THE SPECIALIST

THE MAGAZINE OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

ISSUE 109 | DECEMBER 2016

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CARTOONS BY CHRIS SLANE

"AGE, FRUSTRATION AND CALL": UNDERSTANDING INTENTIONS TO LEAVE THE NEW ZEALAND PUBLIC HEALTH WORKFORCE

PRELIMINARY FINDINGS AS PRESENTED TO THE ASMS ANNUAL CONFERENCE

DR CHARLOTTE CHAMBERS | ASMS PRINCIPAL ANALYST (POLICY & RESEARCH)

In 1733, Benjamin Franklin famously quipped, "Beware of the young doctor and the old barber." He also noted, however, that "there are more old drunkards than old doctors".

I suggest that these quotes capture an essential tension in the senior medical workforce. On the one hand we need a ready supply of young doctors entering into the public system, but on the other hand we also need experienced doctors in order to provide them with essential training, mentoring and support. Most importantly, we need a health system that balances the two and supports and provides for the needs of both.

We know from recent research conducted by the ASMS that New Zealand's senior medical workforce is experiencing high rates of working through illness and burnout. These statistics are worrying and suggest that the system is not adequately supporting the health and wellbeing of our senior doctors and dentists.

We also know that while the absolute numbers of medical specialists are increasing year on year, in proportionate terms, the number of specialists per head of the New Zealand population remains one of the lowest in the OECD.

Other workforce data indicates growing numbers of women in the medical workforce, which is a trend to be celebrated. Nevertheless, if these young women doctors and dentists follow international trends, they are likely to work fewer hours than their male counterparts. We also know that we have a large cohort of specialists aged 55 and over who are likely to retire or at least consider reducing their hours of work in the next decade.

Combined with these demographic trends, opportunities for private sector work remain attractive for some in New Zealand. We also know that higher incomes and new experiences are readily available overseas. All of these factors will shape our senior medical workforce. As a consequence, we need to know how things may change in the future and what factors may shape these future intentions.

Accordingly, the ASMS has recently completed research into the future intentions of the DHB-based senior medical workforce.

> ***The core aim of this research was to assess rates of intentions to change the level of involvement in DHB-based employment within the next five years.***

We also sought to understand various push/pull factors that may shape these intentions and to examine associations between intentions and demographic factors such as age, gender, medical specialty, and level of job satisfaction.

The survey focused on three possible scenarios that may see individuals exit the public workforce: 1) the likelihood of leaving medicine entirely over the next five years, 2) the likelihood of remaining in DHB-based employment, and 3) the likelihood of leaving New Zealand permanently to go overseas. For those remaining who did not signal an intention to leave, we asked them whether they would like to change their current FTE over the next five years, and whether they might like to change their on-call or shift work duties.

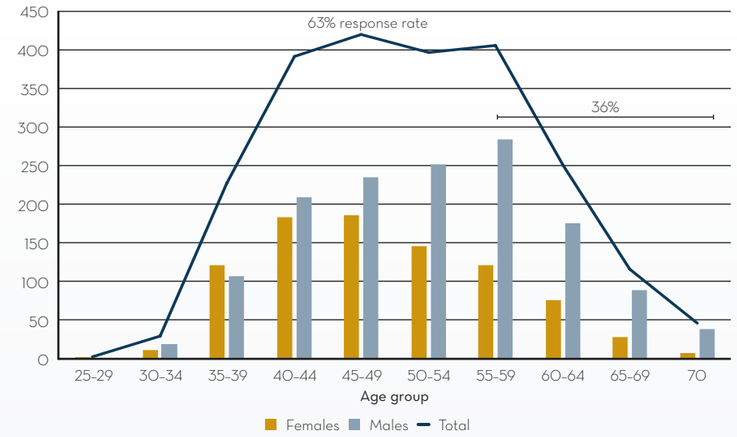
We defined future work intentions to include changes that may be sought in the course of work but have not yet been formalised and, indeed, may not occur or be possible. As a prospective study, this is one of the key limitations: what people might like to do may not happen or may not be possible. Nevertheless, there is some research to suggest that intentions are a strong predictor of future action and combined with core demographic information, including age profile and level of job satisfaction, the results are likely to give us important insight as to those who are at risk of leaving.

> ***The research will also provide us with a better understanding of the possible reasons that motivate people to leave, which in turn may assist with developing interventional strategies for the future.***

WHAT DID WE FIND?

The survey had 2424 respondents, resulting in a 63% response rate. A total of 2390 left gender and age information. The following graph describes the age and gender composition of respondents. It shows that 36% of respondents were aged 55 and over and 7% were aged 65 and over. The overall survey findings are a good fit with other Medical Council of New Zealand data as well as echoing patterns in workforce trends currently being undertaken by the Ministry of Health.

ALL RESPONDENTS BY AGE AND GENDER N=2390



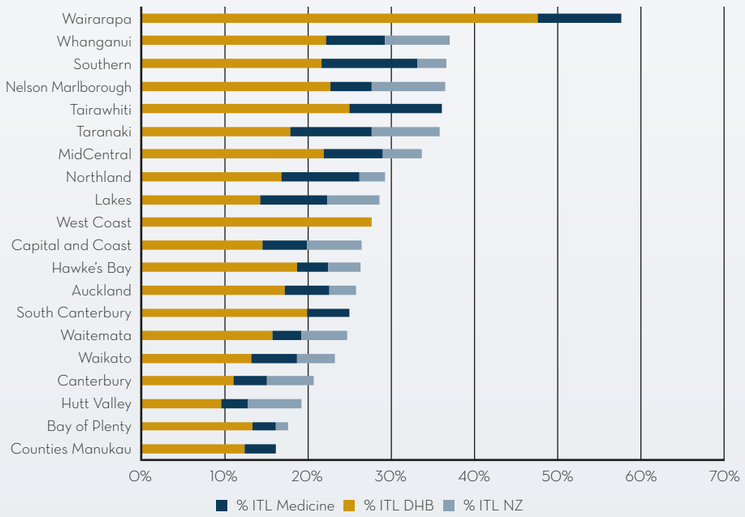
Of those who responded, 24% (n=572) signalled either a likelihood or an extreme likelihood of intending to leave the public medical workforce in some capacity over the next five years. This was made up of 16.2% intending to leave medicine entirely, 5.4% intending to leave DHB-based employment and 4.2% intending to leave New Zealand to practise medicine abroad.

The majority of those intending to leave were aged 60 and above, and all women aged 70 and above were intending to leave in the next five years.

There were significant associations between intentions to leave and various independent variables including age, having older dependents and level of job satisfaction.

There was a significant association between intending to leave medicine entirely and DHB. In particular, Wairarapa had nearly half of its current specialist workforce signalling an intent to leave. These findings are detailed in the following graph.

ALL INTENTIONS TO LEAVE SCENARIOS BY DHB



Intentions to leave also varied significantly by medical specialty, and there were significant intentions to leave for some of the smaller sub-specialties such as nuclear medicine, forensic pathology and developmental paediatrics. Large specialties such as endocrinology and rheumatology also signalled a reasonably significant intention to leave.

PUSH AND PULL FACTORS

The survey also sought the reasons behind people's intentions to leave. The open text data was open-coded into core themes which gave important insights as to why people are considering leaving and what factors may induce them to stay.

> ***For those considering leaving medicine entirely, the single most commonly cited factor was age, with 60% mentioning feeling too old to continue or feeling that they had reached an appropriate retirement age.***

Seventeen percent cited exhaustion, burnout and pressures of work as inducing them to leave. Comments included:

- *Increasing age. Desire to finish work while reputation intact. Loss of confidence in staying up to date. Long post-acute ward rounds becoming more physically and emotionally demanding. Desire to commence retirement in good health and fitness.*
- *Getting close to retirement age. Nights on call are busy and draining. Getting worn out. Front line anaesthesia is clinically demanding and stressful and there are no easy ways of doing a less demanding job.*

On the other hand, consideration of the factors that may encourage reconsidering leaving medicine entirely, 35% said that nothing would induce them to stay, with 15% asserting that the provision of flexible working hours or part-time work would make a big difference to their intentions to leave.

- *Not really. I'll do my bit till I'm 65 provided I remain fit and up to the mark. There is a time for every purpose.*
- *Absolutely not – why would I work like I do when I can sell real estate with no qualifications for triple+ the money? This country is totally screwed.*
- *If I can find a role that does not have after hours work, that provides the weekday flexibility, team environment and interest of my current role. However, I don't think it's fair to expect my colleagues to carry me as a weekday only person and load up the after-hours on the younger people.*

> ***For those considering leaving DHB-based employment, 31% cited disillusionment with DHB management and the New Zealand public health system as the most significant reason influencing their intention to leave.***

A further 27% cited low morale, poor job satisfaction and the inability to make changes as core factors.

- *I feel undervalued and taken for granted. There is a constant drive for more for less which is incredibly draining. We are asked to make savings when in psychiatry we truly believe we require more resources not less. Rates of methamphetamine and general referrals to mental health are increasing. We believe deprivation is increasing in our DHB. Why stick in out when I can earn more and work less in private practice? My only concern is I will truly miss working in a team and teaching medical students, junior doctors and allied staff.*

Thirty-one percent noted that having the ability to take leave would encourage them to reconsider their intent to leave DHBs, and 20% cited improvements to management culture and less bureaucracy as important changes that may induce them to stay.

- *Managers who listen to and respect clinicians. Actually being able to achieve change without having to be difficult. A respectable job sizing offer. A decrease in clinical workload without then being asked to do more to meet FSA targets when I already work 15-20 hours extra per week.*

For those considering leaving New Zealand, 30% cited better remuneration as a core push factor, with 25% citing the desire for better experiences and career opportunities as influencing their intention to leave.

- *Poor DHB management and lack of facilities available to provide comprehensive patient care. Poor remuneration for services provided.*
- *I am fed up with targets and chronic understaffing and lack of resources.*

Similarly, 30% suggested that better remuneration would encourage them to reconsider leaving, although 21% said that nothing would influence their intent to leave.

- *If I felt more secure about our retirement savings I would stay in NZ. It took many years to pay off the student loan, then time out to have children has meant I do not have enough saved for our future.*

OF THOSE REMAINING

The 76% who were likely to remain in the New Zealand public health workforce were asked whether they would consider changing their FTE or their on-call commitments. The following two graphs detail the possible future scenarios with respect to these core work intentions.

SUMMARY

The results from this survey, despite the limitations of the prospective approach, present a worrying lens on the future of the senior medical workforce. They suggest that 24% of the 63% of current ASMS members who responded to the survey may leave over the next five years. Of the remaining 76%, 40% want to decrease their FTE, 30% would like to decrease their call and shift work commitments, and 8% would like to drop their call and shift work commitments entirely.

The survey highlights the consequences of an aging medical workforce but also draws further attention to the consequences of low morale and associated concerns for workplace culture, high workloads and poor conditions.

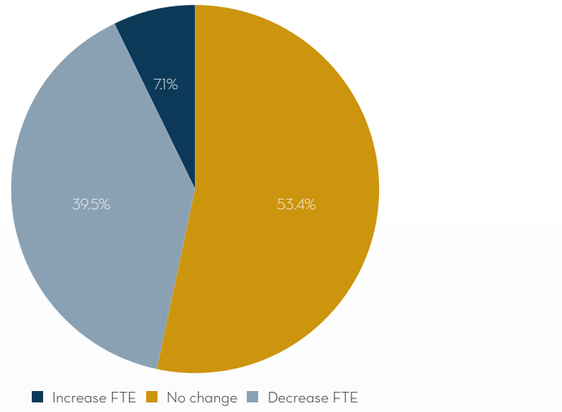
The survey suggests that smaller DHBs may feel the impact more keenly of an exodus from the public medical workforce. Similarly, some of the smaller sub-specialties may have critical shortages. Other than finding the elixir of life, this research points to the importance of enabling people to take leave, to have flexible working hours, and for the urgent need to improve the working conditions at our country's DHBs.

At the current juncture, we know that we have long-term entrenched shortages in New Zealand. We also have one of the lowest rates of medical graduates per population in the OECD. We are continuing to depend heavily on IMGs to fill workplace shortages and the pressure on international staff shortages is likely to increase also. The findings from this research alongside the trends for presenteeism and burnout further support the notion that the culture and working conditions in our DHBs present an additional pressure to the public medical workforce. There is a need to give urgent consideration to recruitment and retention strategies for the existing workforce while also aiming to support the needs of older doctors who wish to continue working for some time to come.

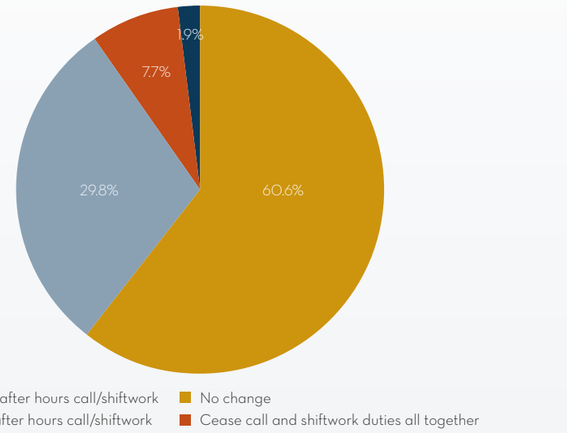
The full findings from this research will be published in early 2017.

Dr Chambers' conference address can be viewed at **http://www.asms.org.nz/news/asms-news/2016/12/02/dr-charlotte-chambers-age-frustration-call/**

WITHIN THE NEXT 5 YEARS, WOULD YOU LIKE TO CHANGE YOUR FTE? N=1778



WITHIN THE NEXT 5 YEARS, WOULD YOU LIKE TO CHANGE YOUR AFTER-HOURS ON-CALL OR AFTER-HOURS SHIFT WORK COMMITMENTS? N=1770



PRESIDENTIAL ADDRESS TO THE ASMS ANNUAL CONFERENCE

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

Three years ago we were asked whether a "Mid-Staffordshire" could happen here in New Zealand. What was your answer? We participated in an ASMS survey to determine the level of burnout in the Senior Medical Officer workforce. What were the findings?

District health boards have two major functions. They are responsible for providing or funding the provision of health services in their district. They also have a responsibility as an employer to look after the staff they employ, including their health and safety.

Three years ago I spoke about burnout and compassion fatigue. In 2014 I spoke about building a joyful workforce. We listened to Dr Peter Huggard speak on "Building resilience in the health workforce", and Dr Tony Fernando spoke on "the science of happiness". Maureen Bisognano, the then President and CEO of the Institute for Healthcare Improvement (IHI) spoke at the 2014 APAC meeting and stated: "Joy is the key to providing the kind of care we want for our patients. Through joy, we gain the energy and resilience to do our jobs well. And that's an important concept, because healthcare is tough – it's one of the most intellectually challenging, physically demanding and emotionally draining professions there is." In 2016 the IHI has not forgotten the importance of joy in the workforce. Alongside all of its other activities, it continues with research, publications and work to increase joy in the health workforce (**http://www.ihi.org/sites/search/pages/results.aspx?k=joy**).

A 713-person study by economists at the University of Warwick in the UK asked the question "Does 'happiness' make human beings more productive?" They found that happy employees' productivity was 20% above the control group and unhappy workers were 10% less productive than the controls. Additionally, they found that individuals who are happier tend to:

- manage their time more effectively
- exhibit more creativity
- solve problems more effectively
- collaborate better around common goals
- make better leaders **(https://www2.warwick.ac.uk/fac/soc/economics/staff/eproto/workingpapers/happinessproductivity.pdf)**.

> *Being happy and finding joy in your work is of the utmost importance not just for your own well-being but also for your patients and your employer.*

Is it important to you? Do you feel it is important to your employer?

Let me do a quick stocktake. In the past year or so, what have we learnt about the SMO workforce? At the 2015 ASMS Annual Conference, Dr Charlotte Chambers presented her research: "Superheroes don't take sick leave – Presenteeism in the New Zealand senior medical workforce". Over a period of 24 months, 88% of us went to work while unwell. Reasons for doing so included a strong sense of duty to patients and colleagues but also a lack of workplace cover for any unexpected short-term absences.

Following that, another survey showed that burnout is rife, with 50.1% of SMOs reporting burnout. This is a shocking result that should ring the alarm bells, but at a national level the response is mute, and at a local DHB level, variable.

We also have evidence that bullying, sexual harassment and inappropriate behaviour is commonplace in our work environment. Dr Charlotte Chambers has presented the findings of her study: "Exploring intentions to leave the New Zealand public health workforce". This highlights a looming potential retention crisis if no proactive steps are taken to address the vulnerability of the senior medical and dental workforce in DHBs.

Presenteeism, burnout, bullying and harassment, and a pending retention crisis. Not a very "joyful" picture.

You might rightfully ask: Why do SMOs keep going back to work?

I would like to give you some insight into the SMO culture and psyche. In the Declaration of Geneva (Physician's Oath) we pledge: "The health of my patient will be my first consideration". This is part of our "patient first" culture, but it has become an increasing "problem" in the modern practice of medicine. Dr Jim Cross, a retired emergency physician, was the keynote speaker at the Spring Representative assembly of the Saskatchewan Medical Association. He pointed out that the "patient first" mantra can cause harm to the patient, because if you can't look after yourself you cannot look after your patients. Brenda Senger, director of the Saskatchewan Medical Association's Physician Health Program, points out "for physicians, the last area affected by these issues [mental health and addiction] is often their work. They will give up their spouses, their children, their friends, their colleagues, their community involvement, their self-care – all of that. They'll give all of that up, but they'll keep going to work" **(http://www.sma.sk.ca/kaizen/content/files/16_08_23%20Summer%202016%20SMA%20Digest%20WEB.pdf)**.

Dr Sam Hazledine, of Queenstown, New Zealand, started a petition to add the following to the Declaration of Geneva. "I will take care of my health and well-being so I can provide care of the highest standard." Dr Stephen Child, NZMA Chair, has taken the petition to the World Medical Association General Assembly in 2016. You can still sign the petition online (**http://www.medworld.org/petition**).

> *Burnout, fatigue, exhaustion, depression and illness do not stop us from going to work. We know that. What can be done to address it? What gives you joy in your work?*

I started off by asking you what you answered when asked whether a "Mid-Staffordshire" could happen in New Zealand. Three years ago my answer was "Unlikely". I want to revisit that.

The Robert Francis inquiry examined the quality of care at Stafford Hospital that occurred during 2005–09 and the many reasons why it was so bad, and it produced devastating conclusions. Once the shocking facts became clear, it had the effect of the proverbial frog being put straight into boiling water. Everyone realised that what patients and their families endured was horrific and should never happen again. The then British Prime Minister, David Cameron, said three fundamental problems were highlighted in the Francis report:

- a focus on finance and figures at the expense of patient care
- the attitude that patient care was always someone else's problem
- defensiveness and complacency.

David Cameron asked Dr Don Berwick, founder and previous president of the IHI, to produce a set of recommendations for implementation in the NHS in England. Don Berwick summarised his recommendations as follows:

1. Put the experience of the patient first. The patient comes first no matter who you are in the system.
2. Hear the patient, empower the voice of the people we are trying to help. They have more information than almost anyone else in the system.
3. Invest in the growth and development and capabilities of the staff, their ability to improve what they do and the ability to work together to improve what they do both within and across the organisations.
4. Take a big leap towards transparency that is absolute and complete.

WHAT IS HAPPENING IN NEW ZEALAND?

The ASMS keeps highlighting the unmet health need of the New Zealand population. The Ministry of Health has acknowledged that the problem exists but continues to be defensive regarding the extent of the problem. The ASMS has helped fund Associate Professor Philip Bagshaw to research and investigate the true extent of secondary care unmet need. He delivered an excellent presentation last year at our 27th Annual Conference. He pointed out that our current system is designed to reduce the expectation that patients, communities and GPs have regarding access to secondary care.

There is a constant stream of reports in the media about patients being turned away and not receiving the care they need. Some of them go as far as selling their house to fund their surgery.

> *It is not uncommon to read that patients are living with chronic pain, and have lost their mobility and independence due to a lack of access to secondary care. The public and us have grown used to those reports. We have become desensitised.*

Figures now show that access to primary care has also become a major concern. The latest Ministry of Health survey reveals that one in nine New Zealanders are not getting the GP care they need because of cost. That equates to nearly half a million people in New Zealand who experience difficulties in accessing primary care.

The latest revelation is that patients are losing their eyesight due to delays in getting follow up appointments (follow-ups are not counted for the elective targets, a perverse incentive). In response, the Ministry of Health said the average waiting time for ophthalmology treatment had reduced from 66 days in December 2014, to 59 days in August 2016. Health Minister Jonathan Coleman is reported to have said of the Southern DHB, "They have got to do a lot better." He said that the eye specialists had not specifically raised this issue when they visited him. Are these comments patient centred and transparent?

It is with great concern that I read some of the explanations given for this year's adverse events report. As an example, the Nelson Marlborough DHB's response is reported by Samantha Gee as: "The board says the jump in numbers is down to a new reporting system and improved staff culture so people feel more confident about reporting events". Let me compare their response to Stafford hospital's initial response. Stafford blamed the increase in their mortality rates on coding errors. Don Berwick recommended a big leap towards transparency that is absolute and complete. David Cameron highlighted defensiveness and complacency as contributing factors. In the words of the Health Quality & Safety Commission Chair, Professor Alan Merry, commenting on the release of the "Learning from adverse events" report: "Each of these very sad incidents has affected a patient, their family and whānau, and the health professionals who care for them."

Let me get to the point. The public, the health workforce, DHBs and the Government have become desensitised to the unmet health need and the fallout from that. Desensitised to a system that is under strain and is underfunded. I have changed my answer to the question on whether we could have a Mid-Staffs here in New Zealand.

> ***I am telling you today that we are having a Mid-Staffs, it is just happening in slow motion. Unlike Mid-Staffs in the UK we are slowly warming up the frog in the water and it will eventually be boiled before anybody realises it.***

WHAT HAS THE ASMS DONE SO FAR?

Before I point too many fingers, you might ask: What has the ASMS done so far in regards to putting the patient in the centre and to addressing concerns about the SMO workforce?

- We have created a path to patient centred care. This can be seen and followed on our website. This includes excellent papers on the topic of patient centred care. This work is ongoing and we have one further publication to complete.
- We have put a new claim forward in our MECA negotiations: minimum standards for patient centred care. This is still under negotiation, but the DHBs find this threatening.
- We have a new clause that has been agreed during current MECA negotiations: "Recovery time".
- Research done by the ASMS on presenteeism, burnout and future workforce intentions have highlighted some of the problems that our SMO workforce experience. We are actively working with DHBs through the JCC meetings to address burnout. If we cannot look after our own health, we cannot look after the health of our patients.
- We have highlighted workforce shortages in articles in *The Specialist*. We are concentrating on specialties with severe shortages. We hope to publish these as a standalone publication early next year.
- The ASMS, along with the RDA and DHBs, has been proactively investigating systems and solutions to reduce bullying, harassment and inappropriate behaviour.
- The ASMS has said for a number of years that there are entrenched shortages in the SMO workforce. We continue to warn that the system is under tremendous pressure and ongoing underfunding is contributing to this. We are not crying wolf. We are genuinely concerned.

A WAY FORWARD

I want to start by looking at lines of responsibility. The public votes and determines who governs the country. The Ministry of Health is part of the government structure. The Minister of Health appoints DHB Chairs (and a number of other board members). The DHB Boards appoint chief executives, who in turn appoint managers and, indirectly, staff to deliver services.

Put that in reverse order and you have managers reporting to chief executives, chief executives reporting to the DHB Boards, who report through their Chairs to the Minister of Health, who reports to Government (cabinet) who is voted in by the public. It will come as no surprise that DHBs do not like staff talking directly to the public. That bypasses a whole lot of reporting levels.

We should not forget the role of the Treasury. From their website: "The Treasury provides advice to Ministers on the purchase and regulation of health services. This advice covers areas such as the structure and management of health spending, institutional and governance arrangements in the health sector and health sector strategies and policies."

DHBs have explicit responsibility for providing or funding the provision of health services in their district and responsibility for the health and safety of the staff they employ. However, we all have a role to play and decisions that need to be made. Everyone in the above chain has a responsibility.

- The public: Next year they can exercise their democratic right and vote.
- Government: How are you going to spend our "rock star economy" money? Reduce tax rates before the next election, or keep them the same and invest the money into the health of New Zealanders? Should you consider increasing taxes by 1 or 2% and ring fence the money for health (like they did in Scotland)?
- Treasury: What is your advice going to be on the spending on health services?
- DHBs: Are you going to keep doing what you're doing or is it time to start thinking whether you are being set up to fail? Efficiency savings have been done and dusted. The fat and low hanging fruit is gone. You are still expected to do more with relatively less in a shorter space of time with an increase in quality and safety. Do all that with staff that are increasingly unhappy and burnt out. That reminds me, you do have a responsibility for the health and safety of your increasingly unhappy and burnout staff.
- Workforce: Continue to advocate for the patients we see and treat. Continue to report from the frontline. Get as much joy from your interaction with patients and colleagues as you can. The system is running a bit low on joy at the moment.

We *have* to get the heat out from under the frog. We all have a responsibility to achieve that.

Dr Stander's conference address can be viewed at **http://www.asms.org.nz/news/asms-news/2016/12/02/dr-hein-stander-presidential-address-asms-annual-conference/**

ASMS ANNUAL CONFERENCE 2016

It was the conference that nearly didn't happen.

The 7.8 earthquake that struck just days before the ASMS Annual Conference was due to open in November sparked a flurry of checking to make sure the venue was safe – as well as a few anxious phone calls from delegates due to attend. Fortunately, the Conference was given the all-clear to go ahead and all was well, despite the occasional shake as the after-shocks continued.

The conference began with a moment of silence for former Council of Trade Unions President Helen Kelly, who died in October after a long illness. She was a good friend of the ASMS and a strong advocate for the rights of working people in this country.

Speakers over the two days included:

- ASMS National President Hein Stander, with his presidential address (see separate article, including links to a video of his presentation).
- Dr Charlotte Chambers, ASMS Principal Analyst (Policy & Research), on her research 'Age, frustration and call: exploring intentions to leave the New Zealand public health workforce' (see separate article).
- Ian Powell, ASMS Executive Director, on the DHBs' offer for settlement of MECA negotiations.
- Dr Derek Sherwood, Chair of the Council of Medical Colleges, on the proposed funding model for vocational medical training.
- Health Minister Dr Jonathan Coleman (his speech notes are available at **https://www.beehive.govt.nz/speech/speech-association-salaried-medical-specialists-conference-te-papa-wellington**).
- Dr Tim Frendin, ASMS National Executive member and Geriatrician at Hawke's Bay DHB, on the concept of frailty.
- Associate Professor Phil Bagshaw, General Surgeon and Chair of the Canterbury Charity Hospital Trust, on physician advocacy.
- Shamubeel Eaqub, economist, author and commentator on the economics of the health story and the role of public engagement.
- Michael Fleete, outgoing President of the New Zealand Medical Students Association, on the importance of two-way mentoring between new and experienced doctors.
- Maria De Vecchis, Federal Executive Officer from the Australian Salaried Medical Officers Federation, with a message of solidarity and support.

Videos of these addresses are now on the ASMS website.

Highlights of the first day included the awarding of life membership to respiratory physician Dr David Jones (see separate article), a short performance by The Improvisors ahead of Dr Chambers' presentation, and the first fledgling steps towards establishing a 'women in medicine' network. On day two, delegates commented on the way the three main presentations on frailty, physician advocacy, and the economics of the health story came together to provide new perspectives on these issues.

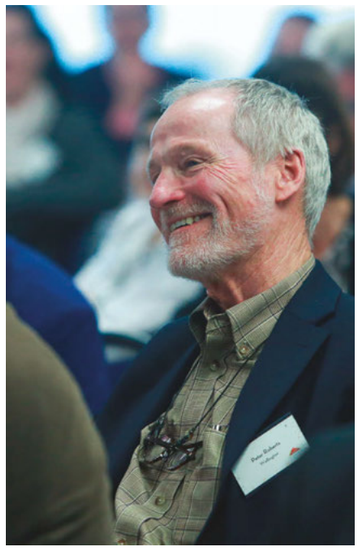
All regions were well represented at the conference, with more than a hundred delegates from around the country.

MECA RESOLUTIONS

Delegates at the ASMS Annual Conference passed the following resolutions in relation to MECA negotiations with DHBS:

1. That Annual Conference rejects the DHBs' settlement offer dated 30 September 2016. *(Carried unanimously)*
2. That Annual Conference agrees a membership ballot regarding the DHBs' settlement offer dated 30 September 2016 is unnecessary. *(Carried, 1 abstention)*
3. That Annual Conference reaffirms the focus of patient centred care in these negotiations. *(Carried, 3 abstentions)*


HELEN KELLY



THE MINISTER'S STATISTICS...

LYNDON KEENE | ASMS DIRECTOR OF POLICY & RESEARCH

Health Minister Jonathan Coleman used a raft of statistics for his address to the Association's Annual Conference. Many are not quite what they seem. To give a few examples:

WHAT THE MINISTER SAID: "Health funding increased by $568 million this year."

COMMENT: This is $131 million short of the $689 million estimated to be needed to keep up with costs, population growth and aging without providing for new or improved health services.

WHAT THE MINISTER SAID: "Claims that health funding has been cut are incorrect. This year, New Zealand is forecast to spend 6.26% of its economy, GDP, on health. Prior to this Government, the percentage of the economy spent on health was under 6%."

COMMENT: Treasury data show Core Crown Health Expenses did fall below 6% of GDP in the 2000s but then rose to 6.67% of GDP by 2009/10. An additional billion dollars would have been needed in 2015/16 to bring health funding up to the levels of 2009/10 as a proportion of GDP.

WHAT THE MINISTER SAID: "Since 2008, the number of FTE specialists in DHBs has increased by over 1,100, and the DHB employed specialist workforce is currently increasing at around 140 per year."

COMMENT: The New Zealand specialist workforce growth started from a low base. In 2008 New Zealand had one of the lowest numbers of specialists per population in the OECD. Despite the growth, it remains among the lowest. According to the annual DHB Salary Surveys, the average net growth of DHB-employed specialists is 156 per year since 2008 (fluctuating between 76 and 223). To put this into context, for New Zealand's total (public and private) specialist workforce to match Australia's forecast specialist-per-population by 2021, New Zealand needs an annual net growth of 342 specialists (including those working solely in the private sector), or an average annual net growth of approximately 282 DHB-employed specialists – 126 more than the current average growth. (Australia's specialist-per-population ratio is well below the OECD average.)

WHAT THE MINISTER SAID: "Mental health … demand has increased from 2.3% of the population a decade ago to 3.5% of the population in the last year – that's an increase from around 96,000 people, up to 164,000."

COMMENT: Recent data from the 2015/16 New Zealand Health Survey show 6.8% of the adult population experienced psychological distress in the four weeks prior to the survey – up from 4.5% in 2011/12. The results were significantly higher for Māori adults (10.5%) and Pacific adults (11.3%).

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DR DAVID JONES

NEW LIFE MEMBER FOR ASMS

Respiratory physician Dr David Jones has been awarded life membership of the ASMS.

Delegates at the ASMS Annual Conference in November voted unanimously to recognise Dr Jones' many years of service as a branch officer and member of the National Executive.

A standing ovation greeted Dr Jones as he made his way to the front of the conference hall following the vote by delegates.

Fellow life member and former National President Peter Roberts told conference delegates that Dr Jones' contribution to ASMS had been "phenomenal".

"When we talk about ASMS as an advocate for doctors, he was the person sitting at the table saying: What about our pension plan? Are our members planning for their future? Are our members in good health?"

David Jones expressed his appreciation for being made a life member, and recalled how he came to be involved with the ASMS.

"My first involvement was when I came up to work in Wellington and Hutt back in the late 1980s," he says. "I was told by colleagues at Hutt that you must go to an annual conference and report back, so I went and was absolutely struck by the level and quality of discussion.

> ***"I thought: This organisation knows what the future requirements are, and I must be part of it."***

He was a Wellington regional representative and served twice on the National Executive, each time for eight years, before resigning in 2011. He looks back with fondness at that time.

"Every time I went to an Executive meeting I came out feeling better. They were always very enjoyable, the discussion was good and there was always such a lot of thoughtfulness."

He says he is proud to belong to ASMS and praised its defence of public health both now and during the so-called health reforms of the 1990s.

"There was this wave of neoliberalism that came into politics and economics, and there were some absolutely crazy policies adopted. ASMS had to fight a rearguard action against a chipping away at the stability and the quality of the public health service, and I think it did this pretty well."

A short videoed interview with Dr Jones can be viewed at ***http://www.asms.org.nz/news/asms-news/2016/11/30/new-asms-life-member-awarded/***

DR JEFF BROWN

SUBSCRIPTION INCREASE FOR 2017 - YOUR NATIONAL SECRETARY EXPLAINS WHY

DR JEFF BROWN | ASMS NATIONAL SECRETARY

After three years of no subscription increase, the 2015 Annual Conference endorsed the Executive's recommendation for a subscription increase, and in fact it voted for a greater increase to avoid excessively running down our reserves.

Midway through this current financial year we undertook a reforecasting exercise as three of our budget assumptions were not bearing out, and we were seeing the true costs of our planned increase in staff and services to members.

We had assumed that membership growth would continue to offset cost increases, as it has done historically. However, DHBs have tightened up and are drawing out our MECA negotiations. This has the effect of increasing the costs of negotiations for the ASMS (keeping in mind that we appear to be in for a long battle) and will also delay the receipt of income from 'bargaining fees' (income from non-members which ends on expiry date of the MECA).

Three more permanent staff (two industrial officers and one in our administration team) have expanded our industrial team. Those members experiencing increasingly hard line attitudes in DHB land will appreciate the work of our industrial officers who spend a lot of time travelling to help sort out the myriad of tensions and tussles. We have also seen the immense value of our policy and research activity discovering haunting horrors of presenteeism, burnout, and intentions to quit the DHB workforce. One could argue that our employers, or the Ministry, should have been finding these figures, but it has been left to us to uncover the sad truth, and to publish the results of our high quality research. The costs of industrial, policy and research activities, the very core of our business, have become clearer during this financial year.

We are still in a strong financial position, but reforecasting has shown that to maintain reserves at the current level, we would require either a further 800 members, or ask current members to pay $1,110 annually. Your Executive recommended a middle ground, by running down our reserves for the next five years, increasing subs by $100 this year, and projecting annual $75 increases to eventually maintain reserves at a lower but even level.

These conservative forecasts and budgeting process have been affirmed by our accountants, Grant Thornton, as among the most robust of organisations they are exposed to. As an example of our conservatism, if we do achieve 105 more members, our income will increase by $100,000.

Your Executive presented our reforecasting, their examination of costs and expenditure, and various scenarios for reserves depending on decisions about subscriptions.

At the 2016 Annual Conference, your delegates voted overwhelmingly for the recommended increase in subs to $950 (GST inclusive) with many commenting on the value of this payment in terms of industrial representation, fighting for our MECA, and strong policy and research activity that ASMS is renowned for.

ASSOCIATE PROF PHIL BAGSHAW

PHYSICIAN ADVOCACY IN WESTERN MEDICINE: A 21ST CENTURY CHALLENGE

ASSOCIATE PROF PHIL BAGSHAW

What has the history of physician advocacy got to teach us about how we should behave as advocates for the health of our patients and society?

Scholarly literature from various disciplines reveals views of the medical profession that most doctors would find surprising and shocking. It paints a picture of us as often only having been committed to such advocacy when it suited our own selfish interests. It also describes how genuinely motivated advocacy could advantageously influence our relationships with our patients and society as a whole.

In the 19th century, when medical treatments were often ineffective and/or dangerous, doctors bolstered their positions in society by speaking out in defence of the public good in health. Then with the coming of the 20th century, medicine became more scientifically based, and treatments became more effective and safe. As a consequence, doctors no longer needed to openly advocate for the public good in order to retain their social standing. Therefore, in our hubris, we stopped advocating and indeed frequently came to see it as unnecessary and undignified.

We should have been wise enough to know that this utopia would not last. From the 1970s onward, the medical profession came under increasing attack from political, technological and socio-economic forces that threatened our autonomy, prestige and power. With individual exceptions, as a body we responded to these threats by becoming more bureaucratic and hierarchical.

> *In this way we staved off some of the threatening forces but again omitted to keep faith with society by adequately advocating publicly on their behalf.*

Regrettably, this omission became embedded in the medical culture.

Why are many public healthcare systems now in difficulty?

This century, most Western governments have come to the erroneous conclusions that health costs are running out of control and can only be managed by a process of rationing of elective health care services (described in the medical management literature as "altering the trajectory of demand").

Governments have also closed their eyes, ears and minds to the consequences of increasing levels of unmet health care need in society, and to the growing body of evidence that investing in health care pays large fiscal dividends.

Or put another way, delay or avoidance of timely management of health saves money for the current government but predictably and unnecessarily will increase manyfold the fiscal burden thereafter.

Should the medical profession respond to this lamentable situation by reassuming a strong advocacy role?

Well, the scholarly literature describes how we are deeply divided on the subject. Some authorities argue that we should only advocate on medical issues when asked by governments or other authorities for our expert opinions, and that we have otherwise no greater right to take up an advocacy role, whether it be behind closed doors or open to public scrutiny, than any other citizens. The opponents assert that advocacy for health care, for patients and society, is an essential component of medical professionalism, which is not only our right but also our responsibility.

> *I challenge all doctors in New Zealand to decide on which side of this argument they align themselves. We certainly can't have it both ways.*

From the beginning of New Zealand's so-called health reforms in the early 1990s, our once proud universal access secondary health care system came under attack by legions of arrogant, ill-informed people from the business and political worlds. At that time our professional bureaucratic, hierarchical representatives in our medical colleges, societies and associations made few public statements of protest. And similarly, they have continued to make few such statements in response to the more subtle and occult attacks that have subsequently persisted to this day. They may argue that they have energetically advocated with the levers of power behind closed doors. Unfortunately, all of the evidence shows that this has been largely ineffective. The amount of unmet health care need appears to be increasing to unacceptably high levels, and health care funding is reducing annually in real terms.

So what of the future of physician advocacy?

Well, we in New Zealand seem inextricably bound to slavishly follow the failed and failing health care models in the USA and UK. Indeed, in the latter, where the National Health Service is imploding, the medical and surgical colleges, previous bastions of conservatism and stoicism, have finally woken from their slumbers. They have come to realise that contemporary politics is not about "Leadership" but rather about "Followship" – that is, the pursuit of the vagaries of shifting public opinion. Therefore, the political process can only be changed by open public advocacy, which they are now, at last, actively pursuing. It is a pity that this epiphany might be just "too little – too late" to save the NHS. Do we in this country have the collective ability to learn from these unfolding events?

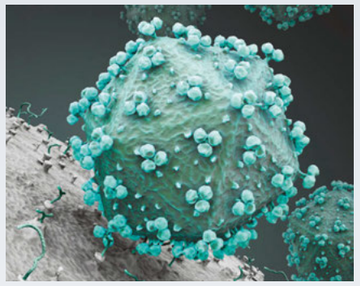
What do our patients and society expect from us doctors in New Zealand?

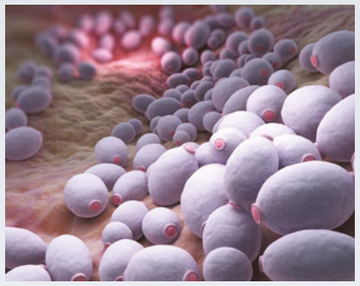
There can be no greater honour than that they trust us with their lives and wellbeing, and look to us for guidance on health matters. In return they naturally assume our competency and commitment. I contend, however, that they expect and deserve more. They want us to be their champions and to fight publicly and effectively for their right to health care. Who else, they believe, is as well placed as we are to do so? It is undoubtedly a privilege to represent them in this way.

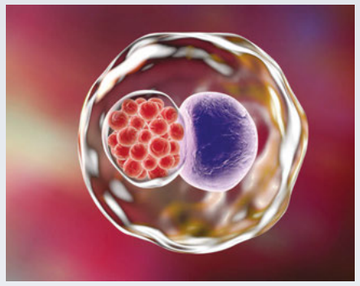
So far, our professional representatives in our medical colleges, societies and associations have largely been weak and pathetic in this regard. We hear next to nothing about our health care problems from them. Indeed, there is some irony in that, while our professional representatives appear to rest on their laurels, some of our industrial representatives, such as the Association of Salaried Medical Specialists, have taken a strong stance against growing unmet health care need and the chronic underfunding of our public health care system. I have asked a number of senior colleagues for their views on the reasons for this striking difference in approach. They all agree it is simply a leadership issue.

I only hope something soon galvanises our professional leadership in New Zealand into action before the deterioration in our public health care system becomes irreversible. In the circumstances, it is heartening to hear recent news of some individual and groups of doctors, such as the orthopaedic surgeons at Waikato District Health Board, advocating publicly for their patients and the clinical services for which they work. Perhaps such local expressions of concern are the way forward.

The history of physician advocacy has much to teach us. Perhaps no one has better encapsulated both the spirit of a bygone age, and a recommendation for future action, than the well-known 19th century pathologist and advocate Rudolf Virchow, when he famously said, "Medicine is a social science, and politics nothing but medicine on a grand scale."







FUTURE SHAPE OF AUCKLAND'S REGIONAL SEXUAL HEALTH SERVICE UNCLEAR

Auckland's sexual health physicians are hoping their managers will see sense and abandon a proposal to cut specialist numbers at a time when HIV and syphilis rates are on the rise.

By the time you read this, Auckland District Health Board managers may have made a final decision on the future shape of the region's sexual health service.

We will report that decision on the ASMS website - but at the time of writing, Auckland's sexual health senior doctors are still wondering if the DHB will insist on changes that will see a reduction in specialist numbers.

If that happens, they say people already struggling to access sexual health treatment in the Auckland region could face even more of an uphill battle, and they are concerned for the future safety of the service for both doctors and patients.

ASMS Executive Director Ian Powell has criticised the DHB's consultation process, saying it has marginalised the very people who should be leading any review of the service.

"Any review should be clinically-led and driven by the need to deliver clear benefits for patients, while also looking after the existing workforce," he says.

"However, in this instance Auckland DHB's review and consultation process has all the hallmarks of a hastily cobbled together cost-cutting exercise without any real consultation with the people currently providing the sexual health service, or evaluation of the likely impact on the community.

> *"Obviously we're hoping that the DHB's managers will listen to what their highly experienced sexual health doctors are telling them and not do anything that jeopardises the quality or safety of the service."*

International best practice indicates that one medical specialist is needed per 100,000 population but, under the Auckland DHB's proposal, the region would have just one specialist per 500,000 people.

Dr Sunita Azariah, who has been working in sexual health for more than 20 years, used to be the clinical director of the service but resigned last year, frustrated that the concerns she was raising about what the service needed were not being heard.

"I feel that it's all about the money," she says. "It feels like an exercise to take money out of the budget but with no proper engagement with primary care to ensure they can pick up this work or ensure they have the capacity. Our service runs on a shoe-string anyway and I think we do an amazing job given the constraints we work under.

"The whole process has been very stressful and it's hard to concentrate on our jobs, which is to develop our service and provide better care for our patients. We seem to just spend the whole time responding to their proposals. There's also never been any consultation with the community about what they want, and our impression is that nobody understands what we do, or the skills or expertise we have."

She says there's a significant and ongoing outbreak of syphilis in the Auckland region, along with high rates of chlamydia and gonorrhea.

"GPs and sexual health nurses do a fantastic job within their scopes of expertise, and we work very closely with them, but there is very strongly a role for specialists in sexual health within the region.

> *"We need specialists to deliver the best possible sexual health care and the pressure will really increase on the remaining doctors and other health professionals if there are any cuts."*

She's very critical of the lack of robustness around the consultation process, particularly the lack of clinical and community involvement.

"There's no clear rationale driving the proposed changes from what I can see. Of all the time they've chosen to do this, this is probably the worst time. I never used to see a case of syphilis but now I see it every day. There's a complete lack of understanding of the pressure we're under, the need for specialists in this area, and the current outbreak of serious infections we're dealing with."

DR SUNITA AZARIAH

A DAY IN THE LIFE OF A SEXUAL HEALTH PHYSICIAN

DR SUNITA AZARIAH | SEXUAL HEALTH SPECIALIST, AUCKLAND DHB

I arrive at work and log into my computer. A friendly nurse colleague offers to make some coffee. A quick scan of emails – most aren't urgent. I start on the morning's clinical admin, checking Concerto for letters to sign off, etc. Outlook reminders pop up to phone people about results and to fax through prescriptions for a couple of HIV patients.

I check the e-referrals inbox and find half a dozen waiting to be triaged. These include some for people with gender dysphoria, recurrent candidiasis, a straightforward case for management of genital warts, and someone with positive syphilis serology.

I print out the referral for syphilis as it's likely to be infectious, and give it to the clinic triage nurse to arrange for us to see the patient ASAP. When I check the clinic bookings, I see there are a few familiar patients scheduled as well as some new ones.

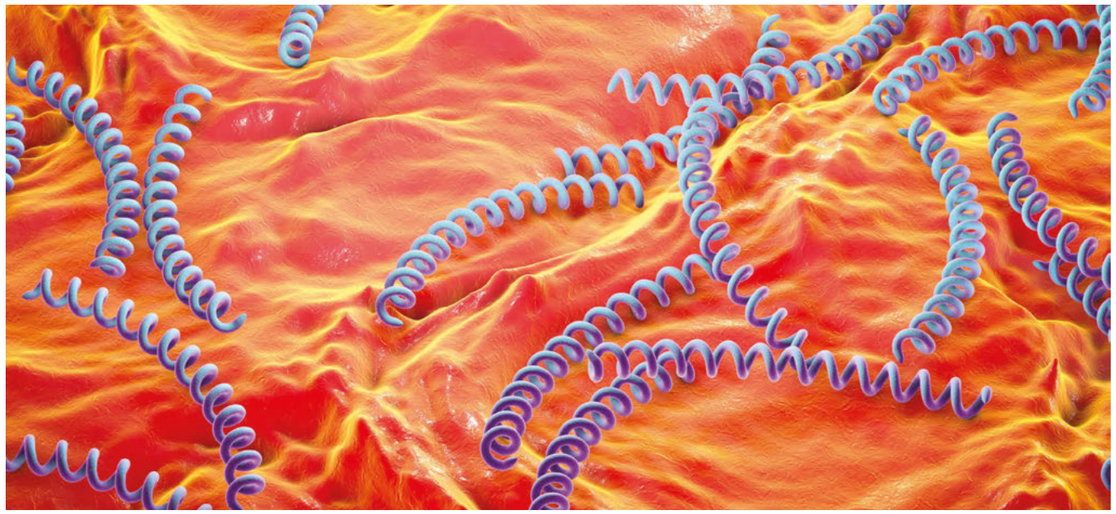
Mid-morning – a meeting with the research team for our New Zealand PrEP study. We are planning a demonstration project for HIV pre-exposure prophylaxis in New Zealand. Progress has been difficult as only one of us is a full-time researcher. We have managed to secure most of the funding from Gilead but still need some more to cover the behavioural arm of the study. The Health Research Council has declined our application and we are now looking at other avenues.

Then it's lunch-time – a chance to catch up with other staff and share a few laughs.

After lunch I start clinic.

> ***The first person I see is a long-standing patient with HIV. I have just switched him to a new medication that has been recently funded, as his virological control wasn't optimal. So far he is doing well.***

Next is a new referral, a woman with a "large painful wart" who could have been booked to see a nurse. She comes across as very anxious and worried. I take her history – she has had cancer in the past and has been in a long-term relationship for many years. Her GP has done routine tests for STIs, which were negative. I talk to her and carry out an examination, finding just a tiny vulval wart and nothing else of note. I freeze it with nitrous oxide gas. I talk to her about genital warts and



HPV (human papilloma virus) and reassure her that it is not uncommon for people in long-term relationships to develop warts, usually from a previous infection with HPV. She says she feels much better and leaves with a smile.

The next patient is another referral with possible warts, this time a young man who has only had one lifetime partner. He has had treatment for genital warts with his GP. Examination reveals raised pink papular lesions on his penis. I think it may be lichen planus. I consult a colleague, who agrees, which means we can avoid doing a biopsy. I treat the patient with clobetasol cream and arrange to review his situation in a fortnight. He is very relieved that he doesn't have an STI!

My next patient is a man who tested positive for syphilis with a rapid test at a New Zealand AIDS Foundation clinic. His HIV test was negative. He has no past history of STIs and has a male partner, plus he has had sex with a couple of people he met casually via Grindr. He has noticed a rash on his scrotum in the past few days but no sores.

> *When he lifts his shirt, I can see the typical rash of secondary syphilis.*

He also has an extensive rash on his scrotum that is red and scaly, which could easily be confused with psoriasis or tinea. I ask him if our nurse and a registrar can look at the rash. He agrees so they both get an opportunity to see how syphilis can present. He has had routine STI tests for chlamydia and gonorrhoea at the New Zealand Aids Foundation, so we do syphilis serology to confirm the diagnosis and then repeat his HIV test, as the serum sample is slightly more sensitive than the rapid finger prick tests.

He has no allergy to penicillin so we treat him with a single dose of intramuscular benzathine penicillin. I advise him not to have sex for two weeks and that his partner will need to come in for treatment. He says he cannot contact any of his casual partners. Usually for secondary syphilis we recommend that all sexual contacts in the previous six months should be treated.

My next patient involves a follow-up with a woman who was referred with recurrent candidiasis. At her last visit I treated her with topical nystatin cream for two weeks as she had a strain of candida that was resistant to fluconazole. At this consultation she seemed angry and upset, and said she didn't feel any better since using the cream. She reported she was still experiencing an almost constant burning feeling in her vagina. I asked her if it was painful to have sex and she burst into tears and said she hadn't had sex in ages as she was worried she was going to pass something on to her partner. I immediately wondered if the burning was due to her distress and feelings of being contagious.

I examined her again, and everything appeared normal. I took a vaginal smear that I Gram stained in the lab and did microscopy checking for bacterial vaginosis and candida (both negative) and did a repeat candida culture.

> *I spent a long time reassuring her the examination was normal and that candida is not an STI, and that if her partner has no symptoms we didn't need to treat him. She said she felt much better.*

I said I would ring her with the results – a week later the candida culture was reported negative and she said her symptoms of burning had fully resolved.

Then came a patient who had been referred with a positive HIV test on routine immigration screening. They had no obvious risk factors as they were heterosexual and had never injected drugs, nor were they from a country with high HIV prevalence. They came in with a support person from the peer support organisation Body Positive, and they had a distressing story to tell about how they had received the news they were HIV positive.

In essence, they had been given a print-out of their results by the GP's reception staff and then sat in the waiting room for half an hour before they were called in and spoken to in a very cold manner. There was no care or concern or referral for ongoing care. They got in touch with the group Body Positive by googling HIV services, and – luckily – found the help and support they needed.

I spent some time talking to them about HIV and the fact that it was treatable. I answered all of their questions, carried out a brief physical exam and routine blood tests, and arranged a further follow-up with them.

* These examples are based on common clinical scenarios presenting to the sexual health service.

HOW MANY TIMES DO ALARM BELLS HAVE TO FLASH BEFORE GOVERNMENT AND DHBS NOTICE?

IAN POWELL | ASMS EXECUTIVE DIRECTOR

Much of the ASMS Annual Conference focussed on the DHBs' proposal to settle our multi-employer collective agreement (MECA) negotiations. As you are aware their proposal was unanimously rejected by Conference delegates essentially because it failed to recognise the precarious vulnerability of the senior medical and dental workforce in DHBs and, as a direct result, the lack of workforce capacity to provide quality and comprehensive patient centred care.

PLURALITY OF "MID-STAFFS"

There were two related presentations at the Annual Conference which highlight the seriousness of this precariousness. The first was the warning in his Presidential Address by Dr Hein Stander that our public health service was at high risk of being subject to not one Mid-Staffordshire but several. In a nutshell, Mid-Staffordshire in the English National Health Service (fortunately the NHS in Scotland, Wales and even Northern Ireland have different drivers) is code for disastrous standards of patient care when those authorities responsible for the provision of this care are preoccupied by financial targets.

In the case of Mid-Staffordshire the financial target was for this NHS Trust to seek Foundation Trust status in order to achieve greater financial and organisational "freedoms". This became the focus with quality and patient safety sacrificed.

> *In the case of district health boards in the land of the long adverse weather cloud that is our public health service, the financial targets have to be seen in the context of over $1.5 billion in relative terms being sucked out of DHB revenue since 2010.*

In this context we have:

- pressures to do more with less,
- pressures not to have deficits (or get out of deficit as quickly – the reality for most DHBs) despite increasing patient demands and growing unmet need, and
- pressures for rigid compliance with targets which focus on those things that can be counted rather than most things that health professionals do for patients.

OPHTHALMOLOGY LESSONS

Dr Stander had the shocking example of a recent "Mid-Staffordshire" – ophthalmology – in his sights. Despite endeavours by government to marginalise it to three DHBs, this is a national controversy which had led to the tragic case of some patients losing their sight. What were the factors that sit behind this? What about:

- systemic underfunding since 2010
- significantly increased demand due to innovation in the treatment of macular degeneration (ophthalmologists warned government that this was coming but this was not acted on)
- shortages of optometrists, nurse specialists and ophthalmologists
- struggling to keep up with the treatment of other chronic eye illnesses
- neglect of clinical follow-ups with patients (critical for patient well-being but follow-ups fall outside the electives target)?

This latter point – disregarding of the clinical importance of follow-ups because they are outside the target – was also a feature of the orthopaedic service in the hapless Waikato DHB under its militaristic leadership culture.

PENDING RETENTION CRISIS

The second presentation was a work in progress by ASMS Principal Analyst Dr

Charlotte Chambers on a survey of DHB-employed ASMS members about their work intentions over the next five years with a view to better understanding the factors influencing their decisions as well as the link with demographic factors such as age, gender, medical specialty and levels of job satisfaction.

This is discussed more fully elsewhere in this issue of *The Specialist*. But the alarming conclusion of her analysis to date is worth repeating.

> ***A quarter of all senior doctors and dentists who took part in this survey intend to leave either medicine or dentistry completely or their DHB in the next five years.***

Increasingly the medical and dental workforce is aging and, within this demographic, few want to continue doing after-hours acute call, which is an essential requirement of public hospitals. Those that want to continue working in a much less onerous environment have the options of private work or locuming.

This points to a looming exodus of DHB-employed specialists from our public health service. Further, this exodus is consistent with below-the-radar analysis conducted in the Ministry of Health. It is clear that there is a significant gap between our rate of recruitment and rate of retention.

This work on work intentions is the third major piece of research based on surveys undertaken since the employment of Dr Chambers nearly 18 months ago. The first, reported at the ASMS Annual Conference last year, revealed a disturbing level of senior medical staff working while sick (presenteeism). The second, reported to a national workshop of branch presidents and vice presidents in August this year, revealed an alarming burnout rate of 50% (much higher than anticipated). And now the third reveals a staggering loss of nearly 25% in the next five years.

HEALTH LEADERS AND ALARM BELLS

Any health leadership with a modicum of insight would hear the alarm bells ringing and start considering measures such as increasing the number of specialists employed by the DHBs in order to make their working conditions more tolerable and reducing burnout.

Instead we have a Minister of Health who espouses soundbites on target results and whose stock response to those who disagree with him is to state that "we will have to agree to disagree" without engaging in substance over the disagreement. We have a Ministry of Health focused on the absurdity of creative disruption while the medical workforce creaks and strains in DHBs, and DHBs which hide behind their shared services agency's efforts to discredit the results of a survey that revealed a message they find unpalatable (the burnout survey results).

I guess we will have to hope that the answer to the question of how many flashing alarms does it take for our government and DHBs to act is not infinite.

DEMOGRAPHIC AND ATTITUDINAL CHANGE IN THE NEW ZEALAND SPECIALIST WORKFORCE

LYNDON KEENE | ASMS DIRECTOR OF POLICY & RESEARCH

This is an edited version of an ASMS Research Brief, which can be read in full at **http://www.asms.org.nz/wp-content/uploads/2016/11/Demographic-and-attitudinal-change-in-the-NZ-specialist-workforce-research-brief_166927.1.pdf**

Three concurrent trends in the specialist workforce will impact on the capacity to meet New Zealand's growing health needs and require a rethink in the way immediate specialist workforce planning is approached. They are:

- the growing proportion of females in the specialist workforce
- attitudinal changes about the importance of work-life balance
- the aging of the specialist workforce.

While many specialists continue to work long hours, each of these trends is contributing to a growing number of specialists working part-time, thereby reducing the average number of hours worked per specialist. Similar trends are occurring internationally, which adds a further challenge to New Zealand's workforce planners given this country's high dependency on international medical graduates (IMGs).

THE SHIFT TOWARDS GENDER BALANCE IN THE SPECIALIST WORKFORCE

Medical Council of New Zealand (MCNZ) data show that in 2014, women comprised 31% of the specialist workforce, compared with 19% in 2000. Gender statistics for practising registrars indicate the proportion of female specialists will continue to increase. In 2014, 50% of registrars were female.

Internationally, female doctors tend to work fewer hours, on average, than their male counterparts. In New Zealand, this is indicated in MCNZ workforce survey data which show female doctors work (ie, paid work) on average 40.1 hours per week compared with 46.1 hours for males, due in part to a greater proportion of women working part-time. In 2014 (the latest data available) 37% of female specialists worked part-time (less than 40 hours per week), compared with 14% of their male colleagues.

> ***This has particular implications for public hospitals, which depend on them to a far greater extent than, for example, general practice or private practice, on acute after-hours call rosters.***

In addition, career breaks are more frequently taken by female doctors. In a survey of National Health Service (NHS) and university doctors in the United Kingdom (UK), 10% of male respondents had taken a career break, compared with 58% of female respondents. Time out for family reasons is the most common factor.

There is also evidence that female doctors tend to have lower activity rates, as measured by the number of patients seen, than their male counterparts. Much of it comes from North America, where doctors are paid primarily by fee-for-service, so reported lower activity rates suggest an element of individual choice. However, a study of salaried NHS hospital consultants' activity rates has also found women, on average, have lower rates than men, after accounting for age, specialty and hospital trust. The reasons for this were unclear, though the researchers suggested: "The result could reflect women taking more time with each patient, having different communication styles and perhaps being more meticulous, comprehensive and holistic in their care."

This was supported in analysis of 26 studies of the gender effects of medical communication, which found: "Female physicians engage in communication that more broadly relates to the larger life context of patients' conditions by addressing psychosocial issues through related questioning and counselling, greater use of emotional talk, more positive talk, and more active enlistment of patient input."

These elements, taken together, are considered central to patient centred care approaches, which have been shown to result in improved patient outcomes, improved safety, quality and cost effectiveness, as well as levels of patient and staff satisfaction. The difficulty for doctors to find time for genuine patient centred care, due to workload pressures, is commonly cited in the literature as a major barrier to its delivery.

The growth in the number of women in medicine, coinciding with increasing health needs and increasing funding pressures, has sparked much debate overseas about the effects on health service "productivity", generally measured by patient volumes. However, the importance of ensuring quality time for communicating with patients raises the question as to the relevance of crude productivity measurements, such as patient volumes, as opposed to considering quality of care and patient outcomes.

The rate of "feminisation" of the medical workforce internationally has so far occurred more in specialties where the clinical workload is relatively more "plannable", such as general practice, public health, paediatrics and psychiatry, or in specialties with relatively greater orientation towards interaction with people, such as obstetrics and gynaecology.

> ***In New Zealand, female specialists outnumber males in public health medicine and the smaller specialties of family planning and sexual health medicine.***

Female specialists make up close to half of the workforce in clinical genetics, general practice, obstetrics and gynaecology, paediatrics and palliative medicine. On the other hand, they comprise a relatively small proportion of the surgical specialties (Figure 1).

The picture will change, however, as more women enter the specialist workforce from the current vocational training programmes. In 2014 females outnumbered males in vocational training in:

- psychiatry (52%)
- general practice (60%)
- pathology (61%)
- paediatrics (73%)
- obstetrics and gynaecology (84%).

Females made up close to half of registrars in emergency medicine, anaesthesia, internal medicine and diagnostic radiology.

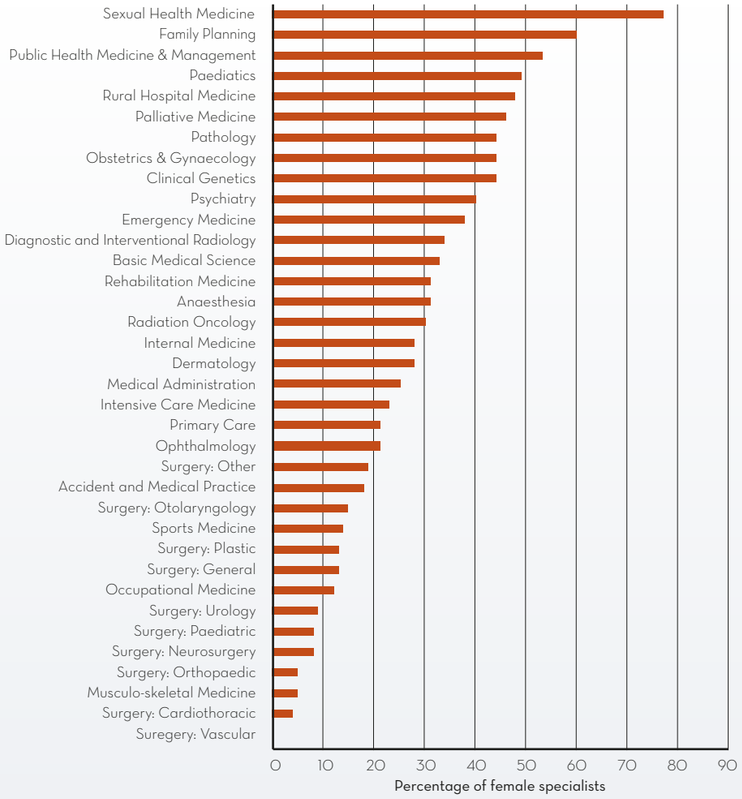


FIGURE 1: PROPORTION OF FEMALE SPECIALISTS BY SPECIALTY, 2014
Source: *MCNZ Medical Workforce Survey 2014, MCNZ 2016.*

The gender shift is already evident in the younger age groups of the specialist workforce. Of those aged under 40, 47% are female.

The continuing inflow of IMGs may also add to the increasing "feminisation" of the specialist workforce, given 43% of the current IMG specialist workforce are women.

WORK-LIFE BALANCE

There is much discussion about the growing importance of balance between work and the rest of life among the "millennials", but there is increasing evidence that work-life balance is equally important across the generations, if for different reasons.

This was illustrated in a survey of Australian and New Zealand hospital doctors which found 81% of respondents want a better work-life balance by having more flexible working arrangements.

Flexible work is considered to be more than access to leave and flexible working hours. It includes flexible working hours, working places and working practices.

While flexible working arrangements are more common for females than males, the survey found the desire for work-life flexibility is similar for both.

Further, the survey found the desire for flexible arrangements is not only strong among the new generation of doctors but also among their senior colleagues, with 69% of resident medical officers wanting more work-life flexibility, against 73% of senior salaried doctors.

MCNZ medical workforce survey data reflect a shift towards more work-life balance in the New Zealand specialist workforce through the growth in part-time work (for both women and men), though the growth has slowed in recent years, with 15.6% of specialists working under 40 hours per week in 2001, rising to 19.8% in 2007 and to 21.0% in 2014.

The trends vary when broken down by broad age groups, however. While specialists aged 60 and over had the largest proportion of the workforce working less than 40 hours per week in 2014 (32%), this had reduced since 2001 (44.6%). At the same time, the proportion of mid-to-late-career specialists (aged 40–59) working part-time in 2014 has overtaken the proportion of "new generation" part-timers in the under-40 age group.

THE AGING SPECIALIST WORKFORCE

In 2001, 14% of the total (public and private) specialist workforce was aged 60 or over; by 2016 this had grown to more than 22% (Figure 2), and according to Ministry of Health workforce modelling, it is projected to be more than a quarter of the workforce by 2021.

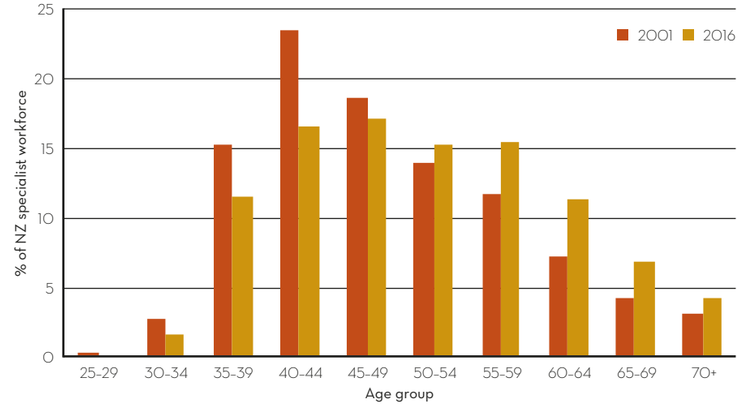


FIGURE 2: PERCENTAGE OF TOTAL (PUBLIC AND PRIVATE) NEW ZEALAND SPECIALIST WORKFORCE BY AGE GROUPS, 2001 AND 2016
Source: *MCNZ Medical Workforce Survey Data 2001, and Ministry of Health data (from the Medical Register) 2016.*

While many OECD countries have a higher proportion of older specialists than New Zealand, most OECD countries also have a higher number of specialists per head of population to cushion the effects of an aging workforce. New Zealand's relatively low numbers of specialists internationally reflect prolonged specialist workforce shortages, as recognised by HWNZ.

While the workforce is growing, the growth rate has been insufficient to catch up with New Zealand's increasing needs owing to the growing and aging population. (The population of those aged 65+ has increased by an estimated 24% since 2009/10.)

> ***Workforce growth rates will come under further pressure over the coming years as the number of specialists retiring from the workforce will increase, requiring a corresponding increase in the number entering the workforce.***

A national study of ASMS members' career intentions indicates 25% of respondents intend to leave the DHB workforce within the next five years. Specialist workforce modelling by the Ministry of Health, projecting workforce numbers based on recent trends, suggests the net growth rate of the specialist workforce will decline so that by 2021 the total workforce (private and public) will be less than 1.4 specialists per 1000 population, which will keep New Zealand well below the OECD average and is likely to exacerbate current workforce shortages.

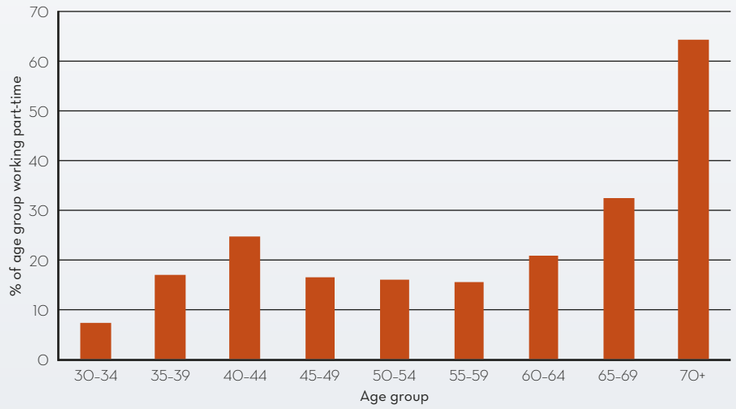


FIGURE 3: PROPORTION OF SPECIALISTS WORKING PART-TIME (LESS THAN 40HRS/WEEK) BY AGE GROUP, 2014
Source: *MCNZ Medical Workforce Survey Data 2014, MCNZ 2016.*

Furthermore, specialists, on average, reduce their hours of work as they grow older (Figure 3).

In addition, the aging specialist workforce in many countries is leading to increasing use of IMGs to fill the gaps opened up by retirements, and is therefore creating an increasingly competitive market for doctors. New Zealand's heavy reliance on IMGs (among OECD countries only Israel is more dependent) makes it especially vulnerable in this respect.

> ***There is broad agreement in the literature that policy responses are needed to encourage retention as senior doctors grow older.***

Suggested strategies, some of which are already in place in some countries, include various aspects of work flexibility, such as more flexible scheduling of shifts, limiting on call, interventions to reduce stress, integrating more permanent-to-temporary employment opportunities where workers can work on an "as needed" basis, expanding options for phased retirement, and increasing the opportunities for part-time or job-sharing placements.

CONCLUSION

Pressures on recruitment and retention of specialists in New Zealand and internationally are increasing due to demographic and attitudinal changes in the specialist workforce, in addition to increasing workloads from growing and aging populations.

Three key areas of change – the increasing proportion of women in the specialist workforce, increasing desire for more work-life balance in both genders, and the aging of the workforce – all signal a growing need for more flexible work arrangements, particularly more part-time work opportunities. This in turn requires higher headcounts of specialists. Because these changes are happening internationally, competition for specialists will increase.

Strategies are urgently needed to attract and retain specialists by creating working conditions that establish DHBs as employers of choice, and established New Zealand as a country of choice.

CHOOSING WISELY CAMPAIGN LAUNCHES

Choosing Wisely is a new campaign for New Zealand that encourages health professionals to talk to patients about unnecessary tests, treatments and procedures. It is health professional-led and is about providing the best quality of care for the patient.

The campaign is being run by the Council of Medical Colleges, in partnership with the Health Quality & Safety Commission and Consumer New Zealand, and with support from many health sector groups. It has funding from the Commission and the Ministry of Health.

Choosing Wisely is centred on helping patients make good choices and focuses on areas where evidence shows that a test, treatment or procedure provides little or no benefit to a patient and could even cause harm. These are not grey areas where evidence is debatable.

> ***Health professionals will be encouraged to discuss the risks and benefits of these tests with patients, so patients can make an informed choice.***

Choosing Wisely encourages patients to ask their health professionals these four questions:

- Do I really need to have this test, treatment or procedure?
- What are the risks?
- Are there simpler, safer options?
- What happens if I do nothing?

Council of Medical Colleges chair Dr Derek Sherwood says there are a large number of medical tests, treatments and procedures available, but that doesn't always mean we should use them.

"For example, not only do X-rays and CT scans expose patients to potentially cancer-causing radiation, but many studies have shown scans frequently identify things that require further investigation but often turn out to be nothing. This means patients can undergo stressful and potentially risky follow-up tests and treatments for no reason.

"Other examples of tests and interventions to consider carefully before use are imaging for patients with non-specific acute lower back pain and avoiding prescribing antibiotics for upper respiratory tract infection."

> ***He says there is evidence some inappropriate clinical interventions and treatments are being used in Australia and New Zealand.***

"The common factors across countries that contribute to health professionals ordering unnecessary services include patient expectation, lack of consultation time, overall uncertainty and fear of missing a diagnosis or malpractice concerns, reimbursement incentives, the way health professionals are taught, and avoiding the challenge of telling patient they do not need specific tests. The result can be care for patients that adds little or no value and may cause harm."

Seventeen medical colleges and specialty societies in New Zealand have already developed recommendations about which tests, treatments and procedures should be avoided. These have been developed with health professional input and consultation after review of the evidence. Each recommendation is supported by evidence and resources to assist health professionals.

Dr Sherwood encourages health professionals to review the lists of tests, treatments or procedures to be questioned and act accordingly.

"It is important to talk with patients about the care that is being recommended and use shared decision making. This includes listening to the patient about their experience of illness, their social circumstances, attitude to risk, and their goals, values, preferences and support needs."

Patient education and engagement is an important part of *Choosing Wisely*, and the Council of Medical Colleges is working with Consumer New Zealand and other organisations to promote campaign messages and develop resources for consumers/patients.

The campaign will communicate these messages in a number of ways, including via a website, posters and other printed material, online advertising and in social media. To find out more, go to **www.choosingwisely.org.nz**

SHARED CARE RECORDS

DR TIM COOKSON | MEDICAL ADVISER, MEDICAL PROTECTION

In the last article I discussed patient portals. These are systems which improve information flow between GPs and their patients. In this article I outline systems which are improving the information flow between primary and secondary care.

Until recently, patient information has been kept in silos; information held in primary care was not available to secondary care providers apart from when a referral was made, and information from hospital records was not available to primary care providers apart from discharge summaries and clinic letters. Often there were barriers within sectors as well – After Hours Medical Centres were unable to view information held by the patient's GP, and within hospitals, notes may be stored in different areas by different services.

Different projects have developed around the country to address this problem. Although it may have seemed more logical for a national programme to have been produced which would have provided identical access throughout the country, this was not done for a number of reasons. The UK had tried to introduce a similar system nationwide which failed to gain support from providers and patients alike, and was quickly shelved. Enthusiasm for developing such programmes also varied throughout the regions, and those regions that were keen on the idea did not want to be held back by others that were less keen.

> ***The basic principle of the shared care record is that a health provider who is separate from the GP can access information that has been uploaded from the GP's computer system regarding a patient presenting to them.***

The viewing health provider might be working in an after hours setting, within the hospital, providing domiciliary care, or be an ambulance officer.

The amount of information available varies, but usually includes long-term diagnoses and classifications, long-term and recent medications, allergies, and recent results. Notes from consultations are not generally available to view.

For such a system to be of use, the majority of patients must be on the system and their information available to be accessed. The UK tried a system which was opt-on where patients were asked if they wished to be on the system and were signed up individually. Uptake was generally poor with less than 20% of the population enrolling, which meant the system had little practical value. A "hit rate" of less than 20% did not encourage clinicians to use the system.

The other option is an opt-off system whereby all patients are put on to the system, and individuals can request to be removed from it. Typically, this opt-off rate is about 1%.

However, an opt-off system does raise significant privacy issues. The Privacy Commissioner was approached for a ruling on the acceptability of an opt-off system. The advice was that it was acceptable provided a number of criteria were met. These included adequate publicity; a simple system for patients to be removed from the system; that consent is gained where possible prior to accessing the system; and that adequate audits are done to ensure that access is not misused. Proper governance needs to be in place.

> ***Ironically, most patients believe that their information is already able to be viewed by different providers, and the first response to discussions about the system is usually "but I thought you already could".***

At the other end of the spectrum, my practice received the longest complaint for the Capital & Coast and Wairarapa regions – four closely typed A4 pages with 27 different issues to be answered – and this was before the programme had even been launched.

The system is primarily to make information held in primary care accessible to other providers. In some regions – including Hutt Valley, Canterbury, Otago and Southland – GPs can also access hospital records, and this two-way access is steadily increasing.

There have been challenges in rolling out the programme in the Capital & Coast and Wairarapa regions, and I am sure these challenges are not unique to our area. Some GPs were initially reluctant to "give up" their information and needed reminding that the information actually belongs to their patients. Understandably some GPs are concerned that if their clinical records are not up to date then the viewing clinician may not get an accurate picture. Diagnoses may not have been coded and medications may not have been put on to the long-term medication lists. Allergies may not have been recorded in a location that is accessible to another provider.

Those accessing the information need to be aware that the information may not be complete and should always be checked directly with the patient. I suspect that the knowledge that some of my general practice record is available to others has improved my enthusiasm for accurately recording diagnoses and updating changes to medication promptly.

The benefits of the system can be significant. From my own experience working in an after hours setting, it is invaluable to be able to check the medication list of an elderly patient whose memory for details is patchy. Anecdotal evidence from clinicians in ED suggests they believe significant harm has been prevented because of the additional information immediately available to them. Other providers report a much greater efficiency because of the time saved not having to try to obtain this information in other ways.

The biggest concern with these systems is possible privacy breach. It is increasingly easy for a health provider to log-on and access health information on patients when they have no rights to this information. As more providers are able to access information, the potential for misuse increases. There have been a number of well-publicised cases, including in Auckland and Christchurch, where patient information was improperly accessed. Patients and providers must be able to trust that the shared care record is not being accessed improperly. Publishing the results of audits of access is one way of providing reassurance. Patients can also see who has accessed their files.

Shared care records are likely to be a step along the pathway to fully integrated records where there is just one single patient record, and all those providing care will not only be able to access the record, but also contribute to it. Provided this is done well, both patients and providers will benefit.

DID YOU KNOW ...

...ABOUT PAYMENT FOR PUBLIC HOLIDAYS OVER XMAS AND NEW YEAR

This year the four public holidays over Christmas and New Year fall on a Sunday or a Monday. This means that these holidays will be officially observed a day later (on a Monday and a Tuesday).

Special rules apply for the holidays that fall on the Sunday (25 December or 1 January).

If the Sunday would otherwise be a working day for you, then this day must be treated as your public holiday, and your public holidays will be Sunday and Monday that week.

If the Sunday would not otherwise have been a working day for you, then the following Tuesday must be treated as the public holiday, and your public holidays will be Monday and Tuesday that week.

If you work on "any part of" the days designated as your public holidays, you are entitled to your usual pay for the day worked, plus an additional 50% of your "relevant daily rate" for every hour worked during routine hours on the public holiday. You are also entitled to a day-in-lieu on full pay at a later date.

If you are a shift worker, eg, in ICU or ED, and you are rostered off on a public holiday, you are entitled to a day-in-lieu on full pay on another mutually convenient day.

MORE INFORMATION IS AVAILABLE HERE:

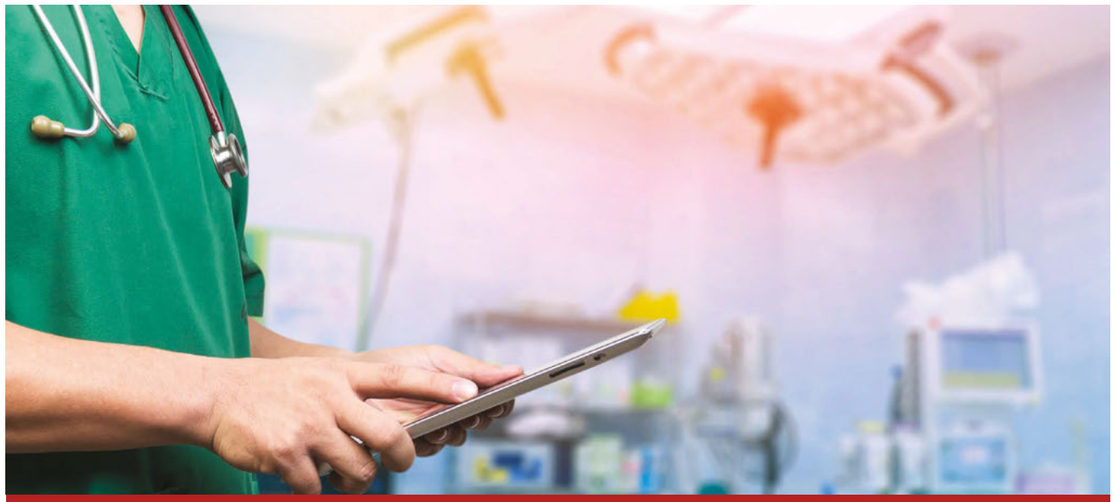
http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-24/

AND HERE:

http://legislation.govt.nz/act/public/2003/0129/latest/DLM237128.html

AND HERE:

http://legislation.govt.nz/act/public/2003/0129/latest/DLM237121.html



VITAL STATISTICS

In 2015 there were an estimated 119 practising specialists per 100,000 population in New Zealand, and an estimated 131 practising specialists per 100,000 population in Australia.

For New Zealand to match Australia's specialist workforce per population in 2015, an additional 570 specialists would have been required (the equivalent of 10.5% of the current New Zealand specialist workforce).

SOURCES:

New Zealand Medical Register, June 2015

Statistics New Zealand: Population Estimates

Australian Institute of Health and Welfare: Medical Workforce 2015

Australian Bureau of Statistics: Population Estimates

NOTE: Australian and New Zealand figures exclude provisional registrants and general practitioners. They include specialists whose main work role is non-clinical (eg, teaching, research).

HISTORIC MOMENTS

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

Letters to Newspapers

Christchurch Hospital
5th November, 1964.

Dear

Grave dissatisfaction exists at present among wholetime medical specialists in our public hospitals. As the Executive of the Wholetime Senior Medical Officers' Association of New Zealand we bear the responsibility of making submissions when requested, through established channels, on matters concerning the terms and conditions of service of wholetime specialists.

Current anxieties have recently led some of our members to seek the aid of their Parliamentary representative in bringing these difficulties before the House. Although they have obtained a sympathetic hearing, they have not so far succeeded in their object.

Our Association has made repeated submissions through established channels in efforts to obtain relief for the difficulties which we know to be causing serious disquiet. In October 1961, and again in September 1963, detailed suggestions for revision of terms and conditions of service were put forward, but entirely without effect. Because of this, unrest among our members is now such that serious losses of key hospital medical staff have already occurred and are likely to increase. Recruitment is also suffering. Unfortunately the standard of medical care available to hospital patients is likely to deteriorate.

We wish to stress that our anxieties arise equally from two factors. Firstly, unsatisfactory working conditions, in particular lack of advancement because of an arbitrary grading system. Secondly, the increasing disparity between wholetime salaries and the earnings of other doctors here and abroad.

Our Association has always pursued its objectives through the channels established for this purpose. Because the use of these channels has failed, we are now taking the unprecedented step of seeking your direct aid. We believe that the standard of care given to patients in public hospitals is a matter of the widest public interest and deserves your attention. We enclose for your information a statement about the training and function of wholetime medical specialists, as well as some of the difficulties now facing them. More detailed factual material is available from our Association at the above address.

Yours sincerely,

D. W. Beaven, Hon. Secretary.
J. R. E. Dobson.
A. M. Goldstein.
F. W. Gunz, President.
D. T. Stewart.
T. S. Weston.
for the Executive, Wholetime Senior Medical Officers' Association of New Zealand.

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 DHBs, 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 because 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*.

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

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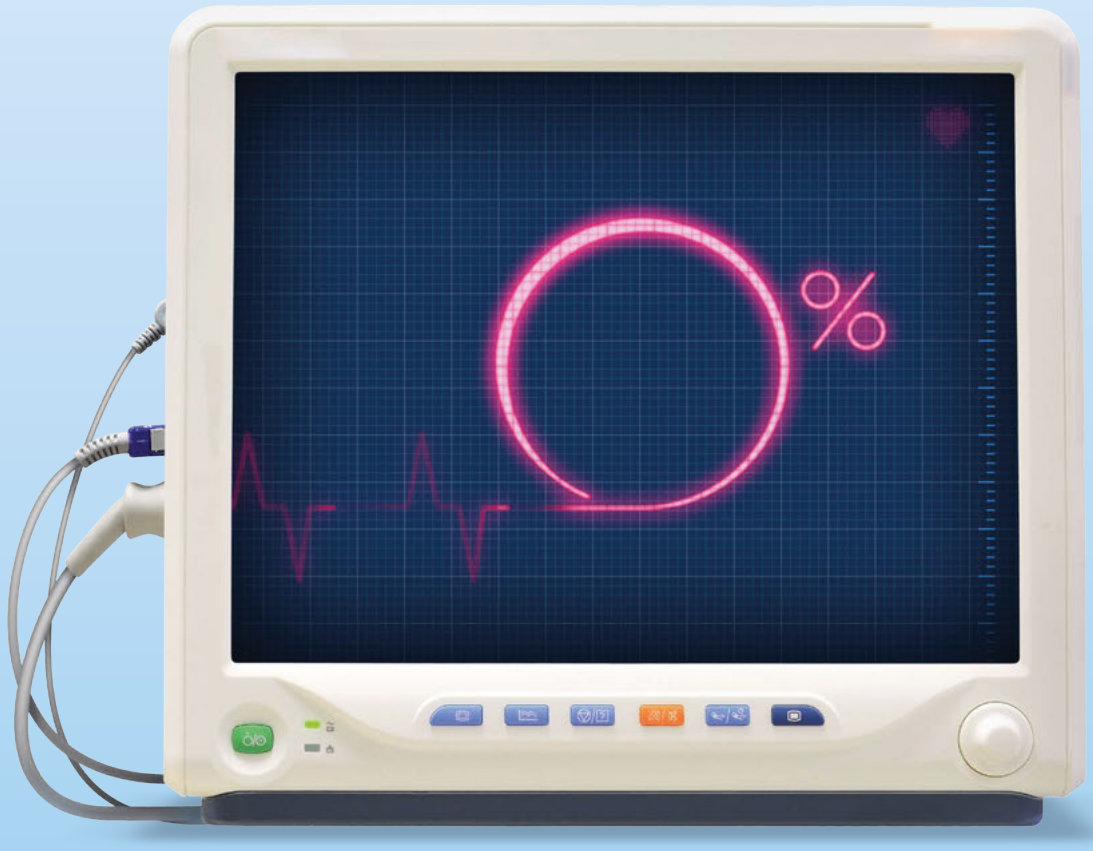

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