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Data and member engagement

Professor Murray Barclay | ASMS President

As I near the end of my three-year term as ASMS President, it is timely to look back. My fellow Executive members will likely agree that my two major themes have been data and member engagement.

These two themes combine when we survey members. Three years ago we had data showing unacceptable levels of SMO/SDO burnout, presenteeism, and bullying related to workload. Ongoing surveys have shown an average 24% shortage of hospital specialists across DHBs, before accounting for unmet patient need, which likely affects around 500,000 New Zealanders. ASMS has pushed hard for more routine application of service-sizing and job-sizing, the best tools to match staffing to workload. Where service and job-sizing have been implemented, there have usually been major benefits for staff and patients, but there is a long way to go before it becomes routine.

It is very concerning that our recent membership survey shows no improvement in our burnout rate despite measures by DHBs to try and address burnout, such as workshops, mindfulness training and other psychological support systems. No amount of mindfulness and introspection is likely to overcome unreasonable workload due to staff shortage. Furthermore, our data show that around 72% of DHB departments report difficulty recruiting specialists.

No amount of mindfulness and introspection is likely to overcome unreasonable workload due to staff shortage.

Part of ASMS' push to help with recruitment and retention of specialists was to look across the Tasman to compare salary and other contract conditions with Australia, where 1700 New Zealand-trained specialists are now working.

The comparison showed a 67% salary differential, and better conditions in Australia in every regard except annual leave. It fed into this year's MECA negotiations, which were unfortunately cut short by the Covid-19 pandemic. The negotiating environment will again be very different when we start talks in February, but the gap with Australia will need to be addressed at some point if we are to hold on to our own specialists and attract international medical graduates.

Our suspicions of a significant gender pay gap were confirmed by contracted research in 2019-20. An average 12.5% salary differential between women and men doing the same job was revealed, which is technically illegal. The Ministry and DHBs recognise that the gender pay gap must be corrected. ASMS is working on this with both individual DHBs and through the NJCC meetings.

What I had not predicted three years ago was that the Executive would face its most important task – recruiting a new Executive Director for ASMS, for the first time in 30 years. We left no stone unturned in the process and I think we did very well with Sarah Dalton as our final choice.

And of course, no one could have predicted Covid-19 and its impact. As with many other organisations, Covid-19 sparked a major change of focus for ASMS, and delayed some of our objectives, particularly our MECA negotiations, but also some of our data-focussed projects. However, there was a silver lining. The reduction in staff travel costs resulted in a large budget surplus for the year, bringing our reserve funds into our target range, which will help us into the future.

More broadly, we can be extremely grateful to the response to the Covid pandemic by our health officials and the Government, as we enjoy lives of comparative normality. There is no doubt that if the measures taken had not succeeded, we would not have been able to handle the huge increase in hospital cases. Our health system was already broken from neglected investment in both workforce and building maintenance. Shortfalls in public health physicians and ICU beds were highlighted by Covid but these shortfalls exist across all areas of medicine and surgery.

Politically, we are in interesting times. The Labour Government displays some understanding that health needs a lot more investment. It now has a larger mandate and fewer excuses to get on with it. However, there is a possibility that the restructuring of DHBs as recommended in the Simpson Review will divert energy away from the real needs of our system, which are correcting staff shortages and investment in hospital infrastructure. Let's hope Minister Andrew Little is prepared to really listen to those at the coalface rather than depending just on Ministry advice.

Let's hope Minister Andrew Little is prepared to really listen to those at the coalface rather than depending just on Ministry advice.

Lastly, I have to say I have enjoyed this role and have learned a lot, particularly about people, leadership and the importance of trust and communication. I feel very privileged to have had this role in the ASMS team, which is an amazing group of people who work hard every day for the benefit of our members and the public health system.

Health matters for doctors as well as patients

Sarah Dalton | ASMS Executive Director

Hopefully, by now many of you have had a chance to read our publication *Health Matters – framing the full story of health*. If not, you can go to our website and find an e-copy. In summary, it sets out a range of factors that are critical to people's long-term health and wellbeing, including: poverty, housing, healthy food and good access to primary health care.

It's not a list that will surprise any of you, and there's strong local and international evidence about the types of things we could do to have a positive impact on people's health. To date, we haven't been very good at putting joined-up, proactive programmes in place, despite knowing perfectly well that, for example, fluoridation of water and limiting the availability of sugary drinks would make a massive positive difference to our national oral health stats.

Health Matters will be a focus for much of ASMS' wider advocacy work over the next year or so. It also forms the basis of our briefing to the incoming government.

Much of your non-clinical commitment is undertaken unpaid, at home, during evenings and weekends. We know that many of you, as well as your families, are fed up with this. We're fed up too.

Meanwhile, we've been working our way through the responses from our membership survey. These data are informing our MECA claim and will also focus our engagement with DHBs in 2021. Other than SMO shortages, which remain your number one concern, many of you highlighted the challenge of accessing protected non-clinical time. We will be working hard to get better traction on this, not only in bargaining but also in our regular JCC meetings with DHB leadership, as well as through our industrial officers' regular interactions with members, clinical leads, and DHB managers.

As you'll be aware, the existing MECA provision recommends that 30% of your working hours (excluding after-hours work) should be non-clinical time (clause 48.2). We know that application of non-clinical time varies, by both service and DHB. We accept that many full-time ED doctors work three clinical shifts and one non-clinical shift each week – effectively, this equates to 25% non-clinical time. We also know that some procedural specialties include non-rostered, non-clinical time, to manage part-timers and allow some flex in clinical rosters.

However, we also know that many of you have no rostered non-clinical sessions at all. Others find that clinical work (both patient-facing and administration) eats up all your 'non-clinical' hours. This means that, apart from meetings, much of your non-clinical commitment is undertaken unpaid, at home, during evenings and weekends. We know that many of you, as well as your families, are fed up with this. We're fed up too.

Over the course of your medical career, you need time to attend to professional learning and development, to teach RMOs and other clinical colleagues, to audit and report, to develop models of care, to have collegial conversations of all kinds, and to think, reflect, plan and dream. Without decent chunks of non-clinical time, your work becomes reactive, less rewarding, more tiring, less enjoyable and less safe.

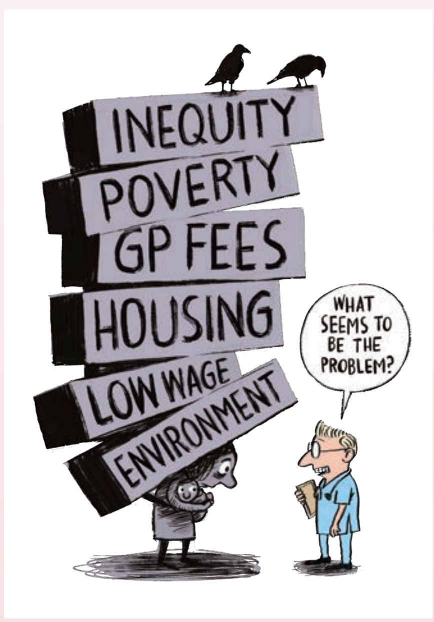
Lack of access to non-clinical time contributes to the massive levels of burnout that continue to characterise the senior medical and dental workforce. We've been talking about this for some time, but now is the time for deeds, not words. We will be focusing our steely gaze on developing and enforcing written non-clinical commitments, as well as on rosters that make non-clinical and recovery time visible and protected. Our industrial team will be working assiduously to get these entitlements locked in.

You can help us. Don't take no for an answer when it comes to accessing non-clinical time. Let us know what your service needs are and how you'd like us to help. We can take on any intransigent managers and support you and your colleagues to develop service agreements that are written and reviewable, and that describe the bottom-line non-clinical and recovery provisions you need to keep your working lives safe and sustainable.

Come February, we will be making all this very clear in MECA bargaining, aiming to strengthen the existing provisions in your favour.

In the meantime, I want to thank each of you for your service to the people of Aotearoa. It's been a huge and, at times, uncertain and frightening year. I hope you will be able to find some time and space to rest, recuperate and enjoy being with whānau and friends. I'll be somewhere along the Milford Track over the New Year, counting my blessings and enjoying some time off-grid before we launch into 2021.

Nō reira, tēnā koutou katoa, me ngā mihi o te kirihimete me te tau hou.



Annual Conference 2020

The full house sign was well and truly up at this year's Annual Conference in Wellington.

175 people filled the Oceania Room at Te Papa while about 15 members attended virtually. For the first time conference registrations had to be closed off early due to the numbers wanting to attend. The 32nd ASMS Annual Conference opened with a silent tribute to all the health workers around the world who have died from Covid-19.

Workforce pipeline

The Conference theme, *Building the Workforce Pipeline, Stopping the Drain,* ran throughout the two days, punctuated by the launch of ASMS' report of the same name. It warns that urgent, co-ordinated action is needed to tackle staffing shortages and future proof the specialist workforce.

Members should have received an electronic copy, but the report is also available on the ASMS website.

The workforce pipeline was the subject of a lively conference panel session. Anna Clark, who heads the Health Ministry's workforce division kicked off by sharing key workforce facts and figures. It was encouraging to learn that the Ministry intends to become more open with the workforce data it holds but measuring it against unmet need is still a work in progress.

Professor Peter Crampton from Kōhatu, Centre for Hauora Māori at Otago University, was very direct in his analysis that our 'settler society's' unequal distribution of wealth and access to care must change. That resonated with keynote speeches on our equity kaupapa. He also said if New Zealand wants to train more doctors maybe it needs a third medical school.

Dr Deborah Powell, representing the Resident Doctors' Association, stressed that the burnout afflicting senior doctors is having flow on effects to the resident medical workforce and called for tangible steps to ensure that SMOs have safe, sustainable work. Dr Richard Storey, vice-president of Specialty Trainees of New Zealand (STONZ) gave a hands-on view of the RMO work from the coalface, reflecting on the need to give more space and time for advanced trainees and SMOs to teach junior doctors.

Orthopaedic surgeon Mr Peter Robertson's remarks, based on his work with the Orthopaedic Association, tackled the problems New Zealand has in ensuring adequate specialist coverage in rural areas, along with the frustration experienced by surgeons who are ready and willing to operate, and who are constrained by lack of theatres, nursing and allied staff.

L-R: Dr Charlotte Chambers, Anna Clark, Mr Peter Robertson, Dr Deborah Powell, Dr Richard Storey, Professor Peter Crampton

Professor Joanne Baxter

Dr Jade Tamatea

Equity kaupapa

A strong focus of this year's Conference was our equity kaupapa and what that means in terms of clinical practice and to ASMS' practices as the union for salaried senior doctors and dentists. Keynote speakers tackled several issues, ranging from who gets to go to medical school, through to the framing used to engage with patients during ward rounds and clinics.

Associate Dean (Māori) at Otago University Professor Joanne Baxter (Ngāi Tahu, Ngāti Apa ki te Rā Tō) asked members to consider why it's important to match our training pathway to our population profile and what the health workforce can do to support equity. She pointed out that an increase in workforce diversity reduces health disparities. "Reflecting our whole society in our health workforce is the right thing to do, it's critical and achievable," she said.

Those themes were expanded by Waikato DHB endocrinologist, Clinical Equity Lead, and Senior Lecturer Te Kupenga Hauora Māori at Auckland University Dr Jade Tamatea (Ngāti Maniapoto, Ngāti Kahungunu). She stressed that "equity is not a problem for Māori clinicians to fix." She appealed to ASMS members to be "unapologetically brave", look at their own clinical cultural safety, "lean into the discomfort" and "use your privilege" to address health equity. For ASMS, she said it is important to address whether equity and Te Tiriti is included in its organisational framework.

Writers who Doctor

The creative talent of doctors was on display during the "Writers who Doctor" session with renowned authors Drs Eileen Merriman, Renee Liang, and Glenn Colquhoun. They each gave readings from their work and spoke about how they turned to writing to help manage the stresses of their medical work and how they juggle two careers. "I do grab any last little minute to write," Eileen Merriman said, describing how she writes on planes, taxis and on her phone in bed. Renee Liang said she often draws on the emotions she sees as a doctor and translates that into her writing. They all agreed that writing used a different part of their brains than medicine and encouraged all clinicians to find a creative outlet to improve wellbeing and work-life balance.

L-R: Drs Glenn Colquhoun, Renee Liang and Eileen Merriman

CME in the post-Covid era

Auckland anaesthetist Dr Marty Minehan beamed into the Conference virtually to challenge members to think about their carbon footprint and CME travel. He said 40% of Auckland City Hospital's carbon footprint in 2019 was from air travel. He gave practical solutions around alternatives such as using CME money to improve technical equipment for a better virtual experience or getting groups together to attend virtual conferences so there is also a face-to-face network for discussions.

Sustainability in digital healthcare

The Chair of the New Zealand Telehealth Group and Waikato DHB Clinical Director of Information Services Dr Ruth Large, alongside Darren Douglass from the Ministry of Health, took the Conference through where digital healthcare in New Zealand is at now, and where it could be in the future. Dr Large said we have grown up in a fractured digital environment with no national platform. She said there is proven value for patients in telehealth and so many new tools which improve accessibility to healthcare. There are also big gaps in digital maturity between DHBs and she urged clinicians to take poor digital literacy on board.

Women's Breakfast in stitches

Dunedin GP Dr Aimee Rondel had women at the Conference laughing into their muesli during her talk at the Women's Breakfast. With a special interest in women's health, Dr Rondel has created dozens of beautifully embroidered uteruses to reflect the narratives of her patients and to describe things like miscarriage, abortion, and endometriosis. That may not sound like a laughing matter but in describing her artwork, her presentation was full of humorous, engaging commentary and anecdotes. Dr Rondel began her embroidery with her *Lady Garden* series but has moved on to her *Pathological Anatomy* pieces. You can see some of Aimee's work by googling 'the embroidered anatomy of Aimee Rondel'.

Dr Aimee Rondel

New Minister outlines his priorities

The new Health Minister Andrew Little addressed the Conference on Day Two, joking that it was only his 25th day in the job and he has a lot to learn about "the complexity and sophistication of the sector".

He also began by acknowledging the work healthcare staff have done in meeting the challenges of Covid-19.

Mr Little said the Government is committed to health sector reform, telling the conference that "there isn't a perfect healthcare system, but we aspire to have a bloody good one".

He said a transitional unit is already working on an implementation plan for the recommendations of the Health and Disability System Review.

"The Government has the mandate to progress these reforms and leading these changes is really my top priority," he said.

Decisions on which recommendations will be implemented will happen in the new year and he said that many of the reforms should be fast-tracked because the system is "crying out for change now".

Touching on the conference theme, Mr Little, who came to parliament from a union background, committed to looking at staffing shortages and prioritising medical workforce planning. "The idea there is no plan for workforce renewal and development seems criminal to me," he said.

Other priorities include improving access to primary health care, easing pressure on crowded emergency departments, closing the gender pay gap in the specialist workforce, along with a very firm focus on health equity. He acknowledged ASMS' recent *Health Matters* report saying it aligned with the Government on the broader social determinants of health.

Mr Little was pushed by members on the issue of sustainable health funding and investment. He responded that some of the significant operational funding increases announced earlier this year would take many years to be felt and ultimately questions over the appropriate level of health spend are a political decision.

Mr Little clearly signalled that the health sector is in for a period of significant change and told the Conference that ASMS' voice is essential.

Members seemed pleased to hear that Mr Little's priorities largely line up with ASMS' but questioned whether he will be able to walk the talk and deliver tangible workforce and workplace improvements and achieve improved health outcomes for New Zealanders.

Hon Andrew Little

Sustainability resolutions passed

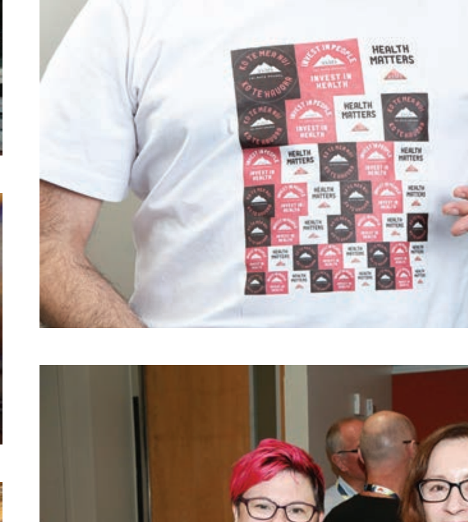
Two resolutions proposed from the floor of the Conference were passed. They came from Counties Manukau DHB members Dr Clinton Pinto and Dr Rob Burrell, respectively.

That ASMS strongly advocate for all DHBs to join Toitū Envirocare.

That ASMS advocate for the establishment of a national Sustainable Development Unit to coordinate and accelerate the health sector's journey to become carbon neutral by 2040.

If you are interested in watching the Conference presentations and the question and answer sessions which followed, we have videos of most of them up on the ASMS website **www.asms.org.nz** under the **Conference** tab. Go and check them out.

Annual Conference



2020 in action

Annual Conference

2020 in action

Membership Survey what's top-of-mind

Dr Charlotte Chambers | Director of Policy & Research

We asked you what you thought and we've crunched the numbers following ASMS' first bi-annual membership survey. The survey was sent out in August and we had a very pleasing 45% response rate.

You told us that accessing non-clinical time, breaks and leave is challenging and shared your concerns regarding access to locums, the hours of work and the adequacy of staffing levels. The information gives us valuable insight as we prepare for next year's MECA negotiations.

We also ran the Copenhagen Burnout Inventory for the first time in five years. Those findings are still being analysed and we hope to report back in depth on them early in 2021.

Key survey takeaways

Non-clinical time: Many of the respondents said that while there is rostered non-clinical time, it is not at the recommended 30% as stipulated in the MECA. Comments suggested a lack of clarity as to what constitutes non-clinical time, as well as growing 'clinical creep' making taking non-clinical time a challenge.

> *"For me personally, and my service, the main issue is getting non-clinical time for myself, but also nursing/AH staff to be able to audit/improve service, etc."*

Access to leave: Comments emphasised lean staffing, as well as difficulties in taking leave because of high workloads.

> *"We are so thin on the ground that although we do cover for each other, it takes very little (e.g. someone on leave and someone off sick) for there to be no available SMO support. For most of the week (when all SMOs are available), there is only one SMO clinically available, leaving the service and SMO at significant risk."*

> *"We are working under a resource constraint environment. We are expected to cover colleagues on sick or annual leave, hopefully with advance notice, but most of the time we don't. We work in a subspeciality that demands ongoing self-improvement and upskilling. We do not have the luxury to do so."*

Hours of work: Most respondents said they worked between 40 and 50 hours per week. In the week before the survey, 26.3% had worked less than 40 hours in total and 15% had worked more than 50 hours. Most respondents (54%) did not work in private practice. Of those who did, most reported fewer than 10 hours of private work per week.

While most had had a 24-hour break free of work, over half had not managed 10 hours or more of rest between scheduled work. Nearly a third had worked more than 14 hours in a single stretch.

Recruitment issues: Responses strongly suggested that recruitment is a pervasive issue. All the specialties surveyed reported issues with recruitment (Figure 1).

Of the 401 overall departments 72.3% reported difficulties with recruitment.

Issues of importance: We asked about your key issues moving into 2021. There were eight possible issues to select, as well as an 'other' option. Figure 2 displays the items, with the most important issue given a ranking of 1. The line displays the mean rank for each item where the lower the mean, the more important the issue.

The survey also pointed to member concerns about relationships with management, safety post-Covid, improving physical working conditions (including provision of office space and safe facilities), improving flexible work schedules for greater work-life balance, issues relating to call work, CME and gender equality.

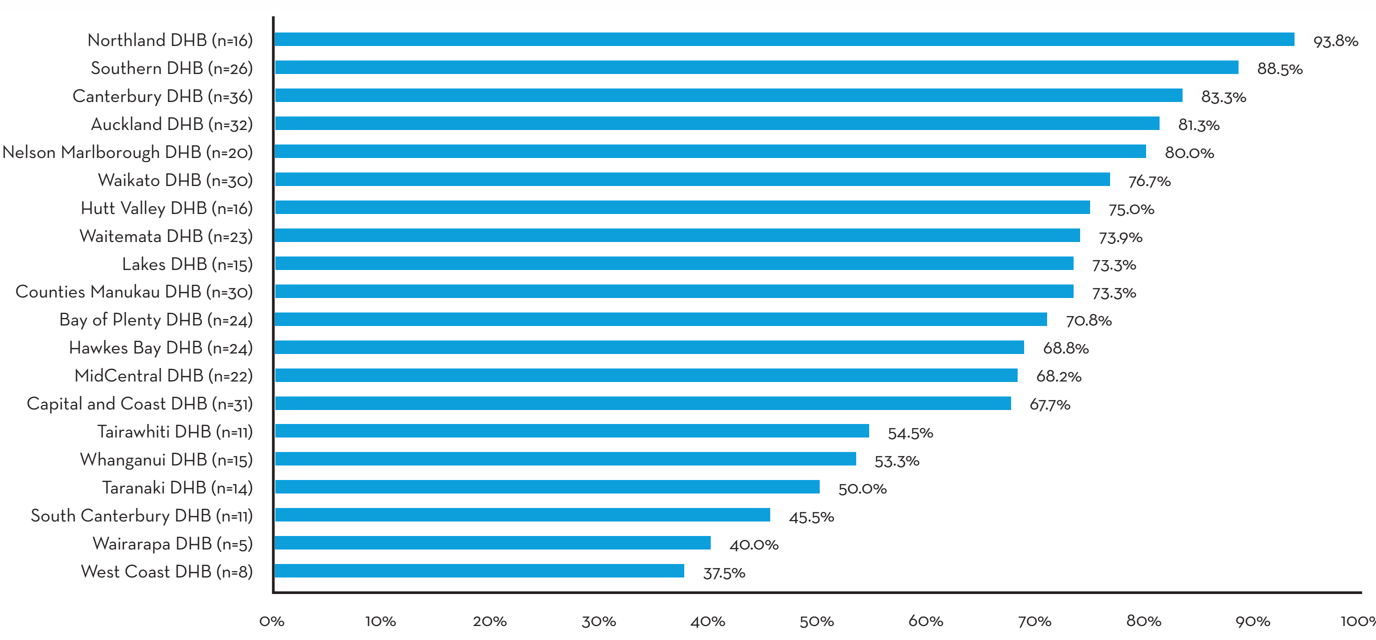


Figure 1: Specialties by DHB with recruitment issues (n = number of specialties represented in survey)

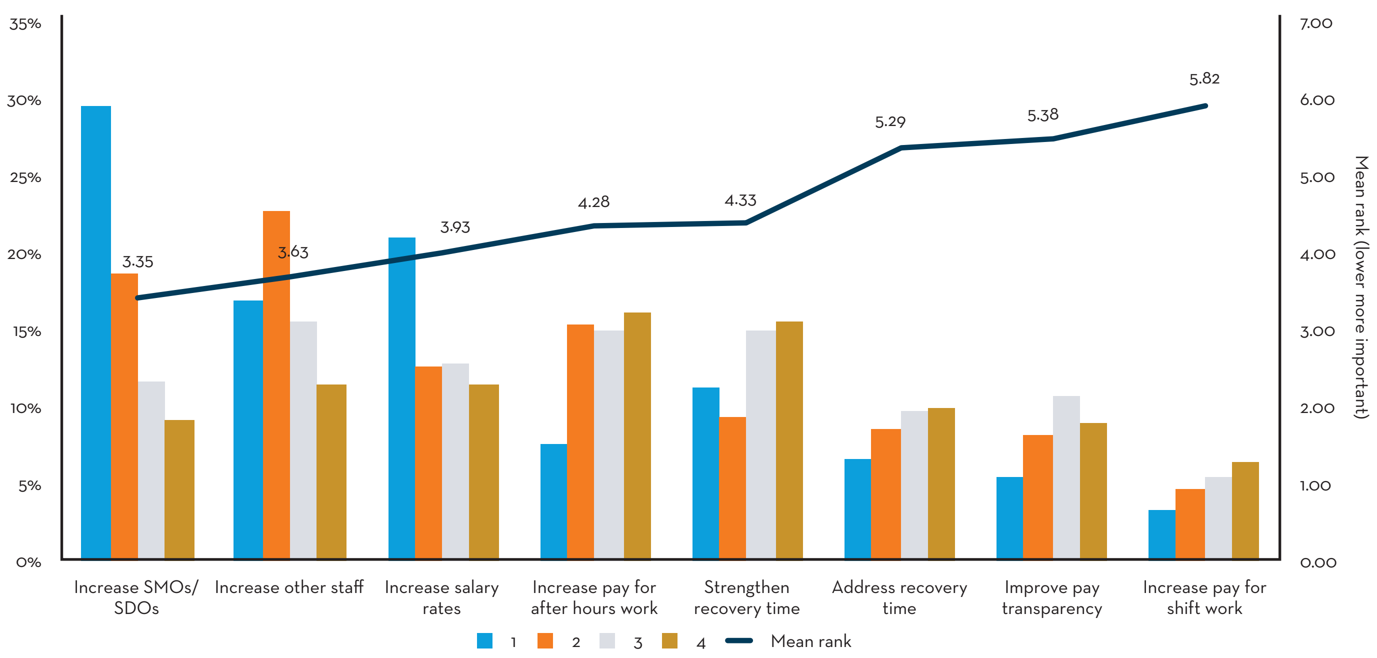


Figure 2: Ranking percentage (top four rankings with average rank of item) on issues of importance for the year ahead (n = 1773).

You said:

"WORK ENVIRONMENT IS NOT CONDUCIVE FOR DOCTORS TO STAY. MORALE IS LOW SINCE COVID, IMPACTING WORK CULTURE NEGATIVELY."

"I currently work in a tight, cramped, shared office space (with no door) which is in a busy thoroughfare. I have no peace and quiet, no private space and I am having increased pressure to put through more and more work - yet I am not being provided with the environment in which to make safe diagnoses."

"The physical work site in our ED is a third-world sweat shop. No physical distancing, dirty, not enough computers or sit-down space, noisy, cold, etc."

"I WOULD LIKE TO SEE MORE FAMILY-FRIENDLY WORKING ARRANGEMENTS AND POLICIES DEVELOPED; E.G., FLEXI TIME (ESPECIALLY AROUND SCHOOL HOURS AND HOLIDAYS)."

"AS A FRONTLINE WORKER, I AM CONCERNED AT THE RISK OF ACQUIRING COVID, MOST LIKELY FROM OCCUPATIONAL EXPOSURE. I AM NOT CONFIDENT THE HOSPITAL WILL LOOK AFTER ME OR FRANKLY, EVEN CARE."

"Management does not seem to address reasons why people leave the service, rather just filling gaps as they arise. Internal audit would be helpful in understanding physical wellbeing and capacity to do work safely, efficiently and optimally due to decreasing resources."

"THERE IS NOT A FAIR DISTRIBUTION OF WORK IN MY WORKPLACE, AND NO TRANSPARENCY AS TO HOW NEW WORK IS ALLOCATED. I BELIEVE THERE IS SEXISM AND AS A WOMAN, I GET THE THINGS THE MEN DON'T WANT TO DO."

"The huge number of extra hours we're having to work aren't recognised in any way. It doesn't have to be financial; they just need to be recognised and then ameliorated."

Dr Peter Doran

When DHBs collide

Elizabeth Brown | Senior Communciations Advisor

One of the most high-profile recommendations in the Simpson Health and Disability System Review is to reduce the number of District Health Boards. This is causing more than a little disquiet.

The new Health Minister, Andrew Little, told the ASMS Annual Conference that critical decisions on the Simpson Review recommendations will be made early next year and he would like to see reform fast-tracked.

The Review, which was released in June, envisaged the recommendations would take up to five years to implement fully.

"In my view, we should take 18 months to two years to make foundational changes that we need to make, so that work in establishing processes and culture can then begin," Mr Little told the Conference.

An implementation team has already been put in place, led by former Director General of Health and former CMO of the Counties Manukau and Hutt Valley District Health Boards, Stephen McKernan.

Under the Simpson Review, the number of DHBs would be reduced from 20 to between 8 and 12. It argues that would lead to operational policies being applied more consistently, better regional planning and collaboration, increased efficiency and better use of scarce expertise.

It is likely that every DHB will be affected in some way.

"It can only be bad for us, certainly from an autonomy and local decision-making point of view. There is also a big impact on the community if services are lost to the bigger hospital."

Caught in the middle

South Canterbury DHB is the only DHB in the country without a deficit. Geographically, it is sandwiched between two DHBs that are having well-publicised organisational and financial problems – Canterbury and Southern.

"It seems wrong and alarming that a high-functioning DHB would be forced to join with one of those," says anaesthetist and ASMS Vice President for South Canterbury DHB, Dr Peter Doran. He lists his three main concerns as reduced access to management's attention and interest, loss of services for South Canterbury and erosion of the excellent culture throughout the South Canterbury DHB.

"It can only be bad for us, certainly from an autonomy and local decision-making point of view. There is also a big impact on the community if services are lost to the bigger hospital. It would make our lives a lot more difficult to have to get answers to questions from Christchurch, say, especially around service development and new initiatives. Management would be a long way away – they don't know you and don't care about you as much, because you're not on the same site."

A failed attempt

Wairarapa DHB knows how that feels, after a failed push by the National

Dr Norman Gray

Government in 2012 to have Capital & Coast, Hutt Valley and Wairarapa DHBs share services and management, under what was known as the 3DHB programme.

"There's been an attempt to swallow us up before and people are very much against joining up with bigger health boards, based on that experience," says Dr Norman Gray, an emergency medicine specialist and ASMS Wairarapa Branch President. He believes it is inevitable that the smaller region ends up losing services and their patients miss out.

"Things like radiology services in the Hutt, which are already struggling with their own population, are expected to cover for ours as well. You add another 40,000 plus patients from the Wairarapa and the system just can't cope."

Under any plan to cut DHB numbers, Wairarapa staff would be happier looking to a regional marriage with MidCentral DHB.

Dr Gray says "They don't want to go back to the Wellington/Hutt combination and would prefer to go to Palmerston North as part of a combined central region. We share experiences as smaller DHBs and it's easier for patients and families to get to".

A worrying blueprint

Some specialists at Hutt Valley DHB are concerned that moves to appoint one executive leadership team across both Hutt Valley and Capital & Coast DHBs could be used as a blueprint or model for regional mergers. The two DHBs already share a single Chief Executive and a move to appoint a single CMO has begun.

"There's been an attempt to swallow us up before and people are very much against joining up with bigger health boards, based on that experience."

The single-CMO consultation process has sparked dissatisfaction and criticism. SMOs say a new structure for clinical leadership should be developed in partnership with clinicians, rather than being imposed. A key worry is that the positive clinical things happening at Hutt Valley DHB will become lost and the needs of the Hutt community will not be heard.

Lessons may also be learned from the 2010 merger of the Otago and Southland District Health Boards into the Southern DHB. Covering a large geographical area with two hospitals a long way apart, there have been multiple changes of leadership, differing employment conditions for staff and significant financial and service delivery difficulties. While Dunedin is getting a new hospital and the DHB is facing a growing deficit, there is no money available to upgrade the ailing and cramped Southland Hospital.

ASMS President Professor Murray Barclay believes cutting down on the number of DHBs should not be a priority for the Government. Rather, it should focus on underinvestment in the workforce and buildings, as well as addressing unmet needs, access to primary care, health equity and the establishment of a Māori Health Authority.

"Changing structures at this stage will have no material benefit to staff or patients and will just cause widespread disruption," he says.

The case for a Minister for Public Wellbeing

Lyndon Keene | Health Policy Analyst

The ASMS publication *Health Matters – Framing the full story of health* recommends establishing a Minister for Public Wellbeing, with a dedicated Ministry, to address the social determinants of ill health and health inequities. Health policy analyst Lyndon Keene outlines the rationale for this and discusses some of the key elements required to make it work.

A scan of the international literature about why public health so often struggles to rise above its Cinderella status shows that this is not for a want of good policy and intent. For example, the New Zealand Health Strategy 2000 contained every policy it needed, reinforced by a comprehensive list of public health goals and objectives, as well as an all-of-government action plan. Where things tend to slide away is in the *implementation* of public health policy. Limited and unstable funding, lack of automatic means to track and improve performance, workforce limitations, politically motivated short-term policy approaches, and opposition from powerful interest groups, can all cause public health programmes to fail.

Addressing the determinants of ill health requires a coherent political response, along with strong and sustained collaboration across a broad range of government agencies, NGOs, the private sector and communities. In New Zealand, the Health and Disability System Review hands responsibility for leading this response to the Ministry of Health, "which must utilise all its available levers to influence policy change across numerous sectors".

New approach needed

However, this lead-Ministry approach has not worked well so far. The 2018 Mental Health Inquiry, for example, found a lack of strategic leadership in central government on wellbeing, illness prevention and tackling the social determinants that impact on multiple outcomes – not just mental health. It said, "Multiple agencies are engaged in fragmented and uncoordinated activities…".

The Ministry of Health is already struggling to put its own house in order, let alone having to deal with multiple issues across government sectors. Aside from facing increasing health service needs and substantial unmet need, it must rebuild its neglected public health services and infrastructure, which have had a 33% real per capita budget cut over the last decade.

Further, whatever 'available levers' the Ministry has in theory, they are unlikely to succeed in changing policies in other government departments without the support of Ministers, especially where there are political or resource ramifications. This kind of cooperation can only be driven by Cabinet. For example, when concerted whole-of-government action was needed to tackle entrenched child poverty rates, a new senior Minister position with responsibility for this was established. This occurred again in 2020 when action was needed to better coordinate a multi-sector response to Covid-19.

A senior Minister for Public Wellbeing would help to ensure public health

remains visible and high on the Government's agenda. Their role would be to stimulate cooperation and coordination with other Ministers so that the issue of public health is considered across all other relevant policy areas.

Sweden established a Minister for Public Health in the early 2000s, with a role of coordinating policies and actions with other Ministers and overseeing an inter-sectoral National Steering Group for implementing the policies, including the directors-general of all the relevant government agencies.

A dedicated standalone Ministry

To implement public health policy effectively, a Minister of Public Wellbeing would require critical support, backed up by a dedicated Ministry that could provide the technical, economic, legal and policy resources. This Ministry would facilitate a stronger, integrated approach to policy making and implementation, including 'Health in All Policy (HiAP)' approaches that ensure health and health equity considerations are part of decision making. According to the World Health Organisation, a HiAP approach is unlikely to succeed if there is no institutional or organisational presence in favour of it within the government.

A new Ministry could also develop and oversee wellbeing legislation and regulations, as well as support other Ministries' budget bids for public health initiatives. As a new entity, it would be well placed to advance the reforms introduced under the Public Service Act 2020, which aim to support genuine whole-of-government action by shifting agencies from working as single departments to working as a unified public service on specific issues.

Interestingly, the 2018 Mental Health Inquiry similarly found the need for a 'social wellbeing agency' and made it a key recommendation for providing leadership and strategic policy advice to the Government on investing in illness prevention across a range of portfolios. It would facilitate a robust programme of research and evaluation, as well as working with other agencies, "particularly the Treasury", to address systemic barriers to investment in illness prevention. Notably, the Inquiry found it "important that the function is not co-located in an agency where service delivery or operational demand pressures would compete with the whole-of-government strategy and policy focus".

The last Government rejected this recommendation, although it is not clear why.

Parliamentary and legal backing

An enduring whole-of-government public health plan, with strong parliamentary backing, would be needed to address the social determinants of ill health and health inequities. It would need to be developed through broad public consultation, including all parliamentary parties, relevant state agencies, local authorities, NGOs and public health professionals. Most of the public health goals and objectives of the New Zealand Health Strategy 2000 would be a good starting point.

The introduction of an 'Avoidable Ill Health Reduction Act', along the lines of the Child Poverty Reduction Act 2018, would provide a useful legal framework for achieving political accountability against published annual targets and indicators. Such legislation could require all relevant government policies and legislation to include health impact assessments (HIAs) to identify the potential impacts on wellbeing and health of any proposed policy, strategy, plan or project, along with appropriate actions to manage those effects. The Ministry of Health website says, "ideally policy-makers and planners across all public sectors should use HIA". International evidence points out that laws that are not mandatory are often not implemented.

Social spending and health inequity

Finally, all of this is dependent on adequate resourcing – and for that, a quantum leap in funding across all social services is needed. The Government has identified the need for setting budgets that balance wellbeing factors with economic factors. There is plenty of evidence showing that health and social equity are drivers of wealth. However, the OECD says that New Zealand's stark rich/poor divide took more than a third off the country's economic growth rate between 1990 and 2000.

The Government's vision for New Zealanders' equality and wellbeing, as outlined in its 'Wellbeing Budgets', notes that the Scandinavian countries – Denmark, Norway and Sweden – act as a good point of comparison. In 2018, all three countries were ranked in the top seven in the United Nations Development Programme's inequality-adjusted human development index. New Zealand was ranked 18th. Their levels of government social spending, as a proportion of GDP, are on average 40% higher than New Zealand's (Figure 1). Their health and social care workforces, as a proportion of their total workforces, are 40% to 90% bigger than New Zealand's.

Eliminating health inequities is a core public health principle. Addressing them is the right thing to do. It means the long-term under-investment in health (and the social determinants of health) must be reversed.

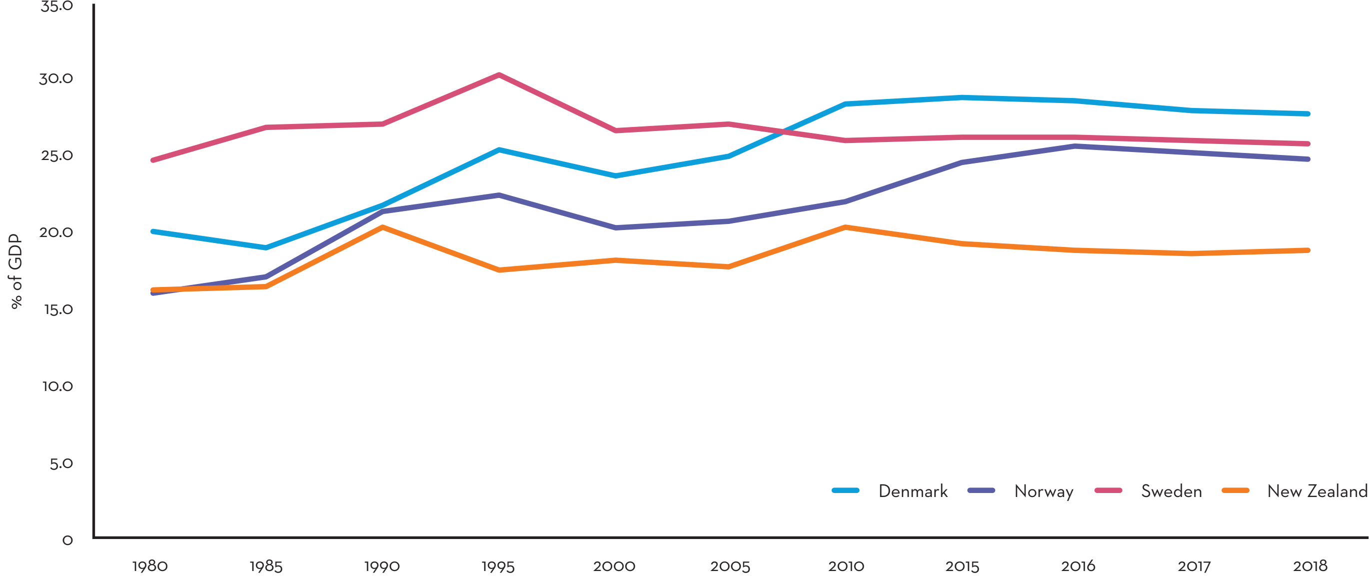


FIGURE 1: PUBLIC SOCIAL EXPENDITURE TRENDS FOR SCANDINAVIAN COUNTRIES AND NEW ZEALAND, 1980 TO 2018.

Sensitivity and legal know-how

Elizabeth Brown | Senior Communciations Advisor

At Auckland's Pohutukawa Clinic, visitors looking around the medical examination room are asked to sign a register, just in case they leave behind any traceable DNA.

The clinic is the heart of the Adult Sexual Assault and Treatment Service (SAATS), which provides a regional service for the 1.6 million people between Wellsford and the Bombay Hills. It offers a 24-hour service for adults affected by alleged sexual assault and abuse. Its clinicians understand the specific forensic requirements and sensitivity needed to provide medical care and support to their patients. They work in a unique environment where medicine, police and the law constantly collide.

Dr Anne Laking is the Service Lead Clinician and a compassionate advocate for the wellbeing of the patients she sees. Most are extremely vulnerable and distressed. They are often referred by the police for a forensic examination after a recent alleged sexual assault. The focus is on gathering information for a possible police investigation, including collection of forensic specimens and providing wrap-around crisis and counselling care. Dr Laking says helping a patient through that difficult time is very rewarding.

"I usually go to court about four times a year, appearing as an expert witness."

"I always feel no matter what the outcome of the police process might be – whether the case goes to court, or whether the alleged offender is, in the end, found guilty or not – what I can do for the patient at the beginning is to make that first experience positive and really empower them."

The other key focus is on therapeutic medical examinations if the patient does not want to involve the police or presents outside the forensic time frame. These examinations are largely defined by the patient's medical and emotional needs, questions and concerns. These patients are often transitioned into counselling.

The Pohutukawa Clinic saw a 15% increase in forensic cases last year. It is not unusual for three or more new cases to come in over a 24-hour period. Dr Laking believes that more reporting of sexual assault and an increased awareness has driven this rise. Unfortunately, with no extra staffing to match the increase in cases, staff are regularly putting in extra hours. There is a small day-time team made up of six doctors and four nurses who all work part-time, along with a larger, 24/7, after-hours on-call team. Around 70% of the forensic cases are seen after hours. Dr Laking explains that much of the work involves liaison with other services and follow-up, and there are a lot of phone calls.

"After the initial examination we ensure that our patients are safe, referring them to support agencies, counsellors, putting family violence alerts in place and talking to police. Follow-up includes phone calls and appointments after one week, one month and three months, to ensure they are well supported and check for any acute or post-traumatic stress disorder."

Another large part of the senior clinical role is writing formal police statements and giving evidence in court.

"I usually go to court about four times a year, appearing as an expert witness," Dr Laking says. "A lot of what we do is to dispel myths. It is still a common misconception that any non-consensual sexual contact will result in a visible injury that clinicians can see, and that is not always the case and it's important that jurors understand that."

She says giving evidence in court can be daunting but there is good training, support and mentoring through their professional body MEDSAC – Medical Sexual Assault Clinicians Aotearoa. It includes court prep, role playing and expert review of written formal statements.

Sexual assault medicine is not yet a vocational specialty and most specialists come from a related field, such as family planning and reproductive health, sexual health, or general practice.

"That's tricky because there is no real set career pathway and succession planning is difficult. The number of doctors doing this type of work is quite small, but demand is growing," says Dr Laking.

As well, a stigma is still associated with sexual assault, which affects the resourcing of the service, and clinicians can often feel marginalised.

"We care for patients at a very vulnerable time and empower them and help them on their journey to recovery."

Sexual assault medicine as a speciality is relatively new, and Dr Laking recently completed a Master's in forensic medicine to expand her knowledge. There are also important developments to keep on top of, such as a 2018 law change around a new offence of non-fatal strangulation, which will have future workload implications. Trying to grow the quality of care given also includes better targeting of Māori and Pasifika patients, along with improved clinical facilities.

Dr Laking says sexual assault medicine is very rewarding.

"We are part of an amazing team of doctors, nurses, crisis support and police. We care for patients at a very vulnerable time and empower them and help them on their journey to recovery."

Dr Anne Laking

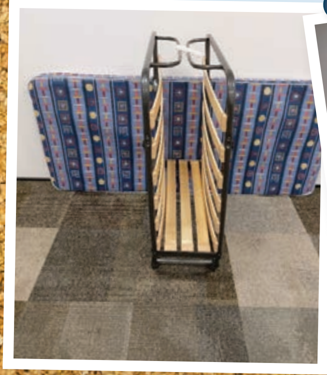
ASMS Working Updates

CME in the Covid-era

ASMS members are increasingly concerned with the carbon impact of air travel. While ASMS encourages the thoughtful development of sustainable practices throughout the health sector, we are not suggesting that air travel must end. We have recently put together a Covid-era CME discussion document which has been sent out to members. It is still being developed but suggests ways of using CME differently and creatively, in relation to sustainability and during this time of Covid travel disruption. We'd love to know your thoughts and get your feedback.

A better night's sleep

Our June Specialist story *Losing Sleep: the fight for better on-call accommodation,* highlighted poor overnight SMO accommodation in so many DHBs. We know for members in some services and hospitals, it is non-existent. But after much lobbying and advocacy by members at Northland DHB and ASMS industrial officer Miriam Long, there is now a quiet room with a proper bed available for O&G SMOs, next to the birthing unit at Whangarei Hospital. While this room does not meet the standard described in the MECA, it is certainly better than the camp bed in a shared staff area that preceded it. The fight for proper overnight SMO accommodation continues in other DHBs, and ASMS' message to DHBs is to remember to factor in staff sleeping accommodation when you renovate and undertake new builds.



Holidays Act

Work on Holiday Act remediation is finally gaining some traction in terms of getting national responses to common issues emerging from the 20 DHB working groups. However, some of the DHB representatives do not seem to have a good grasp of what a "bipartite approach" means, so the unions are having to undertake some education work along the way. ASMS understands that Northland DHB is nearly at the point of being able to remediate (pay out) staff, but most other DHB are some way off. ASMS has also been advised that Treasury is unwilling to release funds until it is confident that rectification (repairing the payroll systems) has occurred. This means it is likely that no one will receive backpay until their DHB is considered to be compliant.

Living Wage Employer

ASMS is proud to be an accredited Living Wage Employer. We hope that in the next year or so many DHBs will join us.

CMO appointments

A number of DHBs will be recruiting new CMOs in the very near future, for example Bay of Plenty, West Coast, and Capital & Coast. These are key SMO appointments and ASMS wants to ensure members have input. Your local staff association is one avenue for this. You can also check in with your local ASMS branch officials and your local industrial officer if you have comments, questions, or concerns.

Taking the lead on SMO wellbeing

Dr Joanna Sinclair | Anaesthetist and SMO Wellbeing Officer

Dr Joanna Sinclair is an anaesthetist at Counties Manukau DHB – she is also its first-ever SMO Wellbeing Officer. She explains how the role came about and the work she is doing.

In 2018, concerned about the high levels of distress I observed in my colleagues, I asked the consultant anaesthetists at Counties Manukau Health to complete the Mayo Clinic's Well-Being Index survey. It is a simple, nine-question tool that screens doctors for burnout, fatigue, distress. The response rate was close to 100% in my very large department and the results were sobering. I was then asked to survey all SMOs at Counties Manukau, and found similarly high rates of burnout, fatigue and mental health concerns.

After almost a decade working as an anaesthetist at Counties, functioning as the departmental wellbeing advocate and learning all I could along the way about doctors' health, I believed the following to be true:

- Doctors are generally very resilient – if they are distressed, it is probably something about the circumstances they are having to work in.
- Doctors are not good at admitting they need help.
- As doctors, we are becoming less connected to each other in the way we work; but connection and belonging are basic needs.
- Burnout, moral distress and fatigue are issues common to doctors in all specialties.
- These issues do not affect just doctors.
- The return on investment in staff wellbeing programmes is well established.

With all this in mind, I shifted my focus to organisation-level wellbeing initiatives. I consulted with colleagues across different specialties, as well as with our Chief Medical Officer and HR Director. I then submitted a report on the survey results to our Chief Executive, along with a proposal that a new role of SMO Wellbeing Officer should be established. Eighteen months later, I started as 'SMO Wellbeing Lead', working out of an office in HR for three sessions per week, along with four sessions per week of clinical work.

My first responsibility was to launch the Wellbeing Index and associated app for all SMOs. Just as I was settling into my new office, the Covid pandemic hit and my focus quickly changed to the wellbeing of health care workers.

We did launch the Wellbeing Index survey in April, with data collected over a four-week period, mostly during the Level 4 lockdown. It suggested a significant improvement in wellbeing over that month. As we know, although we were preparing for a flood of Covid patients, that didn't happen in New Zealand. Our hospitals were quieter, elective surgery was on hold and as no one was taking leave, there were more staff on the floor. Interdepartmental co-operation increased and SMOs were involved in planning and decision making. All these things feed into the autonomy, purpose and mastery that are so important to the meaning and satisfaction a doctor derives from their job.

Unfortunately, that didn't last. The second set of data, collected when we were back to 'business as usual', suggested a return to the usual state of wellbeing. However, more importantly, it showed that the app was giving our senior doctors an opportunity to think about their own wellbeing, and how and why it can change over time. It was also providing them with local resources to help them identify steps to improve their wellbeing.

We have been busy working on introducing some new programmes that aim to increase connection, belonging and meaning for all staff. In December, we will pilot the first of these programmes (Schwartz Rounds), focusing on the human dimension of health care. Open to all Counties Manukau Health staff, it will provide an opportunity, in a safe and confidential space, to share experiences, thoughts and feelings on compelling topics or actual patient cases. This practice has been shown to decrease feelings of stress and isolation, improve teamwork and communication, and increase insight into the social and emotional aspects of patient care.

We hope that the investment that Counties Manukau Health is making in staff wellbeing, as well as in my role, is viewed by our SMOs as a step in the right direction.

Dr Joanna Sinclair

Dr Annemarie Mitchell

Dr Anna Elinder

Striking the right balance

Elizabeth Brown | Senior Communciations Advisor

There was a large turnout at the joint ASMS DHB SMO engagement workshop at Waitematā DHB last month, after plans to hold one earlier in the year were disrupted by Covid-19.

At least 75 people came in person, while another 35 or so joined via Zoom. Chief Medical Officer Dr Jonathan Christiansen commented that it was the largest turnout he had seen, and introducing the remote option had worked well. Waitematā DHB is the largest elective surgery provider in the country, has the largest domiciled population and employs a total of 583 SMOs.

Workshop attendees heard organisational, building and financial updates from CEO Dr Dale Bramley and new Chief Operating Officer Mark Shepherd, along with briefings on the Covid-19 response and the shift to telehealth. The liveliest discussion was around CME in the post-Covid era, which was led by ASMS Branch President Dr Jonathan Casement and Vice President Dr Keat Lee. SMOs shared their experiences of attending overseas conferences virtually, expressing frustration over time differences, technical difficulties and the lack of human interaction. It was agreed that some new and creative approaches towards professional development should be explored.

Several attendees offered their comments about the engagement workshop. Intensive care specialist Dr Annemarie Mitchell found the workshop informative, but she believed in future, there needs to be more open and honest discussion on topics that SMOs want to raise.

Haematologist Dr Anna Elinder said it was useful, especially because collegial opportunities for SMOs have been so rare this year. To make the workshop more interactive, she suggested making a chat option available in the auditorium, similar to the one available to Zoom participants, so people could type in questions during a session without the pressure of getting up to a microphone. They could do this anonymously if they wished.

Waitematā Branch Vice President Dr Keat Lee, Branch President Dr Jonathan Casement and CMO Dr Jonathan Christiansen address the workshop

Dr Jonathan Christiansen said his takeaway from this first workshop that he had curated as CMO was to find a better balance between the informational DHB sessions and the round-table sessions that offered open discussion and engagement. He thought next year's engagement workshops could offer some really interesting topics, such as medical ethics around the End of Life legislation, the restructuring of the health sector under the Simpson Review, and SMO wellbeing.

ASMS says ideally, each DHB should have annual (or at least biennial) engagement workshops to allow SMO/SDOs and management to exchange their views and ideas. Members should talk to their industrial officers to get engagement workshops underway in their DHBs.

with Dr Morgan Edwards

Dr Morgan Edwards is an anaesthetist at North Shore Hospital in Auckland. She is a women's health advocate and social media influencer with over 17,000 Instagram followers.

What inspired you to get into your field of medicine?

Anaesthesia drew me in, with its allure of exciting applications of pharmacology and physiology, real-time changes, exciting surgeries, trauma and transfer. But what's ended up being its immense pull is the clichéd but very real ability to truly, positively, impact someone's surgical journey. I am incredibly passionate about making a material difference, specifically to outcomes for kiwi parents on their journey through pregnancy, birth and beyond. Anaesthetists are uniquely positioned to walk alongside women during their most intimate and emotionally charged birthing moments (especially in the emergency setting) and I take immense pleasure in working to make these moments the best they can be.

What are some of the most challenging aspects of the current health environment?

I firmly believe that we have one of the greatest health care systems in the world, in terms of what we achieve with what we have. I am especially proud to be an SMO at Waitematā DHB, which supports health innovation and displays immense digital leadership. Delivering health care through a pandemic has been a challenge nobody saw coming, but by pivoting quickly and pushing 'play' on pipeline projects, we were able to serve our community much better than we imagined possible. Taking the lessons learned from Covid-19 and applying them to 'business as usual' is the challenge we now face.

On a national level, we are plagued by the inequity of health outcomes in Aotearoa. There is an imperative for the Crown, under Te Tiriti o Waitangi, to promote and protect the health of Māori. An immense cultural shift is needed to achieve that.

What's your passion?

Improving patient access to reliable information. Whether it's understanding more about their surgical journey or information gathering ahead of an upcoming labour and birth. We know our patients do better when they are better prepared. Historically, doctors (and especially anaesthetists) have been invisible to the public outside of clinic appointments or brief on-the-day conversations. Further, the perioperative journey is often shrouded in mystery, which allows gaps in knowledge to be filled with anecdote or imagination. I'm very lucky to work alongside clever and similarly passionate people to help bridge that gap.

How did you become a social media influencer?

Entirely by accident! At the start of 2020 I had a few thousand followers and mostly spoke about obstetric anaesthesia. Frustrated with the gross misinformation spread about labour-pain coping strategies, I decided to create a website myself, and I used Instagram as a means of sharing this with New Zealand women. When Covid-19 hit, my followers began asking questions about the virus and more specifically, about the response here in New Zealand. I found myself answering questions and explaining the tools and information provided by the Ministry of Health. I think simply by being approachable and breaking down information into digestible pieces I was able to provide reassuring information to my rapidly expanding list of followers! I've covered topics ranging from vaccination to breastfeeding and alcohol. Instagram, in particular, allows me to carefully consider my responses, usually in collaboration with colleagues. For me, this has truly highlighted the potential for using social media to engage with our communities.

What keeps your happy outside of work?

My wonderful husband Ryan and our two fantastic children, Henry and Bean (Maeve), which is fortunate as we've spent a lot more time together this year than I would've imagined! I also love my daily F45 sessions, photography and being outdoors. My ideal weekend would combine all of it together: being together in our new camper trailer beside a stream in the bush, exploring, and ending the day with toasted marshmallows beside the fire.

Why did you become involved with ASMS?

I've been an executive on the New Zealand Society of Anaesthetists since 2016 (when I was a trainee rep). There, I quickly learned the value of advocacy and community within medicine. The work that ASMS does, not only in promoting the importance of equitable health care access for all New Zealanders but also ensuring fair workplaces for SMOs, is vital and requires support. On a more personal level, I have relished the opportunity to work alongside ASMS with their NZ Women in Medicine Facebook page. What started out as an idea has flourished into a vital space of collaboration, growth and community.

Discovering Wellington's great outdoors

Dr Kelly Phelps at her 'office' at the Ministry of Health

A very homegrown sabbatical

Elizabeth Brown | Senior Communciations Advisor

When the Covid pandemic put paid to Dr Kelly Phelps' planned sabbatical in Argentina, she decided to do something different and, more importantly, close to home.

The emergency medicine specialist at Whakatāne Hospital hung up her scrubs and headed to the Ministry of Health in Wellington for a taste of life as a public servant.

Originally from the US and having arrived in New Zealand in 2009, Dr Phelps felt she didn't know a lot about the Ministry, or government in New Zealand in general. She also wanted to understand the interface between the Ministry and her own workplace better.

"I'm a kiwi citizen now, so I thought it was time," she says.

"I went back home with a fuller understanding of how the Ministry operates and made some really good connections."

She contacted the Chief Medical Officer of Health, Dr Andrew Simpson, to set the wheels in motion. He welcomed her call.

"Many people have the impression that people do sabbaticals overseas, but a sabbatical is about widening your experience, getting new insights, learning new skills," he says.

"Often, as clinicians we're really focused on service delivery for the patient in front of us, or the environment we work in. Working with a central agency can provide some wider context, and you can learn about the functions of the Ministry and the machinery of government."

Dr Phelps arrived at the Ministry in June and spent about a month there. She describes it as an interesting time, as staff were beginning to filter back into the building after the Covid-19 lockdown. Fresh from her experience of working through the Whakaari disaster, she was keen to meet with disaster response officials, along with workforce and Māori health teams.

She enjoyed meeting new people, making new friends, getting away from shift work and being able to enter a completely new, non-clinical environment. She also enjoyed discovering the Wellington region and taking advantage of everything on offer in the capital.

"I got to take the time to process Whakaari. I was able to review some national and regional guidelines around emergency response and disasters, have some input and bring a clinical lens, which was really appreciated."

She also became involved in some Covid-based work as new policies were being drafted, and she studied documents that she says, "I would never have had the chance to read otherwise".

"I went back home with a fuller understanding of how the Ministry operates and made some really good connections."

Dr Andrew Simpson says it's a win-win situation for everyone.

"We get access to expertise and experience and we get to understand each other and look at ways we can work together. It also gives increased transparency around the Ministry and knowledge in the sector about how things operate."

The Ministry covers a wide range of activity that people may be interested in, including the Covid-19 response, regulatory implementation and monitoring (e.g. End of Life Choice), service delivery and development, including community care, ethics and so on. There are 12 directorates at the Ministry, covering a wide range of issues (Office of the Chief Clinical Officers, Mental Health, Data and Digital, and others), and we are happy to be approached to discuss opportunities.

"There's a huge wealth of stuff to get involved in and we would welcome people to come and join the Ministry for a period of time because it actually helps the expertise in house as well."

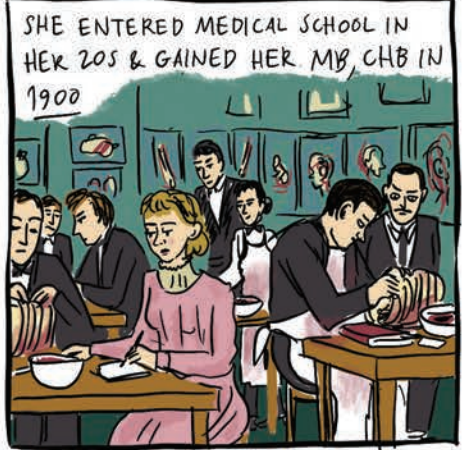
"There's just a huge wealth of stuff to get involved in and we would welcome people to come and join the Ministry for a period of time because it actually helps the expertise in house as well."

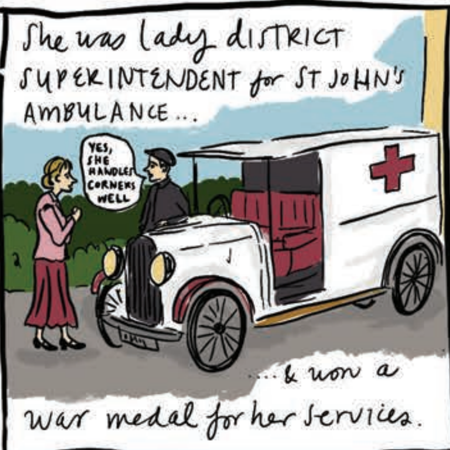
As Covid-19 will continue to put the brakes on sabbaticals well into next year, SMOs may increasingly want to look at homegrown opportunities.

Sabbatical leave is covered under Clause 36.5 of the ASMS-DHB MECA and there is specific advice *Sabbatical and secondment – MECA 2020-2021* on the ASMS website in the publications section, under Standpoint & Advice.

Women in medicine

BY SARAH LAING





The New Privacy Act 2020

Jenny Gibson | Barrister Medical Protection Society

The Privacy Act 2020, which came into force on 1 December, is designed to protect our information and the information that we hold about others. This is the first major overhaul of the original Privacy Act since 1993.

The following four changes may affect doctors:[1]

- Serious breach notification is mandatory.
- Access determinations can be ordered by the Privacy Commissioner.
- The Privacy Commissioner can require compliance.
- There are new criminal offences, with fines up to $10,000.

Mandatory breach notifications

Before 1 December 2020, notifications to the Privacy Commissioner (OPC) were discretionary. Now, if your agency (or you personally, if you are running a consultancy) becomes aware that there has been a serious privacy breach (i.e. likely to cause serious harm), it is mandatory to report it. Health information is generally viewed as being sensitive, requiring careful security; therefore, a breach of this information should be viewed as reportable.

Notification must be made as soon as is practicable to the OPC, as well to the patient or individual (except for some very limited exceptions). The anonymous OPC tool, Notify Us,[2] can assist with determining the nature of a breach and guiding you through the process.

An automatic privacy breach may be found if you fail to, or choose not to, notify the OPC, even if you have managed the breach yourself. Until further case law guidance is developed, you should discuss all serious privacy breaches with your indemnifier and complete the Notify Us tool.

Access requests, corrections and determinations

Doctors will be familiar with requests for patient notes (access)[3] and/or requests for correction of the medical record.[4] You still have 20 working days to respond to an access or correction request. There are more grounds to consider if you are exercising the discretion to withhold information, including protection of an individual. You are still required to notify the requestor if you withhold any medical records and the legal grounds for this, as well as their right to complain. The correction of medical records remains discretionary, but the requestor must be notified of the decision, the reason for any refusal and their right to complain. Statements of correction (i.e. an attachment from the patient, setting out the reasons for the request) must be considered if requested, or as an alternative to a refusal to amend a record.

A failure to respond to a request for access or correction within the 20-working-day period is still an interference with the privacy of an individual. If the OPC considers you have failed to address an access request appropriately, they can issue

a direction to release information and you must comply. Access directions can be appealed but noncompliance is a criminal offence with a fine of up to $10,000.

Compliance powers

Previously, the OPC could only make recommendations – now, the office has compliance powers. It can issue a compliance notice requiring an organisation to meet its obligations or to stop it from doing anything that is in breach of the Act.

New criminal offences

Several offences are now specified and a person or organisation may be liable for a fine of up to $10,000 if they:

- obstruct, hinder or resist the OPC without reasonable excuse
- fail to comply with a requirement of the OPC
- mislead or provide false information to the OPC
- falsely represent an authority under the Act
- impersonate an individual to obtain access to, use or destroy that individual's information
- destroy documentation after a request has been made.

Finally, some of the privacy principles relating to health have been amended. For example, you can collect identifying information only if it is necessary; and when collecting information from children and young people, you must consider whether you are collecting it in a way that is fair to them.

What does this mean for you?

- Review your privacy policy and update it to reflect that a serious breach notification to the OPC is now mandatory, and incorporate information about the Notify Us tool. Check that you have systems in place to identify and report privacy breaches.
- Ensure your staff are aware of their obligations under the Privacy Act 2020 and the Health Information Privacy Code 1994. Update them on the changes. Ask your staff to review the OPC's dedicated site about the new Act, including the excellent free e-learning modules with practical examples.[5] Remember, the agency collecting the information will be liable for breach in the first instance, not the staff member concerned, so it is important that your staff are well trained.
- Check your digital and physical systems to ensure they are secure. Talk to your IT specialist about the email system you are using. Does it comply with the Health Information Security Framework (HISF)?[6]
- Consider your policy on digital platforms, email and texting. Incorrectly sent emails are one of the most common privacy breaches. The OPC recommends using protective measures such as delayed delivery, external pop-up reminders and alerts to protect security.[7]

The OPC's emphasis for the first 6 to 12 months of the new Act is education, so upskill yourself and your staff and use the MPS and its resources.

Jenny Gibson is a Wellington barrister who has been working with MPS for many years. Privacy law is a special interest of hers.

REFERENCES

1. This article does not address cross-border changes or the extraterritorial effect of the Act (information transferred overseas must be to countries with comparable data protection laws).
2. https://www.privacy.org.nz/privacy-for-agencies/privacy-breaches/notify-us/
3. Health Information Privacy Code Rule 6.
4. Health Information Privacy Code Rule 7.
5. https://www.privacy.org.nz/privacy-act-2020/campaign/
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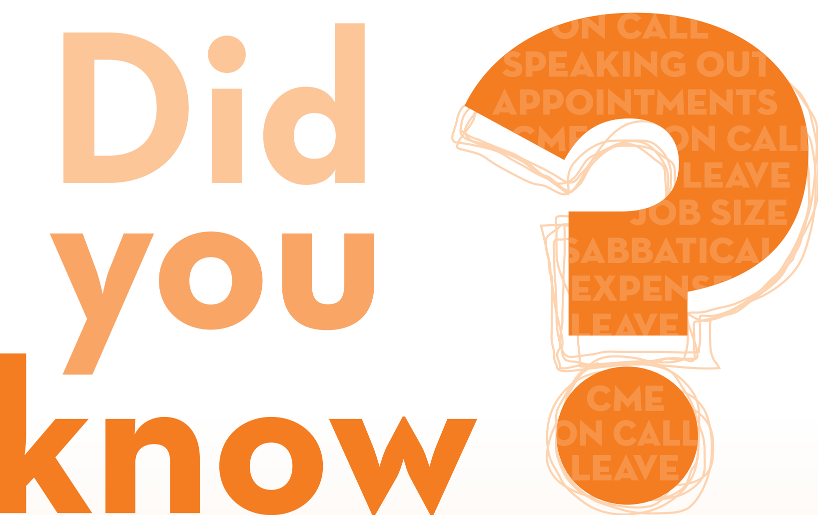
7. https://www.privacy.org.nz/blog/help-just-hit-send/



Your employer must offer union membership.

In May 2019, the Employment Relations Act changed, and a new clause was introduced requiring all employers to advise new employees that a collective agreement covers their workplace and which union negotiated that agreement. A form is sent, along with the offer of appointment letter, which new employees are asked to fill in and return to the employer. It asks the new employee if they intend to join the union **and** if they agree to the employer notifying the union that they have accepted an offer of employment with the new employer. This has been a very positive improvement to the legislation however simply ticking yes to those questions does not mean joining up to ASMS. There is an extra step which is going to the ASMS website (www.asms.org.nz) clicking the membership tab, then clicking Join Online and filling in the details.

When welcoming new colleagues, it would be great if you checked they have followed that process while also discussing the benefits of joining. Our strength is in our numbers and your help in connecting new employees to ASMS is appreciated.

Book review
The Silence of Snow

Dr Rebecca Grainger

Dr Rebecca Grainger – rheumatologist at Hutt Valley DHB and Associate Professor at Otago University reviews fellow ASMS member Dr Eileen Merriman's latest novel *The Silence of Snow*.

I'll never forget how grown up I felt flying to Nelson to interview for my first house surgeon job. As a trainee intern, I thought I must have really 'made it' if someone else would pay for me to fly. I also recall the interview clearly and despite my nerves, I must have done okay, as I was offered the job.

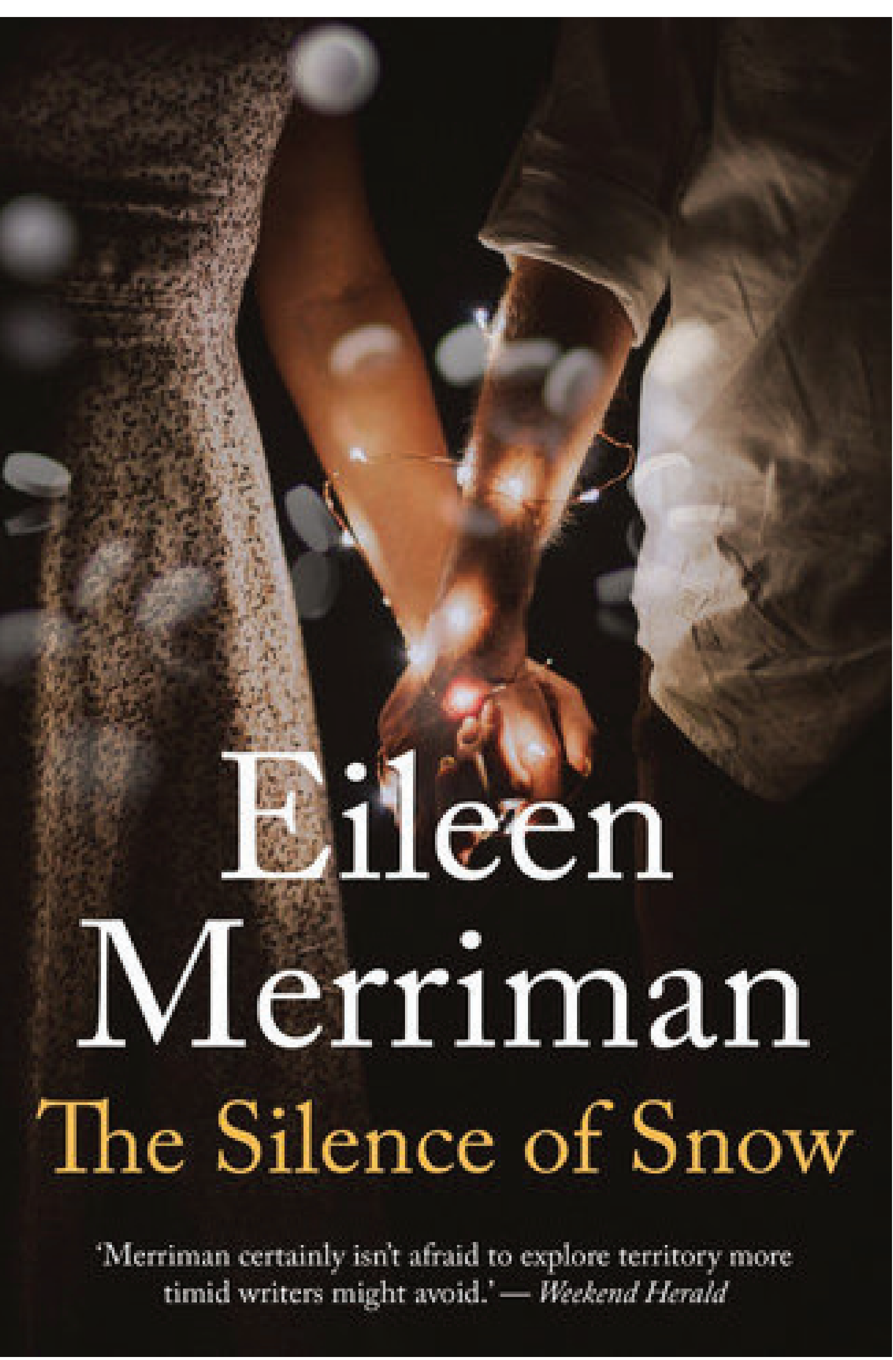
It was a 'sliding doors' moment for me – I declined the job offer and never worked at Nelson Hospital. But I could have, which is one of the reasons following Eileen Merriman's character, Jodi Waterstone, in the book *The Silence of Snow*, as she navigates the transition and challenges of working as a first-year doctor at Nelson Hospital, was so relatable and engaging for me.

But that's just one reason. Anyone who has navigated transitions in medicine, first love, true love, addiction, loss or betrayal will find something that resonates. Running below the surface is the distress of being beholden to a system that is, at best, strained and at worst, broken and dehumanising. The novel follows two protagonists, Jodi and Rory, as they navigate these challenges. The strong development of their characters is a key thread that draws the reader along and is a compelling dynamic throughout the novel.

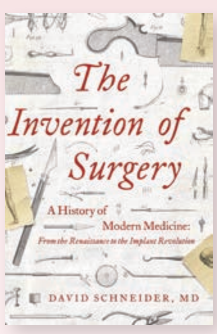
Despite the universality of the themes, *The Silence of Snow* is unashamedly a medical novel – it says so on the back. The highs and lows of working in a New Zealand hospital are so well captured, as are the medical and personal issues facing the patients the characters care for. The medical details are authentic and accurate given Dr Merriman is a working haematologist. Any, and perhaps every, doctor in New Zealand should read this book, to remind ourselves of the burden that can be shouldered by our colleagues when circumstances have conspired against them. It reminds us to be vigilant about our colleagues' behaviour and compassionate in providing support if it is needed.

But far from just being a medical novel, in this work Dr Merriman develops the characters so strongly that they almost feel real. Rory is far from home and facing challenges that are inextricably linked to his professional identity. The distress he feels is only soothed by anaesthetic drugs and his developing relationship with Jodi. Jodi is close to home and facing professional and personal challenges while she develops her identity at a new phase of adult life. Dr Merriman's sympathetic character development drew me into their lives and both characters stayed with me long after the book ended. Actually, I recommend that you should set aside some time for this book – I found it hard to put down, and reading till 1 am is not ideal for my wellbeing!

Dr Merriman has produced a uniquely kiwi medical novel, which also manages to defy the restraints of the genre due to the universality of the themes and deeply developed characters. It is also a cracking read. I highly recommend you get a copy and settle in for the journey.

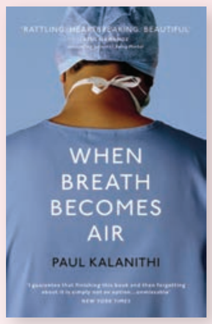


After putting *The Silence of Snow* on your list, here's some other medically themed reading suggestions you might enjoy.



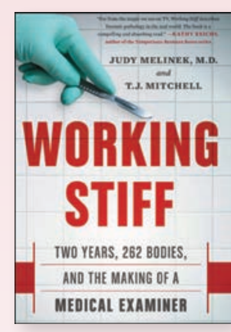
***The Invention of Surgery: A History of Modern Medicine* – Dr David Schneider**

Dr David Schneider provides an in-depth history of the practice of surgery and the personalities of its practitioners, from the guesswork of ancient Greek physicians through to the world-changing 'implant revolution' of the 20th century – and whatever might be next.



***When Breath Becomes Air* – Dr Paul Kalanithi**

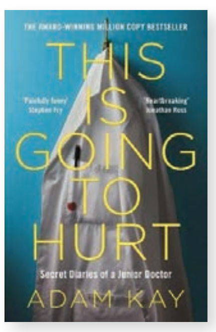
Dr Paul Kalanithi had almost finished his training as a neurosurgeon when he learned he had Stage IV metastatic lung cancer. When Breath Becomes Air is a moving memoir about his life and his battle with his illness. It was posthumously published in 2017.



***Working Stiff: Two Years, 262 Bodies and the Making of a Medical Examiner* – Dr Judy Melinek and T. J. Mitchell**

This memoir of a young forensic pathologist's first season as a New York City medical examiner gives readers an insight into some of the most harrowing deaths in that city during that time. It reveals the truth of work in a morgue, which bears little resemblance to the type of autopsy work shown on popular TV series.

Dr Melinek and her husband, T. J. Mitchell, are now living and working in Wellington, after moving to New Zealand from California earlier this year.



***This is Going to Hurt: Secret Diaries of a Junior Doctor* – Adam Kay**

Former junior doctor Adam Kay tells his story of why he decided to hang up his stethoscope. This account of the endless days and sleepless nights he spent working in the NHS provides a graphic insight into the reality of being a junior doctor.

***Mind that Child: A Medical Memoir* – Dr Simon Rowley**

An insightful and deeply humane memoir from New Zealand paediatrician, Dr Simon Rowley. He charts his decades of medical experience, touching on an array of issues, from the high-stakes management of tiny, pre-term babies to the serious impacts of drugs, alcohol and technology on developing minds. The book weaves real-life cases into a candid and compassionate narrative.

***War Doctor: Surgery on the Frontline* – Dr David Nott**

For more than 25 years, David Nott has taken periods of unpaid leave from his job as a general and vascular surgeon with the NHS to volunteer in some of the world's most dangerous war zones. He has carried out life-saving operations and field surgery in the most challenging conditions and trained other doctors in the art of saving lives threatened by bombs and bullets. War Doctor is his extraordinary story.

***The Knife's Edge: The Heart and Mind of a Cardiac Surgeon* – Professor Stephen Westaby**

An intimate and compelling exploration of the unique psyche of the heart surgeon. For heart surgeons, the cost of failure is death of the patient and in The Knife's Edge, Westaby reflects on the mindset of those who are drawn to the profession and chronicles the pioneers who grasped opportunities and took chances to drive innovation and save lives.

Feedback

I was very pleased to see the 2 articles on sustainability. Particularly in addressing the CME travel as this is a huge issue. I know many who use this for exotic holidays and trips to the northern hemisphere at least once per year if not twice. It will become a major issue for accountability to the public in justifying this level of travel for often dubious educational benefit. My friends in general practice get no such 'perks' and are lucky if their Annual Conference fee is reimbursed let alone accommodation or travel. In terms of sustainability this needs to be discussed and explored. Having the employer/DHB pay for the carbon offset is not the answer and I would encourage that this needs to be an individual responsibility not an employer. Even if carbon is offset SMOs need to have a hard think about this and their moral responsibility.

Thank you again for raising this issue.

Dr Wendy Hunter, Paediatrician, Nelson

MECA 2021

We are all set for MECA 2021 as we head back into negotiations with DHBs in February.

Annual Conference gave us a good chance to get further feedback on our claims which continue to focus on wellbeing and safe and sustainable work.

There will be regular updates to members once the talks get going so watch this space.

www.asms.org.nz

The ASMS National Executive and National Office staff would like to thank you for being part of your union this Christmas season.

Union membership has never just been about the benefits and services we offer to our members as individuals. Your contribution builds our capacity and power to improve conditions for all salaried medical and dental officers, including those who aren't members.

We also thank you for your commitment to our NZ public health system. It's been a tough year for us all, and we acknowledge your hard work and care for the people of Aotearoa.

We wish you and your loved ones a very Merry Christmas and a safe and prosperous New Year.

Arohanui ki a koutou katoa

The National Office will close early on the afternoon of Thursday 24 December 2020 and reopen on Monday 11 January 2021.

For queries over this period please check the ASMS website for contact details.

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 5,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

Other services

ASMS job vacancies online

Check out **jobs.asms.org.nz** a comprehensive source of job vacancies for senior medical and dental specialists/ consultants within New Zealand hospitals and health services.

Contact us

Association of Salaried Medical Specialists
Level 9, The Bayleys Building,
36 Brandon St, Wellington

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

P 04 499 1271
E **asms@asms.org.nz**
W **www.asms.org.nz**

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Rossi Holloway
Doctor and
MAS Member