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INTENTIONS TO LEAVE THE SENIOR MEDICAL WORKFORCE

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

How many senior doctors and dentists are likely to leave the district health board (DHB)-based workforce over the next five years? What factors are encouraging them to consider doing so and what might encourage them to remain? These are the questions at the heart of the latest ASMS *Health Dialogue* (about to be released) on the future intentions of the DHB-based senior medical workforce.

The research finds that approximately 24% of the 2424 DHB-based senior doctors and dentists (63% overall response rate) were either likely or extremely likely to leave DHB-based employment over the next five years. The survey focused on three possible scenarios that may see individuals exit the DHB-based workforce:

- those considering leaving medicine entirely either because they wish to retire, or because they wish for a career change
- those who intended working in medicine but not in a DHB-setting
- those who may be contemplating leaving New Zealand permanently to work in medicine overseas. Nearly half of respondents aged 55 and over were unlikely or extremely unlikely to continue with some form of DHB-based employment.

> *The research finds that the most significant factors associated with intentions to leave are increasing age and low job satisfaction.*

Men had on average a higher FTE than their female counterparts but were more

likely to signal an intention to leave DHB-based employment. There was also significant variation in intentions to leave across all three scenarios by medical specialty, whether respondents had dependents and by the Full Time Equivalent (FTE) of respondents.

For the remaining workforce who did not signal an intention to leave DHB-based employment, a significant proportion would like to reduce their involvement in the DHB-based workforce, either by reducing their FTE or by reducing the amount of on-call or night-shift work components.

A total of 40% indicated that they would like to reduce their FTE, 30% indicated that they would like to reduce their after-hours call or shiftwork and 8% indicated that they would like to cease call or shiftwork duties altogether. There was significant variation in intentions regarding both changes to FTE and on-call and shiftwork duties according to level of job satisfaction and gender.

DEMOGRAPHIC DETAILS

The research provides important demographic details of the specialist medical workforce: 36% of respondents were aged 50 and over and 18% were aged 60 and over. The report finds this association between increasing age and increasing rates of intentions to leave accords with other research in this field. Older respondents intending to remain were more likely to signal an intent to reduce their level of involvement in the workforce. The association between decreasing job satisfaction and increasing intentions to leave mirrors trends in other research and, importantly, suggests that many could be encouraged to remain should levels of job satisfaction increase.

The qualitative analysis provides context for and insight into these patterns and details the reasons why senior doctors are contemplating leaving.

> *Of key significance are the findings that feelings of disillusionment and frustration are acting as potent disincentives for senior doctors to continue working, particularly for those in the older age groups.*

This suggests that there may be many competent older doctors who are considering leaving not simply because of their age, but because of growing feelings of disenfranchisement and dissatisfaction.

ENCOURAGING RETENTION

Conversely, the qualitative analysis finds that provision of flexible working hours, including the ability to take leave, as well as improvements to management and DHB culture, could encourage many to remain. Quantifying the main reasons for leaving and main factors that could encourage retention finds that 73% of the overall 24% intending to leave, could be encouraged to remain if improvements were made.

As such, the report highlights that while aging is an incontrovertible reality, there are many competent older senior doctors as well as senior doctors across the younger age-spectrum who could be encouraged to remain working.

Initiatives to improving conditions of work, for example, strategies to provide recognition for good work and increase clinical involvement in decision making are likely to pay dividends in terms of improving levels of job satisfaction and in turn, increasing the likelihood of specialist retention.

Addressing the core areas of dissatisfaction highlighted by this research and expanded on in the qualitative comments would be a sound place to start.

> *Overall, the report suggests that existing specialist shortages across the board may continue to affect DHBs and specialties in the future.*

For small DHBs and sub-specialties with existing low numbers, the future is of concern. For smaller rural DHBs such as Wairarapa, the research suggests the rates of retirement and attrition affect a significant proportion of the existing workforce and will require future monitoring. Acute shortages are already well documented for specialties such as forensic pathology and it is well established that proportionate specialist numbers in New Zealand are low by OECD standards.

The research focuses on the rates of those intending to leave and understanding the reasons why. As a consequence of this emphasis, the report does not consider how those likely to leave the DHB-based workforce may balance against those entering the specialist workforce and the demographic patterns therein. Further work is needed to consider future workforce input requirements but the first step must be to ensure every effort is made to retain the experienced senior doctors we already have.

> *This research highlights potentially significant specialist workforce attrition over the next five years unless interventions are made to improve working conditions and retention.*

Future workforce input needs will be shaped by the timely implementation of successful policies to improve job satisfaction to support and retain many more of the existing specialist workforce in New Zealand. A copy of the *Health Dialogue* on workforce intentions will be sent to members with the September issue of *The Specialist*.

KEY STATISTICS

- Across all age groups, 23.9% (n=546, 95%CI 22.2 to 25.7%) of all respondents (n=2281) were unlikely or extremely unlikely to continue with some form of DHB-based employment in the next five years
- 44.7% (n=365, 95%CI 41.3 to 48.1%) of all respondents aged 55 and over (n= 816) were unlikely or extremely unlikely to continue with some form of DHB-based employment in the next five years compared with 12.4% (n=181, 95%CI 10.7 to 14.2%) of all respondents aged 54 and younger (n=1465).
- 38.1% (n=311, 95%CI 34.8 to 41.5%) of all respondents aged 55 and over (n= 816) intended to leave medicine entirely in the next five years compared with 4.1% (n=60, 95%CI 3.1 to 5.2%) of the 1465 aged 54 and younger intended to leave medicine entirely.
- 56% of all respondents scored as dissatisfied with the level of recognition they received for good work. This increased to 79% dissatisfaction for those respondents intending to leave DHB-based employment. Other core areas of dissatisfaction included ability to choose method of working, hours of work, and remuneration.
- For all respondents, the top 5 themes cited as justification for not wishing to continue with DHB-based employment in some form over the next five years were:
  1. age (n=217)
  2. disillusionment with DHB management and the direction of the New Zealand public health system (n=82)
  3. exhaustion, burnout and pressure of work (n=74)
  4. low morale, poor job satisfaction and feeling unable to institute change (n=70) and;
  5. wanting more time for leisure or other interests (n=51)
- The top 5 themes cited as possible inducements to remain were:
  1. provision of flexible working hours or part time work (n=71)
  2. better management culture and less bureaucracy (n=66)
  3. better resourcing and staffing levels (n=56)
  4. reduced on-call, shift work and after hours (n=54) and;
  5. more respect, greater professional freedom (n=35).
- 35% of comments suggested that nothing would induce them to remain.
- Significant correlations were found across all three scenarios between intending to leave, increasing age and low levels of job satisfaction. There was significant variation across all three scenarios for intentions to leave and medical specialty, whether respondents had other dependents and the Full Time Equivalent (FTE) of respondents.
- For the remaining workforce who did not signal an intention to leave DHB-based employment, 40% indicated that they would like to reduce their FTE, 30% indicated that they would like to reduce their after-hours call or shiftwork and 8% indicated that they would like to cease call and shiftwork duties all together in the next five years.

QUALITATIVE COMMENTS FROM THE RESEARCH INCLUDE

(EACH QUOTE IS FROM A SEPARATE PARTICIPANT):

- "The problem is that entrenched poor attitudes from hospital managers, particularly those in senior positions, to senior medical staff, discourage engagements. My advice to your specialists is to either work in private or move overseas."
- "I have about 20 years till my retirement, but don't see myself staying in the DHB for more than another 6-10 years, unlike my older colleagues. While I find my chosen speciality really rewarding, the demands from the DHB for more clinical care, with more targets to be met, but with little regard for the impact on clinicians and their wellbeing - means I will not be able to continue full time in the DHB till I retire - not without cost to my wellbeing."
- "Many SMOs doing gen med are getting frustrated with the heavy workload and limited resources we are expected to work with. It does not help that all our concerns have gone unheeded by management. Even as a junior SMO, if I was given the opportunity, I would be seeking to reduce my after hours on call duties and maybe overall FTE. Life is too short to be spending most of it working like a dog for very little recognition and job satisfaction."
- "I think that the level of frustration of SMOs working in the DHBs coupled with the expectation of doing more with less (and the "spin" about how much more efficient we will be while resources are decreasing) will make more and more wish to leave earlier or go into the private sector."
- "Often the FTE hours we are paid for is insufficient to complete the work required - many colleagues I talk to accept this as a part of life. I beg to differ and think clinicians need to be recognised and paid for all the work they actually do, not expected to do work after hours or in weekends simply because there is no other option."
- "Currently DHBs have zero recognition of shift work and the aging physician. There should be the ability to reduce on call and evening shift work without having to reduce FTE. I even doubt that that reducing FTE would allow a reduction in after hours commitment as we currently have SMOs on 0.7 contracts but they are expected to work proportionally more after hours!"

BUDGET SIGNALS NO LET-UP ON HEALTH FUNDING PRESSURE

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

The Health budget announced in May signals more belt tightening for district health boards (DHBs) for the next financial year.

A detailed Council of Trade Unions (CTU)-ASMS analysis, updating a preliminary analysis undertaken on Budget day, shows DHBs will be approximately $107 million short of what they need to maintain current service levels and cover the cost of 'new policy initiatives' announced in the budget (many are not 'new'). Possible effects of the Ministry of Health's error concerning DHB funding were being investigated at the time of going to print. The shortfall is less than estimated on Budget day due mainly to a reduction in the capital charge DHBs pay to government.

Some of the 'new initiatives' announced in the Budget are not fully funded but depend on being partly funded from DHB budgets. A $224 million 'boost for mental health' over four years, for example, relies on a $100 million 'contingency' fund coming from DHB coffers. Indeed, much of the $224million 'boost' has turned out to be more creative accounting than real money, as detailed in a separate analysis by the CTU and ASMS (**https://www.asms.org.nz/news/asms-news/2017/06/07/called-budget-mental-health-funding-boost-cut-real-terms/**). It is difficult to envisage the 'increasing gaps, if not chasms, in [mental health] service provision' observed by Professor Max Abbott, senior consultant to the World Federation for Mental Health, being addressed with effectively less funding.[1]

> ***Vote Health's total operational funding, including funding for the Ministry of Health and national services funded directly from the Ministry, is estimated to fall short by approximately $214 million.***

Access to new medicines will also be tightened in 2017/18. While Pharmac received a $20 million increase, with a further $11 million coming from DHB budgets, the latter is cancelled out as it also occurred in 2016/17, as indicated in the Minister of Health's Budget day media releases on the last two Pharmac budgets.

A $20 million increase (2.4% on Pharmac's 2016/17 budget) is a cut in real terms when accounting for inflation and population growth. A recent study, commissioned by pharmaceutical industry body Medicines Australia, shows New Zealand is already lagging behind every one of the 19 other OECD countries it examined when it comes to access to new medicines. While one should be cautious about industry-backed studies, there is no government data available to counter the findings. Improved access in the coming years appears unlikely as the announced funding increases for Pharmac over the next four years indicate continuing cuts in real terms.

Despite elective surgery being a priority area for the Government, elective services will take a funding cut of $26 million in real terms in 2017/18. Again, this is an area where New Zealand already compares poorly with many OECD countries. The World Health Organization ranks us in the bottom half of OECD countries in terms of surgical procedures per head of population.[2]

New research findings published in the *New Zealand Medical Journal* in March suggest that at least 9% of New Zealand adults have an unmet need for hospital care.[3]

> ***The effects of financial pressures on DHBs identified by Treasury earlier this year are likely to continue.[4]***

They include some DHBs 'sweating their assets and under-funding repairs and maintenance to help balance their books' and cutting funding to non-DHB services 'when DHBs are under pressure to meet hospital output targets and avoid running deficits'.

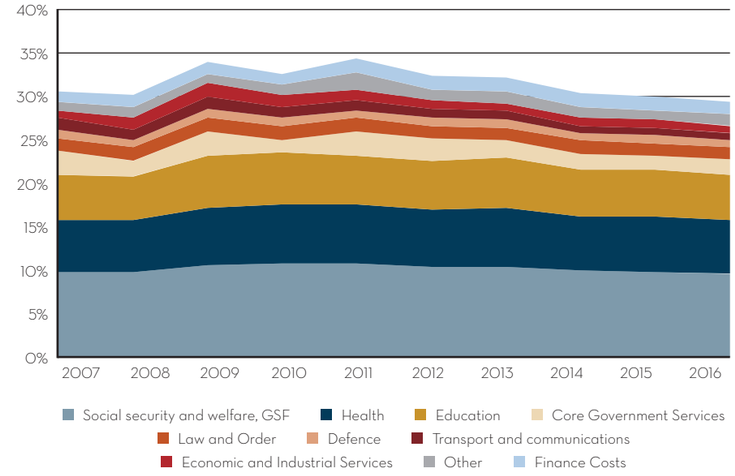
In the past, governments have argued that health funding must be contained to levels that the country could afford. More recently, the rationale for funding constraint is mostly about government priorities, a high priority being 'building fiscal resilience' – or running increasing surpluses to reduce debt. Consequently, core Crown spending – including health spending – has been reducing as a proportion of gross domestic product (GDP), as illustrated in Figure 1. However, the downside is not only mounting health and social costs, but also economic ones.

Among the many international studies highlighting the often substantial economic costs of ill health, two from Canada and England estimate the cost of mental illness as approximately 4% of GDP, much of it a result of unmet need.[5] A report prepared for the Royal Australian and New Zealand College of Psychiatrists estimates the total cost of mental illness in New Zealand equates to about 5% of gross domestic product (GDP), or 7.2% of GDP with the inclusion of opioid dependence.[6]

The rising-surplus priority, nevertheless, is set to continue. While the Government's long-term objective is to keep core Crown spending below 30% of GDP, it is diving even further. In 2015/16 it had dropped to 29.2% of GDP; by 2020/21 it is forecast to be 27.5% of GDP. It is likely, therefore, that health spending as a proportion of GDP will also continue to fall.

Conclusion: Not a healthy budget for the public health sector.

FIGURE 1: CORE CROWN EXPENDITURE TRENDS PER GDP 2006/07 – 2015/16.



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RECERTIFICATION – BUILDING CONFIDENCE IN OUR COMPETENCE

MR ANDREW CONNOLLY | CHAIR, MEDICAL COUNCIL OF NEW ZEALAND

As many of you are aware, the Medical Council of New Zealand (Council) has recently consulted on important changes to recertification for vocationally registered doctors. This has generated much feedback and commentary.

At Ian Powell's invitation, I recently met with the ASMS executive to discuss the recertification consultation in detail. What has been clear from a number of submissions received is that some confusion exists about Council's intent. The meeting was an opportunity to clarify these areas of concern. This article summarises much of the discussion.

> *The case for change is clear: we must be able to assure the public we are competent.*

One important component of this assurance is CPD, as there is evidence that competence is much more likely to be maintained by doctors engaged in learning and reflecting on their practice, than by doctors who are not.

I am on record as saying the Annual Practicing Certificate is not just a tax receipt – it is tangible recognition by Council that the holder is considered competent. A key part of that conclusion is active and successful participation in an accredited CPD programme.

Many international regulators are moving forward in this arena. The Medical Board of Australia (MBA) is currently considering its next steps in this area and the bi-national nature of many of our colleges means we need to consider the impact of potential changes across the Tasman. Broadly speaking, the principles being considered by the MBA are similar to ours.

Recertification is a term used in the Health Practitioners Competence Assurance Act (the legislation that regulates doctors and other health practitioners). Essentially it can be thought of as a strengthened CPD process, with an increased emphasis on 'value' and peer review.

PRINCIPLES-BASED APPROACH

Council recently adopted a principles-based approach to recertification. These principles include profession-led, evidence-based, and relevant to the scope of practice of each doctor. To be very clear: recertification is designed to be 'therapeutic' for each doctor and is NOT a diagnostic tool for Council. Council relies on a number of processes to identify competence or conduct concerns – recertification is not one of them.

With respect to recertification and the individual doctor, Council is only interested in the outcome – that is, the doctor has successfully completed the relevant accredited college CPD programme. Council will not seek nor see the content of any individual doctor's CPD programme. It is true, however, that we expect colleges to inform Council of any doctor who does not comply with their CPD programme.

There is evidence that maintenance of competence does take a commitment from each doctor to keep up to date. It may be with new medications, or new diagnostic tests, or new procedures. No branch of medicine is without change. There is evidence that feedback and reflection, done well, aids each doctor to remain competent. Council is consulting on how best to engrain these activities in our normal working life. These activities should aid each doctor to plan their CPD for the coming period.

> *For most doctors, the changes we are consulting on will mean little, if any, material difference to what each of us does now to fulfil our CPD requirements.*

Council accredits colleges and part of this process is accrediting the CPD processes of the college, but Council will not set the content of your CPD; Council sets the over-arching principles for any CPD programme and the college sets the content, mapped broadly to the principles. Each college is the 'subject expert' for each vocation and therefore rightly needs to set the content of the programme. Some colleges will further devolve this work to various specialty groups.

EVIDENCE OF EDUCATIONAL VALUE

We are likely to challenge each college CPD committee to ensure the content of their programmes does, where possible, reflect evidence of the activity's educational worth. For instance, if there is evidence that activity 'A' is of significant value to the maintenance of competence, is the 'credit' a Fellow can claim for activity 'A' reflective of that value compared with other activities where the evidence of value is less?

If we consider some of the existing CPD programmes, we see areas of compulsion in anaesthesia for many Fellows regarding the simulator; we see mandatory mortality audit involvement in surgery and so on. All these activities are mandated by the colleges, not by Council. We know there is evidence for the value of multisource feedback, if done well; again, my college, the Royal Australasian College of Surgeons (RACS), has multisource feedback available – this therefore maps well with one of Council's principles – 'evidence based'. If it is compulsory or not remains the decision of the RACS, not Council.

We have attached some key words such as 'Professional Development Plan' to activity many of us already undertake via an annual meeting with our Clinical Director and/or service management. We do expect all doctors to reflect on an aspect of their practice – for instance, as a surgeon I already review my bowel cancer outcomes with my fellow colorectal surgeons in the department.

For quite some years many of us have undergone annual appraisal; these have been of variable value and probably pretty inconsistent. Our consultation document is a potential starting point for services to look at wrapping employer and college processes into one structure.

> *This is a key challenge for us – we must avoid unnecessary duplication of time or activity to make any enhanced CPD process a success.*

We are likely to insist all colleges have a practice visit as an option for all Fellows – if it is compulsory or not will be up to each college board to decide. Some groups already have compulsory practice visits – orthopaedics being a prime example. These activities all have evidence to support their value.

THE AGING MEDICAL WORKFORCE

Perhaps the most contentious aspect of the debate has been around older doctors. Again, to be clear, Council is not introducing examinations or mandatory processes for older doctors. Nor are we introducing mandatory retirement or mandatory places of practice to avoid isolation and so on. We are, however, looking at the issues of safe practice and aging. This is something all responsible doctors (and regulators) should be interested in.

We know cognitive decline affects doctors at the same rate as it does the rest of the population, and we know retirement can bring added stressors. We are suggesting that as we all get closer to retirement, we plan for it.

In my field of general surgery, I need in the next few years to consider if I should remain on the after-hours roster. There is good evidence that as I get older, my decision-making at 2am may well be different to that at 2pm. This does not mean I should not be a surgeon, but it does mean my colleagues and I should think over these issues well in advance. This is perhaps even more important for those in sole or remote practices, as the implications of change may be much harder to address.

I am heartened by the volume of responses Council has received on this important consultation. We will need time to consider all the feedback and to look at our next steps.

I hope the information above reassures you that Council is not planning radical changes; indeed, we are mainly formalising and strengthening existing college programmes with little real change needed by most individual doctors given the strengths of many existing college CPD structures.

I reiterate, this process is about aiding each of us to maintain our competence. I firmly believe it is not adding significantly to my work as a busy doctor, but it is adding to the confidence the public can have of my competence.

SOMETIMES BAILING WATER IS NOT ENOUGH

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

The heart is a pump. It can increase its output by pumping faster or by increasing the stroke volume or by doing both. There are physiological limits for heart rate, stroke volume and for the duration that the heart can sustain a higher rate and stroke volume before it starts to fail. Similarly, when your ship takes on water you can bail more water by bailing faster or by using a bigger bucket or by bailing faster with a bigger bucket. There are limitations to how long this increased activity can be sustained...

It will come as no surprise to anyone if I state that our health system is under significant pressure. In fact, it has been in trouble for some time.

> *Our ship is taking on water in an environment of increasing demand and insufficient resourcing.*

I am not going to go into an academic discussion or do number crunching to try to prove or validate my statement. Both The New Zealand Treasury (**http://www.treasury.govt.nz/publications/informationreleases/health/dhb-performance/dhb-performance-feb17.pdf**) and the Council of Trade Unions, with the ASMS, have reported on this (**https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1435-27-may-2016/6891**) over the past year and they still disagree. However, staff at the sharp end of the health care delivery know who to believe (**https://www.yeswecare.nz/nine-in-10-heath-workers-feel-under-resourced/**).

A YesWeCare.nz survey of 6,000 health workers in March 2017 found:

- 90% say the health system doesn't have the staff and resource required to give New Zealanders the healthcare they need when they need it.
- 61% say New Zealanders access to health care over the last five years has decreased.
- 90% say the Government's current level of health funding is affecting New Zealanders' access to healthcare.
- 72% say their workload and work pressures aren't reasonable.
- 84% say their workload and work pressures have increased over the last five years.
- 82% say the Government's current level of health funding is affecting their workload and work pressure.

IMPACT ON HEALTH CARE WORKERS

What does it feel like at the coal face? What is being expected of health care workers and what impact is it having on your personal health and life, and on the safety of patients - and more importantly, how can you influence this?

Let me start off by quoting Health Minister Johnathan Coleman. In his 2016 address to the ASMS Annual Conference delegates, he stated:

"The growing pressure on elective surgery means we need to continue to do more – and that's what the Government is focused on delivering. Around one in ten Kiwis received a FSA in 2015/16. That's a total of around 550,000 patients - a rise of almost 10,000 on the previous year, and an increase of around 119,000 patients over the last eight years. In 2015/16, over 171,000 patients received elective surgery. That's over 53,500 more surgeries over the last eight years – a 45 per cent increase."

He further stated: "Ophthalmology FSAs have increased from 45,000 in 2008/09 to nearly 56,000 in 2015/16 – nearly 25 per cent increase. Ophthalmology discharges have increased from 18,000 in 2007/08 to 23,000 in 2015/16 – a 28 per cent increase. Avastin injections have doubled from 4,000 in 2011/12 to 8,000 in 2015/16."

I am not going to question or dispute the figures the Minister quoted, but I do want to focus on how DHBs achieved that.

> *What is the impact of "we need to continue to do more" and the relentless pressure on the workforce?*

What are the actual real-life outcomes for some patients, ie, do those figures actually translate into a win for patients in the real world?

Let me start with ophthalmology. Despite the 25% increase in FSAs over the term quoted and despite a doubling of the number of Avastin injections, we subsequently learned that in real life an alarming number of ophthalmology patient across New Zealand were harmed by the system. Despite the increase in *measured* performance, demand still outstripped supply. It also begs the question; did the Ministry of Health measure the right thing? Have we learned any lessons from this and if so, are we making use of our new knowledge and perhaps planning to include patient outcomes as a routine measure?

At first glance, 119,000 more FSAs and 53,000 more elective surgeries looks quite impressive, but how was this achieved? By asking staff to bail water faster with bigger buckets. Yes, I acknowledge that DHBs have employed more staff and some extra buckets to help their colleagues bail water but unfortunately there are not enough extra hands on deck to cope with the increasing rate of the ship taking on water. (Increasing demand is a complex issue that warrants a discussion by itself).

DHBs achieved the figures quoted by getting you to do some or all of the following:

- SMOs are requested to do extra clinics and theatre lists. It is not unheard off for these lists to be done on weekends or on days or at times that the clinician/s would not usually be expected to work. This in other words goes well beyond increased efficiency. It is a matter of making already hard working staff work even harder. Modern health care delivery is done by teams and the increased workload does not only involve SMOs but all the other team members as well.
- SMOs are asked to fill in for vacancies by doing 'internal locums' or additional shifts.
- SMOs (and other health care staff) don't get time to take annual leave, evidenced by a blowout in annual leave balances.
- Working longer hours and using non-clinical time for clinical duties.
- Doing work while in your own time from home by logging in to your hospital desktop to check patient results, deal with urgent emails etc.
- Manipulating out-patient appointments by having short follow-up appointments or no follow-up appointments. (A coroner noted: "I am also very concerned that Waikato DHB claimed the outpatient 'slots' are only ten minutes for patients. This is a ridiculously short amount of time to elucidate a complex problem such as that presented by [the woman]" **http://www.stuff.co.nz/national/health/90111037/dhb-ordered-to-apologise-after-woman-dies-of-cancer.** Further: "A group of orthopaedic surgeons has accused Waikato District Health Board managers of stopping them from making follow-up checks on patients, so they could assess new patients instead to meet national health targets" (**http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11753565**). I am not "picking" on Waikato DHB. It is just that the above became public knowledge. I believe the manipulation of out-patient appointments also occur in other DHBs.

THE HIGH COST

The cost to staff includes, but is not limited to, the negative impact on our health, stress, burnout, a reduction or loss of job satisfaction, low morale and a steady erosion of the traditionally high levels of goodwill that staff in health care usually have.

> *The ship's captain increasingly relies on over-worked staff to bail water faster with bigger buckets to keep the ship afloat. We tend to comply in best the interest of patients and to the detriment of our own health.*

In defence of the DHBs' CEOs, they are very aware of the situation they find themselves in. They must cope with limited resources and an increasing demand. If that is not enough there is the ongoing need for them to meet and achieve the health targets. It recently became public knowledge that in 2016 they went cap in hand asking for more funding. Their very reasonable request was turned down (**http://www.newshub.co.nz/home/health/2017/05/revealed-govt-shortchanged-health-system-by-250m.html**).

I do have concerns that we might be heading towards another revelation that the system is causing patient harm, and that safety and quality have been compromised. My concern stems from several conversations I have had over the past few months. It is becoming clear that, increasingly, additional work and pressure are being placed on our radiology colleagues.

Radiology is a core diagnostic service and clinicians and patients rely heavily on investigations being performed in a timely manner and on quick turnaround times for reporting. It is similarly important that clinicians have the opportunity to consult with radiologists if they need to discuss more complex cases.

There seems to be an over-reliance on temporary workarounds just to keep up with the increased volumes of reporting that would normally have been done during 'office hours'. Radiologists are being asked to work longer hours to try to cope with the increasing volume of work. The performing of ultrasounds, CT and MRI scans are increasingly being outsourced to cope. The outsourcing of after-hours reporting to off-site private radiology firms (sometimes offshore) is becoming more and more common.

Despite the above measures, some departments are barely keeping up and some are falling behind. Delays in reporting and/or intervention or not being able to discuss complex cases with a radiologist, can delay timely treatment, intervention, and compromise patient safety and the quality of the service they receive. The impact of this is being felt over a wide spectrum of specialties.

I have not yet mentioned the current crisis in the New Zealand mental health services. It deserves to be a topic in its own right.

How do you help to turn the ship around and keep it afloat? The answer is not: "keep bailing faster with a bigger bucket". That will only bring relief for a limited time. You must voice your concerns.

> *The more workarounds and interim solutions that occur in a department (especially if the workaround become business as usual), the more likely it is that patient safety will be compromised.*

If your concerns are not taken seriously through the usual channels, then please bring them to the next JCC meeting. You can find the date of the next one by following this link **https://www.asms.org.nz/events/**

In the March 2017 issue of The Specialist, ASMS Executive Director Ian Powell gave an excellent overview of the JCC meetings.

These meetings provide you with an ideal opportunity and safe environment to raise and voice your concerns. You have direct access to senior management, with support from Ian Powell or Deputy Executive Director Angela Belich and an ASMS Industrial officer.

Minutes are kept and DHBs are held accountable to complete agreed action, etc. My only plea is for you to give your ASMS team as much notice and background information as possible when you want to raise an issue. You also have an opportunity to discuss things with them, in person during the ASMS pre-JCC meeting.

ALISON'S STORY

Seventy-year-old Alison* says she has been waiting six years for a knee replacement – but she's not sure she has even made it onto the surgical waiting list.

"I feel very let down," she says.

"Every day I worry about falling and I feel anxious and have pain. I want to be able to walk further than my letterbox and to walk up the stairs. I can't interact properly with my grandchildren aged four and six as I can't get on the floor with them."

Alison says her GP confirmed she needed a knee replacement and sent a referral. However, she has had appointments repeatedly cancelled or changed due to specialists leaving the hospital, and she says there has been little continuity.

"I've probably seen six or seven orthopaedic surgeons by now," she says. "I'm waiting for another appointment. I don't know that I've ever really made it onto the waiting list for surgery. Every time I do see someone, they tell me they'll see me again in six months' time. Then when I ring the orthopaedics outpatients to see where things are at, they say they don't have anyone to see me."

She worries that she will not be able to continue living on her own if her knee isn't fixed. Living with constant pain and a physical disability affects her every day.

"I can't explain how horrible it is," says Alison. "My right leg doesn't bend far. I tripped on the steps earlier this year. When I go to the supermarket, it's very hard to find vacant disability car parks so I try to park with my driver's side next to a trolley outlet so that I have enough space to get my leg out of the car.

"I try to volunteer at two places but it takes several minutes to stand up and put weight on my leg, and if one of those places doesn't have a free car park near the building then I can't go there. This is really affecting my life"

* Not her real name.

ASMS 29TH ANNUAL CONFERENCE

THURSDAY 23 & FRIDAY 24 NOVEMBER 2017
THE OCEANIA ROOM, TE PAPA, WELLINGTON

DINNER AND PRE-CONFERENCE FUNCTION

A pre-conference function will be held at the Boatshed on the evening of Wednesday 22 November, and a conference dinner will be held on Thursday 23 November at Te Marae, Te Papa.

These are a great opportunity to mingle with conference delegates and others in a relaxed social setting and to enjoy some of Wellington's excellent hospitality.

LEAVE

The MECA includes provision for members to attend Association meetings and conferences on full pay.

The ASMS will make all travel and accommodation arrangements for ASMS delegates to attend its 29th Annual Conference on full pay.

Members are encouraged to make leave arrangements and register for the conference by emailing ASMS Membership Support Officer Kathy Eaden at **ke@asms.nz.**

ASMS
TOI MATA HAUORA

www.asms.nz

RESOLVING THE GENERAL PRACTICE WORKFORCE CRISIS

DR BEN GRAY | SENIOR LECTURER, DEPARTMENT OF PRIMARY HEALTH CARE & GENERAL PRACTICE, UNIVERSITY OF OTAGO, WELLINGTON

ASMS has done a brilliant job of highlighting the manner in which our health system has been underfunded by the current government.

This work came out of a decision that ASMS will not only narrowly advocate for the needs of members in negotiating employment contracts but also engage in lobbying with an "over-arching theme of achieving patient-centred care and sub-themes of unmet need, entrenched shortages…"

I am one of a tiny minority of ASMS members who works in primary care (200 out of 4300) so I expect the bulk of the ASMS focus to be on the needs of the DHB employees. However, I would hope that in the wider advocacy work, ASMS will look at the health system as a whole with an appropriate focus on primary care.

It is widely recognised that a health system without a well-functioning primary care sector cannot deliver good health outcomes (the USA is the prime example of this).

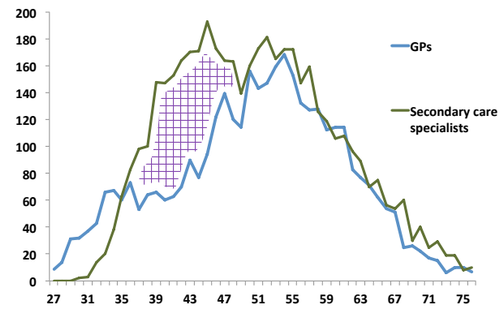
> *Primary care in New Zealand is heading into a crisis. Currently there are parts of the country that cannot employ sufficient GPs (mostly rural or high deprivation urban areas).*

In addition, the RNZCGP estimates that 44% of the GP workforce intends to retire in the next 10 years.

The graph below compares the age profile of specialists with general practitioners. The specialist graph has an appropriate plateau from about age 36 to age 59. The GP graph has a peak at age 54. The shaded area between the green and blue graphs represents all the GPs that we are missing as a result of failing to train or recruit sufficient GPs during the 1980s and 1990s.

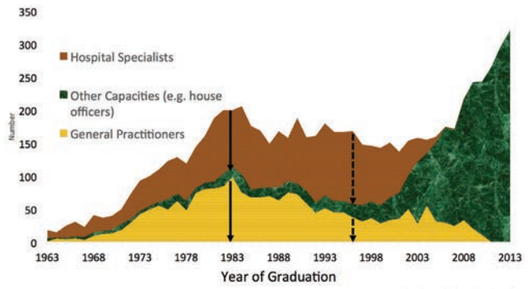
The small plateau in the GP graph from ages 32–39 represents the increased recruitment that has been happening since around 2007. However, this modest increase cannot possibly be sufficient for the inevitable retirement of the doctors currently aged between 50 and 60.

COMPARISON OF THE AGE PROFILES OF GPS AND SECONDARY CARE SPECIALISTS MCNZ 2014



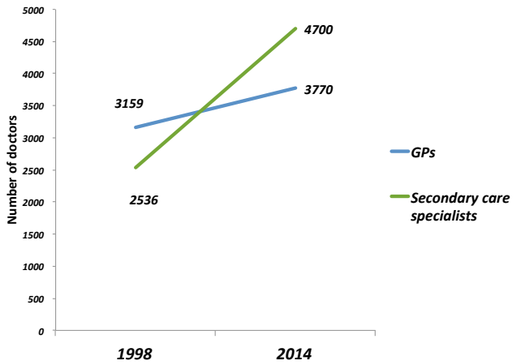
The next graph shows the changes in employment of New Zealand medical graduates. The high number of GPs proportionate to specialists among 1983 graduates can be contrasted with the lower proportion among late-1990s graduates.

2014 SNAPSHOT OF PRACTISING NZ MEDICAL GRADUATES, BY YEAR OF GRADUATION AND 'WORK CAPACITY'



The graph of the changes in numbers of GPs and specialists shows that we have moved from GPs outnumbering specialists 55% to 45% in 1998, to 2014, when specialists outnumbered GPs 56% to 44%. As the predicted peak of GPs starts to retire, on current trends, that proportion is likely to go lower.

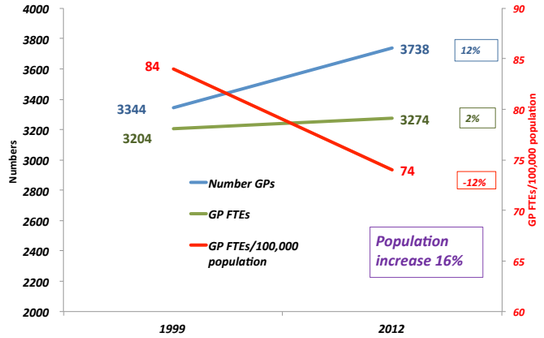
CHANGES IN THE NUMBERS OF GPS AND SECONDARY CARE SPECIALISTS BETWEEN 1998 AND 2014 (MCNZ SURVEY DATA)



Finally, the crucial figure is the number of full-time equivalent GPs per 100,000 population. This has gone down not only because of recruitment problems for GPs but also because of the population increase, and the decreased number of hours that GPs work on average.

There is general acceptance that general practice needs to take on more tasks, particularly increased screening (bowel cancer, cardiovascular risk) and to lessen pressures on the hospital sector, management of renal colic, compliance with pathways (increased steroid injection of knees, for example), and decreasing waiting times in the emergency department, to name a few. To achieve this, the FTE GPs per 100,000 needs to be rising. By comparison with our 74 FTE GPs/100,000, Australia (2011) had 109 FTEGPs/100,000, nearly 1.5 greater than New Zealand (p 14).

TRENDS IN GP NUMBERS, GP FTES AND GP FTE TO 100,000 POPULATION RATIO 1999-2012 (MCNZ)



In summary, New Zealand is currently short of GPs.

This will get worse in the next 10 years as significant numbers of GPs retire, and it will be exacerbated if new graduates continue to prefer hospital specialties over general practice.

WHAT SHOULD ASMS DO?

There is no question that part of this problem is the size of the pie. Funding for both the primary and the secondary sector has decreased in real terms, and lobbying to address this is vital.

The numbers of GP registrars entering the profession this year increased to 195, but it is still well short of the aim of 50% of the graduating class – around 300 a year. There are many potential barriers to achieving this.

> *Funding for GP registrar training is woefully iniquitous.*

A total of $180 million is currently allocated for post-graduate clinical training, of which $127 million goes to DHBs (for specialist registrars), and only $25 million goes to training of GPs. There is a strong argument for that budget being split 50:50, given that the aim is for 50% of graduates to train in general practice.

Amongst other disparities, GPEP2/3 registrars get virtually no support – they must pay for their own books and resources, don't get study leave, and usually pay their own course fees. Meanwhile, hospital registrars have all of these things covered. ASMS could be supportive of ensuring equity in training support between hospital and general practice registrars.

Another important barrier that is within the mandate of ASMS is the perception that medical students have of the value of general practice.

Whilst there are significant differences between the UK and New Zealand, it seems likely that the findings of a recent National Health Service report into recruitment into general practice have relevance here.

An important finding was:

> *Students experience an uncomfortable divide between primary and secondary care across which they meet unfortunate professional tribalism leading them to perceive primary care of 'lower status'. This must now be addressed as unacceptable. What may sometimes be said in jest does, we learnt, impact on student choice. (p 5)*

This view was echoed in New Zealand in a recent study looking at the experiences of PGY attachments in general practice.

> *Within the hospital there is often a negative view of GPs because there is the perception that they send all their patients to hospital, but this is not the case, the practices do not send everyone to hospital....it was good to be able to see things from the GP perspective. (HO 1) (p E)*
>
> *Some of the specialists at the hospital have a low opinion of the role that GPs play and the difference they make, which is unfair. Patients don't have that perception. Most patients value the relationship they have with their GP and trust them. (HO 2) (p E)*

Our task is fundamentally different from the task of a hospital specialist.

> *We spend time caring for people with self-limiting illness, a large focus of our work is on the management of often complex long-term conditions, we are expected to 'know' all of medicine, spend short amounts of time with patients and have limited access to investigation.*

It is inevitable that if a new important diagnosis is ever 'missed', then most of the doctors who will miss that diagnosis will be GPs because we see most patients first. The retrospectoscope is a wonderful thing. These problems are particularly difficult in high needs areas, where up to 30% of patients forgo a visit to their GP each year due to issues of access and cost (p 32).

When resources are scarce, it is very easy to focus on the proximal issues. ASMS has done a good job of pointing out the issues of presenteeism, and chronic specialist vacancies at DHBs. My fear is that ASMS will be successful on behalf of their specialist members in having DHBs put more resources into these areas, and that this will be at the expense of primary care funding as has happened at Capital & Coast DHB .

If we look at the strategic level, 7.8% of health funding in New Zealand goes to primary care, compared with 10% in Australia and 8.5% in the UK. It seems reasonable to suggest that we are relatively underfunding primary care, and that in the event the pie gets bigger, the proportion of the pie going to primary care should also increase.

There is no easy solution to these problems. Increasing the size of the health budget will help, but we must maintain our focus on the whole; we are all in this together.

ACKNOWLEDGEMENTS

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DHB DEFICITS, WHERE SHOULD THE SWEATING RESIDE

IAN POWELL | ASMS EXECUTIVE DIRECTOR

I recall vividly a comment by former Health Minister Tony Ryall a few years ago, at a meeting with the ASMS National Executive. The subject was DHB deficits and I had opined publicly that neither Government nor DHB bosses should get too hung up over deficits because they only comprised 1-3% of DHB funding. The tail should not wag the dog. Mr Ryall firmly responded that deficits worried him nevertheless. This private view was consistent with his public comments.

Fast forward to current Minister Jonathan Coleman. When quizzed on DHB deficits by Radio New Zealand and other media outlets, he responds in the same way as I commented in his predecessor's reign. Don't worry, deficits are a tiny proportion of funding.

So is Minister Coleman a convert to my approach? Absolutely not. Unlike his predecessor, there is inconsistency between his public statements and private practice. He requires the Ministry of Health to closely monitor DHB financial performance and plays hardball over whether a deficit can be approved or not. If the deficit is too much, the DHB can be placed under 'intensive monitoring' and a crown agent added to the board. High transaction cost compliance requirements bog DHBs down. Chief executives, chief finance officers and other senior managers can understandably sweat and lose sleep when under this pressure.

The most recent financial data available shows DHBs recording combined deficits of $50.6 million for the 10 months to April 2017, $38.3 million worse than their plans. But as concerning as this might be to Government, it is not something that should dominate the focus of the leadership of the health sector.

POLITICAL LEADERSHIP AND DEFICITS

Funding and its relationship with increasing costs is critical to the understanding of deficits. Analyses of annual Vote Health budgets by the Council of Trade Unions and the ASMS have found successive funding shortfalls since 2009/10 which have accumulated to more than $1.4 billion, most of which is carried by DHBs.

> ***Is it any surprise that we have deficits? It is more surprising that DHBs, given this extent of underfunding, don't have far greater deficits.***

But other Government actions also contribute to deficits. Partly through ideology and partly through the short-sighted incentive of short term gain, the Government is pressuring DHBs that require major capital works development to adopt a funding arrangement similar to Private Public Partnerships in England that will worsen DHBs finances.

The first example is the small new $12 million 'integrated family health centre' in Westport. The Government, through its misnamed partnership group, is pressuring West Coast DHB to adopt a method of funding branded as 'capital recycling' that is a PPP by another name. The practical effect is that the DHB is likely to pay between $750,000 to $1,000,000 annually for about the next 34 years more than would it would have to under the normal way (Government loans repaid at a lower interest rate).

In order to make the Government's books look good, the DHB's financial position has to worsen, thereby increasing the likelihood of deficits. Imagine if this new system of funding continues with the next and much bigger new outpatient facility as part of the post-earthquake Christchurch Hospital rebuild. This new facility could end up costing somewhere in the vicinity of $100 million which would then involve Canterbury DHB incurring extra annual costs of up to say $100 million.

In fact, one does not have to imagine anything. It has already been acknowledged that 'capital recycling' is on the cards and it was inappropriate involvement in it by the former Canterbury Board Chair that led to his, in effect, forced resignation. It is not good for one's health to contemplate the financial implications for the struggling Southern DHB, with the extensive rebuild of the rundown through neglect of Dunedin Hospital now reported to cost over one billion dollars.

DEFICITS AND NATURAL DISASTERS – INFLEXIBLE POLITICAL GOVERNANCE

The DHB with the greatest deficit is Canterbury, which is unsurprising given the ongoing impact of the earthquake devastation. Like other DHBs, Canterbury receives its regular operational income through the Population Based Funding formula. PBF is a robust methodology, although it suffers from a lack of transparency in its application.

> ***More seriously, however, PBF is not designed to deal with unanticipated natural disasters that cause devastation which, among other things, significantly disrupt the reliability of population data and leads to unplanned large scale capital works requirements.***

This has served to blow out Canterbury's deficit. But, as with other rebuilds, the Government is requiring that it repay it with the standard capital charge. As it happens the capital charge for the earthquake rebuild to date roughly equates to Canterbury's deficit.

There is a compelling argument that, given the exceptional nature of Canterbury's circumstances, the Government should waive the capital charge, thereby removing the deficit and the consequential additional pressures on this victim of a natural disaster.

INVESTMENT OPTIONS IGNORED

The Government also has investment options. It had the option of investing in the SMO workforce capacity in DHBs. In 2009, ASMS and the DHBs jointly developed a document known as the 'Business Case' which concluded that by improving the senior medical staff capacity (ie, employ more numbers through more competitive terms and conditions of employment) to free up more time for specialists to spend time on clinical systems improvements. This would include, for example, reducing clinical variation and adverse events.

> ***Through this approach, considerable financial savings could be made while improving quality.***

Unfortunately, through a negative attitude from then Health Minister Tony Ryall and lack of backbone from chief executives, the DHBs reneged on the agreement. Thus, the opportunity was lost; had the DHBs not lost their nerve, then arguably today's deficits would have been avoided.

Government has lost another opportunity to reduce costs by its failure to learn from the experience in Canterbury DHB of the clinician-led and development health pathways between community and hospital, known as the 'Canterbury Initiative' which has both improved the effectiveness of patient care and saved considerable health dollars.

Again, by investing in clinician-led initiatives both quality and financial performance improve. Prior to this initiative, Canterbury DHB expected it would have to undertake a major hospital rebuild. Because of the initiative's success, it concluded it did not need to – until, of course, the earthquake devastation.

This approach is highly relational rather than contractual. In contrast, the leadership of the three Auckland DHBs finds itself in a virtual state of war with primary care due to the high transaction cost and contractual nature of their relationship. If we had effective leadership from Government in the health sector, this could have required other DHBs to look at Canterbury's relational approach to the community-hospital relationship and adapt this to their own populations.

PAYING FOR DEFICITS

So, while chief executives and their immediate circle may sweat over deficits, why should senior doctors and other health professionals be subjected to this?

> ***Deficits are a consequence of government decisions in areas where they have options.***

Further, the pressures on specialists at the clinical and diagnostic front line, trying to provide quality patient care in a financially retrenched health system, far exceeds the pressures that chief executives come under. Unlike clinical workforce pressures, operational expenditure deficits do not carry over to the next financial year.

Chief executives pay for these politically induced deficits with their sweaty brows and pass the pressure on to their health professionals. As a result, senior medical staff pay for it with their health – it is called burnout.

DR WENDY LEVINSON

REDUCING HARM AND CREATING A SUSTAINABLE HEALTH SYSTEM: *CHOOSING WISELY*

The Chair of *Choosing Wisely Canada*, Dr Wendy Levinson, was in New Zealand earlier this year to address a symposium organised by the Council of Medical Colleges.

Dr Levinson is a Professor of Medicine and past Chair of the Department of Medicine at the University of Toronto. She is an international expert in the field of physician-patient communication, and is coordinating the implementation of *Choosing Wisely* campaigns in nearly 20 countries around the world, including New Zealand.

The *Choosing Wisely* campaign was launched here at the end of last year to encourage health professionals to talk to patients about unnecessary tests, treatments and procedures. The campaign is being run by the Council of Medical Colleges, in partnership with the Health Quality & Safety Commission and Consumer New Zealand, and with support from a number of health sector groups. More information is available at **www.choosingwisely.org.nz.**

ASMS talked to Dr Levinson about *Choosing Wisely* and its relevance to New Zealand.

WHAT IMPACT HAS THE CAMPAIGN HAD IN CANADA?

"We're seeing clear examples of success in Canada. For instance, many centres have decreased their use of red blood cells by 30%. That's having a huge impact. Blood is a precious commodity and we inconvenience people to get it, and it can be very costly. In another example, we've seen a 50% decrease in the use of urinary catheters in Canada and a number of hospitals are also looking at the amount of pre-op testing they do.

"A lot of things happen in hospitals just because they're baked into the system, so it's a case of changing the way we think of them. There are committees in hospitals that are encouraging front line staff to identify examples of waste or things that don't make sense, and then support them to make changes.

"There's a lot of low-hanging fruit for hospital specialists because of the infrastructure that hospitals have. I think there are a lot of opportunities to bring about change.

"The first stage of the campaign is really important. It needs to engage physicians in leading the conversation and ensuring that it continues to be clinician-led. As health professionals, we have a responsibility for the sustainability of the health system as well as preventing harm. It's our job to participate in the discussions around that.

"It's a conversation that also has to engage the public and patients because if patients don't understand that more isn't always better, they will think it's a rationing exercise rather than a quality of care exercise. It's not always easy for patients to understand that a test can be harmful."

WHAT WOULD YOU DO DIFFERENT IN ROLLING IT OUT IN NEW ZEALAND?

"In terms of New Zealand, one thing we could have done better in Canada is engaging patients in the campaign right from the beginning. Some hospitals have educated patients to be part of their *Choosing Wisely* committees, and I think that's been helpful. Patients are asking really pertinent questions.

"We'd also encourage the New Zealand campaign to engage really well with medical students. We've found that students are very aware of things that happen in hospitals that don't make sense."

WHAT ABOUT THE RISK THAT THE CAMPAIGN MIGHT BE CO-OPTED AS PART OF A WIDER POLITICAL PUSH TO REDUCE HEALTH CARE COSTS, AND IN EFFECT BECOME SOMETHING THAT SUPPORTS RATIONING?

"When we created *Choosing Wisely* we wanted a campaign where clinicians could lead and for it not to be perceived as rationing. Clinicians don't get up in the morning to save money for the health care system. We're about patients. We treat the person in front of us and give them the care they need.

"*Choosing Wisely* is about the work of doctoring. It's important to frame it in the right way, to describe the focus of the campaign as being about improving quality and reducing patient harm. The campaign has not been co-opted, I can tell you.

"One politician told me: I always sit on the opposite side of doctors who are telling me to give them more but this campaign allows me to sit on the same side as doctors and talk about what makes care better."

WHAT ABOUT THE RISK OF COMPLAINTS TO THE HEALTH AND DISABILITY COMMISSIONER OR PRACTITIONERS' PROFESSIONAL BODIES IF, FOR EXAMPLE, A PATIENT IS ADVISED NOT TO HAVE A PARTICULAR TEST OR PROCEDURE DONE BUT LATER FEELS THEIR HEALTH HAS SUFFERED AS A RESULT?

"The campaign is not about forcing people to do things a particular way. It's about engaging in a conversation. Patients who feel informed and involved are less likely to sue, in our experience. A fundamental component of *Choosing Wisely* is shared decision-making and information. So far in Canada there has not been a single case where *Choosing Wisely* has come up in a case."

HOW WILL WE KNOW IF IT'S HAVING AN EFFECT IN NEW ZEALAND? WHAT WILL SUCCESS LOOK LIKE?

"It will be a culture change. You will know something is happening by the patient attitudes you are encountering, the attitudes of doctors and changes in organisational practices, including buy-in. Ultimately you will be able to see signs within the health system of decreased utilisation.

"We wouldn't have the problems we do if it was simple to fix the underlying culture. Doctors over-order tests because patients request them, or we have miscommunication or we're afraid of being sued, or because the thinking is embedded in our medical education. There's some really interesting research that if you do your medical training in a place that has a high use of health resources, then you tend to practise like that.

"We have these four questions that we encourage patients to ask: Do I really need this test or treatment? What are the risks? What are the other options? What happens if I do nothing? We know that patients often feel intimidated by doctors. They're not necessarily going to challenge us. But if a doctor says, 'I don't think you need that MRI', then we want the patient to switch from thinking 'the doctor is withholding' to 'maybe I don't need that test'.

"It all sounds so simple, like a no-brainer, but it's complicated to put into practice. Give it time."

SURVEY OF DOCTORS' PRACTICE REGARDING UNNECESSARY TESTS, TREATMENTS AND PROCEDURES IN NEW ZEALAND

The following summarises the results of a survey carried out by the Council of Medical Colleges (CMC) in conjunction with ASMS and the NZMA. The survey gathered information on doctors' attitudes to prescribing unnecessary tests, procedures and treatments in New Zealand.

The full report of this research is available from the CMC and what follows is the report's conclusion.

Since the formal launch of the Choosing Wisely campaign in New Zealand, a total of 20 Australasian and New Zealand colleges and specialist societies have endorsed over 100 recommendations that healthcare professionals and patients and consumers should question[1]. Each recommendation is based on the best available evidence.

The key message accompanying the Choosing Wisely recommendations is that they are not prescriptive but intended as guidance to start a conversation about what is appropriate and necessary. The campaign highlights that each situation is unique, and healthcare professionals and patients should use the recommendations to collaboratively formulate their own appropriate healthcare plan together.

It is clear from the survey results and comments that many New Zealand doctors are indeed already taking a nuanced approach to determine whether certain tests, treatments and procedures are appropriate for their patients. Moreover, they are typically doing so using a process of discussion, negotiation or shared decision-making.

One of the underlying principles of the Choosing Wisely approach is that it should be multi-professional and, where possible, include doctors, nurses, pharmacists and other health care professionals. The survey results underline the importance of this approach, with one of the key themes emerging from comments is that smart choices are not just an issue for the doctor-patient relationship, but one that also that needs to be addressed across the whole healthcare team.

In New Zealand, the CMC currently has the support of the New Zealand College of Midwives and Pharmaceutical Society of New Zealand. CMC is also working with Health Pathways[2] and other groups to improve referral from other health practitioners. The New Zealand Medical Students' Association (NZMSA) has agreed to promote Choosing Wisely to its members. It is following the Canadian students in developing a list of recommendations for medical students and working to get the principles of the Choosing Wisely campaign integrated into medical education.

The surveys found that a significant majority of doctors (61.6%) think that unnecessary testing, procedures and treatments is a serious or very serious issue in the New Zealand health sector. There is as yet little clear data to show how New Zealand compares internationally in this regard. However, a similar survey in the USA[3] found that 73% of physicians indicated that the frequency of unnecessary tests and procedures is a very or somewhat serious problem in the health sector.

There were, however, notable differences in patterns of responses from ASMS and NZMA members. Thus, the degree to which NZMA respondents considered that provision of unnecessary testing, procedures or treatments was either a 'serious' or 'very serious' issue in their current area of practice was considerably higher than indicated by ASMS respondents (56.6% vs. 46.4%)

Moreover, NZMA members indicated that were more likely than their ASMS counterparts to advise against and still provide a test, procedure or treatment they deemed to be unnecessary (22.5% vs 9.7%).

The reasons for these differences are not clearly apparent from the surveys. However, it is notable that NZMA respondents, drawn overwhelmingly from the primary sector, were more likely to mention patient expectation as a factor than their specialist ASMS counterparts.

This is consistent with the finding of a study in the US, which found that primary care physicians feel more pressure from patients for tests and procedures. The study concluded 'that future interventions may need to be specifically oriented toward primary care physicians to equip them with strategies for resisting patient pressure and helping patients to understand that more is not necessarily better'.

While Choosing Wisely has faced criticisms that it is about saving money, one of the core principles of the campaign is that it must be health professional-led (as opposed to payer/government led), about rationalising, not rationing. It emphasises that campaigns are focused on quality of care and harm reduction, rather than cost reduction.

The survey results appear to confirm that it is quality of care rather than cost reduction that is the predominant factor in New Zealand doctors' decision-making as to whether a test, process or treatment is appropriate. While they are conscious of cost, time and resources, this is a secondary factor in their considerations. Thus, a number of respondents indicated they were more likely to agree to a test, procedure or treatment they deemed to be unnecessary if it was harmless and low-cost, than if it was risky - and expensive.

The surveys were completed in November 2016 just prior to the formal launch of the Choosing Wisely campaign in December. They will therefore provide a useful baseline against which we can measure changes in the level of awareness of the campaigning when the next survey is undertaken[4]. They also point to possible areas of the future work for CMC, for instance specifically targeting other health practitioners, junior doctors and the primary care sector.

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1 http://choosingwisely.org.nz/health-professionals/

2 HealthPathways is an online manual used by clinicians to help make assessment, management, and specialist request decisions for over 550 conditions. http://www.healthpathwayscommunity.org/Home.aspx

3 National Physician Survey for the American Board of Internal Medicine Foundation, February 12 through March 21, 2014 March 25, 2014. http://www.choosingwisely.org/wp-content/uploads/2015/04/Final-Topline-Results.pdf

4 This is expected to be by 2018.

THE ASMS/DHB MECA BARGAINING FEE

LLOYD WOODS | ASMS SENIOR INDUSTRIAL OFFICER

Ever since there have been employee associations and trade unions negotiating contracts (or nowadays, collective employment contracts) there have been other employees gaining the benefits of the negotiations without making any contribution to the effort required.

This is commonly known as 'freeloading' or 'coat-tailing' and can be used by employers to disempower unions.

These problems of freeloading were recognised in legislation in Part 6B of the Employment Relations Act (ERA). 2000. Part 6B gave the right for employers and unions to agree during negotiations to a bargaining fee clause. Under Part 6B, the employer may 'pass on' terms and conditions to non-member employees in exchange for those employees paying a bargaining fee to the union that negotiated the agreement.

We have had an ASMS/DHB jointly agreed bargaining fee clause (clause 31) since the 2007-2010 MECA and, given the correct process of balloting etc as required by the legislation, a bargaining fee can be applied at the rate of the normal ASMS subscription.

Basically, for the small proportion of SMOs who choose not to join the ASMS, they will be covered under the terms and conditions of the MECA and enjoy the fruits of the cost and labour involved in getting the new MECA, but be charged a fee that is equivalent to what a member pays for their ASMS subscription as a result. They cannot therefore 'freeload' but must pay their way.

It is logical to join the ASMS and enjoy all of the benefits of membership rather than pay an equivalent amount as a bargaining fee just for the MECA outcome, but some (very few) still choose to do so.

Notably, the MECA outcome can be expected to be far greater in value than the bargaining fee, so it is still a good deal.

Balloting for the bargaining fee will take place once the MECA reaches conclusion. We encourage all members to vote to ensure that, just as they make their contribution to the MECA bargaining, so do others that choose to be non-members but otherwise would freeload.

Occasionally we hear that non-members feel that the bargaining fee is an attempt to force them to join the ASMS. This is certainly not the case. Eligible SMOs have a right to belong or not and we acknowledge that right. Paying a bargaining fee does not make them an ASMS member but simply gives them the opportunity to pay their share.

It is also possible to opt out of both ASMS membership and the bargaining fee. Should an SMO choose to do so, he or she will not get any salary increase or other advantage to their current conditions of employment. It is very unusual to have anyone opt out, and on the one occasion that we are aware of when the SMO questioned why their salary step was very low compared to his colleagues, he was shocked to realise that he had not had any movement in salary for some years as a result of not being covered by the MECA through ASMS membership or the bargaining fee.

In summary, we see it as being sensible and logical for all SMOs who are eligible for ASMS membership to join the Association. Membership brings benefits well beyond just the increases and improvements to salary and conditions through the MECA bargaining.

The bargaining fee matches the ASMS subscription and it seems illogical, given the person is able, not to join. However, where an eligible SMO chooses or is unable to join ASMS, it is logical to pay the bargaining fee.

It is very important that ASMS members vote for the bargaining fee in the eventual bargaining fee ballot if we are to ensure that everybody who benefits pays their fair share.

THE SICK LEAVE BLUES – THE ASMS INDUSTRIAL OFFICERS' GUIDE TO SICK LEAVE

LLOYD WOODS | ASMS SENIOR INDUSTRIAL OFFICER

Sometimes as industrial officers for the ASMS we genuinely look upon members as 'superheroes' in terms of the work that you do and the contribution to other people's lives and the public health system in general that you make. SMOs are an impressive bunch and often go well beyond the call of duty.

But – we do not see SMOs that go to work when they are sick (as is far too often the case per the recent presenteeism survey) as superheroes, but as seriously compromising the health of themselves, their colleagues and, worst of all in many cases, their patients.

Going to work when you are sick is, to be brutally frank, stupid and, in some cases, a breach of the ethical responsibility to only practise if fit to do so. Going to work and spreading your germs is not helping out but is compromising others.

Having been so brutally frank, it is important to note that we understand the pressures to go to work and we sympathise with those of you that suffer this pressure.

PRESSURE TO WORK

We know that in some departments when an SMO goes on sick leave there is an expectation that colleagues will simply 'step up' and fill the gap. We know that SMOs don't like to put that extra burden on colleagues, and we know that in some cases colleagues are resentful of a colleague's absence meaning more work and, in a worst-case scenario, that there is overt pressure on SMOs to 'soldier on' as a consequence. Sadly, we also know that often this pressure is much worse when the SMO requires sick leave for a child, partner or these days quite possibly a parent. This is unacceptable in any case.

We know that even in services where there is not an expectation that colleagues cover your sick leave, there is pressure not to take sick leave due to the need to cancel clinics or lists as a consequence. This pressure is often from the relevant manager rather than colleagues but is also often self-imposed where the SMO feels honour bound to 'soldier on' so patients don't suffer delays or have their health further compromised. One might see this as 'professional behaviour'. We don't!

These pressures (management-, colleague- or self-imposed) are unacceptable in any workplace that talks about staff well-being or a culture of health and safety. Taking time off should not be seen as optional when you are sick or somebody in your family needs your support while they are sick. SMOs who 'soldier on' compromise their own health and safety and those of colleagues and patients. It is time that the pressures described above must stop.

MECA PROVISIONS

The ASMS/DHB MECA has good provisions for leave "on full pay in the event of their personal illness or accident or that of a close family member". This is an absolute entitlement that is there to ensure that you don't have to work when you should not be working.

When you are sick or are needed to support a close family member who is sick, you should not be working. Superheroes get sick too!

That is it, end of argument, from the industrial perspective. It is also 'it' from a Medical Council perspective. It is worth reading chapter 18 of Cole's Medical Practice in New Zealand in full with this regard, but we note under 'The law: fitness to practice':

> *The Council states, "A doctor is not fit to practise if, because of a mental or physical condition, he or she is not able to perform the functions required for the practice of medicine". These functions would include:*
>
> - *the ability to make safe judgements*
> - *the ability to demonstrate the level and skill and knowledge required for safe practice*
> - *behaving appropriately*
> - *not risking patients infecting patients with whom the doctor comes in contact*
> - *not acting in ways that impact adversely on patient safety.*

WHAT TO DO?

When you are too sick to work, or if you are needed by your child or other close family member because they are sick, take the leave. You will need to get a doctor's certificate for absence that exceeds five days, but otherwise take the time off.

If you feel pressure not to take this leave, hand or send them a copy of this article or, if you can, ask the person directly what the problem is.

If you observe a colleague being pressured to work, support them by calling out this behaviour.

If you observe a colleague 'soldiering on', remind them that they don't have to do so and likely are not doing anybody any favours but more likely the opposite.

REFLECTION

DR JEFF BROWN | ASMS NATIONAL SECRETARY

I am normally an inveterate optimist, more often known for being too happy with whatever water is in my glass, or even having access to a glass. When asked to contribute I try to believe in the best intentions of others, and seek any positivity for improvement. However, my sense over recent months and years is a generic swell of negativity competing with increasing exhortations to work better, faster, more disruptively, with relatively less resource in time and money.

What I am being told by my colleagues, senior and junior, medical and others, is that our Director-General has espoused a new New Zealand Health Strategy which still feels like words without action. We hear Uber and Blockchain promoted as models for health delivery. I am hearing that our Minister is an endless font of good news and new money, every media release brimming with "our cup floweth over", while appearing to ignore increasing evidence of unmet need languishing on waiting lists, both real and virtual, a burned-out workforce, and extinguished joy.

I am privileged in my work to continue to feel the pulse of our healthcare, from the bedside to the boardroom. That pulse is faltering. My serial optimism is now so challenged that I am driven to put in verse what is getting worse.

MAGNIFICENT (HEALTH STRATEGY) OBSESSION

My broken cup
Can no longer hold
The half-full hope
Of futures bright

It leaks my
Drawn out optimism
In drips of tortured
Justification, light

On detail enough
To satisfy my lords
That blood is drawn
In diagnosing

Both cancerous ill
And brilliant health
With the divide much
Too close to divine

Each denial of sight
Falling on deaf ears
Of bankers' hype
PPI promises, right

On target, brimming
With block chain solutions
For overflows into
Saucers of slops.

VITAL STATISTICS

Of 25 countries of the Organisation for Economic Cooperation and Development (OECD) which provide data on two measures relating to access to doctors, New Zealand scores poor to middling.

New Zealand ranked 23rd in a measure of doctor consultations per capita (all settings)* in 2014 (or the latest year available up to 2014). The Republic of Korea had the highest number with 14.9 consultations per capita, Mexico had the lowest with 2.6. New Zealand recorded 3.7, with the average for the 25 countries being 6.9.

Of the same 25 countries, New Zealand was ranked 17th in a measure of doctors* per 1000 head of population in 2014. Austria had the highest number, with 5.1/1000, Mexico had the lowest with 2.2/1000. New Zealand sat at 2.9/1000, with the averages being 3.3/1000.

* Includes consultations and visits to generalist and specialist doctors, either in the doctor's offices, hospital outpatient departments, or at home. Excludes consultations during an inpatient or day-care treatment and telephone and email contacts

** All medical graduates, including those from overseas, whose work involves direct contact with patients.

Source OECD Health Data 2016.

LISA DAWSON, MEDICAL ONCOLOGY, WHANGAREI HOSPITAL, NORTHLAND ASMS VICE PRESIDENT

WHAT INSPIRED YOUR CAREER IN MEDICINE?

If I'm honest I wanted to be a vet at first but I grew up in England and I didn't have high enough grades to get into vet school so I ended up doing medicine instead. My dad wanted his three daughters to have professional careers so all of us ended up in medicine for different reasons.

I kept thinking about training to be a vet and contemplated changing over several times. Then in my final year of medicine I met my Kiwi husband and we moved to New Zealand. I was still thinking about being a vet when I got here but I told myself to give it another year.

> *Once I started working, I really enjoyed medicine and haven't looked back.*

I worked as a GP, but I missed hospital medicine. By the time I had six children I had left general practice and re-entered hospital medicine, getting a role as oncology MOSS in Tauranga. That's when I decided I wanted to be a medical oncologist.

So, on completing my year as a MOSS I moved with my family to Hamilton to complete basic training. After so much time out of hospital medicine and with six children, my colleagues were surprised when I passed my exams! I completed my training in Palmerston North.

In 2014 I took up a position in Whangarei, where initially I was the sole oncologist. At that time Whangarei was a satellite unit for Auckland DHB. After being there for about six months we recruited a second oncologist.

Not long after this we opened the Jim Carney Cancer Centre, a purpose-built cancer centre funded by the community. We continued to build up the cancer and blood service and we now have three oncologists, two haematologists, two registrars and a house officer as well as all nurses and support staff.

> *Last year the centre received the Northland Community Innovation Award for their greatly improved model of service, which we're really proud of.*

I was close to being burnt out at the end of last year. One of my children had just had major open heart surgery, and working full time as well as being Head of Department became too much. I stepped down from my HOD role and started working four days a week. I'm now enjoying my work and family again.

WHAT DO YOU LOVE ABOUT YOUR JOB?

Without sounding clichéd, I love being able to help patients understand their diagnosis and treatment options.

There are a number of things we've tried to put in place to improve their cancer journey. One of them was tackling the waiting lists - most people now get an appointment in a week, although at times this can be longer. My best friend was diagnosed with cancer a few years ago and she had to wait three weeks to see someone. There is so much anxiety waiting for a diagnosis and explanation, we want to do better than this.

We have worked hard at creating a supportive environment for our patients with good and clear communication. Our motto is 'Te Waka Eke Noa' – "We are all on this journey together".

I've appreciated the support from the DHB managers to put in place a model of care that helps empower patients by putting them at the centre of their care.

WHAT'S THE CHALLENGING ASPECT OF PRACTISING MEDICINE?

I think the most challenging aspect in the current climate is under-resourcing.

> *We want to help patients as best we can but we are working in a time and resource-poor environment.*

This is very frustrating, and there continues to be pressure to do more with the same level of resourcing.

WHY DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

When I first started as a HOD, I wanted to understand every aspect of management so I went to all of the meetings and read everything I could. During that time I heard about the ASMS conference and I was interested in learning more and understanding the MECA. At the time of the conference the branch Vice President stood down. Ian Page suggested me to replace him and although I probably had too much on my plate, I agreed. It's been really interesting to be a part of ASMS and to attend the meetings and conferences.

WHAT HAVE YOU GAINED OR LEARNT FROM YOUR ASMS INVOLVEMENT?

I think I have broadened my knowledge of what is and isn't acceptable, how job sizing works, what an employer can reasonably ask of you or not, those sorts of things.

Looking back I can see I was uninformed but I've also been surprised by how uninformed other specialists have been, even on issues about whether or not to stand up for themselves.

> *It's good to talk to new specialists about what is and isn't acceptable and to try and support them.*

I've really noticed how different it is from DHB to DHB, too. Northland is a good DHB and I'm very well supported by the CMO and the general manager. We don't have problems with getting leave, or expenses or sabbaticals. It's a good place to work.

Outside of work, I love walking. Northland is an amazing place to climb the hills and take in the view. We have a 47-foot yacht that my husband has recently renovated. We had our first holiday on it this Easter in the Bay of Islands.

HISTORIC MOMENTS

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

12th November, 1964.

The Hon. D. N. McKay,
Minister of Health,
Parliament Buildings,
WELLINGTON.

Dear Mr. McKay,

I write to thank you for your letter of November 10th. You will realize that my Executive cannot regard the announcement of a maximum of £3,800 as satisfactory, for the increase of £300 fails to restore the purchasing power of specialists on the maximum salary to the level which existed in 1961 at the time of introduction of the previous maximum of £3,500.

My Executive is looking forward with anxiety to the far more important decision concerning margins below £3,800 which you are to announce when the recommendations of the Medical Officers Salaries Advisory Committee become available. May I in this connection take the liberty of again reminding you of the burden of our submissions which, as stated during the interview you kindly granted me on March 3rd 1964, and in my letter to you of May 20th 1964, was as follows:

(1) That a revised "junior" specialist scale apply only to temporary assistant appointments.

(2) That appointment to a specialist (consultant) post on the establishment of a hospital should imply senior status.

(3) That a revised senior specialists' scale should give on appointment a range of at least £1,100 over not more than ten years, and that no provision for bars or ceilings be made within this scale.

Although a maximum of only £3,800 may make a range of £1,100 difficult to achieve at the present moment, we regard it as highly important that the principle of an extended career scale with automatic promotion and without bars be accepted now. Only this will provide that reasonable security of appointment and promotion without which recruitment to the Wholetime Specialist Service must become increasingly difficult.

Yours sincerely,

F. W. GUNZ, M.D.
President, Wholetime Senior Medical
Officers' Association of New Zealand.

OFFICE OF THE MINISTER OF HEALTH,
WELLINGTON, N.Z.

17 November 1964

Dr F.W. Gunz,
President,
Wholetime Senior Medical
Officers' Assn of N.Z.,
Pathology Department,
Christchurch Hospital,
Private Bag,
CHRISTCHURCH

Dear Dr Gunz,

This is to acknowledge your letter of 12 November in which you write further concerning salaries of full time hospital specialists.

As you know the Medical Officers' Salaries Advisory Committee is to meet next Friday, 20 November, to consider the fixing of appropriate margins below the top figure of £3,800. I shall see that your views are placed before the Committee for its consideration.

Yours sincerely,

D.N. McKay

Minister of Health

DID YOU KNOW

DID YOU KNOW... ABOUT PART-TIMERS AND REIMBURSEMENT OF CME AND WORK-RELATED EXPENSES?

Part-timers are entitled to full (ie, 100%) reimbursement of their work-related expenses (eg, annual practising certificate, college fees, etc), provided the part-timer has no other income from medical or dental practice.

Similarly, part-timers who have no other income from medical or dental practice are entitled to the full reimbursement of up to $16,000 per annum actual and reasonable CME expenses. The entitlement to 10 working days leave for CME is, however, pro rata for part-timers.

More information is available in the DHB MECA:

Clause 21: **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-21/**

Clause 26: **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-26/**

The ASMS Standpoint on professional development: **http://www.asms.org.nz/wp-content/uploads/2014/08/ASMS-Standpoint-Professional-Development-and-Education.pdf**

DID YOU KNOW... ABOUT LEAVE DURING THE ILLNESS OR ACCIDENT OF A CLOSE FAMILY MEMBER?

Clause 27 of your DHB collective employment agreement provides for sick leave on full pay, not just when you have an accident or are unwell, but also when a close family member is unwell or injured. The length of your paid leave will be determined by the facts and circumstances of each case, as will be the 'closeness' of the family member.

There is no obligation on you to 'make up' any clinics, after-hours call or weekend shifts missed during such leave.

More information is in clause 27 of the DHB MECA: **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-27/**

DID YOU KNOW...ABOUT JOB DESCRIPTIONS?

The DHB is required to consult you whenever it plans to employ a senior medical or dental officer in the same service or on the same roster. Clause 52.1 of the DHB MECA says you are to be consulted on the need for the appointment, the nature of the role, and the skills, qualities and experience appropriate for the appointment.

If required, a new or revised job description must be prepared.

More information: **https://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-six/clause-52/**

DID YOU KNOW... ABOUT BEREAVEMENT LEAVE?

As a DHB employee, you're entitled to reasonable leave on full pay "on the bereavement of someone with whom you have a close association".

Your entitlement is found in MECA Clause 27.1 and is not limited in time (eg, to only three days) or to the death of a close or immediate family member. Each case should be considered sensitively and recognise your particular culture, family responsibilities and travel requirements.

There is no obligation on you to 'make up' any clinics, after-hours call or weekend shifts missed during bereavement leave.

More information is in clause 27 of the DHB MECA: **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-27/**

DO YOU KNOW WHO I AM? TREATING A VIP PATIENT

DR TIM COOKSON | MEDICOLEGAL CONSULTANT, MEDICAL PROTECTION UK, WITH THANKS TO MARIKA DAVIES, SENIOR MEDICOLEGAL ADVISER, MEDICAL PROTECTION UK

Doctors should treat a VIP patient just as they would any other, but this may be easier said than done.

Doctors need to be objective in order to provide good care – but clinical judgement can be clouded when caring for certain patients. This group may include colleagues, politicians, well-known sports personalities and other celebrities. Another group for whom emotional attachment may affect our ability to provide objective care is family and friends, and the Medical Council of New Zealand (MCNZ) has recently published a very clear statement on this. While it will usually be possible to find a different doctor to treat one's family and friends, other VIP patients would need to seek medical care outside New Zealand to avoid any potential impact on their care because of their status. This would obviously not be practical, so we need to be mindful of the potential impact on our clinical judgement when treating this group of patients.

That doctors are likely to manage colleagues differently from other patients, despite their best intentions not to, is reasonably clear.

> ***A recent study of GPs and consultants in Hampshire, UK, found that doctors tended to behave differently when seeing a doctor as a patient.***

The researchers reported that, in an encounter with a fellow physician, 26% of doctors would do more investigations, 22% would be more likely to treat, and 46% would be more likely to refer onwards.[1]

Many doctors will identify with this finding, and will remember consultations where they felt that their clinical judgement and decision making was influenced by who the patient was. A patient whose behaviour or status has the potential to influence a doctor's judgement or actions has been described as a 'VIP' patient.[2]

VIP syndrome also occurs when a 'very important person' receives a level of care not available to the average patient, and which may cause doctors to second guess their normal decision making.[3]

THE RISKS OF VIP CARE

The care of VIPs is often qualitatively different from that of other patients. VIPs may receive greater access, attention, and resources from healthcare staff.[2]

> ***There is a risk of either over- or under-treating VIP patients: doctors may try to spare their patient from embarrassment, pain, or inconvenience, so may omit some investigations or procedures. On the other hand, VIP treatment can result in additional and unnecessary tests, which might not be in the patient's best interests.***

It may be more difficult to follow the 'Choose Wisely' philosophy[4] with these patients, and deviating from standard practice may cause tension within the health care team.

There might be delays in treatment as doctors unwittingly collude with a doctor-patient's denial.[5] There is also the risk that the treating doctor may defer

to a doctor-patient to make clinical decisions, as a result of uncertainty or lack of confidence. The advice doctors give could also be affected: in the Hampshire study 74% said that they felt uncomfortable with challenging their doctor-patients on lifestyle issues, and 9% said they would completely avoid this.

MANAGING THE RISKS

The need for objectivity when treating patients is a key reason doctors are advised not to treat their friends or families: the MCNZ says that doctors should, wherever possible, avoid providing medical care to anyone with whom they have a close personal relationship, and must not provide treatment in specific circumstances.[6]

Doctor-patients may need more reassurance than other patients because of the anxiety that comes with their additional knowledge and experience. Celebrities or the powerful may be used to getting their own way, and there may be organisational challenges because of media interest and privacy issues. But when making decisions about clinical care, the usual rules of good medical practice apply whoever the patient is.

> ***VIP patients should be treated the same as any other patient with a similar presentation, and care should be taken to follow standard clinical procedure as closely as possible.***

It is easy to feel flattered to be chosen to be the doctor of a colleague or a celebrity. Being aware of the risks and following the usual rules of good medical practice will help to ensure that the patient receives the right care, regardless of who they are.

PRIVACY RISKS WITH VIP PATIENTS

Doctors are accustomed to accessing files of patients, and the temptation to quietly access the files of a VIP patient who is not under your care can be hard to resist. However, with the audit programmes currently in place, many of which will particularly look for unauthorised access for VIP patients, the result of any such action may be significant. The personnel who accessed the files of a well-known sports person in Christchurch, and those who viewed certain X-ray images in Auckland of an unusual object in a strange location, were subject to strict disciplinary action. Some organisations will place restrictions on access to clinical information, though this may create problems in an emergency situation if the relevant information is not readily available.

TOP TIPS FOR TREATING A VIP PATIENT

- Remember the person you are treating is – first and foremost – a patient.
- Be aware that your objectivity may be clouded and that preferential treatment may not always be in the best interests of your patient.
- Make sure that decisions about access to treatment are made based on clinical need.
- A patient cannot insist you provide treatment you do not consider to be in their best interests.
- Be prepared to justify your decisions and seek a second opinion if necessary.
- The same rules of confidentiality apply whoever your patient is.
- Don't be tempted into accessing the notes of patients who are not under your care.

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WOMEN DOCTORS WANTED!

In response to the high burnout scores for women specialists aged 30 to 39, ASMS Principal Analyst Dr Charlotte Chambers has obtained ethics approval for a qualitative study that she hopes will go some way to explaining these trends.

The research will focus on the working lives of female specialists aged 30 to 39 who are ASMS members currently working in district health boards.

The research will involve face-to-face interviews away from the place of work for approximately one hour. Participation in the research will be strictly confidential and every attempt will be made to preserve participants' anonymity.

Dr Chambers is seeking expressions of interest from eligible women who might like to participate in the research.

If you are interested please contact her at **cc@asms.nz** from a non-work email address, or send her a personal message through the 'NZ Women in Medicine' Facebook page.

ASMS SERVICES TO MEMBERS

As a professional association, we promote:

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

As a union of professionals, we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

OTHER SERVICES

www.asms.nz

Have you visited our regularly updated website? It's an excellent source of collective agreement information and it also publishes the ASMS media statements.

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

ASMS job vacancies online jobs.asms.org.nz

We encourage you to recommend that your head of department and those responsible for advertising vacancies seriously consider using this facility.

Substantial discounts are offered for bulk and continued advertising.

ASMS Direct

In addition to *The Specialist*, the ASMS also has an email news service, *ASMS Direct*.

How to contact the ASMS

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Have you changed address or phone number recently?

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

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THE FEELING'S MUTUAL

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