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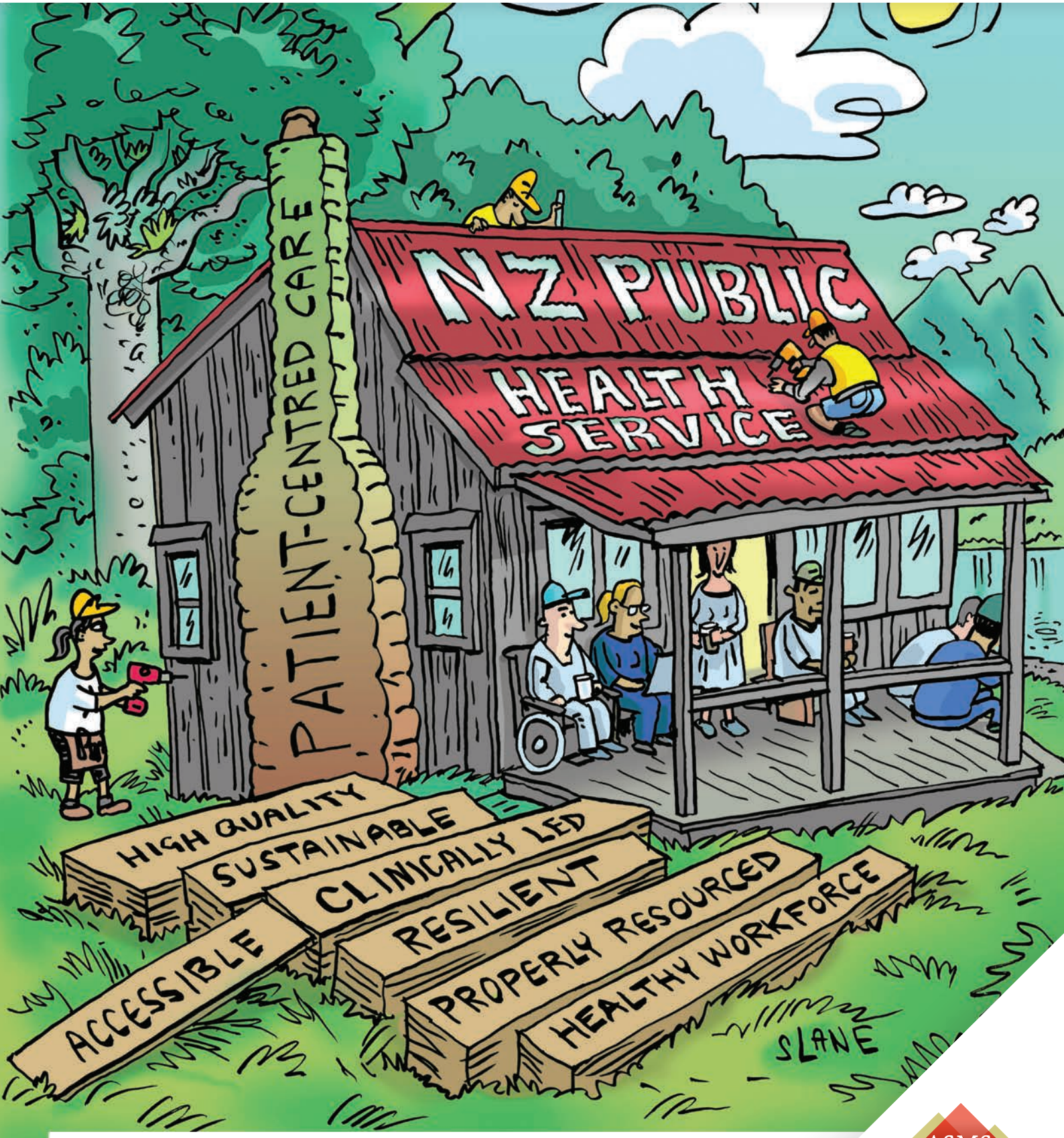

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WHY OUR PUBLIC HEALTH SERVICE IS WORTH FIGHTING FOR

ASMS has celebrated 30 years of representation and advocacy with a special one-day commemorative conference in Wellington.

The anniversary conference was held at Te Papa on 27 June and attended by a wide range of senior doctors and sector representatives.

The conference theme was 'Why our public health service is worth fighting for'.

The keynote speaker was Professor Martin McKee from the London School of Hygiene and Tropical Medicine. He is one of the world's leading researchers on the operation of health care systems in times of economic austerity. An interview with him is on p4.

Other speakers included Dr Otmar Kloiber, Secretary General of the World Medical Association, Dr Samantha Murton, President of the Royal New Zealand College of General Practitioners, and Health Minister Dr David Clark. Interviews with Drs Kloiber and Murton are on pages 6 and 8 of this issue of *The Specialist*. We were also fortunate to have several panels of front line medical specialists to discuss issues arising during the conference addresses.

Videos of the addresses will be available soon.

Professor Martin McKee's visit to New Zealand and the celebration function have been kindly sponsored by MAS.

"The NHS has been starved of resources for almost a decade, and although it has had a recent funding boost, it is difficult to see how this will be sustained."

BREXIT A 'DISASTER' FOR HEALTH

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

New Zealand's struggling medical system will benefit from Brexit, the unsolvable but avoidable crisis that has consumed British public life and imperils the health system.

That's the view of Martin McKee, Professor of European Public Health at the London School of Hygiene and Tropical Medicine, who spoke to *The Specialist* ahead of his keynote address to a special one-day conference in Wellington to mark ASMS' 30th anniversary.

An outspoken critic of the austerity regimes adopted in the UK and some other European countries, Professor McKee, raised in Northern Ireland during the Troubles, was one of the earliest to warn that Brexit imperilled the Good Friday agreement.

"There is no obvious solution, the Government has no idea how to leave and Parliament cannot agree on any way forward. Even now, many British politicians, in the Conservative and Labour parties, simply don't understand how the EU works and don't seem to care. On a personal note I get particularly upset about the callous disregard for the hard-won peace process in Ireland by some English politicians."

IMPACT OF BREXIT

Brexit will affect the health system and health outcomes in myriad ways – loss of much needed health workers, EU supply chain fears, and the health impact of economic decline. And there is the broader and unquantifiable opportunity cost from so much of the state machinery being tied up with solving Brexit, with one former senior civil servant, now in the House of Lords, warning that withdrawal is the easy bit. Brexit, if it happens, will consume the institutions of government for a decade.

"In every way, Brexit is a complete disaster for health and the NHS."

The 2012 Health and Social Care Act was an acknowledged failure, but the current dysfunction means there is no realistic chance of legislative change, he say – and he is pessimistic about the prospect of any solution to the crisis soon.

He believes the Tory party is trapped in a hopeless downward spiral over Brexit, underpinned by a delusion that allowing Brexiteers to lead the talks will solve the riddle.

"Theresa May put pro-Brexit ministers in charge of everything, and they still couldn't find a way to leave."

He believes things will only be resolved when the Conservative and Labour Parties fracture, characterising it as a split between "realism and fantasy".

Professor McKee is happy to admit he's broadly part of an educated "elite" demonised by the likes of the tabloid press and leading Brexiteer Nigel Farage.

"A senior minister said that 'the country has had enough of experts'. I'm seen as one of the cosmopolitan elite - absolutely. I'm an enemy of the people, a term used by some newspapers who seem to be unaware of its history," he says.

"Anyone with any idea of history in Europe in the 1930s can see the extremely worrying parallels. But we have also lost any sense of decency in political discourse, with pro-Brexit parties fielding candidates who peddle extreme xenophobia and suggest that it is acceptable to rape female opponents."

He muses that it's probably going too far to label the UK a "failed state, yet".

Charting political upheavals and their effect on public health plays a central role in Professor McKee's career. Around the time of the Soviet Union collapse he established the European Centre on Health of Societies in Transition focusing on health policy in central and eastern Europe and the former Soviet Union.

UPHEAVAL AND UNCERTAINTY

Akin to the personal upheavals characterising that geopolitical shift, Brexit is changing people's lives. Migrants from the EU - who the NHS desperately need - feel insecure as the government imposes what it terms a "hostile environment", and he says although they claim to want to attract skilled migrants, politicians ignore existing EU rights that are important to people, such as future pension and parental migration rules.

"Those things are off-putting for health workers who might want to move."

This is creating a perfect storm for the NHS with fewer migrant workers, and an expected out-flow to countries like New Zealand.

"The NHS has been starved of resources for almost a decade, and although it has had a recent funding boost, it is difficult to see how this will be sustained, given that every credible economic forecast envisages that Brexit will deal a severe hit to the economy."

He says this is probably fair in a sense as Commonwealth countries contributed greatly to Britain historically, and there is a particular affinity between the UK and New Zealand.

"Many in England still see New Zealand as Kent in the south seas."

He was also startled by "terrifying" new figures showing a precipitous drop in the number of UK-trained doctors choosing to specialise. Since 2011, the number of medical graduates moving directly into specialist training plummeted from 71% to 38%.

Professor McKee has been tracking the population health effects of austerity, the policy that defined the Tory Government before Brexit came along. It's too early to quantify Brexit's health effects, but it's come at a time when life expectancy is stagnating and there is evidence that "deaths of despair" are rising.

"There's a lot of anecdotal evidence that the mental health and wellbeing of EU citizens in the UK has got worse but it's not hard evidence."

Austerity policies such as bullying the severely disabled into finding work are continuing, he says.

"It's still going on. There are so many stories. There's a culture of cruelty permeating public life."

Austerity was brought on by the 2007/08 banking crash. Asked if Brexit could be the catalyst of another sudden financial collapse, Professor McKee believes it's more likely to presage a slow economic decline, and it's already under way.

VACCINATION WOES

Professor McKee is worried about what he calls the "reaction against vaccination" and believes it should be a compulsory public health measure. He cites Italy as an example of compulsory vaccination working well.

"We are now seeing epidemics of diseases such as measles, with some fatalities. This is in part a rejection of enlightenment values, by certain politicians and their followers who reject the concept of evidence in favour of belief and ideology."

He points to evidence that political operatives have latched on to vaccination as a way of undermining people's faith in political institutions. It's linked with a wider political agenda to manipulate people.

"Opposition to vaccination is especially common among populist movements in Europe.

"Interestingly, polling data suggests that the share of the population holding these views has not increased greatly in recent years and, if anything, the opposite has happened. What has changed is the ability of extremist politicians to turn their sentiments into votes.

"Many of these politicians and commentators espouse extreme libertarian views, opposing any form of regulation of products that damage health."

But there is hope, he says, in the number of ordinary people joining street protests and calling for change on issues like climate change and xenophobia.

Professor McKee's address to the ASMS Anniversary Conference will be live-streamed and available online soon after. More information about Professor McKee is available here: **https://www.lshtm.ac.uk/aboutus/people/mckee.martin**.

Professor Martin McKee

"Austerity policies such as bullying the severely disabled into finding work are continuing."

"This was a very exciting moment in history and I was very well aware it would not come again."

POLITICAL PRESSURES GROW

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Political interference in medicine is a growing threat, says Dr Otmar Kloiber, Secretary General of the World Medical Association.

Eleven Turkish doctors were sentenced to prison for up to 36 months earlier this year for stating that war is a threat to public health.

"That brings them prison. This is outrageous. What they say is true. It's a fair statement. The accusation with the 11 was that they were supporting terrorism. This is so absurd," Dr Kloiber says.

It is not just authoritarian countries; the Australian government was criticised for trying to clamp down on the right of doctors to criticise conditions in offshore refugee camps.

And in the United States Dr Kloiber cites a Floridan law, struck down on appeal, that prohibited paediatricians from asking parents about the availability of firearms in homes where children had been accidentally shot. The law was introduced after lobbying from the NRA.

It's not just driven by ideology. With health the biggest single sector in many developed nations, it is tempting for politicians to interfere as there is much at stake economically.

SUPPORTING GOOD DECISION-MAKING

Part of the WMA's agenda is to guide politicians towards good decision-making.

He's pleased the World Health Organisation and WMA last year signed a Memorandum of Understanding advocating universal health coverage, rather than the traditional "siloed" approach targeting certain diseases.

"We think that health care has to be comprehensive. Not episodic, or pointed to a few diseases, but taking human beings as they are with all the problems they have."

In emerging economies like India and Brazil the WMA tries to steer governments towards putting doctors at the centre of primary health care. There is a tendency for philanthropic donors to fund nurses or community workers rather than fostering doctor-led services and medical training, he says.

The WMA advocates for universal health care but is agnostic about how this is achieved.

"Our quest is that the state organises health care in a way that everyone can get it without financial hardship. We have no preference for the actual system. That is not our quest."

A private insurance model per se is not a bad thing, he says; while it doesn't work in the United States, it does in Switzerland.

"The Swiss system has deficiencies but it covers everyone."

Sometimes the WMA has had to reassure doctors in countries moving to universal care that it will be good for their profession, as for some doctors it entails a drop in salary.

Dr Kloiber, who grew up in Cologne, Germany, worked in the 1990s with East German authorities and other Eastern European jurisdictions to develop functioning health systems and democratic health organisations.

"This was a very exciting moment in history and I was very well aware it would not come again.

"The new democracies were under enormous stress pulling them to completely commercial or completely state-run systems and what we wanted to offer was a model of self-governance.

"The old structures of the communist health systems were still prevailing. Those structures were contradictory to introducing health care as something that has to be produced and has to be paid for by somebody, for instance through health insurance."

The notion that health care was free had to be challenged, he says, but the aim was building a socially just system. In some cases it meant replacing systems where doctors were paid under the table by patients.

Dr Kloiber, who has headed the WMA since 2005, says the idea of doctors taking industrial action was not accepted by a majority for decades and it took a long time to change.

WMA Secretary General Dr Otmar Kloiber

"Some of the members thought it unethical to strike. But it depends on how you perform a strike."

Despite living in France, he proudly retains membership of Marburger Bund, Germany's trade union for physicians, and is interested in trade union development.

Membership of the WMA is based on one organisation per country, thus in a few cases member bodies are trade unions. Germany's member body is the German Medical Association, but Marburger Bund is closely linked to the organisation, and works like a political party trying to secure key positions.

CONTENTIOUS ISSUES

More contentious than industrial policy has been the WMA's internal battle over euthanasia. It's shed two members over the issue – the Canadian and Dutch medical associations – after they tried to shift the WMA's position.

The WMA and Dr Kloiber, who has worked in medical ethics, are opposed to euthanasia.

"I am convinced that this is not a role for doctors. Where doctors are involved in euthanasia you have severe loss of trust in doctors."

He does not want to "be a judge" and acknowledges there are some tough cases. The WMA does not demand treatments that unduly extend life when this is not desirable, he says. The will of the patient is important.

He says euthanasia is an issue in rich countries. The WMA's members from poorer states have no interest in it.

Asked about the trend towards liberalisation in many jurisdictions, he says "trends and zeitgeist are not what makes medical ethics".

To deal with the dissension in its ranks, the WMA organised regional conferences to air the matter. As expected there was almost no interest from Asia, Africa, or South America. Ironically, the European conference was hosted at the Vatican, and it of the four was the one where some delegates were in favour of the practice.

"This was kind of interesting," he says.

"It's not the world that's discussing it, it's the rich affluent countries."

"We think that health care has to be comprehensive. Not episodic, or pointed to a few diseases, but taking human beings as they are with all the problems they have."

"I am convinced that this is not a role for doctors. Where doctors are involved in euthanasia you have severe loss of trust in doctors."

"There's no fat in our system to provide urgent care. But we could if it was funded."

PUBLIC ETHOS IN PRIMARY CARE

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

That GPs are investing a large chunk of their earnings in their practices shows dedication to the public health system, says Dr Samantha Murton, President of the Royal New Zealand College of General Practitioners.

Voted into the role last year, Dr Murton is speaking at ASMS' special conference to mark its 30th anniversary and celebrate the public health service.

That general practice is built on a patient co-payment model in no way detracts from the public service ethos.

She says some GPs were "incensed" by a *New Zealand Medical Journal* editorial in February arguing a reliance on "profit generation" was problematic and restricted patient access.

Dr Murton points out that GPs are earning considerably less than their hospital counterparts. The last RNZCGP salary survey revealed the average GP salary was $157,000.

GPs are building flexible teams and care models, like Health Care Homes, to benefit patients. But in some respects they are hamstrung by inflexible PHO service agreements. For instance, the contracts are predicated on the assumption of an 8am to 5pm working day, she says, which does not reflect reality for either patients or doctors.

The growing demand of acute care on hospitals could be alleviated by the GP sector if funding followed the patient.

"There's no fat in our system to provide urgent care. But we could if it was funded."

She says when new hospitals are in the offing there must be consideration of what the primary sector could provide. She is "frustrated" by assumptions that a community's growing health need must always be met with new hospitals.

"The funding goes into a District Health Board and the District Health Board forgets they are actually a health board and think about the hospital more than anything else."

Community-based care garners better outcomes for patients and frees secondary and tertiary providers to focus on what they do best.

"We are all part of the picture. But the bit in primary care isn't funded or supported well enough."

She says there is a problem sometimes with hospital doctors being unaware of what GPs are resourced for, and unrealistic expectations about their ability to follow up on patients after a hospital discharge. She stresses that her own relationships with hospital colleagues are excellent.

"As GPs we are a significant part of the public health system. Although we do charge patients, I don't think any of us think we are a private enterprise like an orthopaedic surgeon working in their own practice.

"We are as public as a hospital service is."

GPs invest their own money in buildings, staff, and professional development.

"From a general practice point of view, we're deeply invested in a public health service as we're personally invested in it ourselves."

GPs still sometimes feel undervalued by a small number of their hospital colleagues, but they are a minority, she says.

RNZCP President Dr Samantha Murton

"The funding goes into a District Health Board and the District Health Board forgets they are actually a health board and think about the hospital more than anything else."

LEADERSHIP REQUIRED TO TURN SITUATION AROUND

PROF MURRAY BARCLAY | ASMS NATIONAL PRESIDENT

I write this from the UK where hospital doctors are reporting similar difficulties in the NHS to those experienced in New Zealand, ie, under-investment in health in recent years resulting in too few doctors, too few nurses, and inability to service a burgeoning patient population with an accelerating requirement for acute hospital services.

In the UK there are at least 100,000 job vacancies in the NHS, including nearly 40,000 nurses and 10,000 doctors. This is 1 in 12 NHS positions. In New Zealand, ASMS data show that we are short of at least 1000 hospital specialists, representing a 22% shortfall.

The news is similar in other parts of the world. Globally, this appears to have resulted from a combination of population demographics in which the average patient age is increasing, and a desire of governments to save money by seeking efficiencies beyond what is humanly possible. However, the situation appears to have reached a very dangerous point where too many staff are now deciding to retire early or emigrate to either recover from, or avoid, burnout. This leaves the remaining staff in a progressively worsening burnout situation, risking collapse of the health system.

So is there a way that New Zealand can avoid this collapse? One major issue for New Zealand is that the labour market for specialists is global. We lose approximately 40% of our own medical graduates overseas over time, and 43% of specialists in NZ hospitals are international medical graduates (IMGs), ie, not trained in New Zealand (and usually therefore not trained in Tikanga Māori for example). Whilst IMGs bring outside knowledge and experience and NZ is highly dependent on them to bolster staff numbers, there can occasionally be cultural difficulties for the specialists or their patients, and they also have a relatively lower likelihood of staying in New Zealand. It would seem preferable, therefore, to retain a higher percentage of New Zealand graduates if possible.

Either way, however, retaining New Zealand graduates or attracting overseas graduates requires our MECA to be internationally competitive with regard to both salary and working conditions. ASMS has had many successes over the years in achieving worthwhile MECA conditions of employment related to leave arrangements, CME, superannuation, expense reimbursements and other matters but there is always room for improvement. The same applies to salary, and New Zealand hospital specialist salaries need to increase to be able to compete with our nearest neighbours and other countries with similar hospital systems and training.

Our MECA negotiations begin in early 2020. This is in the setting of rapidly worsening DHB deficits and with a government that is unwilling to correct the substantial health budget shortfall created by our previous government, apparently for fear of upsetting the business community. It would appear that the health of New Zealanders is subordinate to appeasing corporates.

Some real leadership from the Minister and government will be required in the coming year to fully address the funding issues in the DHBs, allow recruitment and retention of desperately needed medical staff and allow New Zealanders to access the health services that they deserve. This leadership has been missing during the recent resident doctors' strikes, with a hands-off approach by the Minister. When he first became Minister of Health, he appeared to clearly understand the issues in our health system and expressed what appeared to be a genuine desire to correct funding shortfalls and improve the health of New Zealanders. Let's hope that he has the strength of character to begin to follow through on his promise and start taking some appropriate actions.

"It is difficult to see anything but further cuts to services ahead and increasing unmet need for hospital care."

A 'WELLBEING BUDGET' BUT NOT FOR DHBS

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

Is Budget 2019 a 'Wellbeing Budget'? According to Dr Ganesh Nana, chief economist at Business and Economic Research Limited (BERL), and Council of Trade Unions (CTU) economist Dr Bill Rosenberg, the short answer is yes – but with many 'buts'.

In a post-Budget briefing hosted by the two economists, both agreed it focuses on many of the things in life that improve wellbeing, which is commendable. They include a much-anticipated boost for mental health funding (see accompanying article), the indexation of wages to welfare benefits, new initiatives to addressing domestic violence, more money for public housing, KiwiRail and the settlement of pay equity and wages and staffing of our public services.

The biggest 'but' is that, despite the significant increase in the Budget operating allowance ($3.8 billion instead of the earlier indicated $2.4 billion), it is greatly under-funded to achieve what is needed and to be 'transformative'. Political commentator Bryce Edwards called it a 'status quo Budget'. This Vote Health budget, viewed overall, fits this description on initial analysis.

The CTU and ASMS pre-Budget analysis (**https://www.asms.org.nz/wp-content/uploads/2019/06/How-much-funding-is-needed-to-avoid-the-condition-of-the-Health-System-worsening-2019.pdf**) estimated Vote Health needed $18,274 million in operating expenses in 2019/20 to maintain current levels of service. It received $18,157 million – $117 million short. We have called this a neutral budget as it is within the margin of error of our calculations. However, this does not take account of new services announced in the Budget which add costs to the system. This will be further examined in our post-Budget analysis of the Health Vote. That aside, there are relative winners and losers in the Vote.

The biggest losers are district health boards (DHBs) – the losers including the populations they serve and the staff they employ. In our pre-Budget report we estimated they needed $14,282 million just to stand still; their allocation is $300 million short of that figure. The shortfall may be greater when the costs of new services are taken into account.

At the time of writing, DHB deficits were estimated to be about $390 million for 2018/19. With DHB bosses being warned by the Minister of Health, David Clark, to lift their game or face the same fate as the recently sacked Waikato DHB board, it is difficult to see anything but further cuts to services ahead and increasing unmet need for hospital care.

Disability support services also appear to have taken a hit and this will be further looked at in our post-Budget analysis.

Community-based services in general are the relative winners in this Budget, with more money being channelled mostly through the 'National Services' appropriation which is managed by the Ministry of Health. Some large figures

"The biggest losers are DHBs, including the populations they serve and the staff they employ."

have been bandied around, straight out of government press releases - $455 million for expanding primary mental health services, $213 million extra for district health board mental health services, $128 million to expand alcohol and other drug services for offenders, etc.

But these are usually for services spread over four years, they can change over in subsequent Budgets, they do not take account of the depreciating value over that time, and they are not necessarily all 'new' money – they often include funding taken from another part of the Vote. For these reasons the 2019/20 allocations only are reported here, using the net increases to individual appropriations.

The main movements within the National Services allocation include:

- National Child Health Services – an increase of $19.7 million (21%)
- National Disability Support Services – a decrease of $7 million (0.5%)
- National Emergency Services – an increase of $26 million (21%)
- National Māori Health Services – neutral
- National Maternity Services – an increase of $7 million (4%)
- National Mental Health Services – and increase of $61 million (76%)
- National Personal Health Services – a decrease of $4 million (5%)
- National Planned Care Services (electives) – an increase of $34 million (9%)
- Primary Health Care Strategy – an increase of $66 million (25%)
- Public Health Purchasing – an increase of $37 million (9%)

The Ministry of Health received $221 million, representing a much-needed boost of $8 million in real terms given its budgets have been substantially and repeatedly cut over the past decade.

We estimated in our pre-Budget report that the compounding funding shortfalls for Vote Health over the last decade has meant total operating funding for 2019/20 would need to be around $20.2 billion to match the level of funding in 2009/10. After this Budget it remains about $2 billion short of that mark.

While no one would expect so many years of under-funding by the previous Government to be addressed in a single Budget, after two Budgets from the current Government there is no real progress towards restoring health funding to previous levels.

As Dr Bill Rosenberg puts it, resources will always be limited, but the Government is trying to do more with essentially the same level of funding as the previous Government, which has created huge gaps in health, education, welfare, conservation... the list goes on. The 'Wellbeing Budget' may be a worthy enterprise but it is wracked by under-funding.

Both he and Dr Ganesh Nana agreed the New Zealand economy is in very good shape but the Government's Budget Responsibility Rules, which severely limit what can be spent on public services, need to be replaced with principles that are consistent with wellbeing.

ASMS STANDARD FOR SUSTAINABLE WORK

IAN POWELL | ASMS EXECUTIVE DIRECTOR

Of necessity much of ASMS' industrial work on behalf of members is reactive in that members come to us seeking support, ranging from informal advice to formal representation. We have always been proactive as well, although this is constrained by the pressure of the growing needs of members for support.

But this has become imperative with successive governments, Ministry of Health and DHBs turning a blind eye to the effects of increasing SMO shortages such as excessive overwork, extraordinarily high burnout levels, presenteeism (working while sick or infectious) and job dissatisfaction contributing to high numbers seeking to leave DHB employment.

FROM WELLBEING TO A STANDARD FOR SUSTAINABLE WORK

In the last national DHB MECA we included a new provision affirming agreement between ASMS and the DHBs on the importance of SMO wellbeing. It went further by identifying areas where lack of wellbeing can have a negative impact – delivery of services, patient treatment outcomes, patient safety, ability to meet accepted professional standards of care, and clinical practices. Rounding of the new provision is an express commitment to take "reasonable steps" to protect SMOs from harm to their health, safety and welfare.

Initially our proactive approach involved looking at developing a wellbeing checklist but as we thought about it further it evolved into the publication of a new ASMS policy statement called the *Standard for Sustainable Work*. This has been discussed with each of the DHBs through our Joint Consultation Committees and is published on our website at **https://www.asms.org.nz/wp-content/uploads/2019/03/Standard-for-Sustainable-Work-wellbeing_171281.2.pdf**.

SAFE WORKING HOURS

The provision of safe hours is an important theme in the *Standard*, linked to overwork and other effects of shortages, such as burnout. The *Standard* begins by stating that DHBs should not require or expect additional work from staff without providing additional resources. Next it states that services must be correctly job sized for their workload. When a service has been job sized and staff shortages identified, a plan should be developed to fill the agreed vacancies. Further, inaction may be a breach of the Health and Safety at Work Act.

Drilling down further, every service requiring SMOs working shifts should have a shift system in place which has been agreed to be safe by these SMOs, ASMS and the relevant DHB.

Paid recovery time for fatigue because of after-hours rosters was provided in our last MECA settlement, with the expectation that agreed arrangements would be in place by the expiry of the current MECA (ie, 31 March 2019). Implementation of this entitlement is another feature of the *Standard*.

The *Standard* introduces a new term: 'call holiday'. It states that services should be staffed so that after-hours call rosters are never greater than a real 1 in 3 and fair arrangements be in place so that SMOs can take a 'call holiday' because of illness, disability, age, parental or other family responsibilities without unduly affecting the call obligations of other SMOs.

WORKPLACE CULTURAL STANDARDS

The *Standard* is not just about hours of work. It advocates a shift away from the tendency of senior managers to involve punitive disciplinary processes far too early. Few things generate as much angst as an HR letter calling someone to a meeting and suggesting that they may want to bring a support person.

Instead, a relational approach is promoted based on accessible processes, including restorative processes, being established to deal with relationship issues between staff, and inappropriate behaviour. There are positive experiences, albeit early days, of restorative processes being introduced that ASMS industrial officers have helped set up and witnessed.

Other measures affirmed in the *Standard* are:

- DHBs having agreed protocols to allow SMOs access to annual leave, CME leave, sabbatical and/or secondment leave, short and long-term sick leave, including sick leave to care for dependents.
- Services should work to identify and support individuals who may be particularly at risk of burnout, for example, early-career stage SMOs and those returning from longer periods of leave (eg, parental leave or long-term sick leave).
- Provision of confidential collegial mentoring and/or the provision of confidential counselling or professional supervision.
- DHBs must provide appropriate confidential occupational health services.
- Workplaces should be designed to allow physical space for non-clinical work and rest-breaks, and good quality overnight accommodation.
- Staff must be supported and protected from violence, threats, or verbal abuse from patients, with protocols in place to deal with any such incidents.

I encourage ASMS members to discuss the *Standard for Sustainable Work* with colleagues and use it collectively and collegially to provide focus on the critical staffing, resourcing and cultural needs of your service. At the very least, this provides a basis for developing minimum safety standards. Our industrial officers are available to assist.

30 YEARS

SERVICES FOR PEOPLE WITH ACUTE MENTAL HEALTH NEEDS OVERLOOKED IN THE BUDGET

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

The evident need to address the barriers to accessing mental health and addiction services for people with the most severe conditions was under-played in the report of the Mental Health Inquiry. It was a blind-spot in Budget 2019. Services for those with most severe needs received no increase in real terms.

There is no shortage of evidence showing access to specialist mental health and addiction services for those people with severe needs is poor in many cases. The results of a national mental health survey published by the Ministry of Health in 2006 indicated only 58% of those with serious disorder were accessing mental health services. Given the significant cuts to funding that have occurred since then, there is nothing to indicate that situation has improved; it may be worse.

The *People's Mental Health Review* of 2017, which summarised the stories of over 500 users and mental health service providers, described a lack of resources for crisis response, "including a lack of trained staff and beds to provide appropriate care for people who are at risk of suicide".

This is echoed in the report of the Mental Health Inquiry: "A consistent theme in submissions was having to fight for access to mental health care due to high thresholds of acuity, limited and non-existent services, or complex care requirements beyond current service provision. We heard that some people presenting with a high risk of suicide were deemed ineligible for help and were unable to find timely, responsive service… People recounted being told their situation was not serious enough to meet the threshold for specialist services…"

As previously reported (*The Specialist*, December 2018), funding for DHBs is ring-fenced to ensure specialist services are provided for 3% of the population with the most severe mental health needs. Once that target is reached, DHBs may use any remaining funding for other mental health and addiction services for people with less severe needs.

The Mental Health Inquiry report briefly acknowledges the 2006 Ministry of Health report estimating 4.7% of the adult population had severe mental health needs but does not then question the adequacy of the 3% target. Rather, it states: "The target set in the 1996 Mason Inquiry report, of having specialist services available for the 3% of people with the most severe mental health needs, has been achieved. But the subsequent goals of more prevention and early intervention, and more support in the community, have not been realised…" Hence, while the Inquiry report says those in most need must remain the priority, addressing the needs of those

"The consequences are likely to be a continuation of current barriers to accessing acute services, potentially undermining the initiatives such as those aimed at reducing suicide rates and supporting people who experience a crisis."

with more moderate needs - the 'missing middle' - is the primary focus of its recommendations.

That 'missing middle' is similarly the focus of the Government's response to the Inquiry, as reflected in the announcements on the mental health budget. This 'missing middle' is provided for mostly via the 'National Mental Health Services' budget appropriation, managed by the Ministry of Health, which increases by $61 million ($80 million to $141 million) in 2019/20, including:

- $29 million for expanding access to primary mental health and addiction services
- $10.5 million to specialist alcohol and drug services
- $10.1 million to suicide prevention
- $5.2 million to telehealth services
- $4.2 million to forensic mental health services
- $2 million to primary addiction services
- $2 million to mental health crisis support
- $5.5 million to support for community mental health in Christchurch
- $5 million to expanding school-based services

(Note the total funding allocated to these services is partly offset by reductions and in other areas, and "$7.5 million reprioritised in 2018/19 only to help address pressures on disability and mental health services".)

The Government has also shown a willingness to tackle social determinants of mental health, including poverty and homelessness.

ASMS welcomed this much-needed funding boost in these areas. Questions remain, however, about how some of these will be achieved. Among other challenges, the initiatives will require 1600 more workers over the next five years. There are risks that some of those workers may be sourced from already over-stretched acute services.

The bulk of mental health funding which is ring-fenced and allocated to DHBs to cover services for people with the most severe needs has increased by $53 million for 2019/20 (from $1,478 million to $1,531 million) but this is just 3.6% and amounts to no increase in real terms.

The consequences are likely to be a continuation of current barriers to accessing acute services, potentially undermining the initiatives such as those aimed at reducing suicide rates and supporting people who experience a crisis.

ASMS has welcomed the announcement that the re-established Mental Health Commission is to be independent. The details of its roles and functions, however, had not been announced at the time of writing.

The former Mental Health Commission, established in 1996, performed the role of independent oversight and was seen as a strong and effective watchdog. But as the Inquiry report observes, "Over time, the powers, effectiveness and funding of the Commission were substantially reduced," before it was disestablished in 2012. In the year prior to its disestablishment, the diminished Commission received funding of $2.8 million, or just over $3 million in today's dollars. This year's Budget indicates the new mental Health and Wellbeing Commission is to receive just $2 million a year.

ASMS has highlighted the importance of having a new Commission that is well resourced and has real teeth to keep governments to account in light of the Inquiry's finding that lack of progress in improving mental health services was at least partly due to "a fundamental disconnect [that] exists between stated strategic direction, funding and operational policy and ultimately service delivery".

The announced funding for the Commission is not a promising start. ASMS will report further on the Commission when more details are known.

30 YEARS

CULTURAL COMPETENCE, SAFETY, AND HEALTH EQUITY FOCUS FOR MEDICAL COUNCIL CHAIR

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Happily accepting responsibility seems to be something of a theme for new Medical Council of New Zealand Chair Curtis Walker.

Dr Walker was elected Chair of New Zealand's health regulator in February, taking over from Auckland general surgeon Andrew Connolly.

Of Te Whakatōhea and Ngāti Porou descent and grandson of the late Dr Ranginui Walker, he says Māori doctors feel a duty to help their people.

For Dr Walker this meant a big career switch from veterinarian to doctor in his mid-twenties.

"I wasn't going to make much contribution to Māori health as a vet," he says.

"I talk to my Māori medical colleagues and we all feel that extra obligation to do right by our people."

Now a renal and general physician at MidCentral DHB, he has no regrets about needing to retrain, seeing it as positive. It helped foster a wider view of the world that led to positions of leadership after graduating. At medical school he kept working as a vet on a locum basis.

"The biggest thing about being a graduate entry student was the capacity to look at the bigger picture in the health sector as a medical student. I didn't have to re-learn basic physiology. It gave me time to consider how our system works and can work better."

Downplaying the significance of the dual career, he says many people make a choice between vet or doctor training, but admits few go on to train in both.

"Very few of us have done both, but at the time I had no wife, kids, or mortgage, and didn't want to have regrets for not taking the opportunity."

As an RMO, he served as president of the New Zealand Resident Doctors' Association

"I talk to my Māori medical colleagues and we all feel that extra obligation to do right by our people."

"And that's what I mean about an inequitable system that has yet to respond by lowering the age range for bowel screening in Māori."

and believes he's the first ex-RDA president to also chair the Medical Council.

HEALTH EQUITY ON THE RADAR

He has taken the reins of the Medical Council at a time when issues of systemic bias and achieving health equity have never been higher on its radar, having been championed by his predecessor and reflected in its work programme.

Asked if the health system is racist, Dr Walker hesitates before saying "the short answer is yes".

"There is institutional racism and bias. I think individual practitioners being racist is a much more difficult question to answer, but we are all influenced by our personal bias and the evidence shows that this affects how we deliver health care to patients and the outcomes those patients experience.

"These are big topics and difficult to confront, however our health system and wider society needs to work through and resolve these challenges," he says.

Of his priorities at the Medical Council, he says its purpose and agenda remain straightforward - protecting the public by ensuring medical practitioners are competent.

"That's the fundamental role we can't lose sight of," he says.

Its medium-term focus includes strengthening recertification programmes to ensure that the trust the public has that doctors are keeping up to date and improving is warranted.

"We're promoting an evidence-based, profession-led evolution in how doctors undertake continuing professional development. It's what many of us are already doing, and it's not an onerous change, but it is a necessary one."

NEW ZEALAND LEADING THE WAY WITH MEDICAL REGULATION

He remains confident New Zealand's health regulator is "leading the way" compared with its peers in other countries.

"Our political environment and legislative frameworks are strong, and we have good checks and balances and a robust code of patient rights.

"Our pre-vocational training programme for first and second year doctors is viewed positively overseas."

New Zealand is a leader in progressing the role of medical regulation in improving health equity for disadvantaged populations."

He is proud of being the first person of Māori descent to lead the Medical Council.

"For me and the Medical Council it's a unique opportunity to advocate for cultural competence of all practitioners, and to develop the Māori medical workforce of the future. These are important means to improve how Māori experience and engage with our health system."

Pondering the role his heritage plays in clinical practice, he says it is a pleasure to speak Te Reo to patients, whānau and colleagues.

"Wherever we are in the system it's our responsibility to do the very best we can and to practise in a culturally safe way with people from all walks of life."

Growing up in an academic and medical family – his father Stuart is an anaesthetist in Auckland – he was surrounded by people working to improve New Zealand society and race relations.

But Dr Walker is not one for moralising or preaching, frequently pointing to things that are working well or being improved. He is keen to credit Andrew Connolly for launching the Council's cultural competency work programme in 2015.

He says the concept of cultural competency is being updated to reflect a move away from "learning about others" to examining our own bias and acknowledging it is the patient who defines whether our care has been culturally safe. This will be reflected in a new Standard to be released by the Council later this year.

He's reluctant to cite specific examples of where the system fails Māori, saying it's a big question to which there are no short answers.

"To start with a positive, the Government's focus on health equity is welcomed. The system is more responsive to Māori than it used to be, with whānau support rooms and meetings with patients that start with karakia. These are small but important."

On the "negative" side, he cites evidence that Māori patients have a harder time getting a GP appointment, receive shorter consultation times, and fewer prescriptions for appropriate medicines. "In my specialty, Māori kidney transplantation rates are about a quarter of those for Pākehā."

He also mentions the national bowel cancer screening programme. The age range, 60-74, has been criticised as failing the health equity test as Māori on average develop cancer earlier.

The Ministry of Health resisted calls to review the screening range.

"And that's what I mean about an inequitable system that has yet to respond by lowering the age range for bowel screening in Māori."

He says programmes like *Choosing Wisely* should be carefully implemented to guard against unintended consequences. While it aims to eliminate unnecessary tests and procedures, and should benefit patients, there is a risk of unintentionally increasing health inequities for people who are not receiving the tests and procedures they should be getting but aren't.

Asked about the financial costs of addressing unmet need in people who do not receive adequate health care, Dr Walker says it's far outweighed by the harm created by the lack of access.

"The current cost and drag of inequitable health care in this country creates far more harm and damage than putting resources where they are needed and adjusting how we practise."

Dr Walker is married to Dr Megan Pybus, a paediatrician, and has two children, Maire and Tuki.

"For most specialties the gap between the specialist workforce capacity and health service need is expected to widen over the coming years."

30 YEARS

FORECAST HEALTH DEMAND OUTSTRIPS GROWTH IN SPECIALIST WORKFORCE

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

Ministry of Health workforce and service demand modelling show New Zealand's need for specialist health services is projected to increase at a higher rate than the projected growth of the specialist workforce during the next 10 years. The modelling is conservative as it does not take into account current unmet health need. Nor does it acknowledge current workforce shortages.

The findings are published in an ASMS Research Brief, available on the ASMS website (**https://www.asms.org.nz/wp-content/uploads/2019/06/Research-Brief-specialist-workforce-projections-_172060.2.pdf**).

Forecasts weighted for proxies of health need (age, ethnicity and deprivation levels) show that by 2028 health service needs will have increased by 23% above current levels while the projected public and private specialist workforce will increase by 21%.

This means the current estimated workforce shortage of approximately 1000 specialists is projected to continue and indications are that for most specialties the gap between the specialist workforce capacity and health service need will widen over the coming years.

Some specialties will be affected more than others.

In two case studies covering both private and public services using data on workforce entry and exit trends and service use data produced by the Ministry of Health, the workload per orthopaedic surgeon will need to increase by 7% by 2028 to match current service levels (Figure 1). This does not take account of the already significant unmet need today. Inpatient workloads per ophthalmologist will need to increase by 20% (Figure 2), which again is likely to see a worsening of current levels of unmet need. The projections assume the current service model will remain unchanged.

Specialist workforce growth rates are hampered by poor retention rates, especially among newly qualified specialists and international medical graduate (IMG) specialists.

The paper suggests there is potential to make significant inroads into addressing workforce shortages by designing and implementing effective retention measures, taking into account the specific needs of different sections of the workforce.

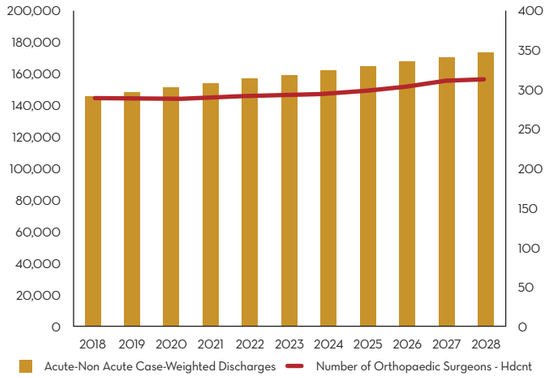


FIGURE 1: FORECAST ORTHOPAEDIC CASE-WEIGHTED EVENTS AGAINST FORECAST ORTHOPAEDIC SURGEON WORKFORCE

Source: Ministry of Health 2019

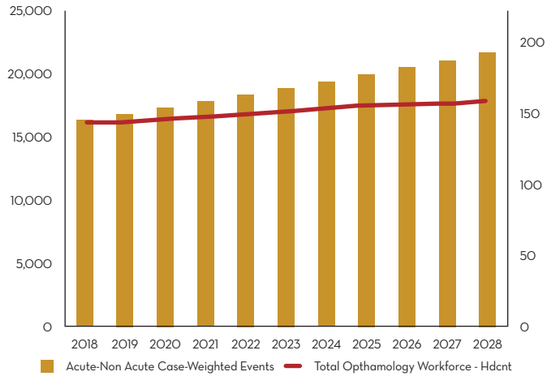


FIGURE 2: FORECAST OPHTHALMOLOGY INPATIENT CASE-WEIGHTED EVENTS AGAINST FORECAST OPHTHALMOLOGIST WORKFORCE

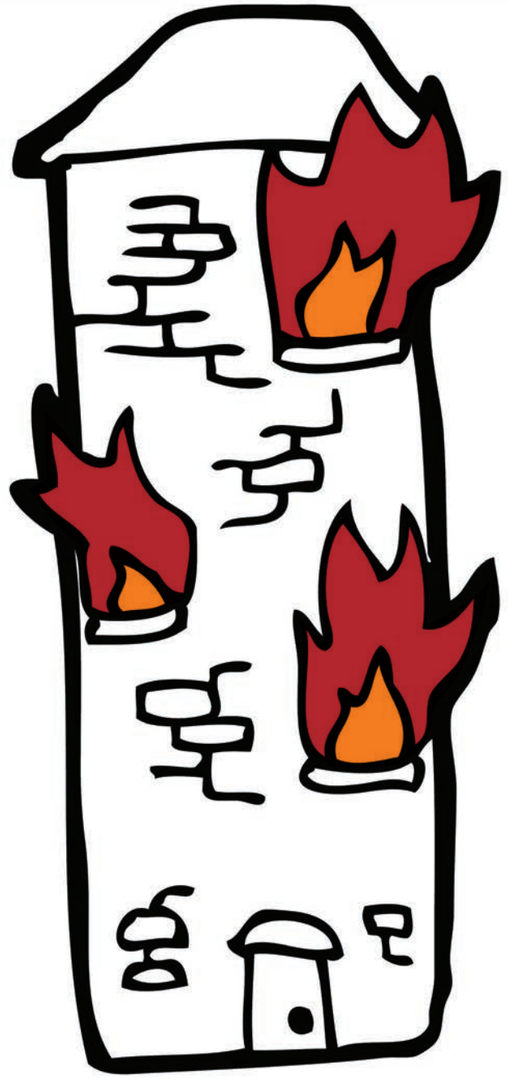
Source: Ministry of Health 2019

"Specialist workforce growth rates are hampered by poor retention rates."

30 YEARS

THE BURNING BUILDING

LUCILLE WILKINSON | ASMS MEMBER, NORTHLAND



There is a building that has been on fire for many years. Each day, firefighters are sent in to put the fire out and to rescue people who keep entering the building. Increasing numbers of people keep entering the building, despite all efforts to keep them out. The firefighters are exposed to toxic fumes and their safety equipment is failing. They get no breaks and stay long hours trying to rescue all of the people in the building.

The firefighters have all become exhausted and are suffering from major health issues. Despite this, they keep coming back each day because they are the only ones qualified to do the work that needs doing. The firefighters have repeatedly asked for help to manage the fire and to help the people who need rescuing.

1. **You are the Chief of the Fire Service and it is your responsibility to keep the firefighters safe. What is the most appropriate response to this situation?**
   a. Continue with the present situation, knowing that it is likely that the firefighters will have severe health consequences and will not be able to keep going for long.
   b. Explain to the firefighters that there is no more resource to help them in their situation and that they need to work faster and more efficiently to rescue the people in the building.
   c. Explain to the firefighters that they should get some help with their health issues so that they can continue coming back to fight the fire and rescue the people.
   d. Make a clear plan to manage the fire and keep up with the number of people who need saving. Resource this plan. Meet with the firefighters to determine what they need to recover from their health issues caused by their work and support them until they are well enough to contribute to the battle against the fire.
2. **You are one of the firefighters who has become unwell. What is the most appropriate response for you to have in this situation?**

Professor Michael Schultz. Photo courtesy Otago Daily Times

SHORTAGE OF GASTROENTEROLOGISTS

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Gastroenterology services are experiencing "unmanageable" increases in demand in bowel cancer and inflammatory bowel disease (IBD) while New Zealand needs 51 more specialists to be on par with Australia per population.

At present it has 1.93/100,000 gastroenterologists compared with 3/100,000 across the Tasman. These are headcount figures; on an FTE basis New Zealand has 1.53/100,000, including private provision.

A recently-released critical analysis of the gastroenterology specialist workforce compiled by the New Zealand Society of Gastroenterology also found four DHBs – West Coast, Whanganui, Tairawhiti, Wairarapa - had no resident gastroenterologists in 2017.

Bowel screening – operating in only eight DHBs after a series of delays – was predicated on faulty assumptions about workforce capacity, the report says. The initial timetable would have seen the programme implemented in all DHBs by the middle of this year. The latest deadline for full implementation is mid-2021.

New bowel cancer cases are increasing by 15% each year in men, and 19% in women.

It is not just bowel cancer treatment and screening piling on additional pressure. New Zealand has one of the fastest growing rates (5.6% per year) of IBD, the collective name for Crohn's disease and ulcerative colitis. The number of patients is expected to double in the next 10 years.

There is an acute shortage of specialist IBD nurses; the ratio at present is 1 to 1155 IBD patients. The report calls for increased recognition of nurses. A fifth of the nearly 21,000 sufferers are children, but New Zealand has no paediatric IBD nurses.

Also, the report says efforts to shift hepatitis C care into the community have been not been successful, while hepatitis C prevalence is rising.

Amongst its recommendations the report calls for the consideration of private sector and Iwi support for establishing scholarships for Māori and Pacific doctors, and for training fellowships in regional centres such as Timaru and Taranaki.

Māori and Pacific people are disproportionately affected, partly because they were more likely to live in DHB areas with no service, and because of general health inequalities.

It also calls for the implementation of the 2018 National Bowel Screening Programme Assurance Review Report, and points to its 2011 workforce report which highlighted the strain on services at that time.

The report calls for a joint Ministry of Health – New Zealand Society of Gastroenterology steering group to oversee the implementation of its recommendations.

Training provision is "suboptimal", and as many as four of the eight new gastroenterologists each year head overseas.

ENDOSCOPY PRESSURES

The report says gastroenterologists on average perform 264 colonoscopies per year in the public system, while general surgeons perform 151 colonoscopies. The initial modelling underlying the national bowel screening programme was based on projections of gastroenterologists performing an average of 660 colonoscopies per year.

"In our view this undoubtedly renders the rollout targets unachievable."

(The Society says the ministry responded by pointing out the figures were applicable only to newly appointed consultants designated to do much more colonoscopy than general gastroenterology).

Comments from anonymous gastroenterologists quoted in the report include:

> *"I think that to roll out screening but have no extra money for increased facilities is putting symptomatic patients at risk."*
>
> *"In our DHB we're constantly being criticised about waiting times for CTs and MRIs, as well as access to theatre and waiting lists for elective surgical procedures. To roll out a bowel screening programme in this environment is simply not sustainable."*
>
> *"While the importance of the NBSP cannot be overstated, it is putting a terrible strain on doctors and nurses at the DHBs who were already having difficulty keeping up with their workload."*

The number of nurses in endoscopy training was too small to have any impact on the endoscopy workload in the next few years, the report says.

Christchurch Hospital gastroenterologist Professor Murray Barclay, who is also ASMS president, tells *The Specialist* the report puts a much-needed spotlight on the strain in the sector and the society has been assiduous in its efforts to improve the situation.

Canterbury DHB had been scheduled to join the national bowel screening programme in the first half of 2018, but it has been repeatedly pushed back.

"At Canterbury we've been working at or beyond maximum capacity for years. There was no extra capacity to do bowel cancer screening. Other necessary colonoscopies are at risk of not being done when we start."

"So they keep delaying it."

While a supporter of the screening programme, Professor Barclay says the delay is essential as CDHB simply does not have the capacity.

"There are not enough gastroenterologists or endoscopy facilities to do colonoscopy even without bowel cancer screening. "With the screening it's putting a hell of a lot more pressure on every unit and every unit becomes understaffed at that point."

Professor Murray Barclay

AT A GLANCE

Survey results (November 2017):

- 93 gastroenterologists, nine of them only in private practice.
- 1.93 FTE gastroenterologists per 100,000 people; Australia has 3 per 100,000.
- Significant regional, income, and ethnic disparities in access.
- Four DHBs had no gastroenterologist.
- 42% of gastroenterologists will retire in next decade.
- Eight new gastroenterologists trained per year.

COLONOSCOPY ACCESS

Data released by the Ministry of Health under the Official Information Act has revealed disparities in DHB colonoscopy actual volumes versus expected share of the procedures.

IN THE YEAR TO JUNE 2018:	ACTUAL	EXPECTED SHARE
Wairarapa	906	586
Bay of Plenty	3794	2863
Whanganui	1078	826
West Coast	569	440
Lakes	1468	1197
Hutt Valley	1877	1554
Northland	2727	2278
Waitemata	7178	5999
Counties Manukau	5677	4795
Tairawhiti	593	503
Taranaki	1616	1401
South Canterbury	833	795
Waikato	4411	4543
Auckland	4495	4707
Hawkes Bay	1866	1964
Southern	2991	3644
Canterbury	4604	5837
Capital and Coast	2226	2930
MidCentral	1532	2091
Nelson Marlborough	487	1969

MINISTRY OF HEALTH RESPONSE

In a paper prepared for Health Minister David Clark, released to ASMS under the Official Information Act, officials say Scotland is a more apt comparison than Australia for specialist numbers. Matched with Scotland's per population ratio, New Zealand would need an additional 29 gastroenterologists.

Dr Clark's office had requested a ministry briefing about the New Zealand Society of Gastroenterology report.

"The need for this level of increase could be ameliorated due to New Zealand's use of other specialist workforces, for example colonoscopies being provided by general surgeons," the paper said.

The paper says the ministry welcomes the report and acknowledges specialists' concerns about workforce capacity constraints. The ministry's previous efforts have included recruiting from overseas, developing the nurse endoscopy training programme, and the colonoscopy wait time indicators.

Officials proposed the following possible solutions – a centralised training centre to support basic and advanced training, removing barriers to practice to grow the nurse endoscopist workforce, supporting DHBs to create extra registrar training places, and creating gastroenterology wait time indicators with a clearer view of demand over the whole service.

But, it says, the ministry needs more time to consider the report's recommendations.

The paper concludes by saying the ministry will consider a collaborative approach with stakeholders to effect improvements.

Southern DHB, which pushed forward with screening despite resourcing issues, is the subject of a highly critical report highlighting relationship issues and poor clinical outcomes.

Leaked to the media last month, the report concludes that limiting access to colonoscopy had gone too far with adverse consequences for patients. Undue delay in diagnosis or treatment was found in 10 of 20 local cases audited by the reviewers. The reviewers, general surgeon Phil Bagshaw and gastroenterologist Steven Ding recommended the DHB urgently overhaul its management of bowel cancer. Southern performed poorly on measures such as emergency department diagnosis of bowel cancer yet had one of the lowest colonoscopy rates.

"These unfavourable standards indicate that there are serious problems with the control of colorectal cancer in the SDHB population."

"Inadequate resourcing appears to be a major impediment to the SDHB dealing with these problems," reported the *Otago Daily Times*, quoting from the leaked report.

Professor Barclay points out the long-running screening pilot in Waitemata, on which the national programme is based, relied on generous use of gastroenterology locums.

"It worked in Auckland in the pilot scheme as they brought in many staff from other DHBs to cope with the numbers."

Professor Barclay says it's inevitable patient care will suffer once screening is implemented with the current resourcing. In fact, it's "probably happening now but we are keeping a lid on it to a certain degree".

Asked about a well-publicised case of a young mother diagnosed with terminal bowel cancer after being declined for a colonoscopy, Dr Barclay says there are "lots of stories like that", and Southern DHB "will have many similar cases".

"Most people don't make anything of it. You hear one or two make it through to the media, but the vast majority no one knows about."

Professor Barclay does not believe nurse endoscopists are a solution, but says it's a matter of debate among specialists.

"For bowel screening you want your most highly qualified endoscopists, as they are amongst the most difficult procedures."

He says surgeons and gastroenterologists deal with polyps and small cancers as they go and do patient assessments, making the system more efficient. Also, in the public hospital system the cost of the endoscopist is only a small fraction of the overall cost of the procedure.

AFTERMATH OF REPORT

New Zealand Society of Gastroenterology past-president Professor Michael Schultz, a Dunedin gastroenterologist, says a lot of work went into compiling the workforce report, which has been disseminated widely in the sector. A meeting followed with Health Minister David Clark, as well as an invite to a Ministry of Health workforce workshop.

He is feeling confident: "It looks like something is happening".

The society has been working constructively with officials to amend faulty workforce capacity figures. Of figures estimating gastroenterologists' capacity for colonoscopy throughput, he says: "those numbers were off the rockers".

A little-known indirect consequence of screening is a significant increase in symptomatic patients. These are often people too young for screening who have become aware of the symptoms because of publicity around the programme. This led to a 25% increase in symptomatic patients in Dunedin.

"The symptomatic patients are killing us at the moment."

"We are doing so many other things. There are more hepatitis C patients. The community didn't want to treat them so it's on us."

At Southern DHB access to specialists had been severely restricted and after the loss of colleagues and a troubled time in the department: "We are in a crunch".

"We have a fantastic new Dunedin Hospital gastroenterology unit but we don't have any doctors to fill it."

Access has been severely restricted in Dunedin for anything but the most serious cases.

Of irritable bowel syndrome (IBS), he says those patients have no chance of being seen. This is a less serious ailment, but seeing a specialist can be a vital reassurance for patients with unsettling symptoms.

"They want assurance that it is IBS and they can't do anything else. I'm sad we can't provide this - 80% of my patients in private have IBS."

The issues are long-standing and there is no quick fix.

"More locums would be a starting point. But the mistake in the past is the Ministry made available lots of money without a directive. Some DHBs used it for locums to make their waiting list look good but they did not invest in services."

Professor Schultz says that when he emigrated to New Zealand, 14 years ago, he met a German surgeon, who told him he had never operated on so many advanced bowel cancers in his career as during his stint in New Zealand.

30 YEARS

GENDER AND WELLBEING: SHINING A LIGHT ON THE CULTURE OF MEDICINE

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

According to research conducted by the ASMS, women in the NZ senior medical workforce work through illness at higher rates than their male counterparts, self-report as bullied at a higher rate than their male counterparts and across all ages have a significantly higher rate of screening as positive for burnout. For women aged 30-39, 71% screened as likely to have very high levels of burnout. We therefore decided to investigate what was behind these statistics.

The result is an in-depth qualitative study focused on the lived experiences of 14 doctors working in a range of specialties in a range of geographical locations around New Zealand. This *Health Dialogue* will be released in the near future.

The key things which the research foreshadows is the need to understand wellbeing of our medical workforce as a quality and safety issue; all too often issues with wellbeing, and especially burnout, are framed as the fault of the individual. What this research encourages is understanding burnout and other indicators as symptomatic of wider systemic issues including workforce pressures but also issues with the culture of medicine.

Significantly, the research suggests the need for a cultural change in medicine. Some of the findings may be controversial but we make no apologies for this. We hope that the study will form the basis of much needed debate about how the culture of medicine must change to meet 21st century expectations of both doctors and the patients who they serve.

The findings have broad ramifications for both the wellbeing of the workforce and for the quality of patient care. We hope the research will encourage debate; these conversations will be the first step towards developing policies that will enable transformational change in the culture of medicine, ensuring the retention and recruitment of the senior medical workforce and high quality patient-centred care upon which the public health system depends.

VITAL STATISTICS

District health boards had 801 fewer full-time equivalent staff than planned at the end of January 2019. Only Nursing Personnel had more staff (299) than planned. Medical Personnel were 222 fewer than planned; Allied Health Personnel were 547 short; Management/Administration were 222 short; and Support Personnel were 110 short.

Forecast DHB deficits for 2018/19: $390 million.

SOURCES:

Ministry of Health. DHB Schedules 2018/19: Schedule 4: Average year to date consolidated accrued full time equivalents (FTEs) for the period ending 31 January 2019.

Walls J. Treasury warns there is a 'significant risk' that further DHB deficits will be higher than expected, NZ Herald, *6 June 2019.*

DR HELEN PILMORE IS A RENAL PHYSICIAN AT AUCKLAND DISTRICT HEALTH BOARD AND THE ASMS AUCKLAND BRANCH PRESIDENT.

"In renal medicine we can look after the same patients for years and I enjoy that long term relationship with patients."

"I've learned that as a department, to get the results you want, you need to stick together to make changes. If something needs to be changed, working conditions or staffing for example, you gain nothing by staying quiet."

30 YEARS

WHAT INSPIRED YOUR CAREER IN MEDICINE?

Ever since I can remember I wanted to be a doctor. It was just what I always wanted to do. None of my family members are doctors so that's not where the inspiration came from, but I guess I'm pretty single minded and I never really considered another job. I wrote an essay about being a doctor when I was eight years old and we were told to write about what we wanted to be when we grew up.

My parents warned me in high school that if I wanted to go down this career path I would have to make sure that I was ok working around sick people. At 16 or 17 I took a holiday job working as a cleaner in a hospice, and then became a nurse aide in the same hospice as a summer holiday job while I was at medical school.

I liked the environment and helping people so I knew it was the job for me.

WHAT DO YOU LOVE ABOUT YOUR JOB?

I love communicating with people and seeing the long term benefits of the care we provide. In renal medicine we can look after the same patients for years and I enjoy that long term relationship with patients.

The best part of my job is looking after renal transplant recipients. It's really rewarding to see a patient's life transformed after a transplant. I've been at Auckland Hospital for 20 years, so I've really gotten to know a lot of patients over a long period of time which is not only enjoyable but also humbling. I'm often amazed at how well people cope with chronic illness and how they manage despite sometimes quite a lot of adversity.

I really enjoy the research side of things too. Most of my research is in the kidney transplant area and we've been doing some clinical trial work recently looking at cardiac screening in patients on the transplant list. The thing I particularly like about research is that the results really can make a difference to how we practise medicine.

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

One of the biggest challenges in our department is that we've become much busier. We have more time pressure and increasingly complex patients. For me one of the biggest challenges over the years has been managing the on call component of my work with having a family. It's quite common for us to be called in the night and reasonably common to be in the hospital in the night when we're on call – I find that pretty tiring particularly when I'm also really busy during the daytime hours.

The other thing that I find frustrating is when we have to do the registrars work, in particular when there's no cover after hours – it doesn't happen all that often but when it does, someone has to do it and that person often ends up being the SMO on service. I find this frustrating, tiring and honestly I suspect I don't do the most efficient job because the RMO on call tasks are not so routine for me anymore. It's also challenging because when you're being the RMO as well as the SMO on service, you can be so busy with RMO jobs that it's hard to find time to concentrate on more difficult patients that need specialist input.

In renal we deal with a lot of impoverished people which can be difficult too. They might have financial or social restraints that make it difficult to get them the right care. We get pretty involved with patients so seeing their struggles and not always being able to assist as much as we'd like can be hard.

WHY DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

Although my family doesn't have a history of working in medicine, we do have a long history of being involved with the union movement.

All of my dad's family were train drivers or factory workers, apart from Dad who immigrated at 19 and worked for the Department of Labour. But the rest of his family were all blue-collar workers and highly involved with the unions in their workplaces, so I've always been aware of the need to look after staff and of how important industrial relations are.

When I started at Auckland DHB, I joined the Auckland ASMS group at the time we had separate agreements for each DHB. I was really enthusiastic about being involved in the negotiations for the Auckland DHB agreement at that time and joined the working group to be a part of that.

It's important as doctors that we advocate for ourselves and make sure that our working conditions are safe.

WHAT HAVE YOU GAINED OR LEARNED FROM YOUR ASMS INVOLVEMENT?

I've learned you have to stick up for yourself and your colleagues.

I've also learned that as a department, to get the results you want, you need to stick together to make changes. There's no harm in speaking out for what you need and sticking to your guns. If something needs to be changed, working conditions or staffing for example, you gain nothing by staying quiet.

I think a lot of people are scared of speaking up in case they're penalised, but you won't be. It makes your department and working life stronger and better.

I think it's important for SMOs to be involved with ASMS – there are a lot of initiatives that ASMS have brought in that have made our working lives better and by having an ongoing relationship with ASMS, there is an opportunity to get changes in the future that are likely to make a big difference to my working life. And honestly - we all spend a lot of time at work so everything that makes the working day better has got to be a good thing.

"For me one of the biggest challenges over the years has been managing the on call component of my work with having a family."

"Working hours that deviate from normal daily rhythms disrupts sleep and affects social patterns."

ASMS SHIFT WORK GROUP MAKING PROGRESS

ASMS is examining shift work and its impact on health and wellbeing in a special project aimed at increasing its profile as a health and safety issue.

In 2016 ASMS published a Research Brief by principal analyst Dr Charlotte Chambers entitled ***Shiftwork, scheduling and risk factors***. It can be read in full here: **https://www.asms.org.nz/wp-content/uploads/2016/07/Shift-work-research-brief_166090.2.pdf**

Night shifts can impair cognitive ability while affecting individual and departmental morale.

Expectations on Senior Medical Officers (SMOs) to spend more time out of hours working shifts, long periods of call, extended working days or weekend work have emerged because of dwindling resources.

Working hours that deviate from normal daily rhythms disrupts sleep and affects social patterns. These disruptions can have negative consequences for cognitive ability, performance, and health.

Shift workers can struggle to get enough quality sleep as the body's circadian rhythms are disrupted. Effects are physiological and psychological. Gastrointestinal complaints, coronary artery disease, and cardiac mortality are among reported physical ailments. Women working shifts are more likely to experience miscarriage and pregnancy complications. Negative mental health effects include social isolation, high divorce rates, burnout and substance abuse.

SHIFT WORK IN EMERGENCY MEDICINE

Shift work is associated with high rates of attrition and difficulties staffing emergency departments. The American College of Emergency Physicians has said "the effects of rotating shifts are cumulative, and represent the most important reason physicians leave the specialty". Research has found an association between the number of nights on call and burnout.

Fatigue has been linked to a heightened risk of adverse events. Disasters such as Chernobyl and the Challenger space shuttle tragedy have been linked to human error during night shift.

In ED physicians, an association has been identified by Stanford University researchers between shift work duration and a decline in the speed to perform complex procedures, for example, intubation and the ability to accurately read clinical notes.

SCHEDULING SHIFT WORK, RECUPERATION, AND LENGTH OF SHIFTS

Most of the literature related to shift work agrees the best schedules are those that maintain natural circadian rhythms. Clock-wise shift rotation patterns are recommended as they are easier to adapt to. The optimum number of night shifts, for rotational shift workers, may be one. Research suggests that concurrent night shifts should be kept to a maximum of three, as phase-shifting starts to occur after that. On this point there is disagreement. The American College of Emergency Physicians believes a long stint of nights, four to six weeks, is preferable. It recommends the person stay up at night even if they are not working to preserve their night orientation.

There is a clear association between hours on duty and risk of negative consequences. Relative to 8 hour shifts, 10 hour shifts were associated with a 13% increase in risk and 12-hour shifts with 27% increased risk in one study, towards the end of the shift. Another found that taking a nap during night shift can improve alertness and reduce the risk of adverse events. A 40-minute nap at 3am significantly improved both performance and alertness.

Research supports a 24-hour recuperation period after one or more night shifts. A longer break, of three days, is recommended to overcome disruptions to sleep-wake cycles.

There is extensive evidence dealing with the relationship between age and night shifts. Declining melatonin levels is a central factor in why older shift workers do not cope as well with its demands.

ASMS SHIFT WORK FOCUS GROUP

Twelve ASMS members – who mainly work in emergency departments and intensive care units – were brought together by ASMS to discuss shift work issues. Group facilitator, ASMS National Executive member Andrew Ewens, an emergency medicine specialist at Auckland's North Shore Hospital, says the group is setting priorities relating to the most pressing concerns for shift workers.

Dr Ewens says DHBs may not fully understand the growing impact of shift work for their senior medical officer employees.

Issues discussed by the advisory group included sustainable rosters, appropriate remuneration for after-hours work, frequency of on-call rosters, call-back requirements after working a full shift, recovery time, recuperation periods and availability of sleeping accommodation.

The group is aware of the risks that shift work poses to long-term health and wellbeing. On average these SMOs expect to have shortened careers leading to lowered income and benefits.

A slightly expanded second shift work advisory group meeting will be held in early August. The outcome of these discussions will be used to advise the ASMS National Executive and assist with the 2020 MECA negotiations.

"DHBs may not fully understand the growing impact of shift work for their senior medical officer employees."

30 YEARS

THE IMPORTANCE OF HAVING CAPACITY IN EMERGENCY SITUATIONS

LUCY GIBBERD | MEDICAL ADVISOR, MEDICAL PROTECTION

It's late on a Thursday night and you are working in the emergency department (ED) when a man is admitted following what appears to be a significant head injury. He smells of alcohol and is disorientated and confused. He refuses to cooperate with a CT scan. There are no family or friends available – can you treat him despite his refusal?

In modern health care law, the concept of patient autonomy and informed consent is king. We all know that patients have the right to refuse or accept investigations and treatments and that health care providers cannot act without their consent. But where autonomy is king, capacity (often referred to as competence) is the kingmaker. Therefore, before we ask for consent for an intervention, the first question we should be asking ourselves is, "does this patient have the physical and mental capacity to give this consent?"

There may be many reasons why a patient may not be considered competent to give consent; they may be a young child, they may have a cognitive impairment such as dementia, or they may have a temporary condition, such as a head injury which renders them incapable of making and communicating a reasoned decision.

The legal test for capacity includes that the patient must:

- understand the situation and the choice they are being given,
- have the ability to weigh up the pros and cons of the choice and reason through the consequences of their decision
- be capable of communicating that decision.

Deciding when a patient has capacity to make a specific decision can sometimes be simple but can often be challenging. If the patient's capacity is uncertain, the Medical Council recommends that you get experienced colleagues involved and obtain a second opinion and sometimes a psychiatrist would be consulted in this situation before providing treatment.

The details and findings of the capacity assessment should be clearly recorded in the notes.

If it is found that the patient does not have the capacity to consent to medical treatment, then the question often arises, how can we provide treatment? In an ideal world every patient who lacked capcity would have previously set up an Enduring Power of Attorney (EPOA), naming the person they want to take health decisions on their behalf, if they were to be incapacitated in the future. However, although these are becoming more common, they are far from universal, especially in situations where incapacity has not been anticipated. In some patients, where the incapacity is long term, the Family Court may have appointed a Guardian, who has similar powers to an EPOA, but is set up by the court when the person already lacks capacity. The EPOA or Guardian are able to make health decisions on behalf of the individual, but they are obliged to act in the best interests of the person and they are not permitted to decline lifesaving treatment.

There is a common but erroneous view that the 'next of kin' has the legal right to consent on behalf of an incapacitated patient. This view is generally incorrect and although the views of family and others close to the patient should be taken into account when making decisions for an incapacitated patient, they are not paramount. However, in the case of a child under the age of 18, where they lack capacity, their parents, who act as guardians, are able to consent on their behalf.

If the lack of capacity is due to a mental disorder, most forms of treatment or investigation for that mental disorder could be justified using the Mental Health Act, but I will not go into this area further in this article.

So, going back to our original question, if there is no EPOA or guardian in sight, can you treat the man with the head

injury who refuses to cooperate but actually lacks the capacity to make that decision?

Right 7(4) of the Code of Rights provides that where a consumer is not competent to give informed consent, and no person entitled to consent on behalf of the consumer is available, you may provide services as long as they are in the best interests of the consumer and you have taken reasonable steps to ascertain the views of the consumer, or other suitable persons who are interested in the welfare of the consumer.

That is to say you can only act if you reasonably believe that the consumer would have agreed to the services if he or she were competent. The doctrine of necessity is also helpful here as this allows you to act where it is not practical to communicate with the person being treated, where the actions you are taking are reasonable and are in the best interests of the patient and there is some sense of the need for immediate treatment – although it does not have to be an emergency.

The doctrine of necessity and Right 7(4) together permit you to treat an incapacitous patient, as long as the treatment is reasonable and in their best interests. However, in this situation, we would suggest that you consult with experienced senior colleagues, to ensure that there is a consensus that this is the appropriate course to take.

On balance it is however probably not appropriate to use Right 7(4) if the incompetent patient appears to be strongly opposed to the suggested management. Although under section 41 of the Crimes Act 1961, you are allowed to use force to "prevent the commission of an offence which would be likely to cause immediate or serious injury to the person or property of anyone", the medicolegal risk of forcing treatment on a patient who is violently opposed could be significant.

In this situation it may be more appropriate to seek an Interim Personal Order under the Protection of Personal and Property Rights Act 1988, whereby a Court can make an order allowing specified medical investigations or treatments to be administered.

Unfortunately, it can be time-consuming to get the courts involved and clearly in an emergency situation, there may be no time to do so. In this situation, if you are unsure, it is better to err on the side of saving life, but you would want to consult with others in the clinical team, any family or friends of the patient and carefully document your reasons for acting without consent.

Of course, in the real world, life is often not just about applying the law, but learning, when faced with conflict, to be flexible and achieve compromise. In the actual case of the gentleman with the head injury in ED, the solution reached was that an orderly managed to talk the patient into staying in the Emergency Department for observation and after a couple of hours, the patient agreed to have the CT scan, without the need to coerce him.

So, in conclusion, I would suggest that before you provide any treatment, ask yourself the question; does this person have the capacity to consent? And if the answer is no, take a step back and check if there is anyone else who can consent, or if there may be some other justification for providing treatment without consent. Deciding whether you can provide treatment to a patient who lacks capacity, can be complicated and at times controversial. Every case has to be considered on its own merits and if the situation is not clear, it may be best to discuss the situation with the legal department of your DHB or your medico-legal indemnifier, before you do anything.

CALL FOR EXAMPLES OF DISTRIBUTED CLINICAL LEADERSHIP

ASMS is keen to promote examples of local clinically-led initiatives that have been shown to improve service quality and efficiency (including cost effectiveness). We are especially interested in hearing of examples based on strong clinical team input and involvement – ie, 'distributed clinical leadership'. We recognise that day-to-day workload pressures for most of you limit the extent to which you can engage in developing new and innovative practices. Be we are also aware that even relatively small-scale changes developed from the 'bottom up' often have potential for large-scale benefits when they are more widely recognised and supported. In considering this request please don't sell yourself short on what might be good examples.

If you have been involved in such an initiative, or are aware of one in your area of practice, please contact ASMS Communications Director Cushla Managh at **cushla.managh@asms.org.nz**.

HISTORIC MOMENTS

30 YEARS

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'.

F 70

Letter to MP's etc.

NORTH CANTERBURY HOSPITAL BOARD

Christchurch Hospital

CHRISTCHURCH, NEW ZEALAND

Telephone 65-409

4th November, 1964.

Dear Sir,

There are at present grave dissatisfactions among Wholetime Medical Specialists in our public hospitals. Serious losses of senior staff have occurred recently and future losses are possible. Dissatisfaction springs more from unacceptable conditions of service than from increasing disparities between current salaries and medical incomes elsewhere.

Representations and suggestions have been made to the Government on many occasions through established channels concerning these difficulties and their adjustment, but without effect. Unless early steps are taken to establish a new and more acceptable structure of the service, future losses of senior staff and discouragement of recruitment will become a serious threat to the standards of care available to patients in our public hospitals.

The current salary scale has been unchanged since 1961. Rising living costs have eroded its value, and [illegible] the prospect of a limited salary increase in the near future, unless accompanied by radical changes in the conditions of service, will in our opinion do little to remedy the present situation.

The function and importance of the Wholetime Medical Specialists in public hospitals are not widely appreciated. They are outlined in the enclosed summary which also points out some of the difficulties now facing specialists. A situation which could well affect the standards of patient care in our hospitals appears to us to be of wide interest. Should this matter become a public issue, we trust that this letter and the enclosed summary will be of help to you in formulating editorial comment.

Yours faithfully,

D. W. Beaven.
Secretary.

F. W. Gunz.
President, Wholetime Senior Medical Officers' Association of New Zealand.

Copies to:
The Prime Minister.
The Leader of the Opposition.
The Minister of Health.
Chairman of Council B.M.A. (N.Z. Branch).

DID YOU KNOW

... YOU MIGHT BE MISSING OUT ON 6% OF YOUR SALARY?

Did you know that Clause 17 of the ASMS DHB MECA provides an additional 6% to your salary but only if you let the DHB know that you want it? The clause specifies that your employer will match any contribution you make to an approved superannuation scheme of your choosing up to 6% of your salary. This can include the KiwiSaver contribution. If you have not informed the DHB of your superannuation needs you may only be receiving the minimum compulsory employer contribution of 3% to KiwiSaver or possibly even nothing. ASMS strongly encourages members to take advantage of this MECA condition.

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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