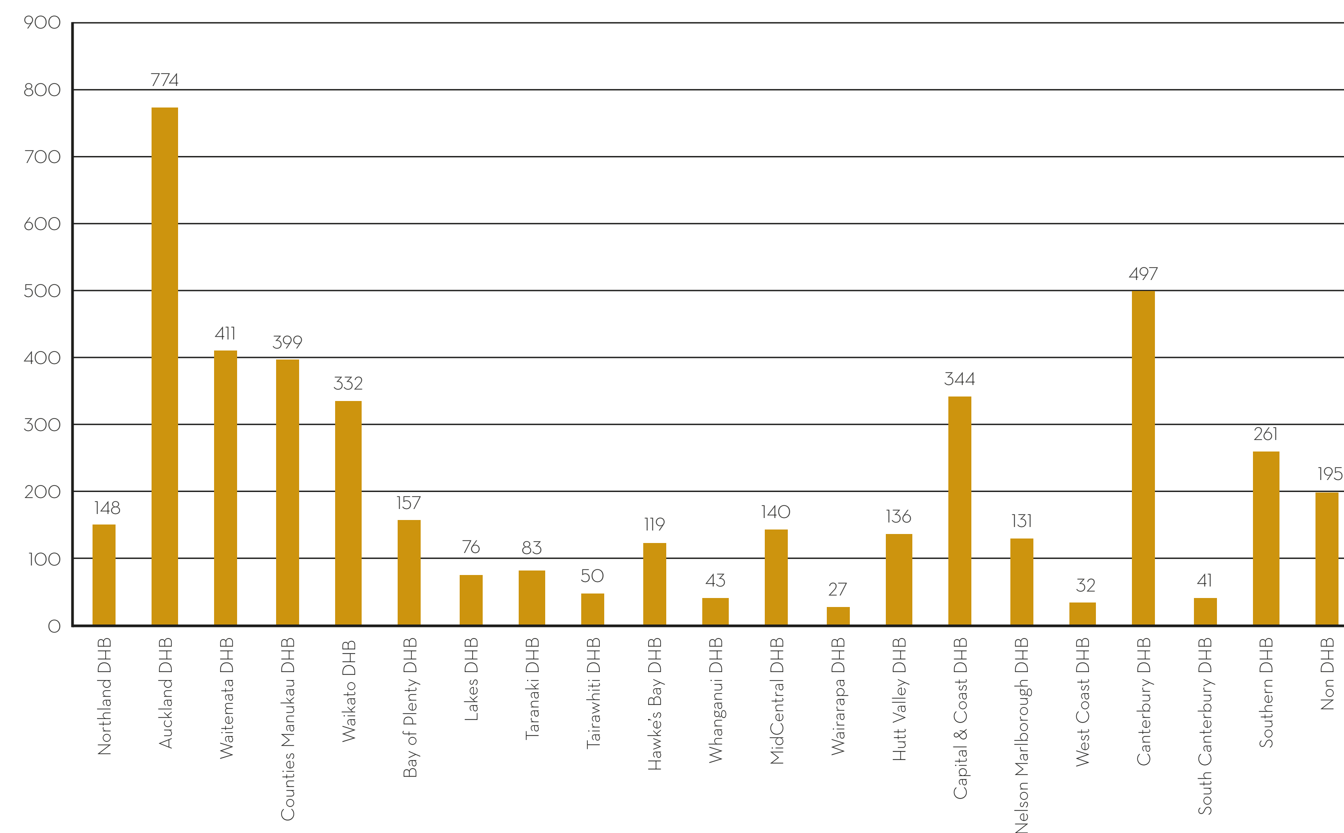
We have strengthened our relationships with the New Zealand Medical Association (NZMA), New Zealand Medical Students Association (NZMSA), and Health Workforce New Zealand (HWNZ). A meeting with the Council of Medical Colleges was constructive and we continue to work with the Resident Doctors Association (RDA), Ministry of Health (MOH) and various other parties (including the NZMSA) on promoting good behaviour. We have also met with Dr Andrew Connolly, Chair of the Medical Council of New Zealand.

CLINICAL LEADERSHIP REVISITED

Distributive and formal clinical leadership have been revisited, with the publication of two documents and a survey on distributive clinical leadership. A great deal of thought, time and work have gone into these, and we hope our thinking on this issue will have the desired effect.

NATIONAL EXECUTIVE INTROSPECTION

It all started with a short conversation at the end of the 2013 ASMS Annual Conference. A further conversation and a few email exchanges followed the 2014 conference. Julie Prior, clinical lead for medical officers, proposed that an additional position be established on the National Executive, to be held by a medical officer to provide a voice and representation for this group within the ASMS and thus reflect that the Executive represents all its members. I placed the topic on the agenda of a National Executive meeting and this led to interesting discussions. Now, let us have a look at the composition of our membership (it now also includes 204 non-DHB members). Further, taking our membership distribution into account, we have to ask ourselves whether our current regions or electorates are still appropriate. (**http://www.asms.org.nz/wp-content/uploads/2015/04/ASMS-Constitution-2014-amendments_162343.2.pdf)** The main question remains: Does the National Executive represent its members, including smaller groups and members in smaller DHBs and non-DHB members?



DHB MEMBERSHIP

Discussions became quite broad at times but in the end three topics started to emerge from formal and informal National Executive exchanges:

- representation on the National Executive
- governance of the ASMS (specifically also the role of the National Executive)
- succession planning.

This is the first National Executive to have a three-year term. We decided to have a National Executive only, full day meeting, to discuss the above topics and general business. The meeting was held 'off site' on the 13th of August. It was a very successful day and in future will become part of the National Executive's annual calendar. The meeting produced quite a few ideas and actions, and these are described below.

REPRESENTATION ON THE NATIONAL EXECUTIVE:

FROM THE ASMS CONSTITUTION:

11 The National Executive

11.1 The Association shall be managed by a National Executive of ten members or such other number as a conference may decide.

11.2 The National President and Vice President shall fill two of the positions on the National Executive and the other positions shall be filled by elected regional representatives.

11.3 The boundaries of the regions or electorates established for the purpose of electing the members of the National Executive shall be decided and may be amended from time to time by an annual or special conference, on the recommendation of the National Executive.

11.4 Two regional representatives shall be elected from each of the following regions:

REGION 1 being the members employed within the boundaries of the Northland, Waitemata, Auckland and Counties-Manukau district health boards;

REGION 2 being the members employed within the boundaries of the Waikato, Bay of Plenty, Lakes and Taranaki district health boards;

REGION 3 being the members employed within the boundaries of the Tairawhiti, Hawke's Bay, Whanganui, MidCentral, Wairarapa, Hutt Valley, and Capital & Coast district health boards;

REGION 4 being the members employed within the boundaries of the Nelson-Marlborough, West Coast, Canterbury, South Canterbury, Otago and Southland district health boards.

A decision was made to establish a short life working party or subcommittee consisting of two current National Executive members and a number of general members to consider changes (if any) to section 11 of the constitution. The working party should conclude and present their findings and suggestions to the National Executive's July 2016 meeting for consideration.

GOVERNANCE AND THE EXECUTIVE

National Executive members are very aware of the strife other organisations have found themselves in when they allowed governance lines to get blurred (reference RACP: **http://www.racp.org.nz/news-and-events/newsletters-and-communiques/announcements/the-president's-message---2-july-2015 BMA http://www.theguardian.com/society/2015/jun/07/doctors-union-secret-pay-hikes-bma**)

We considered our current governance structure and the role of the National Executive and the membership. The constitution is fairly clear on this.

9 Governance

9.1 The governance structures of the Association are:

(a) Members, local branches and delegates;

(b) The National Executive;

(c) Annual or special conferences of duly authorised branch representatives.

9.2 However, the ultimate decision-making authority of the Association lies with its members, whose decision on any particular matter may be ascertained by a national secret ballot conducted for that purpose.

We discussed the interests and skills of individual National Executive members and how that might be used to support national office staff and also contribute to the greater good of the membership.

Decision:

- Paul Wilson: Finance.
- Murray Barclay and Jeff Hoskins: Data, data analysis and surveys.
- Jeannette McFarlane and Seton Henderson: Membership support, industrial and 'pastoral' care.
- Tim Frendin and Carolyn Fowler: Health direction and strategy.

The role of the ASMS National President was also discussed. Should the President be more visible to the public and the health sector? This could further augment the ASMS' current success in terms of our profile, adding the face and perspective of a clinician.

Quite a few challenges were identified in achieving this. In such a role the President will have to be more available in general terms but also at short notice (for example, for media interviews).

The President will have to stay up-to-date (day by day) with developments in medical politics, developments in DHBs, etc, and to achieve this will need to have a very close working relationship with the ASMS Executive Director and National Office Staff.

This will require a considerable time commitment. How does the President 'make time'? One suggestion is that FTE is negotiated with the 'affected' DHB and the DHB is reimbursed by the ASMS to provide back fill. This will mean a temporary reduction in the President's clinical commitment, with obviously a parachute clause.

Additionally (or alternatively) the ASMS could/should have a database of members who have particular interests or specialist knowledge and who are willing to talk to the media at short notice. Eric Monasterio's contribution to the public discussion about the Trans Pacific Partnership Agreement (TPPA) is a good example of this.

Decision: This is something that should be further explored and pursued.

SUCCESSION PLANNING

Succession planning has been a hot topic for the National Executive for some time. I will not be standing for President again. We discussed not only a succession plan for the presidential role but also how to keep the National Executive refreshed and 'ticking over'. One suggestion was to limit the length of time a member can serve on the National Executive. There are positives and negatives to such a proposal.

Some organisations have a stepped approach to succession planning; eg, Vice President, President and Immediate Past President. This will mean a nine-year cycle for the individual.

Should we consider some/all of these options?

YOUR OPPORTUNITY TO BRING ABOUT CHANGE

- put your name forward to become a member of the short life working party to consider future representation on the National Executive
- participate in the ASMS online surveys
- communicate with Branch Officers and the National Executive and let us know your thoughts, ideas or concerns.

PATH TO PATIENT-CENTRED CARE: IMPROVING QUALITY AND SAFETY

LYNDON KEENE | DIRECTOR OF POLICY AND RESEARCH

'Patient-centred care' is well established on political agendas internationally, including New Zealand. But despite its prominence, and the growing evidence of its importance for quality, safety and efficiency, even the limited range of performance indicators currently available show there is a long way to go before it can be said to be truly happening.

On the individual patient–senior medical officer (SMO) level, New Zealand fares relatively well. New Zealand Health Surveys show 9 out of 10 people treated by medical specialists view the quality of care they receive as good or very good. On the other hand, only 47% of New Zealanders surveyed by the Commonwealth Fund on their view of the health system agreed that it "Works well, minor changes needed". (Only 3 of the 11 comparable countries in the survey got beyond 50% approval.) New Zealand also recorded particularly poor results in indicators of access to care to both primary and secondary services.

Though there is no universally accepted definition of patient-centred care, modern concepts are based largely on research conducted in 1993 by the now-multinational Picker Institute, in conjunction with the Harvard School of Medicine. This research identified eight dimensions of patient-centred care:

- respect for patients' preferences and values
- emotional support
- physical comfort
- information, communication and education
- continuity and transition
- coordination of care
- the involvement of family and friends
- access to care.

These features defined the patient's perspective for the first time. In New Zealand, of course, most of these features are underscored, directly or implicitly, in the Code of Health and Disability Services Consumers' [*sic*] Rights.

Research shows there are many benefits from patient-centred care when properly implemented. When health care administrators, clinicians, patients and families work in partnership, the quality and safety of health care rises, costs decrease, and provider and patient satisfaction increase.

Specific benefits include fewer deaths, decreased emergency department return visits, fewer medication errors, lower infection rates, and reductions in both the underuse and overuse of medical services. In the care of patients with chronic conditions, studies indicate that patient-centred approaches can improve disease management, increase patient and doctor satisfaction, increase patient engagement and task orientation, reduce anxiety, and improve quality of life.

> *A patient-centred care approach has also been linked to improvements in long-term outcomes in cardiac patients and is seen as integral to preventative care.*

Further, it has been acknowledged that, to succeed, a patient-centred care approach must address staff needs, because the staff's ability to care effectively for patients is compromised if they do not feel cared for themselves. Once the patient-centred care approach is firmly established, a positive cycle emerges where increasing patient satisfaction increases employee satisfaction, and this, in turn, improves employee retention rates and the ability to continue practising patient-centred care.

An underlying reason why a comprehensive patient-centred care approach has not been well established in New Zealand's DHBs, despite all of these benefits and more, is that it requires health professionals to spend more time with their patients and, where appropriate, their families. This requires an upfront investment in services, especially in the medical and dental specialist workforce, at a time when government funding is squeezing budgets ever tighter. A key challenge for next year's ASMS DHB multi-employer collective agreement (MECA) will therefore be to generate the SMO capacity to enable patient-centred care to be achieved and to further facilitate a supportive culture.

Unless this happens, 'patient-centred care' is in danger of becoming a meaningless slogan and of being reduced to superficialities such as reported overseas where hospitals have been adopting models used by boutique hotels with greeters, greenery, and gadgetry. Although such amenities might enhance the patient's experience, they do not come close to achieving the goals of patient-centred care.

> *It is for all of the above reasons that the ASMS is preparing a programme of work, including plans to liaise with patient advocacy groups, to promote the patient-centred care approach and in particular to examine what is required, from the SMO workforce perspective, to give it real meaning.*

This will include discussion on access to services, the importance of a patient–SMO partnership approach to treatment, the DHB SMO workforce capacity required to dedicate additional time that is necessary for patient-centred care, and distributive clinical leadership. The work will also discuss issues that have become topical in 2015, such as patient access to health service performance data, and patient 'choice'. To address the additional principle promoted by the International Alliance of Patients' Organisations – that of patient involvement in health policy – the work will also examine the effectiveness of elected DHB board members as patients advocates.

PATH TO PATIENT CENTRED CARE

GETTING THE LANGUAGE RIGHT WOULD HELP HEALTH SECTOR LEADERSHIP

IAN POWELL | ASMS EXECUTIVE DIRECTOR

Confused language from the leadership of New Zealand's health system is a scourge which undermines confidence by health professionals and managers. Take the drive from central government (through the Health Ministry) to require greater regional and sub-regional collaboration between district health boards that actually started under the previous Labour-led government but intensified under National's regime (as most certainly it would have under a Labour regime).

GOOD PRINCIPLE, POOR EXECUTION

In principle it made good sense, and in practice it should have also. New Zealand is a small country, with a small population and, consequently, a small critical mass. On volumes alone we can't sustain neurosurgical units or cardiac surgery in every city; or the highest level of big city hospital intensive care units in every provincial hospital. The full range of paediatric and mental health services, for example, that one would expect to find in our larger cities can't be fully replicated in our smaller communities. Collaboration is a no brainer.

However, the execution has been shoddy; a shameful indictment on health sector leadership. At one point a priority was to protect smaller vulnerable services, such as ENT and ophthalmology, which was sensible. But then, inexplicably, central powers said this was no longer the priority, which had the effect of leading to further neglect and increasing rather than reducing vulnerability.

It was over-hyped and over-politicised, leading to debacle (for example, the '3D' brand of collaboration between the three lower North Island DHBs has become a toxic embarrassment). At one point the three Auckland DHBs were supposed to collaborate; then former Health Minister Tony Ryall appointed one of his political favourites – the Chair of Auckland DHB, as well as Waitemata DHB which he already chaired – and only a 'twosome' was left on the dance floor (I suspect the jilted Counties Manukau was privately relieved).

Nevertheless, the policy requirement for inter-DHB collaboration remained. It continued to be pushed by Tony Ryall in his annual 'Letters of Expectations' to DHBs. Allowing for internal inconsistency and poor execution, the intent was clear.

GRABBING CONFUSION BY THE HORN

Earlier this year the low profile but well known supporter of the use of a business competition model to drive the public health system, Murray Horn (banker, former Treasury head and member of the now defunct Business Roundtable), was appointed to run a below-the-radar review of health funding (apparently this was a joint exercise with Health Workforce New Zealand Chair Des Gorman).

It was no surprise, then, that he recommended what was, in effect, a return to the failed attempted competitive business experiment of the 1990s, and its associated fragmentation and disintegration, in which DHBs were expected to compete with each other for health funding.

> *The greater the competition, the greater the destabilisation of DHBs, whose expenditure is far greater on fixed rather than variable costs.*

Murray Horn's (Des Gorman's) recommendations are the antithesis of the Government's push for greater collaboration between DHBs. But the Government knew what to expect from him when they commissioned him to undertake this work. If you ask a committed proponent of market forces to write a report on health funding, what do you expect? If it looks like market forces, barks like market forces, and farts like market forces, then it is an advocated return to market forces. The net result is a very confused message to health leaders and the workforce.

PRIMARY-SECONDARY INTERFACE

Another big area of confusing language from health sector leadership is the interface between primary and secondary care. The relationship between primary and secondary care goes to the heart of the effectiveness of universal health systems. In this respect, New Zealand is well served by international standards. General practitioner gate-keeping alone has done wonders by keeping the system clinically honest and fiscally responsible. More so than most countries (including Australia and the United Kingdom), our DHB structure, which includes being responsible for both primary and secondary care within defined populations, builds on this strength. But gate-keeping is only the start of what can be done.

Former Health Minister Tony Ryall used his annual 'Letters of Understanding' to DHBs to build on this strength. It got off to a difficult start with the clumsy formulation of 'shifting resources' from hospital to primary or community care; in other words, a structural approach which would destabilise DHBs by shifting their funding (but not their fixed costs) to general practices and other primary providers. This was compounded by the unfortunately named 'expression of interest' process in which primary care organisations were invited by government to make proposals for the primary-secondary interface. The quality of bids varied (many were poor) and DHBs were excluded from the initial process and then forced into damage control. Eventually they petered out, with little of sustainable note emerging out of it. The fact that no one now talks about it is a powerful message in itself.

RELATIONAL/ALLIANCING, NOT STRUCTURAL

But over the term of his office Minister Ryall's language rather than resources shifted to the more sensible direction of improving integration between primary and secondary care; from 'land grabs' to collaboration. This was influenced by the impressive experience of Canterbury DHB's 'Canterbury Initiative' based on clinically led clinical pathways across the spectrum of services between hospital and community. This was known as 'alliancing'. Over time this relational, rather than structural, process achieved considerable quality and financial benefits, including reducing the rate of acute admissions more than any other DHB, preventing the need to build a new hospital (until the earthquakes, that is), and reducing the demand on rest homes despite the pressures of an aging population.

(As an aside this makes the increasing tension between central government and Canterbury DHB in the aftermath of the sustained effects of the earthquake devastation doubly regrettable and irresponsible. This includes the former's distracting and wasteful imposition of external business consultants to do a financial review of the DHB, when the expertise on this rests within the organisation.)

This alliancing process is relational contrasting with the structural 'shifting resources' process.

> *It involves much less transaction cost than its structural alternative and, consistent with patient-centred care, is based on what is best done for the patient rather than who owns or controls the resources.*

It builds on, and is strengthened by, the highly integrated elements of our public health system, including the DHB structure.

Unfortunately, the now not-so-new Health Minister Jonathan Coleman has been adding to the confusion by reintroducing the structural 'shifting resources' approach while occasionally doffing his hat to the ongoing alternative relational 'Canterbury Initiative'. Following suit, the much maligned (self-inflicted) Southern DHB in its controversial strategic plan (that was neither strategic nor involved planning) managed to advocate both the structural and relational processes at the same time, despite them being opposites. There is no synthesis emerging from this thesis and antithesis.

The Health Minister, Health Ministry and the rest of sector leadership need to end this inconsistency because it confuses the sector, makes good planning more difficult, is fiscally expensive and engenders loss of confidence in this leadership.

DR STEVE BRADLEY

THE CASE FOR MINIMUM STANDARDS IN DEPARTMENTS

Lakes DHB paediatrician Steve Bradley believes there's a good argument for having minimum standards in place within departments and services. His DHB includes Rotorua and Taupo.

This would provide assurance for both hospital staff and patients that the service being provided was safe.

"At times, it's economically difficult for DHBs to maintain a certain level of staffing, but if a DHB has stated that a location needs to have a specific level of service, then that will carry with it a requirement to have safe staffing levels."

He draws on examples from his own DHB, which covers a population of about 100,000. The DHB's newborn service is staffed for 9 or 10 cots in a unit, which requires two nurses available at all times.

"Because very sick babies can be born suddenly or arrive at the unit, we need to have two appropriately trained nursing staff available 24/7. Because of fluctuations in when babies are born and workload, there might be occasions when there are only one or two babies in the newborn unit – but we still need two nurses available at short notice in case more arrive.

"If you try to cover the newborn unit with intensive care unit nurses, they will have great skills, but they won't be familiar with where equipment is or dealing with a very sick baby in the same way. So the financial imperative for DHBs generally might be to try to get by with just one nurse, but there's a risk and it becomes a safety issue."

He says the same is true of medical staff. For instance, at his DHB, a resident doctor and a paediatrician both need to be on call to provide adequate cover, and to ensure a suitably experienced clinician is available during an emergency.

> *"At smaller hospitals, you can find that the junior doctors who are working, while very good, have not come from paediatrics. That carries a risk. When a very sick baby or young child comes in after hours, if the doctor dealing with them isn't experienced in paediatrics, their ability to be effective will be reduced."*

Steve Bradley says the application of minimum standards is particularly important for medical specialties requiring an immediate or very quick response – eg, acute paediatrics, neonatal paediatrics, emergency medicine, intensive care, anaesthesia and obstetrics.

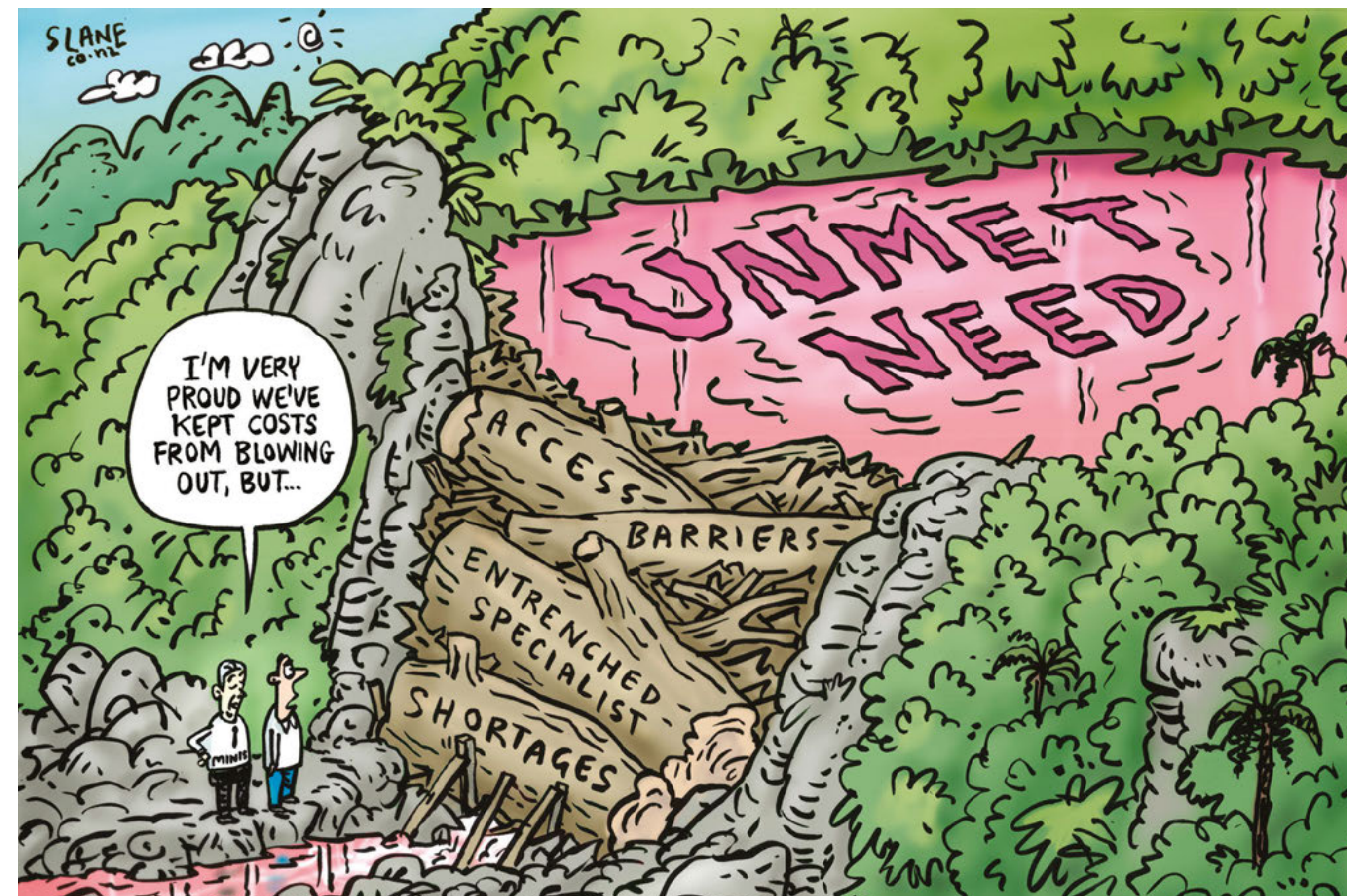
"I believe that it would be helpful to define safe levels of staffing for what the specialty is, and that's for junior and senior medical staff, and nursing staff. At least to have some guidelines."

He says these issues are relevant for all DHBs, not just at Lakes.

"The fact is, if you cut a service back to the point where you have very little leeway, then there's a safety risk. The funding model doesn't account for this. You may actually need to staff a department or service to a higher level than predicted by the funding model.

"I don't know anyone who doesn't want to do a great job. You're in medicine to help your patients. But you also don't want to get burnt by the system around you which pushes you to the point that you are at risk."

The ASMS is looking at developing a potential DHB MECA clause on minimum standards, and this was discussed by delegates at the Annual Conference in Wellington in November.



ASSESSING MEDICAL SPECIALISTS SHORTAGES: AN OVERVIEW

LYNDON KEENE | DIRECTOR OF POLICY AND RESEARCH

There is no single reliable way of measuring a nation's need for medical specialists, as is the case for assessing specialist workforce shortages. However, there is a range of indicators which, when assessed together, provide clear evidence of entrenched shortages – that is, where shortages have become commonplace for so many years that they become the norm. Key indicators are outlined here.

SPECIALISTS PER HEAD OF POPULATION

New Zealand is ranked 30th out of 32 OECD countries in terms of specialists per head of population. Only Turkey and Chile fare worse. This measurement includes trainee specialists (registrars). For primary care specialists, New Zealand is ranked 20th.

UNMET NEED

There is evidence of substantial unmet need but there is currently no accurate measurement available on the extent of it. The New Zealand health surveys from 2011 to 2014 show 27% of adults and one in five children had unmet need for primary care and it can be reasonably assumed that a portion of that is also unmet need for hospital specialist treatment. But even when patients access primary care and are assessed as needing specialist care, the latter is not guaranteed.

A 2013 survey by the Health Funds Association (HFA) and the New Zealand Private Surgical Hospitals Association (NZPSHA) indicated 170,000 people needing elective surgery did not make it onto the waiting list that year. The level of unmet need for non-surgical care is not known. The Ministry of Health is reported to have started measuring unmet need from mid-2014 though no information has yet been released.

An independent and broader research project to measure unmet adult health need in this country is being carried out this year. The ASMS is providing financial support for the project, which is being organised by Christchurch surgeon Phil Bagshaw.

Levels of unmet need may also be reflected in some health activity and health status measurements. For example, OECD data show that out of 35 countries, New Zealand ranked 30th in the number of patient consultations with doctors (GPs and specialists) per capita. New Zealand has among the lowest rates of hospital discharges for cancers and well below average discharge rates for circulatory

diseases, yet has higher than average mortality rates for cancers and ischemic heart disease. (Caution should be exercised in interpreting these comparisons too literally, due to variations in how health activities are measured.)

TIMELINESS OF TREATMENT

In a Commonwealth Fund survey of the performance of health systems in 11 developed countries, published in 2014, New Zealand ranked 7th on overall timeliness of care, including being 10th on equity of access, 11th on access to diagnostic tests, 10th on waits for treatment after diagnosis, 9th on waits to see a specialist, and 8th on waits for elective surgery. All contribute to a growing, hidden unmet need. The HFA/NZPSHA survey in 2013 found that patients on surgical waiting lists had been waiting an average 224 days from their first GP referral and were still counting.

> *So while, as the Government points out, the numbers of operations have been increasing, New Zealand's access to elective surgery (and waiting times for specialist appointments) still lags behind many other comparable countries.*

QUALITY AND SAFETY

One study has estimated that adverse events in our health services could cost $870 million per year, of which $590 million is due to potentially preventable events – mostly in the hospital system. While a range of factors contribute to this, there are many examples indicating specialist staffing is an important factor, including the need for sufficient time for training and supervising other doctors.

Good quality training and supervision, in particular, are seen as key factors for reducing adverse events. The rates of 'serious adverse events' in DHBs has increased from 182 in 2006/07 to 454 in 2013/14. This increase has been put down to better reporting. It is unclear as to whether the trend reflects an increase in actual events. Increasing heavy clinical demands have also meant many specialists are unable to find the recognised professional minimum standard of time for non-clinical duties, including time for continuing education, research, quality improvement activities, and clinical leadership.

Regarding the latter, a national survey undertaken by Professor Robin Gauld (University of Otago) of DHB-employed ASMS members on the application of clinical leadership in DHBs in 2010 found a mere 20% of respondents believed they have enough time to engage in clinical leadership activities or development programmes.

HEAVY WORKLOADS

> *While more specialists are working part-time (an observed characteristic of an aging workforce, as well as having an increasing proportion of female specialists), many continue to work long hours.*

In 2013 around one in eight specialists was recorded as regularly working 60 hours or more a week. A number of New Zealand studies show high work demands have contributed to significant staff burnout, which can have a negative effect on patient care.

A major national survey of ASMS members in 2015 showed 88% of respondents turned up to work when they were sick over the previous two years, and 75% of respondents reported going to work while having an infectious illness. Workload pressures were the most cited reasons given for practising while ill, including concerns about compromising patients' access to timely treatment and over-burdening colleagues.

SPECIALISTS ON THE SKILL SHORTAGE LIST

New Zealand's widespread medical specialist shortages have been acknowledged in Immigration New Zealand's skill shortages lists since they were established in 2004. The lists from that year onwards include almost every medical specialty. None have been taken off.

HEALTH WORKFORCE NEW ZEALAND'S RECOGNITION OF SPECIALIST SHORTAGES

Health Workforce New Zealand's report *Health of the Health workforce 2013 to 2014* states: "The most important issue is the impact of a prolonged period of medical labour market shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors."

VACANCY RATES

There are no reliable data on DHB vacancy rates. DHB budget constraints influence the number of official vacancies as only funded positions are recorded. This has meant that in 2008, for example, the DHBs' official vacancy rate nationally was approximately 10% of positions, but data collected by ASMS in specific DHBs indicated there were up to 24% real vacancies in that year. The latest retention trends suggest that the situation has not improved, and may have become even worse.

AN AGREED PROXY MEASURE FOR SPECIALIST WORKFORCE NEEDS

In the absence of any single reliable way of assessing specialist workforce requirements, DHBs and the ASMS agreed in 2010 that Australia offers a reasonable benchmark. Its population is of a similar age structure to New Zealand's: in both countries 14% of the population were aged 65 and over in 2010, and are projected to grow. Like New Zealand, Australia has roughly an equal proportion of GPs to specialists, as well as a similar proportion of nurses on a per population basis.

In addition, the Government has acknowledged New Zealanders' rising expectations for public services and it is reasonable to assume that expectations for services such as health and education are that they are at least of the same standard as Australia's.

It is if anything a conservative benchmark, as Australia's specialist workforce per head of population is below the OECD average and key health status indicators suggest New Zealand's health needs are greater than Australia's.

Projected specialist workforce data indicate Australia will have an estimated 1.5 specialists per 1,000 population by 2021. For New Zealand to gain parity with Australia by 2021, we need approximately 7,300 specialists in total. Since DHBs account for around 83% of the total specialist workforce (based on trends over the last five years), the DHB requirement is approximately 6,060 specialists. That assumes the DHB portion of the total specialist workforce remains constant.

> *In order for DHBs to achieve the target of 6,060 specialists by 2021, an estimated annual net growth of 278 specialists is needed from March 2015.*

DHB data over the last five years show an annual average increase of just 171 specialists. The current DHB annual growth rate therefore is more than 100 specialists short of what is needed.

For more information, see: http://www.asms.org.nz/?p=1472

THE CHALLENGE OF PROVIDING PSYCHIATRIC CARE IN OLD AGE

CUSHLA MANAGH | ASMS DIRECTOR OF COMMUNICATIONS

New Zealand's psychogeriatricians are struggling to keep up with the demand for treatment as the population lives longer.

This aging population includes more and more people living with conditions that require psychiatric diagnosis, treatment and care. Some people have lived with these conditions for most of their lives, while others have acquired them in old age.

"We know that by 2031, more than 22.2% of the population will be older than 65 and in 2051 that will have risen to a quarter of the population," says Dr Jane Casey, a consultant psychogeriatrician at Auckland District Health Board, and the current chair of the Faculty of Psychiatry of Old Age within the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

"We have an aging population that is generally healthy and well, but there will be a subset who have significant depression, anxiety or psychotic illness and age-related cognitive decline."

She says more psychogeriatricians will be needed if the public hospital specialist workforce is to meet both the current level of demand in addition to what lies ahead.

The numbers tell some of the story. The standard thinking has been a formula of one psychogeriatrician to every 10,000 people in the population, but New Zealand currently averages one psychogeriatrician per 17,000 people. There are regional variations (see sidebar for a breakdown by DHB).

However, just to complicate matters, it's not a straight numbers game. Jane Casey makes the point that some psychogeriatricians are working in large rural areas, while others are providing treatment in areas with a very diverse population and complex needs, or a higher than usual concentration of people aged 65 plus, or of people in aged residential care.

AT A GLANCE

Jane Casey provided the following snapshot of the psychogeriatric medical workforce and the issues they're facing in some DHBs.

NORTHLAND:
2 FTE for 28,000 people. Currently advertising – short of consultants, beds and community services.

COUNTIES MANUKAU:
5.5 FTE for 50,000 people. Filling a shortfall with overseas-trained doctors and recruiting two locums from overseas.

WAITEMATA:
8.3 SMOs and 1 medical officer for 75,000 people. Well-resourced on the surface but the region is short of allied staff (eg, psychologists). Another SMO would take pressure off the service.

AUCKLAND:
6.8 SMOs and 1 medical officer for 50,000 people. Although well-staffed for the population, the service is struggling to cope with demand and manage waiting lists. The region includes a high number in residential care.

WAIKATO:
5 SMOs for 60,000 people.
The workforce is very stretched.

LAKES:
1.6 SMOs for 15,000 people. But as with Waikato, the service covers a large rural area so is very stretched. Both SMOs are overseas-trained and one has provisional registration.

BAY OF PLENTY:
2.2 SMOs and 1 medical officer for 40,000 people. A locum is providing maternity cover.

TARANAKI:
1.8 for 18,000 people. No medical officer and just one house officer.

MIDCENTRAL:
A population of 27,000. 1 FTE and could do with another.

WAIRARAPA:
0.2 FTE for 8,000 people, in private capacity.

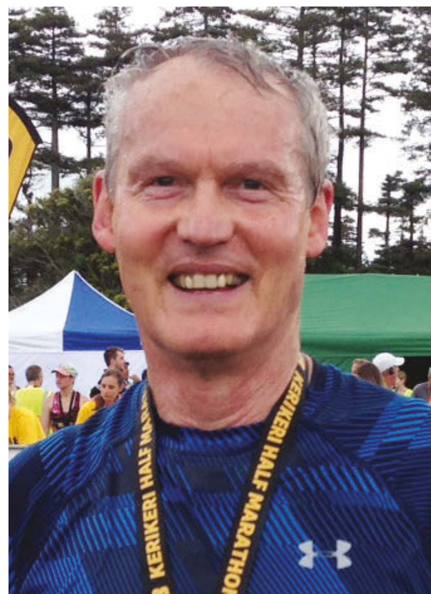
HUTT VALLEY:
1.7 FTE for 18,000.

CAPITAL & COAST:
2.7 FTE for 35,000 people.
The service needs at least 3 FTE.

CANTERBURY:
8.9 for 73,000 people. Includes 2.1 medical officers and 1.7 are not members of the Faculty of Psychiatry of Old Age (FPOA).

SOUTH CANTERBURY:
0.5 FTE for 13,000 people.

SOUTHERN:
2.1 FTE for 47,000 people in Otago but no SMO in Southland, which is of concern.



DR GAVIN PILKINGTON

DR JANE CASEY

The numbers tell us that the workforce of psychogeriatricians is already playing 'catch up', but it's a complex picture.

Dr Gavin Pilkington, a psychogeriatrician at Waitemata DHB, says psychogeriatrics became a sub-specialty in the 1990s and involves two additional years of advanced training on top of the three years of specialist psychiatry training.

He says his career in psychogeriatrics has had four distinct phases.

"The early years were fantastic because it was a new specialty, and we were welcomed with open arms. Then it became busier and we stopped doing some of what we would consider essential work, such as acting as a consultant liaison to geriatric medicine wards.

"In the third phase, the service became very stretched and difficult to manage. We're in the fourth phase now, where we're trying to recover from that. We're doing quite well at Waitemata but it varies a lot around the country – and even though we're doing well here by comparison, we still struggle to get our job-sized non-clinical time."

He says Waitemata gets 1,000 new psychogeriatric referrals each year, resulting in about 150 hospital admissions.

"We're dealing with people developing mood disorders and sometimes becoming severely unwell, people who are suicidal. It's the level of risk that triggers their hospital admission. Some people have a diminished capacity for self-care – for example, if they have dementia. Some people pose a risk to themselves or to others, while another group of people have very complex health conditions and suddenly become unwell.

Gavin Pilkington says one of the difficulties for the workforce is the long lag between the time it takes to understand an issue, such as the aging of the population, and the time it takes to bring about changes in health services in order to meet the changing demand.

"We're in the position of being reactive, rather than proactive."

Jane Casey has 21 years' experience as a public hospital specialist in psychogeriatrics, and she loves her job.

"Old age psychiatry is seen as the least glamorous sub-specialty but for those of us who are passionate about the field and about old people, it's the most rewarding and diverse area to work in," she says. "We see it as a very privileged role to be in, being with older people who share their lives and wisdom with us."

Even though her DHB – Auckland – has the numbers it needs on paper, she says the specialists there are still not coping with the demand coming in the hospital doors. She believes a better way of gauging workforce requirements would be to look at the wider picture in terms of the geography, the needs of the population, workforce skill-sets and the services required.

"There are some good things happening with the service in New Zealand but they are happening in isolation and it's very piecemeal. Overall, we are still significantly behind parts of the UK and Australia when it comes to psychogeriatric services."

RESEARCHERS TEST TOOLS TO MEASURE UNMET HEALTH NEED

ASSOCIATE PROF PHIL BAGSHAW

Stage one of a study to identify the best ways of measuring unmet health need among adults in New Zealand is nearly completed.

Christchurch general surgeon and Chair of the Canterbury Charity Hospital Trust, Associate Professor Phil Bagshaw, who is leading the research project, provided an update on progress to the ASMS Annual Conference in Wellington today.

Earlier this year, the ASMS contributed $10,000 toward the project's costs.

Phil Bagshaw says there is currently no standard way of measuring unmet need so the first challenge for the research team has been to identify which methods work best and are most cost-effective.

Stage one of the project involves three types of population sampling – face-to-face, telephone and web-based interviews – and also a study involving GPs in Auckland and Christchurch. GPs taking part will have a logo appear on their screen that identifies when they are recording an instance of unmet need.

Population sampling is due to be finished by Christmas, and the GP study by March 2016. Analysts will then study the data, with a view to publishing the results mid-2016.

"Once we've collected and analysed the data we will then be pushing very hard for funding of an independent committee, separate from the Government, to do this type of survey every second year to give the public independent information about how the health system is functioning," says Phil Bagshaw.

"It's important that this is done properly so that New Zealanders end up with a good, robust way of assessing what they are getting for the current level of health resourcing, and what it would cost to deal with all of the unmet health need we know is out there."

ASMS Executive Director Ian Powell says ASMS members have first-hand knowledge of patients missing out on specialist treatment or surgery, and they will be keen for good quality information about the extent of the problem.

"We know, both anecdotally and through figures made public about such things as the thresholds for hip and knee surgery, that an increasing number of people are just not getting the health care their doctors consider they need," he says.

"This is a real source of distress, both for them and for the doctors treating them."

THE ASMS NATIONAL EXECUTIVE AND NATIONAL OFFICE STAFF WISH YOU ALL A SAFE AND HAPPY HOLIDAY SEASON.

SEASON'S GREETINGS

The national office will close from 25 December 2015 and reopen on Tuesday 5 January 2016.

If you have an urgent query over this period please email support@asms.nz and someone will get back to you.

DR JEFF BROWN

DR GLENN COLQUHOUN (PHOTO: KATHRIN SIMON)

MEDICINE STORIES PROJECT – SPEAKING FROM THE HEART

"You can't bury your hands in someone's chest and give them a new heart without thinking: that's pretty amazing. Medicine is full of stories. It's built around the anecdote – the history, the case study, bacteria that act like characters."

So says GP and poet Dr Glenn Colquhoun, and he wants to hear the stories that doctors tell each other. He's one of the people driving a new web-based project to collect the writings of doctors – memoirs, stories, poems, reflections, creative jottings.

The project's start can be traced to a meeting of like minds at an APAC conference organised by Ko Awatea. Glenn Colquhoun, who had just returned from a Fulbright scholarship at Harvard, talked to APAC attendees about the narratives of medicine and the importance of stories in people's health. He floated the idea of collecting doctors' stories about the practice of medicine, and a conversation followed with Counties Manukau intensive care specialist David Galler.

"We talked about setting up a website and encouraging doctors to speak and write from the heart," says Glenn Colquhoun.

Over a few subsequent encounters and conversations with National Secretary Jeff Brown, including at our Annual Conference in 2013 where Glenn was a stellar after-dinner speaker, the idea of sharing the setting up and promoting this web-based project led to discussions about seed funding.

The ASMS was approached for funding and the National Executive, after some discussion, agreed to contribute $12,000 to help the project get off the ground.

ASMS National Secretary Jeff Brown says the project is a leap of faith but he believes it will provide a valuable forum for talking about the practice of medicine.

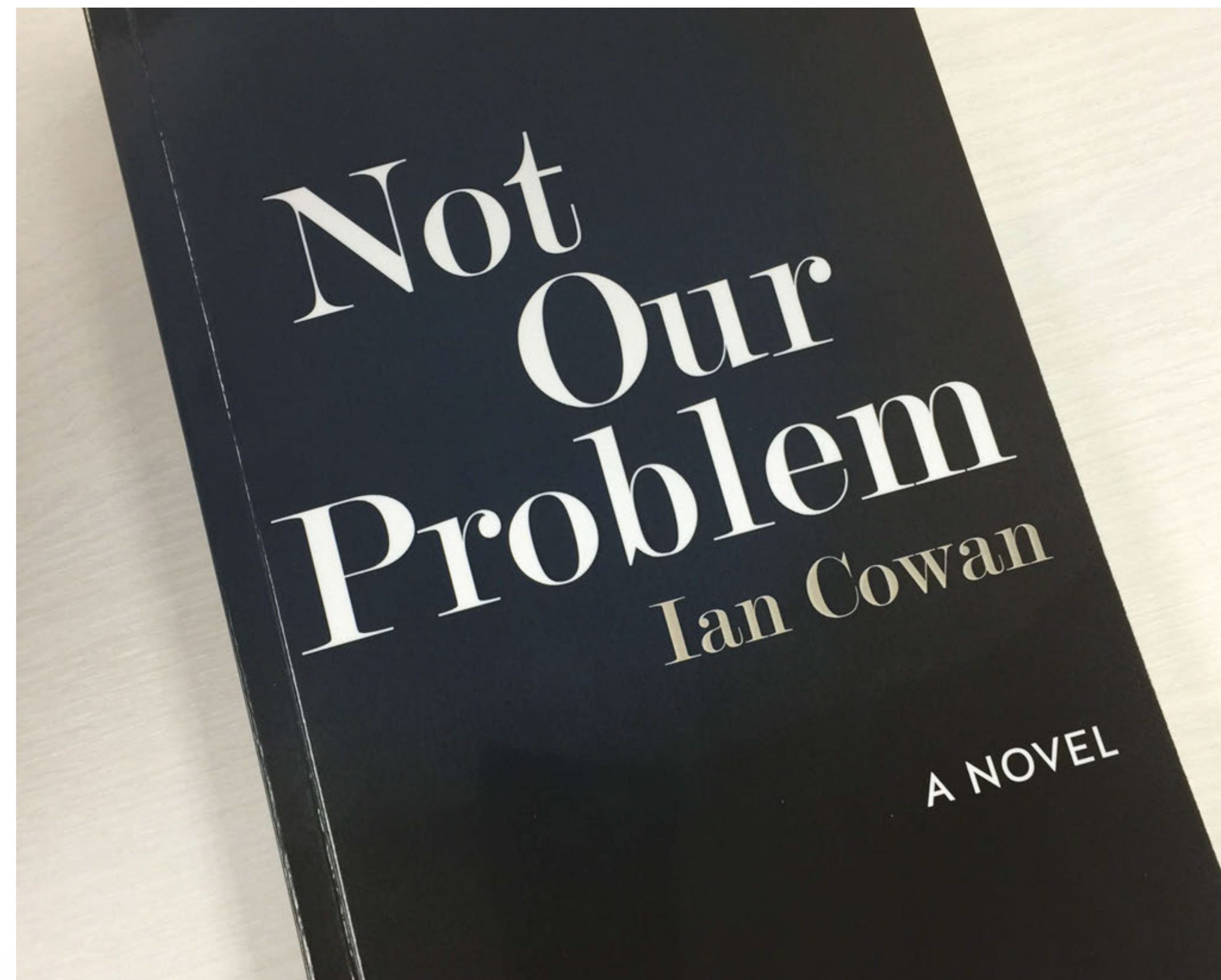
"We don't know if we'll get just one contribution or a thousand, but that's part of the excitement. So much of medicine involves telling stories in one way or another about what it means to be a doctor, and we just want to create a repository for these stories to give them life."

He says some countries have entire journals of medical literature which exist to collate and publish writing, paintings and other art by doctors.

The finishing touches are being put on the project, but the call is already going out for submissions.

"Send us your stories," says Glenn Colquhoun. "Tell us what you know, what galvanises you and makes you feel something."

Stories, poems and other writings can be sent to Glenn Colquhoun, David Galler and Jeff Brown via the email address **medicine-stories-project@middlemore.co.nz.** They will then be edited as needed and curated before being made available at some point to a wider audience. Any issues such as confidentiality will be addressed during this process.



RELIVING THE HEALTH REFORMS OF THE 1990S

The so-called health 'reforms' of the 1990s (based on a 'free market' experiment) are the underlying subject matter for a new book written and published by ASMS member Dr Ian Cowan, a radiologist in Christchurch.

His novel *Not Our Problem* is set against the backdrop of the sweeping changes happening within health at that time, and the impact of these changes on the delivery of health care.

He sent a copy of the novel to ASMS Executive Director Ian Powell to acknowledge the role the ASMS played in challenging these so-called reforms.

"My goal in writing the book was to shine a spotlight on the ideology behind the reforms," he wrote. "I also wanted to demonstrate the consequences, for ordinary people, of forceful application of theory to a part of society where it cannot work."

The novel tells the story of Stephen Cassidy, a surgical trainee at Paxton Hospital, who is burning out from the stresses of his job and now the departure of someone he loves. He needs time off to reorganise his life and win her back – and while he's doing that, he could get a nice 9 to 5 job in hospital management.

Professor Robin Gauld (health policy academic), Professor Tim Hazledine (economist) and Dr Ruth Spearing (Canterbury haematologist) are among those to endorse the book.

"An entertaining story, *Not Our Problem* also captures the atmosphere of a dark time in New Zealand's history and is an important reminder of what can happen when a government forgets the people it's meant to be serving," writes Ruth Spearing on the book's back cover.

And Emeritus Professor Gary Nicholls says the book provides a damning indictment of the 'health reforms', their ideological basis and their adverse effects on patients and health professionals.

"This is an important contribution to the limited historical record."

More information about the book can be found at Ian Cowan's website: **http://www.iancowan.nz/**

WITH CURTIS WALKER

CURTIS WALKER WITH HIS FAMILY

CURTIS WALKER (WHAKATŌHEA RĀUA KO NGĀTI POROU) IS A RENAL PHYSICIAN AT MIDCENTRAL DISTRICT HEALTH BOARD, AN ASMS MEMBER, A MEMBER OF THE NEW ZEALAND MEDICAL COUNCIL, AND A PAST PRESIDENT OF THE NEW ZEALAND RESIDENT DOCTORS ASSOCIATION (NZRDA).

WHAT INSPIRED YOUR CAREER IN MEDICINE?

I come from an academic family. My grandfather, Ranginui Walker, left the family dairy farm in Ōpōtiki in the 1950s for education in Auckland. He went on to do his PhD and he's always inspired us academically. My father, Stuart Walker, is an anaesthetist at Middlemore Hospital in Auckland. My mother's side of the family came from Tokomaru Bay on the East Coast and worked on sheep stations. Honest, hardworking people of the land.

I was interested in science at school so I went off to Auckland University to do a Bachelor of Science. While I was doing that I also did farm jobs as a labourer and that was what led me to be interested in a career as a vet. It was a way of combining science with the outdoors. I completed a veterinary degree at Massey University and found that I enjoyed the small animal medicine more than the rural work. I worked at the Auckland SPCA and then as an assistant lecturer in small animal medicine at Massey for a time.

It's a roundabout way to medicine, but I'm getting there!

After doing a research project on the health hazards of eating stranded whales, I became increasingly aware of the health needs of Māori, and my horizons expanded. I started to ask myself if I was in the right field. I decided I want to make a contribution to Māori health. At that stage I didn't have a mortgage or children, and as I never wanted to regret not taking the opportunity I applied for and was accepted into Auckland Medical School and retrained as a 'vet for humans'. My background in veterinary medicine was very helpful and of course it meant that during the holidays I could locum as a vet, which made life as a student a bit easier.

I qualified in 2007 and worked as a house officer and registrar at Waikato Hospital before moving to MidCentral DHB and then Wellington to complete my training in nephrology. My wife, Megan Pybus, is a paediatrician and is from Ashhurst, and so the move back to live in Palmerston North was always something we'd been keen on.

Although I enjoyed my time as a vet, I don't regret leaving veterinary medicine. It's a fine career and I recommend it, but it just didn't turn out to be for me.

WHAT DO YOU LOVE ABOUT YOUR JOB?

I really like the variety. You can go from working head down on a post-acute medical ward round to dealing with patients and their whānau in outpatient settings discussing their chronic conditions and care. At the moment I'm also contributing to a book chapter on kidney disease in disadvantaged populations, and I was recently elected to the New Zealand Medical Council, which I'm finding extremely interesting.

It's about making a positive contribution. That's really important to me. Being the first Māori renal physician, and given the significant number of Māori who have renal diseases or need dialysis, I feel that I'm in a unique position to help. The focus for me is on trying to improve health outcomes for Māori with renal diseases and improving their experiences within the health system.

For me it's about patients and their whānau. It's what gets us all into medicine and it's what keeps us there.

WHAT IS THE MOST CHALLENGING ASPECT OF PRACTISING MEDICINE?

With the great variety of work comes the challenge of time management. I doubt there's a doctor out there that wouldn't put that at the top of their list. It's about trying to get the balance right between work and the other areas of your life. My wife and I have a six-year-old daughter, Maire, and a four-year-old boy, Tuki, so we work hard to make sure we have plenty of time as a family as well as squeezing in our CME, clinical work, and other commitments.

In a wider sense, the public health system is under pressure to do more and more within constrained resources. That pressure flows through to the workforce and that makes it even more difficult to fit in all the things that are important. Advocating for resources to alleviate that pressure is essential and we need to do that collectively through our unions and other health organisations.

WHAT HAS THE TRANSITION BEEN LIKE FROM BEING A UNION LEADER FOR PEOPLE AT THE START OF THEIR MEDICAL CAREERS TO WORKING NOW AS A SENIOR DOCTOR AND BEING AN ASMS MEMBER?

Coming through medicine as a mature student, and then being an older RMO with my prior experiences, was really helpful as I had more capacity to take on roles outside of the day to day ward work. If you're 23 and you haven't worked before, then you're very focused on your immediate clinical priorities, and wider medical roles are perhaps more difficult to engage in.

Being president of the RDA was fantastic. I felt I was able contribute to the broader discussions going on about public health and as a union leader you're supporting your colleagues so they can perform at their best within their workplaces. It was very clear to me that involving doctors in the design and development of their clinical workplaces is a really positive thing, and what clinical leadership is all about.

I also learned that so much of our public health system relies on the goodwill of doctors and other committed staff. Goodwill is the oil that keeps the wheels of the public health system moving and an important aspect of this are the relationships between the health unions and the DHBs. Even when these are difficult, you've got to find common ground and solutions, rather than going into separate corners and fighting. We went through some strikes during my time as RDA president but we also developed many productive and constructive relationships with the DHBs over the years. At the end of the day, you have to make it work.

I'm still a relatively new SMO and I'm still getting used to the transition to being a senior doctor. I think I have a better understanding now of my senior colleagues and all of the roles they perform. The increased responsibility is part of why you become a doctor, for the increased ability to influence and improve. I'd like to thank the many senior colleagues who taught me and guided me over the years!

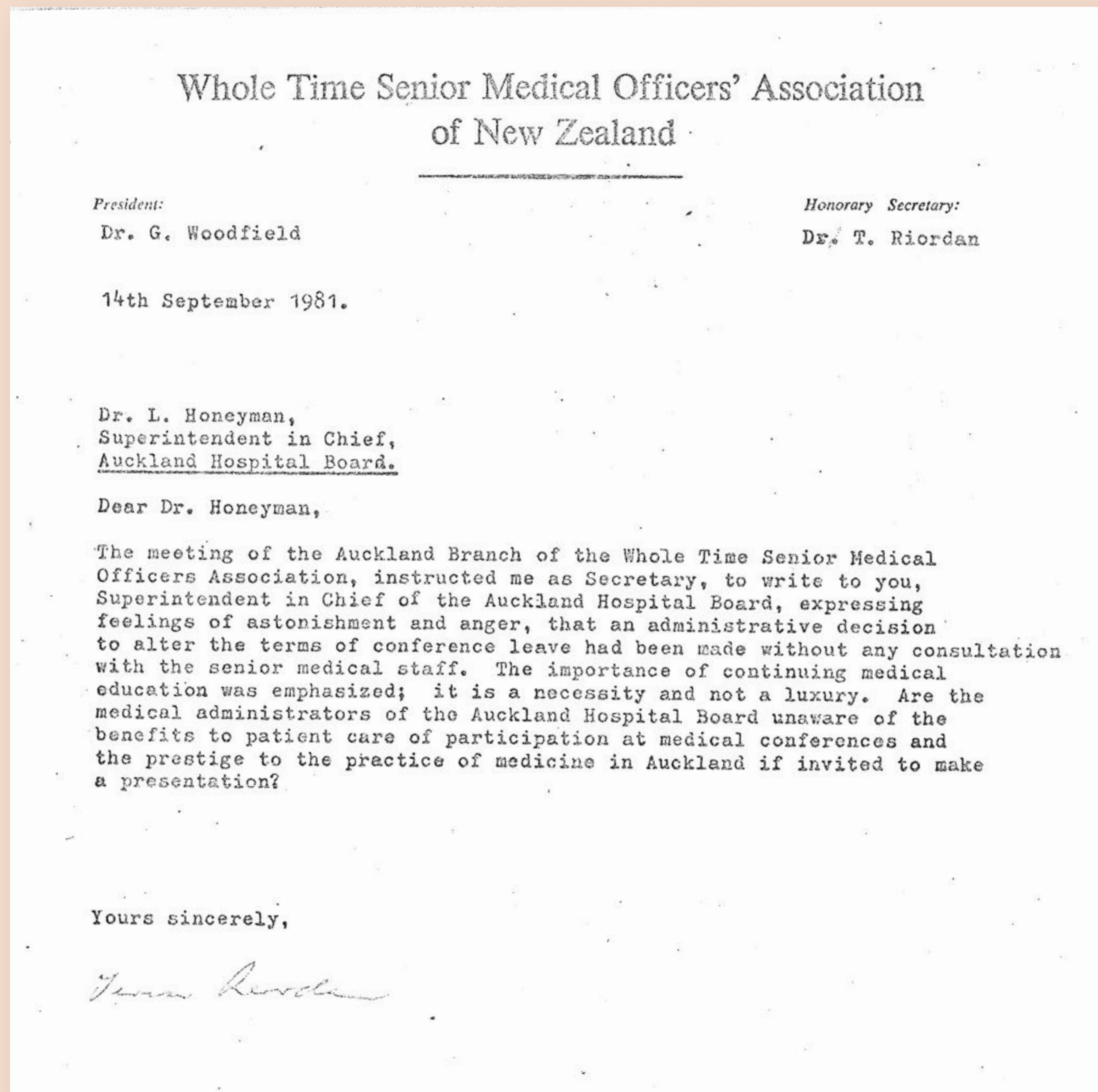
WHAT HAVE YOU LEARNT FROM YOUR UNION INVOLVEMENT SO FAR?

All of the above things but also I've gained a better understanding of the complexities of the health system and the number of levers within it, and how these have to work in concert.

I guess the biggest thing I've learnt is that you can either sit and complain about things, or you can get involved and make a difference, and that's what I'm trying to do.

HISTORIC MOMENTS

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



Whole Time Senior Medical Officers' Association of New Zealand

President: Dr. G. Woodfield

Honorary Secretary: Dr. T. Riordan

14th September 1981.

Dr. L. Honeyman,
Superintendent in Chief,
Auckland Hospital Board.

Dear Dr. Honeyman,

The meeting of the Auckland Branch of the Whole Time Senior Medical Officers Association, instructed me as Secretary, to write to you, Superintendent in Chief of the Auckland Hospital Board, expressing feelings of astonishment and anger, that an administrative decision to alter the terms of conference leave had been made without any consultation with the senior medical staff. The importance of continuing medical education was emphasized; it is a necessity and not a luxury. Are the medical administrators of the Auckland Hospital Board unaware of the benefits to patient care of participation at medical conferences and the prestige to the practice of medicine in Auckland if invited to make a presentation?

Yours sincerely,

DID YOU KNOW

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

...ABOUT LEAVE FOR ASMS ACTIVITIES?

Elected and appointed branch officers and executive members are entitled to leave on full pay to attend ASMS meetings. Make sure to give early notice but also be aware that Clause 29 provides that leave "shall" be given: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-29/

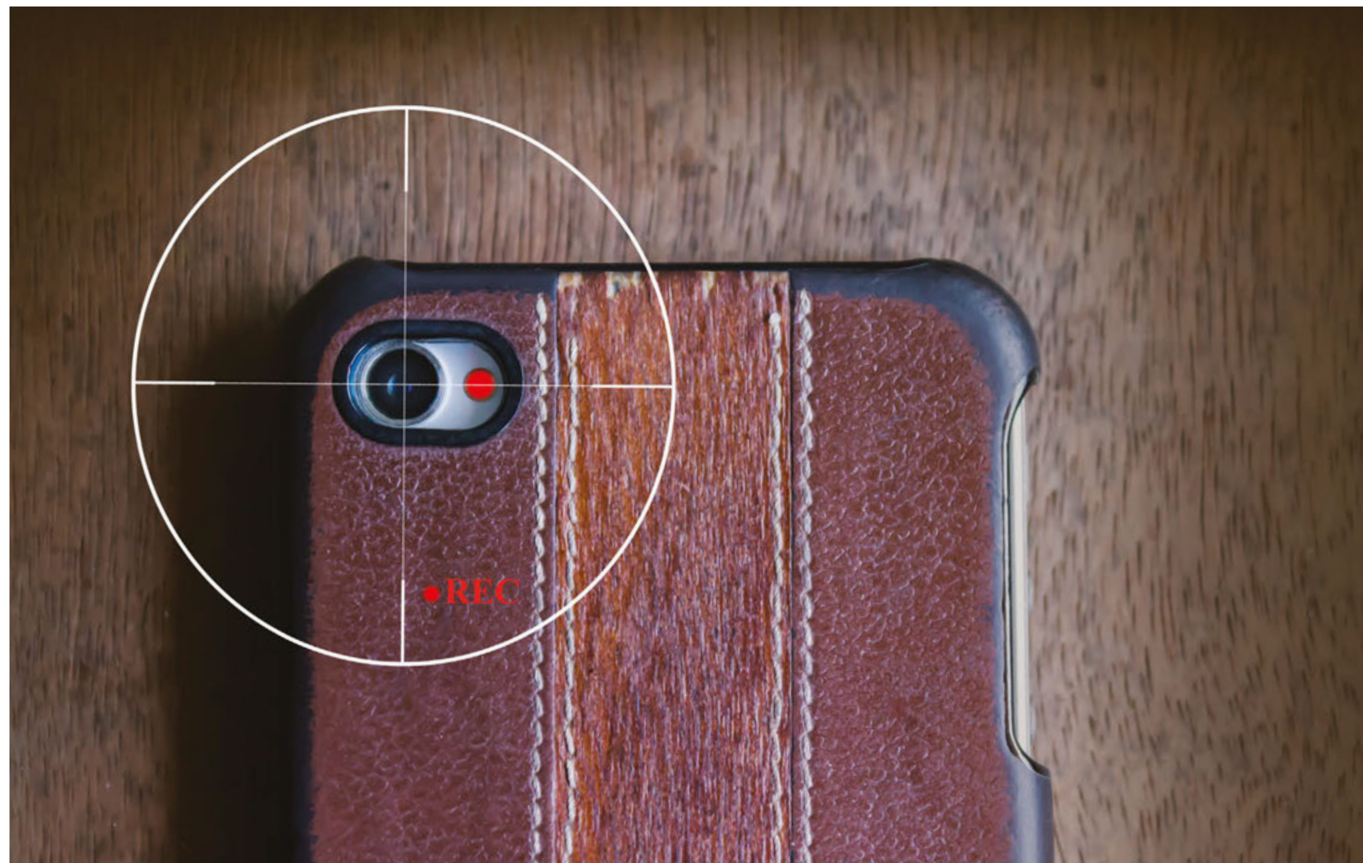
...ABOUT CLINICAL LEADERSHIP?

If you have designated clinical leadership or management duties, these should constitute a separate time allowance in your job description. In other words, these duties are extra to (not part of) your non-clinical time entitlement. This is clearly outlined in MECA Clause 11.6: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-one/clause-11/

...ABOUT COVERING FOR RESIDENTS?

Where an SMO is required to cover work usually done by an RMO, you are entitled to extra pay. Generally, the situations where this applies are limited and specific, but it's worth checking Clause 13.4 if you think this might be happening in your workplace, and that you have an entitlement. Ring ASMS and talk to an industrial officer if you're not sure.

More information is available at http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-13/



OFF THE RECORD: WHAT YOU NEED TO KNOW ABOUT RECORDING CONSULTATIONS

DR ROB HENDRY | MEDICAL DIRECTOR, MEDICAL PROTECTION

In our modern age, technology makes it extremely easy to record dialogue and behaviour. For doctors and health care professionals, this means being aware of a range of scenarios.

There have been many recent examples in the media where supposedly private or personal material has been brought into the public domain, causing considerable distress and problems for those involved.

Medical Protection is increasingly hearing from members who seek advice, either where recordings have been made or proposed in clinical settings. Managing the situation depends greatly on who is intending to make the recording, how this is done, and for what purpose.[1,2]

A CLINICIAN WISHES TO MAKE AN AUDIO OR VIDEO RECORDING

The Health Information Privacy Code 1994 (the Code) was established to ensure that health agencies (including individual practitioners) abide by strict rules when handling patient information. This is in recognition of the confidential and often sensitive nature of health information.

As patient information is confidential and often sensitive, if a health provider decides to record a clinical interaction, they must ensure that they comply with the Code.

The Code is 'technology neutral' and considers audio or video recordings in the same way as information recorded in a traditional paper or electronic medical record. Therefore, collected or recorded information must be necessary for a lawful purpose or health agency function.[3] Patients must be informed exactly what will be collected, why it is being collected and what is going to happen to the information. Patients are also entitled to request a copy of any recording that is collected or used on the basis that it constitutes their personal health information.

Health information must not be collected by a health agency by unlawful means or by means that are unfair or intrude to an unreasonable extent upon the personal affairs of the individual concerned.[4] A recording made without the patient's knowledge is an example of where collection is likely to be deemed unfair. In some circumstances, additional safeguards require that explicit consent is gained from the patient before a video or audio recording is made.[5]

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

A PATIENT ASKS TO MAKE AN AUDIO OR VIDEO RECORDING

The Code only applies to health agencies and does not have any role where a recording has been made by a patient. It is possible that the Privacy Act 1993 could apply in circumstances where personal information of the doctor was included in a recording made by a patient, though this would be unusual.

Patients may ask to record a clinical interaction for a variety of reasons, such as an insurance or ACC claim. In such an instance, the Medical Council of New Zealand (MCNZ) requires you to consider the patient's request, and if you do not consent, ask the individual to arrange consultation with another doctor.[5]

The MCNZ refers to the case of Jackson v ACC, which upheld the patient's privilege to record a consultation, though also acknowledged that doctors have a privilege in deciding how a medical assessment should take place.[6] The doctor must be able to reasonably and clearly justify a refusal to allow recording. Such circumstances might include if:

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

Medical Protection is aware of cases involving members where these problems have arisen. In situations where a doctor agrees to the recording of a consultation, it is suggested that the doctor consider making an agreement with the patient, prior to any recording, to receive a copy of the whole recording from the patient. Alternatively, a doctor could seek the patient's agreement to make his or her own separate recording of the consultation.

A CLINICAL ASSESSMENT IS COVERTLY RECORDED BY THE PATIENT

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

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

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

MATERIAL RECORDED COVERTLY IS PROVIDED TO THE DOCTOR

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

If a health assessment has been recorded it is important to ascertain from the information provider whether the patient is aware the information has been provided to you before you consider it. If the patient is unaware of the material then it may be difficult to form a valid medical opinion on a video or audio recording that has been made without the knowledge of the patient, in non-clinical circumstances and without the opportunity to ask the patient questions arising from examining the recording. You may decide to return such information.

If there are legal proceedings in existence or anticipated, or if you are unsure of your obligations when dealing with covert recordings, it is important to contact Medical Protection or your medical defence organisation (MDO) as soon as possible.

A PERSON MASQUERADES AS A PATIENT AND RECORDS THE INTERACTION

Medical Protection is aware of cases where individuals have presented to doctors with factitious complaints to manipulate and covertly record consultations for their own purposes. We recently assisted a member following a complaint made to the MCNZ by a journalist alleging inappropriate prescribing. The journalist had pretended to be a patient and had presented to several GPs seeking to obtain medication with the potential of abuse by deception and, at least in one case, intimidation. This was done to form the basis of a newspaper article and a covert recording of one consultation was used by him in his subsequent complaint to the MCNZ. After considering the response from the doctor detailing the circumstances, the MCNZ took no further action.

In summary, the doctor-patient relationship is based on mutual trust. Recording consultations without the knowledge or consent of one party inevitably undermines this trust, damaging the relationship and the potential effectiveness of care. However, with recording devices a ubiquitous feature of modern life, it is best to assume all consultations are potentially being recorded.

NOTES

1. http://www.stuff.co.nz/auckland/local-news/6317929/Election-tea-tape-leaked-online
2. www.levesoninquiry.org.uk
3. Health Information Privacy Code 1994, Rule 1
4. Health Information Privacy Code 1994, Rule 2
5. The Medical Council of New Zealand (MCNZ): Non-Treating Doctors Performing Medical Assessments of Patients for Third Parties Doctors (Dec 2010).
6. Jackson v ACC, the Mental Health (Compulsory Assessment and Treatment) Act 1992, Section 68, and the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, Section 52.

MORE PHOTOS FROM THE ASMS ANNUAL CONFERENCE

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TOI MATA HAUORA
www.asms.nz

ASMS SERVICES TO MEMBERS

As a professional association we promote:

- the right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists.

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in 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.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
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.nz***

How to contact the ASMS

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Level 11, The Bayleys Building,
36 Brandon St, Wellington

Postal address: PO Box 10763,
The Terrace, Wellington 6143

P 04 499 1271
F 04 499 4500
E asms@asms.nz
W **www.asms.nz**
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Have you changed address or phone number recently?

Please email any changes to your contact details to: **asms@asms.nz**

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