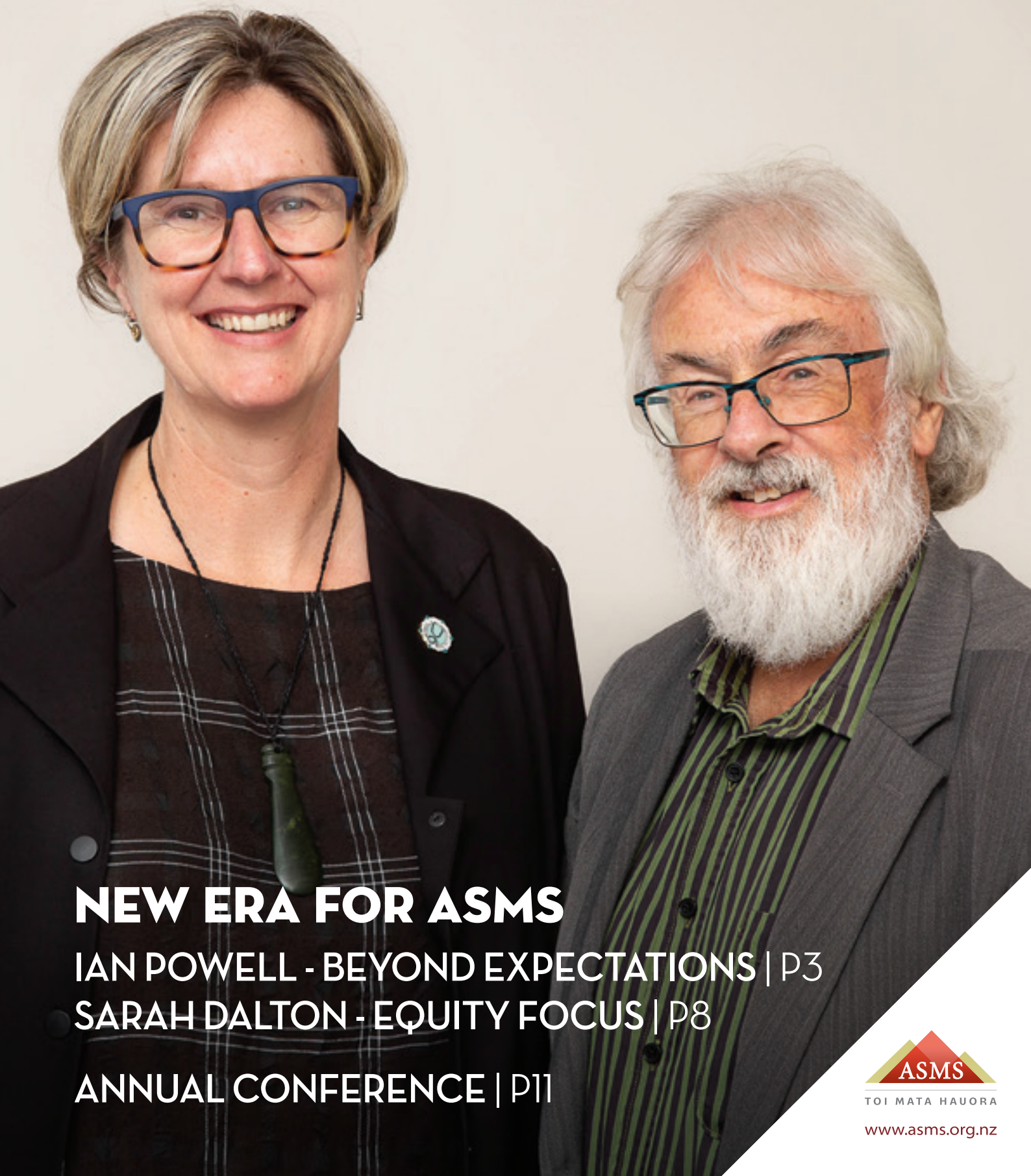


# THE SPECIALIST

THE MAGAZINE OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

121 | DECEMBER 2019



## **NEW ERA FOR ASMS**

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30 years of ASMS leadership



# GOODBYE

IAN POWELL | ASMS EXECUTIVE DIRECTOR

**This is my final contribution to *The Specialist*. After 30 years and a wonderful send off at our Annual Conference last month there are five brief messages I wish to leave, plus an appreciation.**

## FIVE MESSAGES - COURAGE, MECA NEGOTIATIONS, DISTRIBUTED CLINICAL LEADERSHIP, WORKFORCE UNDER-INVESTMENT, AND BEING NON-DIDACTIC

ASMS and its representatives, including staff, should never be afraid to advocate and articulate what we believe is right, regardless of whether we are swimming against the current (often we are but currents can change), nervous about public perception, or anxious about how the government or health bosses of the day might react. Wherever possible we should ensure we have a strong empirical foundation to support what we say and we must always be value based. But afraid? Never!

Second, our approach to negotiating the national MECA covering DHB-employed members must recognise that we are in a shared specialist job market with Australia

as the commissioned BERL report (see p25) confirms. According to BERL, the average wage and salary gap ranges from 20% to 30% in favour of Australia, but for specialists it is over 60%. The top of our specialist scale (15 steps) is lower than the bottom of every scale in the six biggest Australian states (with an average of around nine steps).

We are at serious risk of losing specialists to Australia, particularly mid and late career specialists, advanced trainees and medical students. But the greater immediate crisis is that we need to recruit specialists in the international market and Australia is our nearest neighbour. When competing with Australia, aside from those recruits with a snake phobia, DHBs are dog tucker.

The massive salary gap revealed by the BERL report must inform our approach to the forthcoming MECA negotiations.

ASMS needs a building block approach to bridging the gap. It is a huge ask to address this in one negotiation, but it is reasonable to insist at the very least a significant start in the visible pathway to this objective. Otherwise serious specialist shortages will continue, the benefits of patient centred care will not be sufficiently realised, and the senior medical and dental workforce will continue to suffer excessive burnout, fatigue and presenteeism.

Third, ASMS should continue to advocate and campaign for distributed clinical leadership. This is the most effective way of improving both the quality of and access to patient-centred care and the financial performance of DHBs. SMOs are masters of complexity in their clinical and diagnostic work. More of their time must be freed up to address the complexities of a 24/7 highly-integrated and largely acute sector in their services, hospital wide,



Professor Murray Barclay presenting Ian Powell with a farewell gift from the ASMS National Executive

and between community and hospital. If our public health service is to be fit for purpose it needs comprehensive clinical leadership from the wider SMO workforce below the excellent work undertaken by formal clinical leaders. With our current level of high specialist shortages DHBs are well short of the capacity to deliver distributed clinical leadership. Further, it runs up against the dominant and destructive culture of managerialism which is so widespread in DHBs.

This is something former health ministers Annette King, David Cunliffe and (at least initially) Tony Ryall were interested in. But the current health minister is tragically uninterested. If ASMS does not advocate and campaign for distributed clinical leadership no-one else will and managerialism will become even more entrenched.

Fourth, ASMS should forcefully advocate that after over two years in office the Government has no excuse to continue the under-investment in the DHB workforce including senior medical staff. The Government is right to state that it inherited the consequences of underfunding over the eight years prior to the last election. But it can't dine out on this forever. It has an obligation to at the very least start funding DHBs at the level of anticipated operational costs. It does not take rocket science to estimate these

costs. If this happened then we would not have deficits. ASMS needs to push strongly for this specific action. Our excellent publication *Hospitals on the Edge* published in November provides the justification and suggests the means of achieving it. No further evidence is required.

Fifth, I am pleased that our excellent research both in-house and commissioned has lifted the lid on some concerning issues including bullying, gender-based discrimination and the gender pay gap. These can lead to uncomfortable discussions, particularly around gender. But discomfort does not make them avoidable. What's important is the way these discussions are undertaken. There is a need to recognise the often systemic and unconscious nature of these outcomes. They should not be didactic discussions. There is no place for moral instructions in this sensitive discussion.

#### FINALLY, AND SARAH

Finally, I want to express my gratitude for having the privilege to represent such a wonderful committed and passionate medical and dental workforce. I have an enormous sense of pride to have had this opportunity. All branches of medicine and dentistry have impressed me. There is a special place in my affections for orthopaedic surgeons because they hunt in packs and have no comprehension of

ambiguity; attributes to be admired.

When I came into this job I had no experience in the health sector. But I had studied Middle East politics as part of my MA. I could not have asked for a better background for understanding the politics of health. My successor Sarah Dalton has neither a health sector background nor has she studied Middle East politics. But as an experienced secondary teacher and assistant principal she has worked with troubled teenagers. I could not think of a better background for understanding the temperament of health.

There is something sweet in Sarah being my successor over and above her attributes as an excellent appointment. One of my dear aunts was her year one teacher at Burwood primary school in Christchurch so many years ago. Sarah obviously remembers that year and her teacher with affection. When we discovered the connection she brought into the office a match box car she made that year. It is nice to know Aunt Alice had such an important role teaching my successor to read. It doesn't get much better than that.

To take former All Blacks coach Steve Hansen one step further, not only has it been a pleasure to be gifted the opportunity to be ASMS Executive Director for so long, it has been an honour.

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***“We are at serious risk of losing specialists to Australia, particularly mid and late career specialists, advanced trainees and medical students. But the greater immediate crisis is that we need to recruit specialists in the international market and Australia is our nearest neighbour.”***

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*“If poor staffing levels and hospital working conditions are not addressed urgently, the pain and suffering of New Zealanders will steadily worsen over the next few years and this will become increasingly difficult to remedy as fewer medical staff will want to work under these conditions”*

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# HEALTH SYSTEM AT PRECIPICE

PROF MURRAY BARCLAY | ASMS NATIONAL PRESIDENT

**This is a pivotal time for ASMS as we prepare for our first change of Executive Director in our 30-year history and embark on MECA negotiations at a time of crisis in the health sector.**

In June we celebrated the 30-year milestone with a special anniversary conference.

We celebrated Ian Powell's career-long contribution to ASMS last month at Annual Conference. We also welcomed Sarah Dalton, who takes his place on 1 January.

The Executive is confident Ms Dalton has the right skills for this challenging role, and we are looking forward to the next phase of ASMS history.

ASMS enters the triennial MECA negotiations with DHBs in early 2020. This is happening at a time when our hospital system appears to be on the edge of a dangerous precipice.

When we look at population growth, spiralling acute care demand, and the very limited capacity we have in the New Zealand health system to deal with such growth, our system and staff are having to overperform or overwork on a daily basis.

This cannot continue.

The theme of last month's conference was *Hospitals on the Edge*. Progressive underinvestment in our health system has resulted in decaying buildings, worsening waiting lists and access to health care, and a health workforce that is suffering.

Overwork and burnout are causing poor morale in many sectors of our health workforce, and it seems that virtually every health workforce union in New Zealand has had to go on strike in the past 18 months to achieve even minimal improvements in work conditions. DHBs are working under unbearable financial pressure and ultimately patients pay the price with their health.

When the Government came to power two years ago, there was much hope our health system would finally have some appropriate investment after the decade of retrenchment.

Health Minister Dr David Clark seemed intelligent and aware of the problems.

It seemed like he was prepared to listen and really make a difference to health investment and well-being.

Within a year of coming into office, it became obvious that various influences were putting Dr Clark off his target of addressing the gross underinvestment in health.

One could speculate that political survival by demonstrating “fiscal responsibility” has a higher priority for the Government than the health of New Zealanders, or that Ministry of Health staff may have been giving very poor advice.

Whatever the reasons, the required uplift in health investment has not happened. To rub salt into the wound, a \$7.5 billion budget surplus was announced.

Meanwhile, we have seen lengthening waiting lists, sicker patients and no evidence of improvement in doctor well-being. The Ministry of Health has forced DHBs to save money on hospital rebuilds by cramming hospital specialists into open-plan offices that are shown to have negative outcomes on productivity and well-being. In a recent case in Waitemata, SMO facilities have not been included at all in a new hospital design.

For the past year ASMS has been offering a solution to the Minister of Health and DHBs to address inappropriate staffing levels in the form of a safer staffing accord. This would facilitate service-sizing and job-sizing to match staffing to workload. The Minister has repeatedly taken a hands-off approach to the accord and seems happy to leave senior medical staff with no mechanism to improve fatigue and burnout.

Our MECA negotiations happen amid this stressed and febrile atmosphere. They also fall in a general election year, potentially heightening the level of political pressure.

Until now the Minister of Health has piled enormous pressure on DHBs by underinvesting in health while avoiding political risk by largely not getting involved in solutions to the various industrial disputes in the past 18 months. It will be interesting to see whether he can maintain this stance during the SMO MECA negotiations.

This is a critical point in the history of health care in New Zealand. Our country has an important choice to make. If poor staffing levels and hospital working conditions are not addressed urgently, the pain and suffering of New Zealanders will steadily worsen over the next few years and this will become increasingly difficult to remedy as fewer medical staff will want to work under these conditions. We can already see this happening in the UK's National Health Service, where more than 100,000 vacancies in health cannot be filled.

Membership of ASMS is growing steadily, the organisation is larger and feels stronger than ever. We are in good shape to deal with significant challenges.

Over the past two years the Executive has reviewed governance processes and documentation and we feel more confident that we can better predict finances and risks to ASMS.

New Zealand's health system may be under enormous threat and feels like it is about to go over the edge, but ASMS will be doing everything possible to try to avoid this.

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*“He’s provided superb leadership in terms of being our advocate. He got his head around the medical dental politics and integrated superbly. He’s become recognised as a go-to person for the media as well as politicians, in terms of commentary on the health sector, hospitals and DHBs”.*

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## IAN POWELL: BEYOND EXPECTATIONS

ELIZABETH BROWN | SENIOR COMMUNICATIONS ADVISOR

**Ian Powell only meant to stay at ASMS for five years. That was 30 years ago.**

Appointed in 1989 as the union’s first Executive Director, he’s taken it from a fledgling organisation with 1200 members to a 5000-strong member union with 18 staff.

He applied for the job out of curiosity after spotting an ad for someone to set up and lead a new union. At the time he was happily working as an industrial officer at the education union NZEI.

Dr James Judson, one of ASMS’ founding doctors, says Mr Powell was an impressive candidate.

“He asked for super contributions and a car which made us gulp. But we thought if he’s as good at negotiating with the Government as he is with us, he’ll be great, and that’s the way it’s turned out.

“He’s gone beyond all expectations”.

Once appointed Mr Powell set up an office, developed procedures, protocols and union rules, embraced the complexities of the health system, wrote newsletters and chose a filing system, which is still in use at ASMS.

For what he says were both practical and philosophical reasons he quickly affiliated ASMS to the Council of Trade Unions.

Mr Powell admits it was “flying by the seat of his pants stuff” as the 1990s brought the

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*“I valued Ian’s foresight, passion and his commitment to a public health system. He was driven to make a difference and he did.”*

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*“I have a strong sense of pride over who I’ve been working for because of what they do. The complexity and intellect of the senior medical workforce and the complexity of the system all really press my buttons and keeps it quite exhilarating.”*

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Employment Contracts Act, single-employer bargaining with Crown Health Enterprises, and the push for individual contracts.

“It was industrial law like we’d never seen before and there was a widespread belief among health managers that collective agreements were not appropriate for senior doctors,” he says.

He developed a reputation as a formidable advocate. During that time ASMS largely fought off individual contracts, negotiated collectively, pushed up salaries and secured a range of professional rights. An earlier achievement was a common salary scale for senior doctors and dentists.

Former health minister Dame Annette King began working with Mr Powell as opposition health spokesperson in the late 1990s.

“I was never left in any doubt what Ian was thinking and what changes were needed to improve health care for New Zealanders. He was dogged in his pursuit of improvement for salaried medical specialists.

“The communication didn’t stop when I became minister. My cellphone would ring regularly with Ian providing me with advice, a reprimand, or at times both!

“I valued Ian’s foresight, passion and his commitment to a public health system. He was driven to make a difference and he did.”

Getting the first multi-employer collective agreement (MECA 2003-06) over the line was a hard-won career milestone. It brought together the complexities of 21 collective agreements.

Three years later the negotiation of the second MECA would prove even harder as DHBs tried to claw back non-clinical time, consultation and engagement rights.

Mr Powell remembers it as a “seriously adversarial time”. It led to ASMS’ well-attended first national stop-work meetings in 2007 which attracted enormous publicity and a national ballot for strike action with an overwhelming majority in favour and a high turnout.

Alarmed by the thought of senior doctors walking off the job, a fresh-faced then health minister David Cunliffe staged an intervention.

“During my first weeks, on-the-job relations between the DHBs and senior doctors were

at a low ebb. At my first attendance at an ASMS board meeting I was told a strike was imminent. Ian took me at my word when I told him I would do my best to sort it out.

“That effort came in the form of a long and memorable dinner in my Beehive office for the ASMS and DHB negotiators together. The food and wine were the best Bellamy’s could offer. The mood was good.

“There was only one rule – no one could go home until we had a deal signed. By 5.30am, having negotiated all through the night, with this young minister running shuttle diplomacy in the office corridors, we had an agreement.

“We would not have got one without Ian’s good humour and wisdom,” Mr Cunliffe recalls

Mr Powell, however, insists ASMS representatives confined themselves to one glass each.

Another battle which sticks out in Mr Powell’s mind is the successful campaign in 2009 to save Lakes District Hospital from what was essentially a privatisation bid by a group of Queenstown GPs, who had the backing of the DHB and government.

He’s proud ASMS has been able to “go against the tide” on the likes of superannuation, after-hours rates and professional rights.

“The British Medical Association has nothing like our engagement and professional rights,” he says.

“That’s why managers who come to New Zealand get themselves in a pickle because they cannot comprehend the rights our members and ASMS have on things like reviews of services and a high level of influence.”

He’s also pleased by the research and analysis direction ASMS has taken on issues affecting the SMO workforce, such as bullying, burnout and gender equity. He says it’s significantly boosted ASMS’ advocacy.

Mr Powell knows the health sector inside out. It’s earned him a lot of respect. Not only has he battled for members’ pay and conditions, he’s taken on the broader fight for good public health.

“Our membership has constantly grown and

I think a lot of that would be due to the pay and rations work we do and the work of the industrial team, but the advocacy for the public health service has been a biggie too,” he says.

Another ASMS founding doctor George Downward says Mr Powell has been a major influence in so many ways.

“He’s provided superb leadership in terms of being our advocate. He got his head around the medical dental politics and integrated superbly. He’s become recognised as a go-to person for the media as well as politicians, in terms of commentary on the health sector, hospitals and DHBs”.

As for what lies ahead for ASMS, Mr Powell believes New Zealand specialists are under threat from Australia in terms of the pay gap. He also expresses deep frustration over SMO shortages and what he calls a “culture of managerialism among DHBs – management knows best”.

“The failure of health bosses and health ministers to deliver on distributed clinical leadership is a lost opportunity for improving the accessibility and quality of patient care and a better return for the health dollar.

“The government of the day has to take the plunge and invest in this workforce because it will be good for the economy, patient care and the financial performance of DHBs. I hope this is a battle ASMS will continue to fight.”

Mr Powell says despite telling himself he’d only be at ASMS for five years, he never found a reason to leave.

“I have a strong sense of pride over who I’ve been working for because of what they do. The complexity and intellect of the senior medical workforce and the complexity of the system all really press my buttons and keeps it quite exhilarating.”

As for life after ASMS, travel, time with his grandson, and maybe even writing a book or two are likely to feature. He also isn’t discounting some sort of continued involvement in health and public commentating role.

As Dame Annette says: “I wouldn’t be surprised to see him standing for public office somewhere, perhaps the Kapiti Coast. Mayor Powell has a ring to it!”



# EQUITY FOCUS FOR NEW EXECUTIVE DIRECTOR

ELIZABETH BROWN | SENIOR COMMUNICATIONS ADVISOR



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*“I’m very pro things that ought to be in the public good, and publicly-provided services; free education, free health care, warm housing, a living wage - all those things that I think should feed into the social determinants of health”*

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*“My role is to take this really strong foundation and keep it flying while we also look at where else we need to go and how we can build on that”*

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**O**bstinate headstrong girl - these words are tattooed on Sarah Dalton's left forearm. The quote from Jane Austen's *Pride and Prejudice* may provide a little insight into ASMS' new leader.

Ms Dalton, 51, takes over from long-term Executive Director Ian Powell on 1 January.

Many members will already know her as a busy Industrial Officer working the Auckland/Northland patch.

Ms Dalton's career began in education. A Masters in history led her to teaching, where she quickly moved up the ladder to become a dean, head of department, and an assistant principal.

Looking for a fresh challenge, she took a role as a policy advisor at the PPTA, the secondary teachers' union. For a self-confessed people person, it wasn't long before she heard field work calling.

“I saw what the field officers were doing. They were out running around in schools poking their noses in and trying to get them to line things up properly, do what the collective agreement said, and support teachers - all the gnarly stuff. And I thought: ‘that’s what I want to do.’”

After seven years at PPTA she decided to take the plunge into health, joining ASMS as an Industrial Officer in May 2015.

“We’re an interesting union. We’re white collar, our members are working at the top of their profession so some people ask: ‘how is that union?’ But we’re working in public health, it’s a public good.

“I’m very pro things that ought to be in the public good, and publicly-provided services; free education, free health care, warm housing, a living wage - all those things that I think should feed into the social determinants of health,” she says.

Ms Dalton describes herself as a life-long learner, which is why she values interacting with ASMS members.

“I love the incidental conversations and what I learn along the way about what’s going on in their service or DHB, what makes their particular specialty tick or what’s important or interesting to them. “It’s really rich”.

Navigating her way through the health sector over the past four and a-half years, she’s witnessed growing pressure on members: stretched services, burnout, fatigue, understaffing and high workloads. She points to unmet need and what she describes as the moral injury to SMOs of not being able to determine “best care” pathways for patients, but rather the “least damaging” ones.

In her opinion New Zealand's investment in health is woefully inadequate.

“As a proportion of GDP it’s feeble and I’m at a complete loss to know why the Heather Simpson review is suggesting there is sufficient resource - I don’t think they’re right. The pie is way too small,” she says.

Ms Dalton views her new role as a proactive, tone-setting one, and is eager to build on existing relationships across the health sector and with other unions.

Her top-of-mind issues include health equity, a diversifying specialist workforce and members’ well-being, which she hopes will feed into next year’s MECA negotiations.

Gender and pay equity are also very close to her heart. ASMS has recently undertaken research highlighting women’s experiences in the workplace and commissioned external research on the size of the gender pay gap among specialists. Ms Dalton is determined to keep those issues in the spotlight.

She’d also like to see more done to better reflect diversity and acknowledge Te Tiriti o Waitangi.

“We have a very diverse international workforce with 40% IMGs. This makes an understanding and acknowledgement of Te Tiriti even more important, because you can only really safely embrace multiculturalism within a bi-cultural framework in New Zealand in my view.”

She dislikes the term “big shoes to fill” but acknowledges, as only the second Executive Director in ASMS history, it’s hard to avoid.

“Ian Powell literally built this organisation from the ground up and he has such an established voice. But it’s an evolving thing and my role is to take this really strong foundation and keep it flying while we also look at where else we need to go and how we can build on that,” she says.

She is a firm believer in respectful disagreement and forming strong working relationships with people who hold differing points of view.

Stalk her social media accounts and you’ll find a fun-loving foodie, keen on biking, books, art, nature, travel, photography, and more than a passing interest in roller derby.

Outlining how she intends to lead ASMS, the former teacher turns to a metaphor of a walking school bus.

“Everyone on a walking school bus is active, so you haven’t got passengers as such, but for it to function effectively you have to be going broadly in the same direction and at a pace everyone can manage. It’s all about shared purpose and agreed direction”.

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*“I love the incidental conversations and what I learn along the way about what’s going on in their service or DHB, what makes their particular specialty tick or what’s important or interesting to them. It’s really rich”*

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# A FULL AND ENGAGED LIFE - DR SUSIE FARRELLY

SARAH DALTON | INCOMING EXECUTIVE DIRECTOR

**Dr Susie Farrelly worked as a medical officer at Cornwall House community mental health for 26 years. She developed an interest in trauma and dissociation, along with a strong collegial concern for the well-being of her colleagues. Dr Farrelly was one of those 'glue' people who help hold things together in the workplace.**

In the last three years she became active in ASMS, taking up the role of Auckland Branch Vice-President. It was always clear to us when she was in the room - enthusiastic, attentive, engaged and enthusiastic. Kind.

We all thought she'd won her battle with breast cancer and that, following reconstructive surgery in the middle of the year, she'd soon be back at work. Alas, a late diagnosis of multiple secondary cancers overwhelmed her, and after only a few short weeks, on 1 November, Susie died.

Her sudden death was a huge shock - and not something any of us were able to prepare for. We can only imagine how tough this must be for her family. One of the things that Dr Farrelly was good at was finding balance between work and the rest of her life. She loved to cook and look after people; she had all kinds of passions and interests apart from medicine. This was evident at the celebration of her life in early November.

We will all be the poorer for her loss, but so much enriched by having known her. As her son Charlie reminded us at her funeral: "love is easy". And it was so very easy to share Dr Farrelly's love for life and for the many people who were so lucky to have known her.

## A LIFE OF SERVICE - DR FRAN MCGRATH

**Dr Fran McGrath was a public health and social justice champion who played a leading role in health policy and patient rights.**

She died in Wellington Hospital on 4 November, aged 64.

Dr McGrath was a Senior Health Advisor to three Ministers of Health, and most recently was Chief Advisor on Population Health and Prevention at the Ministry of Health.

Her other roles included Deputy Director of Public Health at the Ministry of Health, Director of Funding and Planning for the Cook Islands Ministry of Health, and University of Otago lecturer in public health.

Dr McGrath, then a general practitioner, had worked in Honduras in her early career. She served on World Health Organisation expert groups and represented New Zealand at world health assemblies.

She was involved in the development of Wellington Hospital's first patient rights' code, which formed the basis of the subsequent national code.

She had been appointed President of the Public Health Association, to take effect on 1 November, just days before her death.

She was an associate member of ASMS.





# 2019 ASMS ANNUAL CONFERENCE

ELIZABETH BROWN | SENIOR COMMUNICATIONS ADVISOR

**The 31st ASMS annual conference got under way with a mihi and waiata sung by incoming Executive Director Sarah Dalton.**

Almost 200 people gathered at Te Papa for the conference themed *Hospitals on the Edge*. They were joined by invited guests from the German doctors' union Marburger Bund, the Australian Medical Association, the South Australian Salaried Medical Officers Association and the New Zealand Medical Students' Association.

ASMS President Professor Murray Barclay pulled no punches in his opening address. He said the hospital system appears to be on the edge due to under-investment, staff shortages and burnout. He expressed disappointment in Health Minister Dr David Clark (who declined an invitation to speak at this year's conference) and accused him of failing to act.

The conference provided a platform for the release of two major pieces of

ASMS-commissioned research. Dr Isabelle Sin, Senior Fellow at Motu Economic and Public Policy Research, delivered the results of her study, revealing a gender pay gap between male and female specialists of 12.5%. (see p23).

Many women delegates commented they would head back to their DHBs to find out if they were being paid fairly.

A lively panel discussion on ASMS' just-released *Hospitals on the Edge* report led by Drs Lucille Wilkinson, Sunita Azariah, Amy Leuthauser and Alain Marcuse ended with delegates asking what more can be done to speak out and put pressure on the Government.

UK-based Dr Robert Hendry, the Chief Medical Officer from the Medical Protection Society, used his presentation to highlight emerging medico-legal

challenges such as telemedicine, artificial intelligence and robots. He urged caution around doctors' social media use.

The conference provided a chance to formally farewell Executive Director Ian Powell who took to the stage for his final ASMS address. He looked back on his 30 years as leader and thanked members and staff. Former national presidents Drs Jeff Brown and Peter Roberts, along with New Zealand Medical Association Chief Executive Lesley Clarke and ASMS Deputy Director Angela Belich spoke of his huge contribution.

The women's network breakfast again proved popular. Guest speaker, gynaecologist and obstetrician Dr Helen Paterson, inspired members with her story. She gave up a well-paid job and used her retirement savings to set up Te Waka



Wahine Hauora - the Woman's Health Bus - which aims to improve access to gynaecological services for rural women in Otago and Southland.

BERL Chief Economist Dr Ganesh Nana headlined the second day of the conference with the results of an ASMS-commissioned comparison of specialist salaries in New Zealand and Australia. He said the size of the gap had taken him by surprise, noting the huge difference with the general wage and salary gap of around 20% to 30% and the salary gap of over 60% for specialists (see p25).

Overseas guest Dr Andreas Botzlar from Marburger Bund talked about the strategy and tactics used in collective bargaining in municipal hospitals in Germany. That led nicely into a session on next year's MECA negotiations, and breakout discussions among SMOs about what claims to take into bargaining.

In formal business, delegates accepted ASMS' annual and financial reports and

voted in favour of a \$100 membership subscription increase. It will take the annual subscription cost to \$1200 (GST inclusive) for the next financial year and enable us to establish new industrial officer and policy analyst positions.

An amendment was passed to the ASMS constitution allowing salaried doctors and dentists employed by government departments (including the Ministry of Health) to be offered membership. ASMS now intends to initiate collective bargaining on their behalf with the Ministry of Health where the large majority are employed.

Delegates voted overwhelmingly in favour of a resolution put forward by former national presidents Drs David Galler and Jeff Brown: "ASMS abhors the failure of the Minister of Health to regulate the food industry, and calls on him to immediately pass regulations that will prevent dental caries and obesity and their lifelong harm to the health of New Zealanders".

Dr Galler also made a plea for SMO help in the deadly measles outbreak in Samoa.

There was an unexpected star attendee at the conference. Baby Archie was there with his mum Bryony Harrison from the Medical Students' Association. Everyone agreed that with gender equity firmly on the agenda, he was a welcome and timely addition, not to mention one of the quietest conference goers.

Videos of the presentations will be available at [www.asms.org.nz](http://www.asms.org.nz) soon.

## SUBS UP

ASMS member subscriptions will go up \$100 in the next financial year. Conference delegates voted in favour of the increase which will take the annual subscription cost to \$1200 (GST inclusive).









## JUDY BENT LIFE MEMBERSHIP

**J**udy Bent has been awarded ASMS life membership, the first woman to receive the honour.

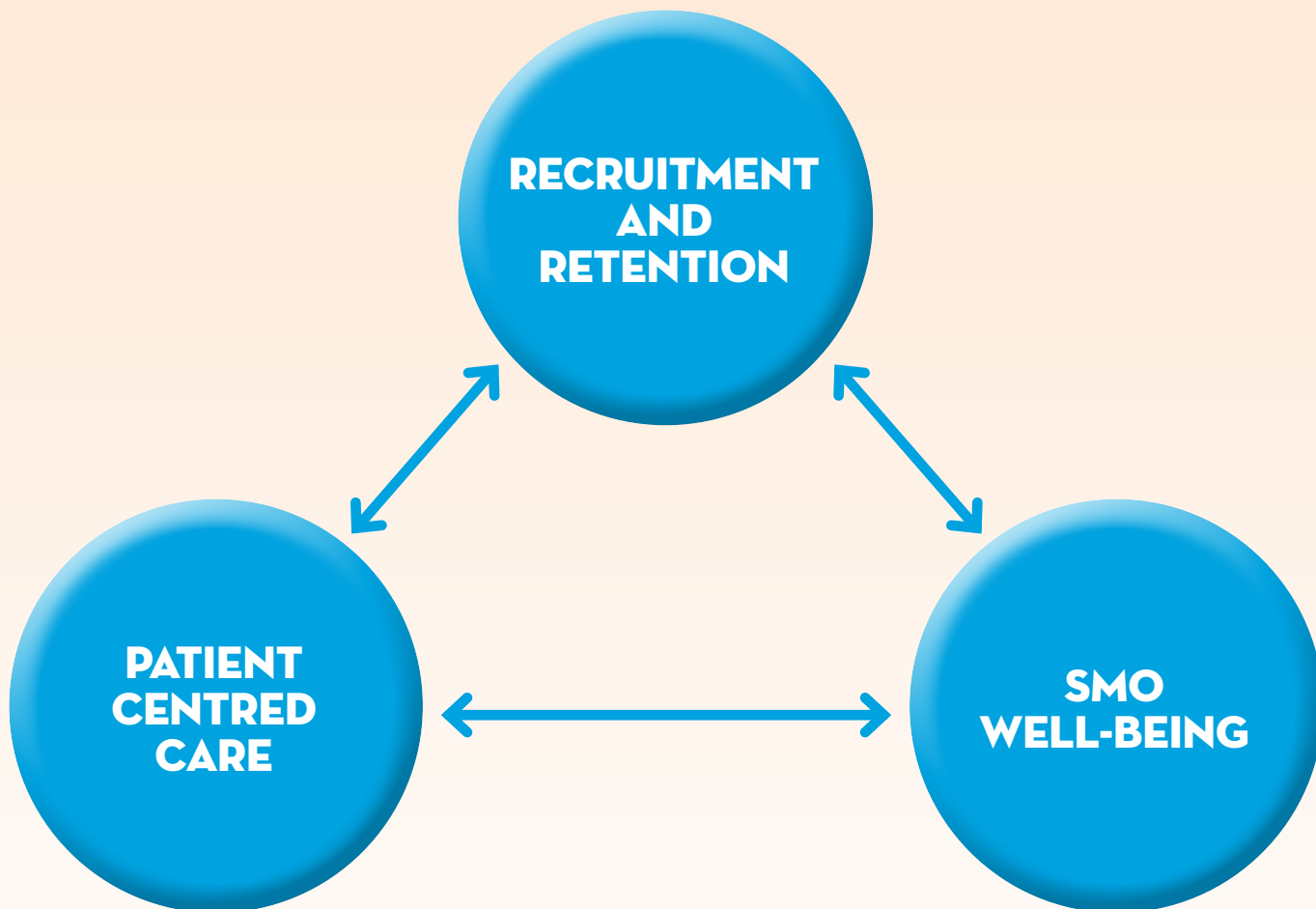
Delegates at the Annual Conference voted unanimously to recognise the retired anaesthetist's outstanding service as a member, which included serving 18 years on the National Executive.

Dr Bent has belonged to ASMS since its establishment and joined the committee for the Auckland Central branch during her first year. She was elected to the ASMS National Executive in 1997 and served until 2015. She attended every annual conference until her retirement in 2017 after 43 years in medicine. Her enthusiasm was driven by a keenness to understand and help shape the future for specialists and to assist her colleagues.

"I was delighted to hear of the nomination and consider it an honour and privilege," Dr Bent says.

Dr Bent joins the other ASMS life members: George Downward, James Judson, Allen Fraser, Peter Roberts, Brian Craig, and David Jones. ASMS' first life member was the late John Hawke.





## MECA 2020: SETTING THE SCENE

LLOYD WOODS | SENIOR INDUSTRIAL OFFICER

**S**ince the 2017 MECA, the ASMS team has been gathering claims, looking at our research to develop claims, and formulating the best bargaining strategy for MECA 2020.

The composition of the bargaining team has been considered by the National Executive, and 22 ASMS members, including the National Executive, were invited and were able to commit to the process (see sidebar).

I have been appointed bargaining advocate with National President Professor Murray Barclay as co-advocate.

The draft claim was presented to the National Executive for consideration in September and, after revision, again in late November. At the ASMS Annual Conference in November there was discussion in working groups about the

general negotiation themes. This brought about some revision and additional claims.

Negotiations will have a strong emphasis on well-being recognising what we now know through our research on burnout, fatigue, and presenteeism. This reinforces our longstanding focus on recruitment and retention, along with ensuring we have SMO workforce capacity able to deliver patient centred care.

A salary claim will ensure DHBs can recruit and retain sufficient SMOs to restore safe staffing levels. Part of this seeks to address the cost of having to work nights and weekends.

All MECA claims will relate to one or other of the themes, although notably (as per the diagram), all are strongly interrelated. It is very clear that SMO well-being is heavily reliant on conditions of employment that allow for recruitment and retention of SMOs. Safe staffing levels (through adequate recruitment and retention) relate directly to minimising fatigue and burnout. Having a workforce that does not suffer fatigue and burnout clearly assists with recruitment and retention. Similarly, our terms and conditions of employment must be sufficient to enable us to compete in a highly competitive international

# ASMS NEGOTIATING TEAM

specialist labour market. Quality and accessible patient-centred care can't be comprehensively provided with significant shortages and a fatigued and burnt out SMO workforce.

As we get closer to formal negotiations we will report more specifically on our claims. The nature of bargaining means it is not sensible to have it known widely before that time.

## PRE BARGAINING AND DHB TEAM

On 12 November we had the first of two pre-negotiation meetings. National President Murray Barclay, Sarah Dalton, Ian Powell and Lloyd Woods attended for ASMS. The DHBs were represented by lead chief executive Kevin Snee (Waikato; formerly Hawke's Bay) along with three staff members from the DHBs shared services agency Technical Advisory Services (TAS) - Gretchen Dean (advocate), Sam Bartrum, and Aaron Crawford. These three and Dan Coward (Canterbury DHB general manager) have been appointed to the DHB negotiating team but the full team is yet to be confirmed. The team reports directly to Kevin Snee.

This was a useful day with the next meeting (12 December) getting more to the crunch with technical and other semi-technical claims for pre-negotiation. This will again be a short line up because none of the claims that will be negotiated are likely to be controversial from a membership perspective.

## NEGOTIATIONS

Confirmed negotiation dates for next year are 12, 13, 26 and 27 February and 11, 12, 25 and 26 March with the MECA expiring on 31 March. Please note that the provisions of the current MECA do not expire for you on 31 March. They continue until a new MECA is agreed.

## SUMMARY

At the time of writing the DHB sector is in crisis due predominantly to under-investment in workforce but we can no longer accept that the workforce, and clearly the SMO workforce, will cover this by putting their own health and safety and personal relationships at risk.

We are well prepared for MECA 2020. We sought eight days of negotiations before the expiry of the current MECA and the DHBs have agreed, giving us a good start. We have a large negotiating team to ensure good membership representation and act effectively as our 'brains trust'.

We will, as ever, be well served by ASMS staff. Our claim has been well thought out. All is in place for the MECA 2020 negotiations and as we proceed all members will be kept well informed.

However, given the negotiations experienced by other unions over the past three years we would be foolish to expect MECA 2020 to be easy. Ultimately, success may be determined by our members' resolve, rather than by logical argument at the negotiating table (even though there will be no shortage of it at the table).

## THE TEAM IS:

Murray Barclay (co-advocate, ASMS President)

Julian Fuller (ASMS Vice-President)

Jenny Henry (anaesthetist, Northland)

Andrew Ewens - (emergency medicine, Waitemata, National Executive)

Julian Vyas (paediatrician, Auckland, National Executive)

Sylvia Boys (emergency medicine, Counties Manukau)

Annette van Zeist-Jongman (psychiatrist, Waikato, National Executive)

Paul Wilson (anaesthetist, Bay of Plenty, National Executive).

Allister Williams (general medicine, Taranaki)

Andrew Robinson (anaesthetist, Lakes)

Angela Freschini (anaesthetist, Tairāwhiti, National Executive)

Kai Haidekker (radiologist, Hawke's Bay)

Nathalie de Vries (paediatrician, MidCentral, National Executive)

Norman Gray (emergency medicine, Wairarapa)

Neil Stephen (dentist, Hutt)

Alain Marcuse (psychiatrist, Capital & Coast)

Katie Ben (anaesthetist, Nelson Marlborough, National Executive)

Stu Mologne (rural hospital medicine, West Coast)

Seton Henderson (intensive care, Canterbury, National Executive)

Matthew Hills (general medicine, South Canterbury)

Chris Wisely (psychiatrist, Southern)

Tom Morton - shift work representative (emergency medicine, Nelson Marlborough)

ASMS staff - Lloyd Woods (co-advocate), Sarah Dalton, Angela Belich and Steve Hurring (as required).



North Shore Hospital ED team finishing the afternoon to night shift handover at 1am (left to right) Andrew Ewens, Jo Egan, Dave Metzger, Satra Browne, Meher Chaudhry.



## THE JETLAG EFFECT

ELIZABETH BROWN | SENIOR COMMUNICATIONS ADVISOR

**A**s an emergency medical specialist at North Shore Hospital in Auckland, Andrew Ewens knows a lot about shift work.

He rotates between day shifts (8am-6pm) and afternoon shifts (4pm-2am). He also works at least one in four weekends. A growing number of his SMO colleagues are now also covering overnight shifts. He believes while there are positive effects for patient care and managing workloads many SMOs find it difficult to sustain the pattern for long periods.

“When you move your biological clock backwards and forwards it becomes fatiguing. If you leave work at 2am one day and then have to be up a few days later at 6am or 7am to get ready to go to

work a day shift, that time-sequencing can be difficult.”

Dr Ewens says it’s all about trying to avoid regular “jet lag effects”, also known as circadian rhythm sleep disorders. “Over time the effect is cumulative and we know that after about 50 years of age, resilience begins to wear thin”.

He adds that trying to sleep in a busy household, especially one with young children, can pose big challenges.

“It may be hard to be the person who’s not in sequence with everyone else,” he says.

Dr Ewens believes recovery time is key and needs to be built into the working week. He says a roster may look like a four-day week but in effect it’s a five-day week, because at least one day is needed for recovery.

Letting the body recharge by spending periods of time completely away from the shift work environment is also important.

Dr Ewens says doctors who train in areas where shift work is required know it will be hard on their body clocks and can adjust, but with time it gets more and more difficult.



ASMS shift work focus group



## SHIFT WORK AND ON CALL CLAIMS IN MECA 2020

LLOYD WOODS | SENIOR INDUSTRIAL OFFICER

**A** SMS members working shifts make up just over 10% of DHB members overall, but this proportion will continue to rise as demand for services outside Monday to Friday 8am-5pm increases. Areas where shifts are not currently used, but are under consideration, include some anaesthetic and obstetrician/gynaecology services, and intensive care units where shifts are not already in place\*.

Shift work comes with its own challenges due to the recurring change in hours of work affecting circadian rhythms. Research shows that shift workers have reduced working lives and on average their life expectancy is shorter.

Dr Charlotte Chambers highlighted some of the negative effects of shift work in the accompanying article.

As a result of these concerns, and in keeping with the theme of employee well-being for MECA 2020, the National Executive decided earlier this year a group of shift work representatives should be selected to consider issues of specific concern and to help formulate claims for

the MECA negotiations. The work of this group was highlighted in the July edition of *The Specialist*.

The group met twice and its work will be reflected in several claims. It was agreed there will be a shift work representative on the MECA 2020 team who will liaise closely with the shift work group and that group will in turn liaise with a wider email reference team.

The National Executive was concerned that members working on call rosters experience similar effects to shift workers. This is true to an extent, but the research suggests their circadian rhythms are not affected to the same extent.

However, because both groups suffer negative consequences to one extent or other most of the claims formulated by the shift work group will also apply as claims for after hours on call.

The well-being of all ASMS members will be to the fore in the upcoming MECA 2020 negotiations and clearly there must be a focus on the conditions of those members where their well-being is most at risk.

\*Please note that the transition from after hours on call to a shift system is very technical, requires mutual agreement from individual SMOs and has a major effect on staffing. If your service is considering a transition to a shift system we strongly advise you seek support from your ASMS Industrial Officer.



# ASMS SHIFT WORK SURVEY

DR CHARLOTTE CHAMBERS | DIRECTOR OF POLICY & RESEARCH

**B**etween February and March this year, ASMS surveyed members working in New Zealand emergency medicine and intensive care units about their working practices. The survey drew an extremely good response rate; of the 476 contacted for participation, we had 307 responses with an overall response rate of 64.5%.

Those working in emergency medicine and intensive care medicine have not scored well in indicators of well-being in recent ASMS surveys. A 2017 survey about bullying in the senior medical workforce found emergency medicine specialists had the highest frequency of bullying, as measured by the Negative Acts Questionnaire-revised (NAQ-r) with 56% scoring as being bullied on a weekly or daily basis, as well as the highest overall rate of self-reported bullying.

For intensive care medicine specialists, the survey found they had the least non-clinical managerial support, as well as the fourth-highest average rate of

bullying as measured by the NAQ-r.

According to 2016 ASMS research into burnout prevalence, those working in emergency medicine also had the highest mean score for personal burnout (50.2) and work-related burnout (51.3) as measured by the Copenhagen Burnout inventory.

Qualitative data derived from interviews with intensive care specialists, presented at the 2019 Australian and New Zealand Intensive Care society conference, also emphasised the gruelling nature of call work in intensive care, and the challenges the specialty presents for

those aged 55 and over. One intensive care specialist noted: "It's hard, the hours are hard, it's emotionally draining. It takes a real toll".

The 2019 survey found that of those working in emergency medicine and intensive care, most are in their 40s (47%), very few are aged 60 or over (9%), and as with the overall specialist demographic, just over 60% are male. Most worked to a roster of weekend shifts of one in four (figure 1) and over a third felt that their roster seldom or never followed the recommended circadian pattern, with 39% asserting that this happened 'sometimes' (figure 2).

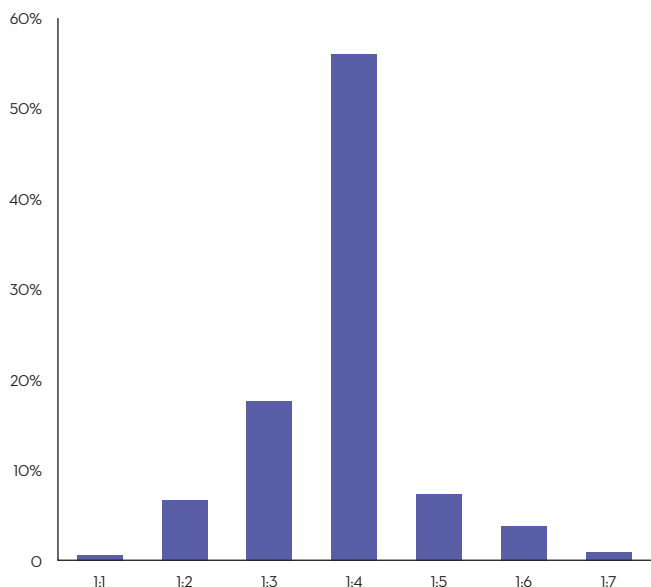


FIGURE 1. WHAT IS YOUR USUAL RATIO OF WEEKEND SHIFTS?

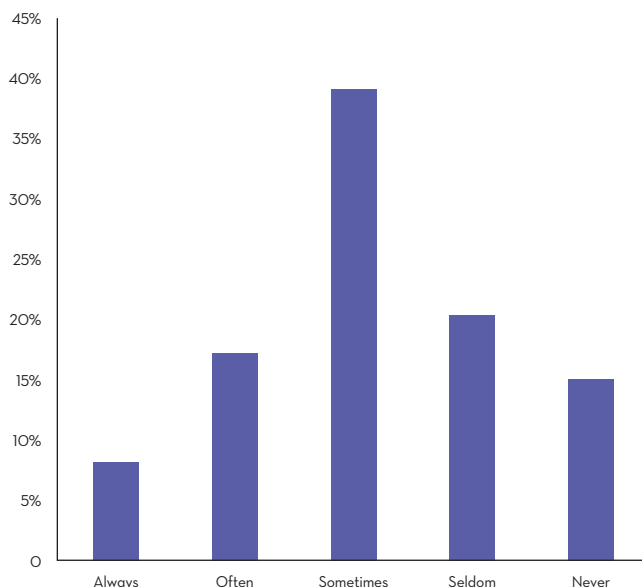
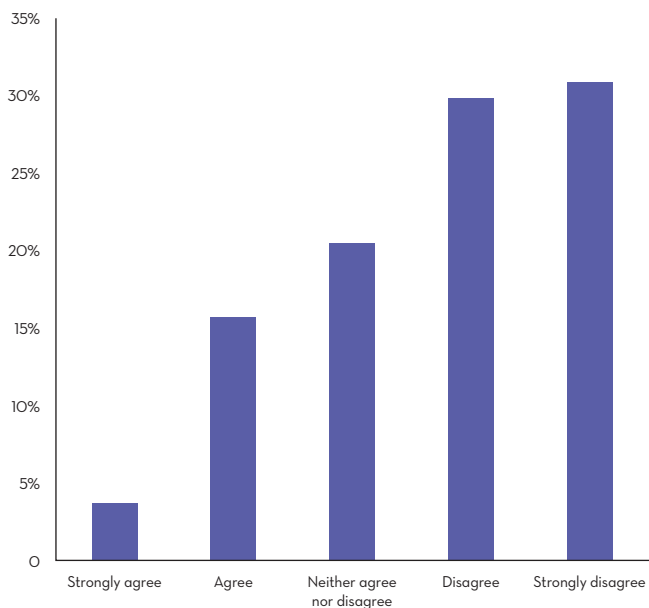
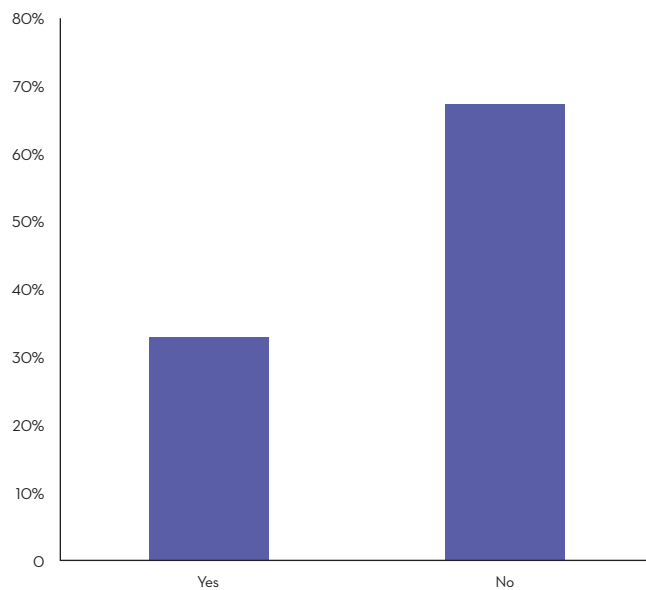


FIGURE 2. DOES YOUR ROSTER FOLLOW THE RECOMMENDED CIRCADIAN PATTERN (I.E IN THE ORDER OF DAY, AFTERNOON, NIGHT, RECOVERY, REST)?



**FIGURE 3. IN YOUR VIEW, DO YOU THINK THERE IS ADEQUATE PROVISION FOR BREAK/REST TIME DURING YOUR SHIFTS (EG. MEAL AND TEA BREAKS?)**



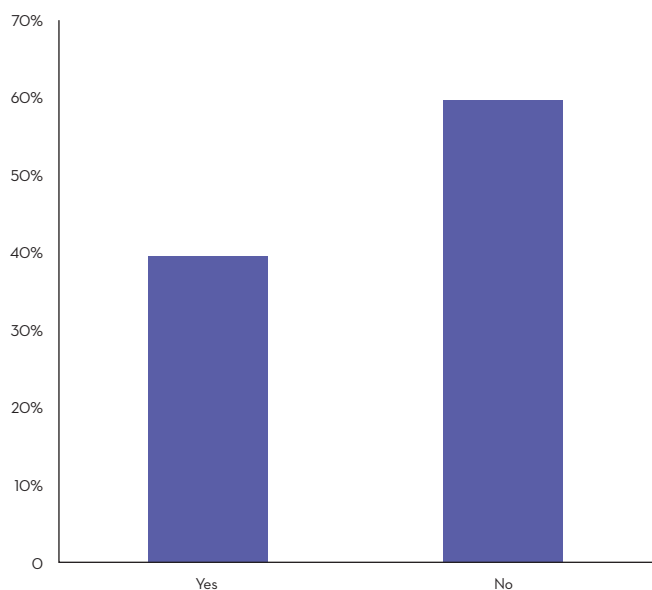
**FIGURE 4. HAVE YOU WORKED MORE THAN 14 CONSECUTIVE HOURS IN ANY ONE PERIOD? PLEASE INCLUDE WORKING OVERTIME AND/OR HOURS ON CALL**

The research also found that very few agreed there was adequate provisions for breaks or rest periods during their shifts (figure 3) and over a third had worked more than 14 consecutive hours in any one period (figure 4).

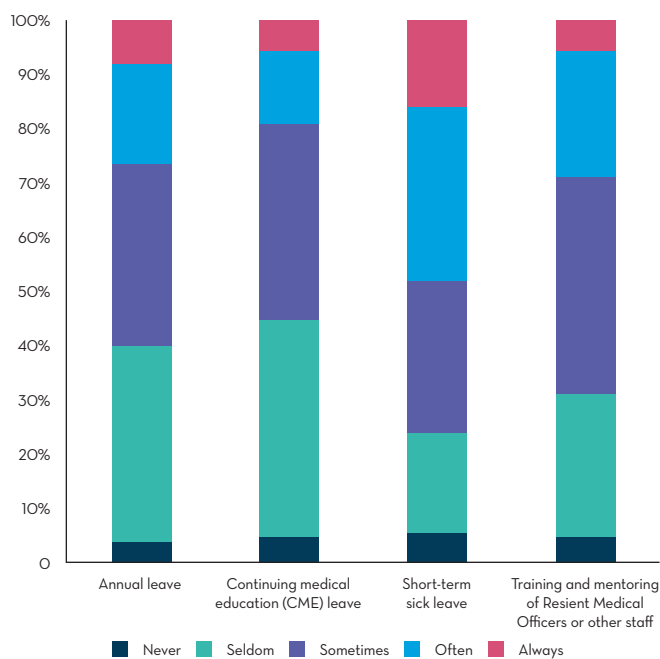
Similarly, nearly 40% had endured a period of rest between their scheduled work of less than ten hours (figure 5). Very few felt that there was adequate staffing to provide for short-term sick leave in their service, and less than half felt there was adequate cover to

provide for training and mentoring of RMOs and other staff (figure 6).

This research was initially presented to the ASMS shift work working party and is being used to inform work leading up to the 2020 MECA.



**FIGURE 5. DID YOU HAVE A PERIOD OF REST BETWEEN SCHEDULED WORK (INCLUDING ON-CALL WORK) OF LESS THAN 10 HOURS?**



**FIGURE 6. BASED ON THE CURRENT SMO STAFFING LEVELS ALLOCATED TO YOUR SERVICE, WHAT IS YOUR VIEW ON WHETHER THERE IS SUFFICIENT INTERNAL SMO COVER TO PROVIDE FOR THE FOLLOWING?**



Sharon Murdoch. Source: Sunday star times (Newspaper). Alexander Turnbull Library



## SPECIALIST GENDER PAY GAP - WHAT'S DRIVING IT?

DR CHARLOTTE CHAMBERS | DIRECTOR OF POLICY & RESEARCH

**Do women doctors earn the same hourly wage as their male colleagues for the same work? The answer seems apparent: it is illegal in New Zealand legislation to pay workers differently according to gender.**

Nevertheless, ASMS has been hearing anecdotal evidence for some time from members that points to the contrary. To answer this question definitively, ASMS contracted Motu Economic and Public Policy Research to conduct a thorough and rigorous study using monthly wage earnings derived from tax data in Statistics New Zealand's Integrated Data Infrastructure (IDI) along with data taken from the 2013 census in the IDI. Dr Isabelle Sin who led the research is an expert in this field having already conducted research to establish that women in New Zealand earn substantially less than their male counterparts.

Her other work has established that women in New Zealand also suffer a significant parenthood penalty that manifests in a larger gender pay gap for women with children when compared with men who are also parents.

A key aim of this commissioned research was to control for as many possible factors that could be used to explain a gender pay gap in medical and dental specialists, including but not limited to age, years worked, medical/dental specialty, hours of work, and time spent out of the paid workforce on parental leave.

The research findings are startling. Male specialists earn a large and statistically significant premium over their female colleagues of the same age, in the same specialty, working the same number of hours each week based on analysis of their DHB employment.

The research finds that on average, female specialists earn 12.5% less per hour than their male counterparts. This compares with research conducted by Stats NZ in 2013 which estimated a gender pay gap (in hourly wages) of 11.2%.<sup>1</sup>

This gender pay gap rises to 13.6% between male and female specialists

<sup>1</sup> Note that the Stats NZ methodology calculates the difference in median hourly earnings, rather than mean, and doesn't control for factors such as age, occupation (specialty) etc. Their methodology is detailed at [http://archive.stats.govt.nz/browse\\_for\\_stats/income-and-work/Income/gender-pay-gap.aspx](http://archive.stats.govt.nz/browse_for_stats/income-and-work/Income/gender-pay-gap.aspx)



Dr Charlotte Chambers

with one child, and 17.2% between male and female specialists with two or more children. This compares with the estimated 12.5% gender gap in hourly wage for parents ([http://motu-www.motu.org.nz/wpapers/18\\_O8.pdf](http://motu-www.motu.org.nz/wpapers/18_O8.pdf), page 26), calculated by Motu<sup>2</sup>.

Crucially, the research commissioned by ASMS found the gender wage gap is not driven by age, specialty, weekly hours worked, or time out of the paid workforce. The analysis flexibly accounts for age, so is not driven by female specialists being younger on average than male specialists.

The analysis compares men and women in the same specialty, so is not driven by female specialists choosing to work in lower-paying specialties. The analysis also controls for weekly hours worked, so is not driven by female specialists being more likely to work part-time and part-time employees earning lower hourly wages than full-time employees. Finally, the gender wage gap for mothers cannot be explained by time out of the paid workforce for parental leave<sup>3</sup>.

So what is driving this gap? The broader literature on gender pay equality proposes employer discrimination and

more successful salary negotiation on the part of men as two potential explanations. It is possible both play a role in the gender wage gap for medical specialists. The wider literature also suggests that implicit bias based on gender schemas is also a key driver of gender based pay-gaps (see Virginia Valian's 'Why so slow?' for a fuller analysis of this point).

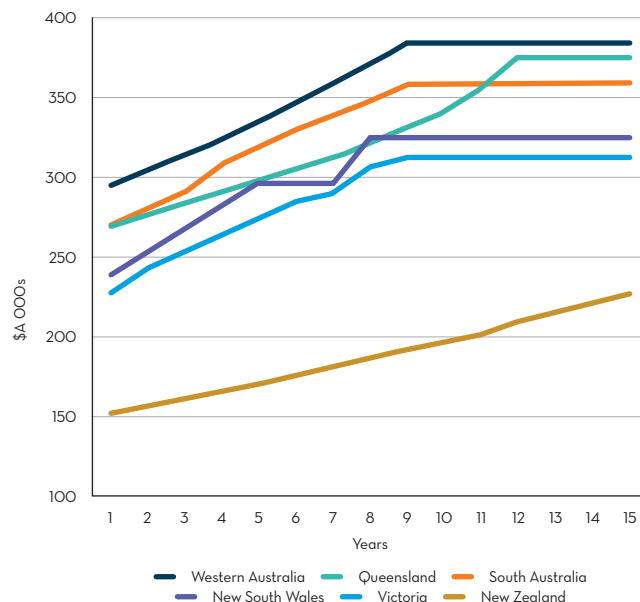
The full Motu report can be found at [www.asms.org.nz](http://www.asms.org.nz) under the independent research tab.



Dr Isabelle Sin, Motu Economics and Public Policy Research

- 2 Isabelle Sin notes the population captured in the other Motu study was not representative of the entire population of parents but did control for age and level of education. Dr Sin suggests that in an analysis of the full New Zealand population the gap for parents would likely be larger.
- 3 Analysis suggests that the average female medical specialist reduces her lifetime months worked by on average five months for each child she bears. Further, the ASMS MECA specifies that specialists on parental leave for up to 12 months will receive the same regular pay increases as they would receive were they not on leave.





# WHOPPING TRANS-TASMAN PAY GAP

ELIZABETH BROWN | SENIOR COMMUNICATIONS ADVISOR

**R**esearch conducted for ASMS has found that on average medical specialists in New Zealand’s public hospitals are earning as much as 60% less than their Australian counterparts.

The BERL research compared the base 40-hour a week salaries of salaried specialists on both sides of the Tasman. The Australian comparator was staff specialists in the six largest states.

It was presented at the ASMS Annual Conference by BERL Chief Economist Dr Ganesh Nana.

While he expected Australian specialist salaries to be higher because salaries in general run 20% to 30% above New Zealand’s, the size of the SMO salary gap took him by complete surprise.

What startled him even more was that the top step in the New Zealand salary scale is below that of the lowest entry-level salary for a newly-qualified specialist in Australia.

“I didn’t expect that at all,” Dr Nana told conference delegates last month.

“It’s really quite inexplicable. We are not less trained or less skilled so it’s hard to make sense of.”

He also noted that pay scale progression for New Zealand specialists is slower. It takes 15 years to reach the top step, compared with nine in most Australian states.

Dr Nana identified non-salary benefits such as long service leave and CME as

others area in which Australian specialists have the edge. He also referred to the additional benefit across the Tasman of salary sacrifice arising out of the distinctly different Australian tax system.

As a consumer of health services, with an interest in the well-being of the nation, he considered this massive gap to be a concerning situation.

He identified the huge salary gap as something that had to be recognised and addressed in some way.

In reference to non-salary benefits Dr Nana said: “in an occupation like yours [these] are essential because I think it’s a vocation and a passion. You’ve got to be kept up-to-date and take time out to stop burnout”.

Key research findings:

- Australia and New Zealand are in the same specialist employment market.
- Specialists in New Zealand’s DHBs are, on average, earning as much as 60% less than their Australian counterparts’ base salaries.
- The top step on the New Zealand salary scale falls slightly below the bottom step in Australia, meaning a newly-qualified specialist there is earning

slightly more than the highest-paid New Zealand specialist.

- Australian specialists have greater non-salary benefits, along with higher overall purchasing power.

ASMS Executive Director Ian Powell believes the BERL report shows Australia is a real threat because of shared specialist training systems, the estimated 24% specialist shortage across DHBs, and New Zealand’s dependence on overseas-trained specialists.

“We compete with Australia so if you’re an overseas specialist looking to come to either country, you’re much more likely to choose Australia because the pay is so much more attractive, other benefits are better, and purchasing power is also higher.”

He added the only area where New Zealand has a known advantage is with annual leave, but noted we also don’t have snakes.

Mr Powell is calling on the Government and DHBs to provide leadership on the development of an effective retention and recruitment strategy and to work with ASMS to achieve it.

The BERL report is available at [www.asms.org.nz](http://www.asms.org.nz) under the independent research tab.



SLANE...  
AFTER ROWSON,  
Royal College & Physicians

DHB clinical heads of department estimate hospitals are operating with about three-quarters of the senior medical staff required to deliver safe and effective care.



# HOSPITALS ON THE EDGE - A SPECIAL REPORT

LYNDON KEENE | POLICY AND RESEARCH ADVISOR

**A** SMMS released a report ahead of its 2019 Annual Conference highlighting the parlous state of public hospitals. The author of *Hospitals on the Edge*, Senior Policy and Research Advisor Lyndon Keene, analyses its key points.

## HOW DID WE GET HERE AND HOW CAN WE PULL BACK?

A few trends give you the general picture. The number of acute hospital admissions and Emergency Department presentations are increasing at more than twice the rate of population growth. The number of mental health clients seen by District Health Boards (DHBs) is increasing at more than three times the rate of population growth. Hospital bed occupancy rates are often close to, and sometimes over, 100%. DHB clinical heads of department estimate hospitals are operating with about three-quarters of the senior medical staff required to deliver safe and effective care. The evidence suggests there are potentially 430,000 children and adults with an unmet need for hospital care.

These trends are among those highlighted in the ASMS report *Hospitals on the Edge*, inspired by a similar publication produced by the Royal College of Physicians in the United Kingdom in 2012.

These pressures are not new, of course. In May 2017 the now Minister of Health, David Clark, described the situation as a 'growing crisis'. He was right: the crisis has since grown in intensity. In the past there were relative quiet periods to recover, but this has changed. DHBs are now in permanent winter crisis.

Statistics on their own provide only an outline of what's going on, however. To understand what they mean in practice, for patients and staff alike, we have asked a random selection of members to comment on their experiences. This, from a surgeon, is typical of what we are hearing increasingly frequently:

*"We're hundreds of patients behind in our clinic FSAs [First*

*Specialist Assessments]. Some clinics are cancelled due to [high numbers of acute admissions]. We're not meeting our cancer targets in terms of operation dates. We're cancelling theatre lists routinely due to lack of staff and bed capacity. We are running about two months behind target for semi-urgent colonoscopies and are struggling to keep up with the demands of the bowel screening project. Short notice stress leave has become more frequent."*

There may be many explanations for how we got to this point but bad policy-making stretching back many years will surely be key. As ASMS National President Prof Murray Barclay writes in the introduction to *Hospitals on the Edge*, hospital services have been subject to privatisations, restructurings, amalgamations, real funding cuts, and narrow, politically motivated targets without due regard or even understanding of the consequences. Too often policies have been based on ideology rather than evidence. And too often they are underpinned by "command and control" approaches ill-suited to complex adaptive system such as health care systems.

Six years ago, a report from the then prime minister's chief science advisor, Professor Peter Gluckman, called for more rigorous employment of evidence for the development of policy and in the assessment of its implementation, especially in areas where complexity makes forming policy particularly challenging.

In a follow-up report in 2017 the lack of rigorous policy analysis remained an issue internationally, with decisions on some of the most challenging social

policies "based on a combination of normative argument, political ideology and electoral considerations".

"There has been a general reluctance to enter into formal randomised trials to evaluate a potential intervention ... probably due [in part] to New Zealand's comparatively short political cycle.

"Added to this is the problem that normative arguments are easy to make, yet may reflect diverse biases."

Adding still further is what Professor Gluckman calls "the worrisome rise of 'post-truth' polemic", as defined in the *Oxford English Dictionary*: "In this era of post-truth politics, it is easy to cherry-pick data and come to whatever conclusion you desire". This brings to mind some aspects of the Health and Disability System Review's *Interim Report* to the Minister of Health (see p 29).

That report runs a familiar narrative that current health trends are unsustainable and new models of care are needed that hinge on shifting "away from a treatment focus towards a prevention focus", as though the latter will automatically reduce the need for the former. This has taken effect in mental health services in the 2019 Budget, with specialist-level services taking a real funding cut, despite well-documented evidence of unmet need for these services.

As ASMS has previously reported (*Research Brief*, Issue 12, 2019), the evidence on the impact of such policies shows the reality is far more complex. The increasing rates of acute hospital admissions have occurred while primary care consultation rates are increasing at more than twice the rate of population growth (Table 1), and despite implementation of policies focused on

**The number of mental health clients seen by District Health Boards (DHBs) is increasing at more than three times the rate of population growth.**

Consultation Type	2010/11 (000)	2011/12 (000)	2012/13 (000)	2013/14 (000)	2014/15 (000)	2015/16 (000)	2016/17 (000)	Percent Increase
GP Consultation	11,969	12,269	12,239	12,532	12,731	13,190	13,410	12.0%
Nurse Consultation	2,221	2,337	2,492	2,648	2,927	3,251	3,307	48.9%
Total Consultation	14,191	14,606	14,731	15,180	15,657	16,441	16,718	17.8%
Population	4,374	4,399	4,426	4,476	4,552	4,644	4,743	8.4%

Source: Ministry of Health (unpublished data) and Statistics NZ. Totals may not add up due to rounding.

prevention. Similar trends are happening overseas.

The evidence shows that in order to relieve increasing pressure on hospitals and community-based services a whole-systems perspective is needed adopting an integrated approach recognising the real world complexities of modern health care.

When initiatives to integrate services are planned and implemented well, they can achieve significant improvements in the quality and effectiveness of services and reduced rates of hospital admissions. But

many attempts at integrating services around the world have been half-hearted – as one commentator put it: “It takes years of [building] trust and hard slog”.

Successful integration depends on upfront and continuing investment recognising that it takes time to produce measurable and sustainable benefits and recognising that such transformations must start from the ‘bottom up’ and are highly organic, adaptive processes.

This requires a shift in policy-making approaches:

- From viewing the health system as a costly burden to a valuable investment.
- From demanding simplistic, short-term results to measuring incremental progress towards comprehensive longer-term goals.
- To give greater emphasis to qualitative performance data to gauge progress.
- To discard some entrenched views that health professionals are motivated primarily by self-interest; to start trusting that they go to work to do the best they can; to commit to policies that support them to do just that.

**FROM THE FRONTLINE:**

**“THERE IS AN OVERALL LACK OF CLINICAL SPACE, AND ISOLATION FACILITIES ARE INSUFFICIENT TO MEET DEMAND, INCREASING THE RISK OF NOSOCOMIAL INFECTION. WORKFLOW IS DICTATED BY CONSTRAINTS OF THE EXISTING LAYOUT, AND AT TIMES BECOMES CHAOTIC, ESPECIALLY DURING WINTER PEAKS WHEN THE CLINICAL TEAM WORK FLAT OUT TO FREE UP BED SPACES FOR ACUTE ED AND GP REFERRALS. DURING A RECENT WEEKEND ON CALL PERIOD, FOUR CHILDREN SPENT THE NIGHT IN ED DUE TO LACK OF CAPACITY ON THE WARD”** - PAEDIATRICIAN

**“The main problem is that FTE is being held, unfilled, across all teams to be reallocated once new service structures are agreed to and in place. It would be a problem for a few months, but it’s been 12 months now with no end in sight and it’s putting huge pressure on us all in our day to day work”**  
- DENTIST

**“The available/allocated resources are not sufficient to provide the service expected and to meet the demand. There is lack of capacity (physical number of beds, rooms for clinics, equipment). Most services have outgrown the footprint within the hospital and need extension”**  
- RADIOLOGIST

**“Knowing that we could do so much better if only we had enough staff and decent facilities to work in, is heart-breaking at best and soul-destroying at worst”**  
- GENERAL MEDICAL SPECIALIST

**“We are just completely overwhelmed with how much the outpatient workload is and I find it distressing that I am not able to offer what I think is a safe service to the patients I do see because I’m so pushed to see them”**  
- GERIATRICIAN/GENERAL PHYSICIAN

**“INCREASE IN ACUTE DEMAND OVER THE YEARS, LARGELY DRIVEN BY INCREASED MEDICAL ADMISSIONS TO HOSPITAL, HAVE NOT BEEN MATCHED WITH INCREASED INPATIENT BED RESOURCES. FOR THE PAST 4 MONTHS THE HOSPITAL HAS BEEN ALMOST PERMANENTLY IN STATUS RED”** - EMERGENCY MEDICINE SPECIALIST



# LITTLE NEW IN HEALTH REVIEW

LYNDON KEENE | POLICY AND RESEARCH ADVISOR

**The Health and Disability System Review, led by former prime minister Helen Clark’s chief of staff, Heather Simpson, released its *Interim Report* to the Minister of Health in September. ASMS senior policy and research advisor Lyndon Keene reports on its findings.**

When Health Minister David Clark announced the wide-ranging review of the health system in May 2018 he described it as a “once-in-a-generation opportunity to improve equity and outcomes for New Zealanders”. With a budget of \$9.5 million, including costs of a dedicated secretariat, consultants, and overseas intelligence-gathering tours, much was expected of the review’s *Interim Report*, released more than a year after its first meeting.

But for all its 300 pages, it contains little that has not been discussed before. Much of its content can be found in other documents, including the last Ministerial review in 2009 and various health-related strategies. The report itself says it “should contain few surprises”. Nor does it contain recommendations. What it does contain is questions – and there is no formal process for submitting responses.

All of which raises the question: what was the point?

To be fair, the report does at least pull the big issues together with a comprehensive overview of how the system operates, its strengths and weaknesses, and the pressures and challenges. It brings to the fore the long-standing issue of health inequities, especially for Māori and Pasifika, with strong signals this will at last be given serious attention.

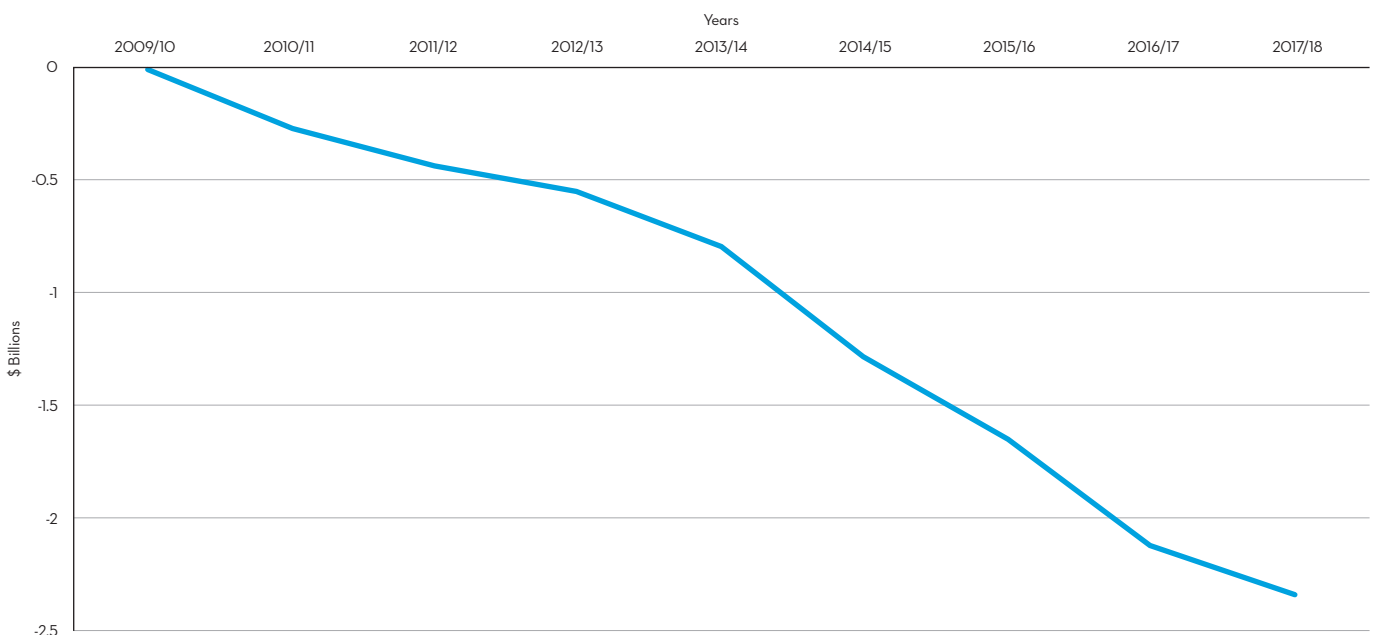
In a chapter on workforce issues, the report acknowledges “high stress levels” and “persistent workforce shortages”, giving a number of examples (but not including specialists). It also acknowledges “potentially high retirement rates” in some workforces, such as general practice, and a heavy dependence on overseas recruits in medicine and nursing, noting global

workforce shortages that could affect both recruitment and retention.

A chapter on digital technology and data provides as good an analysis of the current state of play as you are likely to find.

There is at first glance something to grasp on to for everyone. The problem is that it often tends to slip through the fingers as one reads on. For example, workforce shortages must be addressed. How? The report, rather than emphasising employing more staff, talks about a need for better data and strategic partnerships between unions and employers.

Hospitals need “significant investment” – but while the dire need for capital investment is recognised, the position on investment in hospital services is, at best, equivocal, as they receive a “disproportionate share of funding”



Source: Infometrics 2017

**FIGURE 1: REAL CORE CROWN HEALTH EXPENDITURE (ADJUSTED FOR INFLATION AND POPULATION CHANGES); CUMULATIVE DIFFERENCE SINCE 2009/10 (\$B)**

and their costs in one unnamed DHB are purported to be increasing at twice the rate of funding. And while on the one hand “no system can operate effectively without adequate funding...”, on the other “the [Review] Panel’s initial focus is ... on how the system could operate differently to make better use of whatever financial resources are available to it”.

Questions about the governance, structure and functions of DHBs are raised, and “how to prioritise health spending with constrained budgets”, but these remain parked in the lists of questions and “issues which need further analysis”, leaving the reader none the wiser on what the possible policy responses to these issues might be. There is, however, a narrative running through the report, described at one point as a “reality check on where the system is at”, which offers some clues as to where things are heading. In a nutshell:

*“Continuing with the current model of care, based largely on a Western medical model, employing more and more medically qualified staff focused on treating illness, rather than promoting wellness, will not only be ineffective in achieving the equitable outcomes we desire, it will not be sustainable. The numbers of staff required will not be available and the cost would be prohibitive.” [p 2]*

The “reality” underpinning this narrative tends to represent hospitals (a word overlooked in the Review’s terms of reference) and the medical workforce more as burdensome overheads than as enablers.

*Common themes we heard included ...Concern that hospitals have dominated the system and that strong demand and cost growth in hospital services is putting the health system under financial pressure. [p 178]*

*DHBs may be biased towards spending in their provider arms, since they have greater control over this spending and, potentially, because hospital employees can have a greater influence over decision making. [p 86]*

*“Clinical workforces are expensive, and medical workforces are even more expensive. Senior medical officers spend relatively less time with patients as, over the years, employment conditions have changed with longer annual leave periods (five weeks), time for study (including a substantial training*

*and travel budget), and assigned non-clinical time. Analysis of the accounts of a typical DHB suggests hospital costs have grown 20% over a five-year period, against funding growth of around 10%. Medical staff costs are by far the largest category of cost increase at just over 45%.” [p 204]*

The report’s version of “reality” is often distorted by over-simplification and sometimes does not stack up with evidence. Regarding the above claims in real terms, for example: The Ministry of Health’s DHB Financial Schedules for the five years to 2018 show medical personnel costs increased by 6% when adjusted for Consumer Price Index (CPI) inflation and demographic growth, including the Ministry’s weighting for aging. Over the same period, DHB provider arm revenue decreased by 1.85% in real per capita terms while total costs increased by 3.38%; in other words, a 5.23% gap had emerged between funding and costs. That medical staff costs had increased at a greater rate than total costs should not be surprising given the increased rate of service demand. Nor do the comments in the report appear to recognise the importance and necessity of doctors’ non-clinical time.

The idea pushed in the report that we must shift “away from a treatment focus towards a prevention focus” fails to recognise the significant role that “treatment” plays in “prevention” or the evidence that prevention policies are not a “magic bullet” for reducing hospital admissions. That same idea is the catalyst for hospital bed cuts, which in turn is leading to frequently unsafe hospital bed occupancy rates.

In a chapter on health and disability system workforce issues the report claims: “Workforce projections suggest the current model is unsustainable”. It estimates the current health and disability workforce comprises 8.5% of New Zealand’s total workforce but current trends would see that share increase to an “unsustainable” 10% by 2030, based on what it concedes to be simplistic projections. However, OECD data indicate New Zealand’s health and social care<sup>1</sup> workforce accounted for 10.8% of the total civilian workforce in 2015 while the employment share in Scandinavian countries, Finland and the Netherlands – countries with policy emphases on promoting well-being – ranged from 15%-20%.

The report’s version of health funding trends is that there has been “a sustained period of little real growth”, referring

to real per capita Core Crown Health funding trends, using a GDP deflator. The calculation does not take account of the additional needs of an aging population or the accumulating additional unfunded costs of new initiatives introduced each year and other cost items such as substantial pay equity settlements. There is no mention of the gradual drop in health funding as a proportion of GDP since 2009/10, or the annual analyses undertaken by the Council of Trade Unions and ASMS showing successive years of funding shortfalls for Vote Health, the latest of which estimated that had operational funding maintained the proportion of GDP of 2009/10, it would be \$1.7 billion higher in 2019/20. On average, these analyses have been consistent with those of the Ministry of Health. Nor is there any acknowledgement of the Infometrics analysis commissioned by the Labour Party in 2017 showing a \$2.3 billion gap in real Core Crown Health expenditure between 2009/10 and 2017/18 (figure 1). Infometrics used Treasury’s modelling for calculating real health costs.

To attempt to form a conclusion about a report that presents many questions but no recommendations is probably futile.

There is an argument running through the report that the health system will not be sustainable without making better use of technology, redesigning services, and re-engineering the workforce. The Review Panel consensus as it currently stands is that a significantly larger health and disability workforce is not sustainable; and it is at best equivocal about the need for significantly greater investment in operational funding.

To put this in the context of the Government’s vision for New Zealanders’ equality and well-being outlined in its “Wellbeing Budget”, the Scandinavian countries – Denmark, Norway and Sweden – act as a good point of comparison. Their health and social care workforces, as a proportion of their total workforces, are 40% to 90% greater than New Zealand’s. Their government health spending as a proportion of GDP averaged 8.9% in 2018 compared with New Zealand’s 7.4%. New Zealand government health spending in 2018 would have needed to be \$4.3 billion higher to have matched the Scandinavian average.

The Review’s final report to the Minister is due by 31 March 2020.

A more comprehensive analysis of the *Interim Report* can be found at [www.asms.org.nz](http://www.asms.org.nz) in the Publications, In Depth reports section.

1 Defined as a composite of human health activities, residential care activities (including long-term care), and social work activities without accommodation



# WITH SYLVIA BOYS

## SYLVIA BOYS IS AN EMERGENCY MEDICINE SPECIALIST AT COUNTIES MANUKAU DISTRICT HEALTH BOARD.

### WHAT INSPIRED YOUR CAREER IN MEDICINE?

I first thought about becoming a doctor at a very young age, but at that stage I still had being a fairy on the list!

As an older child it appealed because I was interested in a science-based career, where you also get to care for people and make a difference. Perhaps a better question now is: "Would I encourage my children to enter medicine"?

I have to admit I've been reluctant to encourage them. My daughter was keen to be an ice-cream truck driver, but is now interested in medicine. I find myself suggesting alternatives, partly because of how over-burdened we are. Her interest in medicine is part of why I remain actively engaged with ASMS. My role as an emergency physician is intrinsically linked to the public hospital system, meaning emergency specialists have a vested interest in maintaining a functioning public health system that's safe to work in. I also feel a real drive to ensure our working conditions are manageable, not just for my working lifespan, but also for the next generation of medics.

In emergency medicine you are constantly

aware of the barriers faced by patients accessing health care, and the systematic inequities which have almost inevitably led them to present at the emergency department (ED). These barriers sometimes limit their ability to achieve health, even with the interventions you can provide. This led to my interest in population health, and further study recently while on sabbatical.

### WHAT DO YOU LOVE ABOUT YOUR JOB?

After taking a sabbatical and having a break from face-to-face duties, I am really enjoying seeing patients and their whānau, and having a chance to interact on a one-to-one level.

An ongoing difficulty is those things we cannot change. We probably need to be aware of the mantra of having the serenity to accept the things we cannot change, the strength to change the things we can, and the wisdom to know the difference. That said, as a group we should remember our role as advocates to speak out on issues like social policy and climate change, which although superficially appearing outside the health system have a profound influence on health.

### WHAT ARE SOME OF THE MOST CHALLENGING ASPECTS OF PRACTISING MEDICINE IN THE CURRENT HEALTH ENVIRONMENT?

Turning up at work knowing that even doing your utmost, you will not be able to meet the needs of all your patients. On some shifts, there is a real risk that you will not even be able to secondarily triage those waiting to be seen, so there is a risk they will come to avoidable harm while awaiting care.

### WHAT HAVE YOU GAINED OR LEARNED FROM YOUR ASMS INVOLVEMENT?

Being involved with ASMS has shown me the issues in my work are ubiquitous, which can be useful - at least we're all in this together! I particularly find the JCCs useful, as I think that sometimes ambitious managers tend to paint a rose-tinted picture of their performance, over-emphasising where things are going well and painting over any cracks in their reports to senior management tiers. Having a forum where you can directly present the patient and staff stories behind our performance statistics is very important.



Julie Anne Genter & Dr Charlotte Chambers

## BEEHIVE BUZZ FOR ASMS RESEARCH LAUNCH

**A** SMS research into gender bias and the specific challenges facing women specialists was officially released by the Minister for Women and the Associate Health Minister Julie Anne Genter to a gathering of about 50 people at the Beehive on 7 November.

The report *'Making up for being female: Work-life balance, medical time and gender norms for women in the New Zealand senior medical workforce'* is the result of a study by ASMS Director of Policy and Research Dr Charlotte Chambers.

It's based on long-form interviews with 14 New Zealand doctors aged 30-40.

The aim was to investigate why female medical specialists work through illness at higher rates than their male counterparts, self-report as bullied at a higher rate, and have significantly higher rates of work-related burnout.

The key themes that emerged were work-life balance, medical time, and gender stereotypes. Interviewees spoke about the stress of balancing the expectations of medicine with the practical realities of domestic commitments, including children.

Women make up a growing proportion of the medical workforce. The New Zealand Medical Council estimates women will outnumber male doctors by 2025.

With a shortage of SMOs in our hospitals, it's critical to attract and retain staff.

It's hoped the study will form the basis of

much-needed debate about changing the culture and structure of medical work to meet 21st century expectations of doctors and the patients they serve.

Ms Genter thanked Dr Chambers and ASMS for the research, saying structural inequality needs to be addressed.

"The workforce of the future needs to better reflect the community it's serving, is trained appropriately and is able to achieve better work-life balance."

Watch the event at [www.asms.org.nz](http://www.asms.org.nz) in the videos section.





# TACKLING THE BURNOUT ENDEMIC

DR ROB HENDRY | MEDICAL DIRECTOR, MEDICAL PROTECTION SOCIETY

**This time last year *The Specialist* reported on Professor Murray Barclay’s presidential address at the ASMS Annual Conference 2018. The address was honest and stark in articulating the many challenges faced by New Zealand specialists, and I was struck by the section on burnout, which drew on extensive ASMS research.**

In short, it said half of specialists are fatigued to the point of burnout, and specialists work when they shouldn’t, due to illness, worsening the burnout. A quarter plan to leave the workforce in the next five years, and the situation is much worse for women doctors.

One year on and the causes of burnout in New Zealand continue to be debated - growing demands and complexity of the job, a relentless pace of work and tighter funding constraints. The sense of value that doctors have is being diminished by the environment they work in.

When doctors feel burnt out it is not only bad for the doctors concerned but also for patients and the wider health care team. The obvious reality is that doctors who are happy and engaged find it easier to be compassionate and provide safer patient care.

As leaders, managers, and peers we are all responsible for identifying signs of burnout in ourselves and others and working together to develop strategies to enhance personal resilience. The Medical Protection Society (MPS) has a part to play here - we must listen to and care for our members and I am proud of the work we do to support those dealing with burnout. But I recognise that it is only one small part of the solution.

MPS has just launched its “*Breaking the Burnout Cycle*” report, and as part of that we contacted 300 doctors in New Zealand about their working environment. They told us loud and clear about the impact their work is having on their well-being. Forty-three percent say they do not feel their personal well-being is a priority at work, 30% feel unable to take a break during the day to eat or drink, and 40%

say they have considered leaving the profession. These statistics resonate with ASMS research.

From our work with doctors in New Zealand, and all around the world, we have identified some steps which could help to mitigate some of the risks of burnout in the profession.

We believe organisational level interventions are key in safeguarding the well-being of doctors and avoiding burnout and disillusionment in ever-greater numbers. One of the recommendations in our report is for KPIs or corporate objectives to include well-being, to demonstrate commitment from the top.

We also believe every doctor in New Zealand should have access to someone trained to recognise burnout and offer support. This could be achieved by all health care organisations and private providers appointing a ‘Well-being Guardian’ with a similar dedicated person working with smaller clinics locally.

The ‘Well-being Guardian’ concept originally came from the UK National Health Service Staff and Learners’ Mental Wellbeing Commission, which was set up by Health Education England. The role would create a focus on staff mental well-being by seeking continual improvement in caring for those who look after the public’s health, and how they are supported in their working lives. It would do this by ensuring that enough information is being provided to the health board to create benchmarks, set organisational expectations and monitor performance. We think these Well-being Guardian roles could realistically be in place by 2022.

Medical schools and postgraduate training bodies have an important role to play instilling the right behaviours. Medical practitioners who supervise others must have the time and training to perform key management activities, such as debriefs and identifying and supporting team members who are sick or on the verge on burnout.

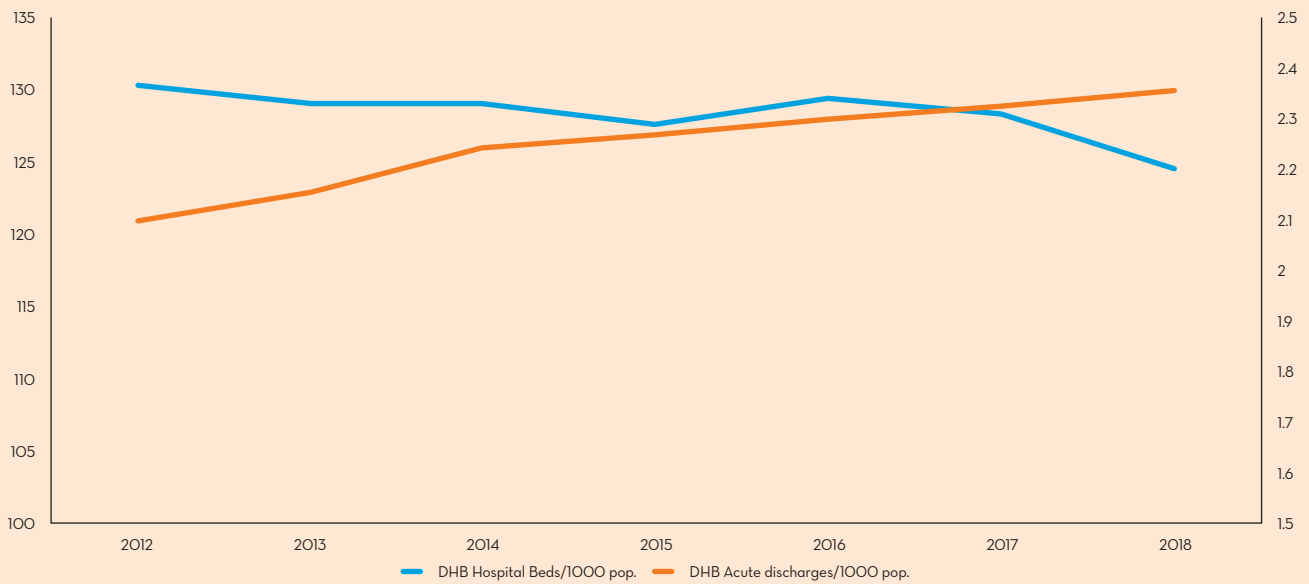
Generally medical schools can play a much more prominent ‘upstream’ preparatory role when it comes to the well-being of their scholars. They have a clear responsibility in laying physiologically healthy foundations for doctors and other health care professionals during their training and supporting them in their professional career development.

They should establish comprehensive standards for doctors’ well-being at every career stage and measure those standards. They should provide scholars with obligatory training in general well-being in the workplace, in building resilience, speaking up for safety, and how to develop good individual coping strategies. We know Auckland University medical school is rolling out a scheme to ensure well-being in their medical students, and we look forward to seeing how this develops.

MPS report offers a lot more detail and a range of recommendations - some for the doctor, some for the health care team, and more suggestions for organisational level change.

Only with commitment from the whole health care community in New Zealand, can we truly begin to tackle the burnout endemic and safeguard the well-being of doctors.

FIGURE 1: DHB HOSPITAL BEDS PER 1000 POPULATION AND ACUTE INPATIENT DISCHARGES 2012-2018



## VITAL STATISTICS

- Between 2012 and 2018 district health boards' acute hospital inpatient discharges increased from 121 per 1000 population to 130/1000 while public hospital beds decreased from 2.4 per 1000 population to 2.2/1000 (Figure 1).
- Emergency readmissions to hospital within 28 days of discharge, increased from an estimated 10.1% of discharges in 2012 to 12.1% in 2018.
- New Zealand's average length of hospital stay for acute care (4.9 days) was the third-lowest in the OECD in 2016 (the latest data available).

Sources: OECD Health Data 2019; Ministry of Health 2018, Health Quality and Safety Commission 2012.

## ASMS VIDEO STARS

**A** SMS has produced a series of videos to illustrate the sorts of pressure senior medical and dental staff in New Zealand are facing.

They feature seven ASMS members working in a range of specialties in various DHBs.

Each shares their views and perceptions about the challenges of trying to deliver effective, patient-centred care in a system groaning under the weight of underfunding, increasing demand and unmet need.

In doing so they address issues affecting the senior medical workforce such as SMO shortages, New Zealand's dependence

on international medical graduates, staff retention, workload, and the pressure to keep doing more with less.

The subjects who took part in the series are:

- Professor Murray Barclay - Gastroenterologist, Christchurch
- Dr Tule Misa - Public Health Dentist, Christchurch
- Dr John Chambers - Emergency Medicine Specialist, Dunedin

- Dr Julian Vyas - Paediatrician, Auckland
- Dr Katie Ben - Anaesthetist, Nelson
- Dr Tanya Wilton - Emergency physician, Hutt Valley
- Dr Annette van Zeist-Jongman - Psychiatrist, Hamilton

The videos can be found at [www.asms.org.nz](http://www.asms.org.nz) in the Patient Centred Care section.

# Women in medicine

BY SARAH LAING



Youngest of 5 children, daughter of the first NZ-born Supreme Court judge, Frederick Chapman, Sylvia graduated from Otago with a MB, ChB in 1921



She spent two years working at Cook Hospital, Gisborne, before becoming a GP in Wellington



She was very involved in the YWCA



Her research into perinatal toxemia earned her a MD & paved the way for the discovery of the RH factor



Her investigations into toxemia in pregnancy led to an enquiry about illegal abortion.

THE MAIN CAUSES OF ABORTION ARE ECONOMIC HARDSHIP & THE LACK OF CONTRACEPTION WE MUST SET UP BIRTH CONTROL CLINICS



She became widely respected & was appointed government nominee to the senate of the University of New Zealand in 1938

YOU WOULDN'T COUNTENANCE SURGERY WITHOUT PAIN RELIEF, SO WHY SHOULD WOMEN HAVE TO SUFFER THROUGH CHILDBIRTH?



She studied Polish during the 2nd world war, hoping to visit & assist the refugees in immigrating to New Zealand

DZIEN DOBRY. DZIEN...



The NZ council of organisations for Relief Services Overseas (CORSO) was formed in her living room

WE CAN'T JUST SIT & WATCH - WE MUST ACT!



She led a medical team to Greece under extremely tough conditions.

NO FOOD, NO HOSPITALS, NO MEDICINE - HOW AM I MEANT TO HELP HERE?



She travelled extensively, instituting blood transfusions & a mobile laboratory

THIS WILL PERK YOU UP

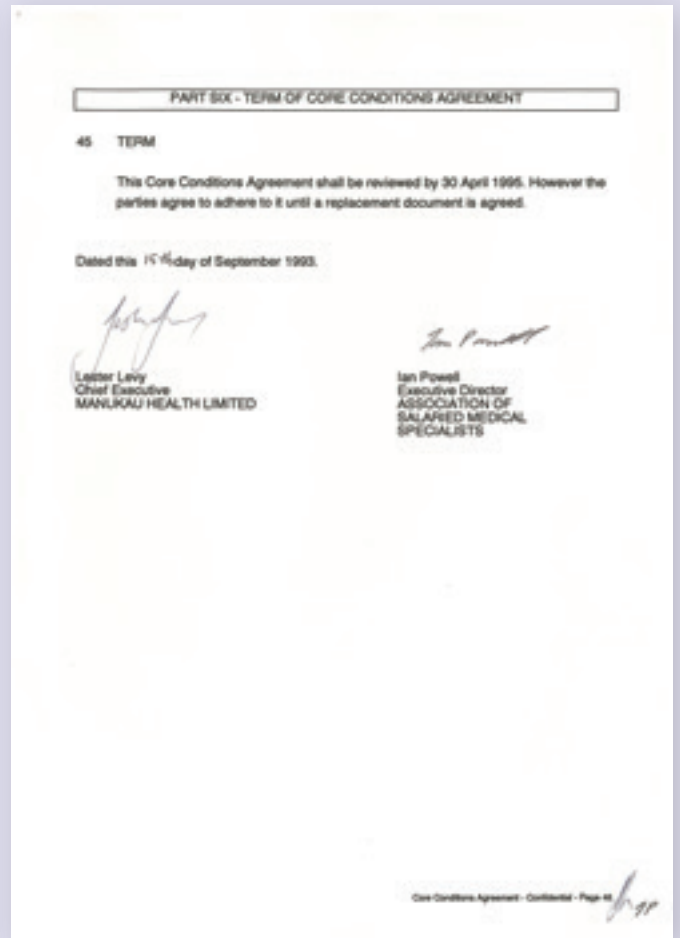
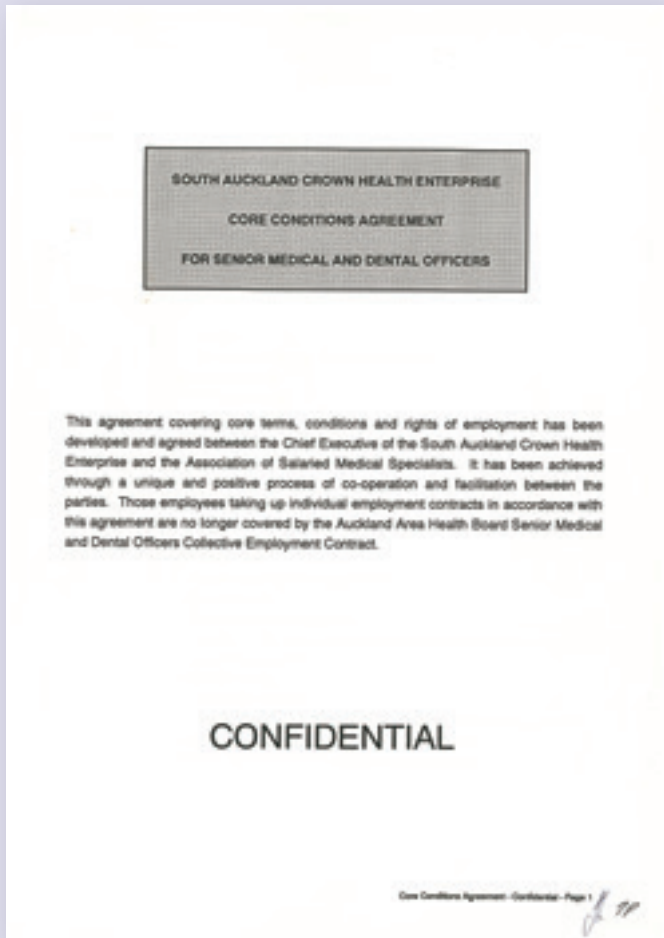


When the CORSO team left Greece in 1946, Chapman moved to England. She never married & lived a quiet life, dying at Bexhill on Sea in 1995, aged 98.

# 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.ORG.NZ](http://WWW.ASMS.ORG.NZ)) UNDER 'ABOUT US'.





By the early 1990s under the now repealed Employment Contracts Act ASMS lost the right to negotiate a national collective agreement covering members employed in public hospitals. For several months we could not get traction to negotiate collectively in the newly formed crown health enterprises (CHEs - state owned companies running public hospitals). Eventually, however, Executive Director Ian Powell and South Auckland Health (now Counties Manukau DHB) Chief Executive Lester Levy signed a new collective agreement called a 'core conditions agreement'. In addition to breaking the impasse in collective bargaining in the other CHEs it included a huge 20% salary increase. Only one signatory grasped in advance the flow-on implications of this outcome and behind the scenes the Government was furious. It led to nearly a decade of ratcheting collective settlements through all the CHEs significantly enhancing not only salaries but also other entitlements (such as annual leave, subsidised superannuation and CME). At certain points major industrial breakthroughs are made. This was one of them.

# DID YOU KNOW



...ASMS MEMBERS HAVE A LEGAL RIGHT AND PROFESSIONAL DUTY TO SPEAK OUT PUBLICLY AND ENGAGE IN PUBLIC DEBATE ON MATTERS RELEVANT TO THEIR PROFESSIONAL EXPERTISE AND EXPERIENCE. THIS IS PARTICULARLY IMPORTANT NOW, AT A TIME OF SERIOUSLY INCREASING WAITING LISTS, UNMET NEED AND STAFF SHORTAGES AT ALL LEVELS OF OUR HEALTH CARE SERVICES.

These rights and obligations are derived from MECA clause 39 – **Professional & Patient Responsibility & Accountability** and clause 40 – **Public Debate & Dialogue**.

They are reinforced by statute in Schedule 1B, Employment Relations Act 2000, also known as the Code of Good Faith for the public health sector.

Most importantly, the MECA records that your DHB employers (who are all parties to the MECA) recognize the primacy of your roles as patient advocates. That role and primacy is an ethical and professional one enshrined in your employment agreement. In particular, clauses 39(b) & (c) expressly link your rights and duties to the guidelines, policies and standards of the Medical & Dental Councils and your respective medical colleges and professional associations.

Your rights and obligations extend to being critical of the funding and resourcing of your services (whether by Government of your employer) and the design and delivery of particular services.

However, your rights are qualified by clause 40.2. If you intend to speak out and publicly criticize your employer or

service, whether directly or indirectly, you are obliged to have previously advised and discussed your concerns with your employer, at a senior level.

Notwithstanding any policy the DHB may have about clearing things first with the DHB's communications team, you have no obligation to do so and do not require their or your employer's consent before going public.

Nevertheless, any comments you make that are directly or indirectly critical of your employer should also be measured, fair and likely to be generally supported by your colleagues.

If in doubt, seek advice from ASMS through a member of our industrial team.

## CLAUSE 39: PROFESSIONAL AND PATIENT RESPONSIBILITY AND ACCOUNTABILITY

The parties recognise:

- (a) the primacy of the personal responsibility of employees to their patients and the employee's role as a patient advocate;
- (b) that employees are responsible and accountable to the statutory authorities such as the Medical and Dental Councils, established under the Health Practitioners Competence Assurance Act 2003, as applicable, including their relevant policy statements and guidelines; and
- (c) that employees are responsible and accountable to the ethical codes and standards of relevant colleges and professional associations.

## CLAUSE 40: PUBLIC DEBATE AND DIALOGUE

- 40.1 In recognition of the rights and interests of the public in the health service, the employer respects and recognises the right of its employees to comment publicly and engage in public debate on matters relevant to their professional expertise and experience.
- 40.2 In exercising this provision employees shall, prior to entering into such public debate and dialogue, where this is relevant to the employer, have advised and/or discussed the issues to be raised with the employer.



# SEASON'S GREETINGS

The ASMS National Executive and national office staff wish you all a safe and happy holiday season.

The national office will close early on the afternoon of Tuesday 24 December 2019 and reopen on Monday 6 January 2020.

If you have any urgent queries over this period please contact Sarah Dalton at [sarah.dalton@asms.org.nz](mailto:sarah.dalton@asms.org.nz).

## ASMS SERVICES TO MEMBERS

**As a professional association, we promote:**

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

**As a union of professionals, we:**

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

Have you visited our regularly updated website? It's an excellent source of collective agreement information and

it also publishes the ASMS media statements.

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

**ASMS job vacancies online**  
[jobs.asms.org.nz](http://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

Association of Salaried Medical Specialists  
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.org.nz](mailto:asms@asms.org.nz)  
**W** [www.asms.org.nz](http://www.asms.org.nz)  
[www.facebook.com/asms.nz](http://www.facebook.com/asms.nz)

**Have you changed address or phone number recently?**

Please email any changes to your contact details to: [asms@asms.org.nz](mailto:asms@asms.org.nz)

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**Deputy Executive Director**  
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“They’ve been insuring  
New Zealand families like  
mine for nearly 100 years.”

**Katherine Reinhold (and Rosa)**  
Lawyer and MAS Member

MAS is 100% New Zealand owned and we’ve been serving our Members, like Katherine, for nearly 100 years now. Not only have we established a foundation to fund health initiatives, we have been awarded *Consumer NZ People’s Choice* across four categories\* for three years running.

**Keep good company with MAS.**

\* House, contents, car and life insurance

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