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TOI MATA HAUORA

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Climate change

A threatening public health emergency – symptoms too serious to ignore.

Russell Tregonning, Orthopaedic surgeon, Senior Clinical Lecturer, School of Medicine, University of Otago, Wellington. Executive member, OraTaiao: The NZ Climate & Health Council. Based on a presentation to the ASMS Annual Conference, 2013.

After decades of peer-reviewed work, the Intergovernmental Panel on Climate Change, an international scientific organisation involving thousands of climate scientists, recently concluded "… warming of the climate system is unequivocal." and "… human influence on the climate system is clear."[1]

Continues next page

ASMS 25 YEARS OF ENGAGEMENT 1989-2014

If you would like to hear some of the best analysis available on the global challenges for public health care, get in quick – there are limited seats available for the ASMS 25th special commemorative conference in August.

The ASMS is holding a one-day conference in Wellington to remember its origins, reflect on the current state of health care in New Zealand and globally, and look ahead to the next quarter of a century.

Professor Martin McKee from the London School of Hygiene & Tropical Medicine will provide the keynote address, and he will be joined by an inspiring line-up of other speakers.

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This work, and observation of health outcomes world-wide is prompting global health authorities (WHO, WHA, BMJ etc) to promote the Lancet/UCL Commission contention that "Climate change is the greatest threat to human health of the 21st century."[2] Dr Margaret Chan, Director-General of the WHO, states "The verdict is in. Climate change is real. Human activities are a prime cause. Human activities can also be the solution. We must act now, together, to find ways to protect human health and the people on this planet."[3]

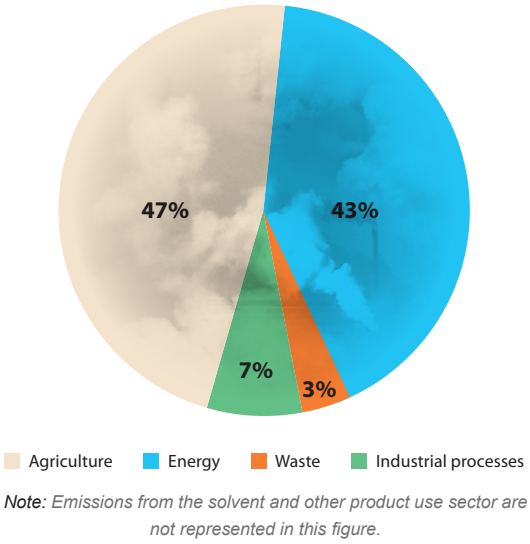


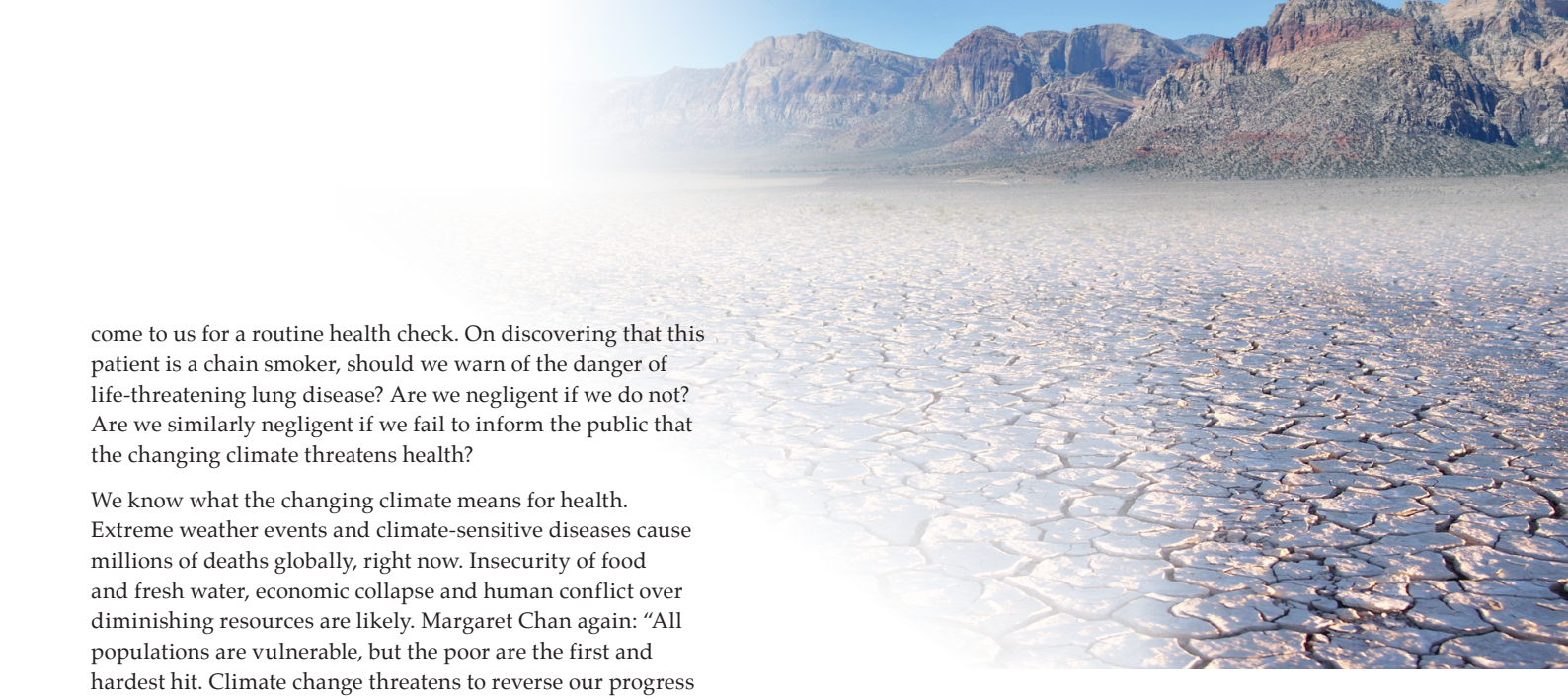
Figure 1: Ministry of the Environment Greenhouse Gas inventory-2011 (NB Transport is included in "Energy" and comprises about 20% total of GHGs

New Zealand is already experiencing climate change: higher mean temperatures, more hot and fewer cold extremes, and shifting rainfall patterns – and it's on track to get worse. Despite this, our media treats the issue as a debate, which confuses the public. Governments encourage fossil fuel subsidy and exploration. Climate and health are largely ignored in their policies on agriculture and transport, the two leading causes of NZ greenhouse gas emissions (Fig.1 NB 'Energy' includes transport which makes up approx 20% of the total NZ GHG emissions).

Promoting Health

What does the reality of climate change and its agreed health implications mean for us medical specialists? My College (RACS Code of Ethics) tells me, a surgeon, that I am charged "to advocate for improvements in individual and public health." The Medical Council of NZ tells me that I am to "protect and promote the health of patients and the public." The NZMA Code of Ethics: Item 10, states that I must "accept a responsibility to assist in the protection and improvement of the health of the community." The World Medical Association Declaration of Geneva (revised 2006) states "I solemnly pledge to consecrate my life to the service of humanity…" These are weighty responsibilities. But that is what we have signed up to.

The strength of the evidence that climate change is linked to human activity is being compared with that linking cigarette smoking to lung cancer. We might consider a patient who has



come to us for a routine health check. On discovering that this patient is a chain smoker, should we warn of the danger of life-threatening lung disease? Are we negligent if we do not? Are we similarly negligent if we fail to inform the public that the changing climate threatens health?

We know what the changing climate means for health. Extreme weather events and climate-sensitive diseases cause millions of deaths globally, right now. Insecurity of food and fresh water, economic collapse and human conflict over diminishing resources are likely. Margaret Chan again: "All populations are vulnerable, but the poor are the first and hardest hit. Climate change threatens to reverse our progress in fighting diseases of poverty, and to widen the gaps in health outcomes between the richest and the poorest. This is unfair – and it is unacceptable."[3]

But fortunately there is good news: climate change action benefits health. More active forms of transport and the consumption of less red meat will cut cardiovascular disease, obesity, diabetes and cancer.

Warmer houses reduce asthma and other pulmonary disease: less air pollution reduces these as well as cancer and heart disease.

Spending on roads nation-wide is markedly increasing. The NZ Land Transport programme (2012-2015) predicts a total spend of approximately $12 billion. Most of this is for Roads of National Significance (RoNS). Cycling, however, will be allocated less than 1% of the total spend. RoNS by induction will therefore encourage private vehicle transport over walking, biking and public transport, thus discouraging healthy physical exercise: and all this at a time when the young are decreasingly seeking their driving licenses, and the vehicle kilometres travelled per person is staying static or reducing (particularly in Wellington (Fig.2).

The NZ Transport Agency policy of its "vehicle first" approach makes current transport policy a threat to international efforts to tackle global environmental problems, including air pollution and climate change: its transport benefit/cost ratios (BCRs) often fail to quantify the health and equity costs[4].

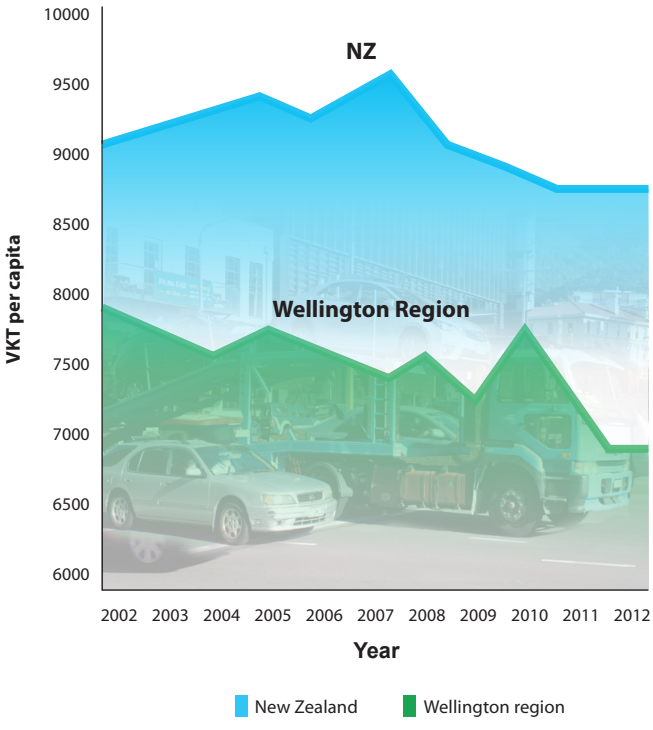


Figure 2: Vehicle-kilometres travelled per capita. Data from Ministry of Transport and Statistics New Zealand.

> *Doctors are ideally placed to bridge the theory of science and the pragmatism of care and treatment.*

So what can health professionals do? People respect and listen to us. Doctors are ideally placed to interpret the science, as we are in the unique position of bridging the theory of science and the pragmatism of care and treatment. We have the greatest responsibility to act, and our professional organisations require it of us.

We should reduce the high carbon footprint of health delivery. We must also push our organisations to divest from fossil fuel industries. We need to ask our politicians for Health Impact Assessments (HIAs) before the formulation of their policies. We have to speak out clearly to the public, the media, government: in so doing we need to provide a strong and unified message – that climate change is real and is a result of human activity; that it is already affecting people globally and is the greatest current threat to human health; and that there are many positive and practical things we can do to avert its worst effects.

1. https://www.ipcc.ch/report/ar5/wg1/
2. http://www.ucl.ac.uk/global-health/outcomes/reports/publications-docs/lancet-commission
3. http://www.who.int/world-health-day/dg_message/en/
4. Woodward et al. Editorial NZMJ:126,1374, May 2013.

NATIONAL PRESIDENT

The accidental clinical leader (and manager)

I bought my first desktop computer in 1989. Many a night was spent with a book on my lap in front of this impressive machine, with its 20 MB hard drive, learning DOS and a programme called Framework III. There was a choice between pixelated green or amber text on a black screen.

A year later when I became a registrar in paediatrics I was able to create, maintain and interrogate a basic spreadsheet. It soon became my duty to do the departmental on-call and leave rosters, from house surgeons all the way up to, and including, consultants.

In retrospect, this gave me a unique opportunity to interact with the whole department on a regular basis; at times there were some very tricky conversations and negotiations around rostering, annual leave and on call requests. When it came to choosing a registrar representative for the paediatric department, I was nominated and elected – most people already knew me due to my spreadsheet skills. From there it was a short jump to becoming a registrar representative on the University Hospital Registrar Board. This became part of my curriculum vitae. Six months into my first consultant job I was appointed Chief of Paediatrics and this was added to my CV – and so it became a self-fulfilling prophecy.

As you must realise by now, due to my ability to do a basic spreadsheet, I became an "accidental clinical leader." Without any formal training in clinical leadership, I somehow managed to wing it.

According to the 70/20/10 Model, 70% of what you learn is based on experience, 20% on feedback and coaching and 10% on formal training. There are many quotes about experience, all of them pretty disheartening and demoralising. "Experience is a good school, but the fees are high," said Heinrich Heine. And from Vern Law: "Experience is a hard teacher. She gives the test first and the lesson afterwards."

Believe me, as an accidental clinical leader I sometimes learned the hard way while my colleagues and family looked on and suffered the consequences of my learning experience.

So let us look at the 20% that consists of coaching and feedback. Not only should this occur but it should be done correctly. Practice is futile unless you actually practise the right thing in the right way. Vince Lombardi: "Practise does not make perfect. Only perfect practice makes perfect."

Experience is important but you can, and should, learn from the mistakes and ideas of others. A few years ago I stumbled across a TED talk which changed my thoughts on leadership and clinical leadership, and stimulated my appetite to read and learn more and to become less of an accidental leader. It was the now famous talk by Simon Sinek (16.5 million views on TED Talks). The catch phrase of his presentation and book is "people don't buy what you do, they buy why you do it". But something in his talk was of particular interest to me. If your 'followers' believe what you believe, they will commit wholeheartedly to your vision with their blood, sweat and tears. Martin Luther King did not get up on stage and urge people to get rid of racial inequality and outline a 10-step plan to do so. He started by describing his vision ("I have a dream"). People who had the same dream and belief trusted him and followed him as a leader.

Those who lead are able to do so because others trust that the decisions being made have the best interests of the group at heart and as a result they are prepared to work hard to achieve something bigger than themselves. Simon Sinek described the underlying principles of creating the 'active follower' – without this trust and confidence, you cannot be a leader.

So to recap, I come from a generation of "accidental clinical leaders". My journey started as a spreadsheet creator. The journey of others probably started differently. Some people would have been elected by their 'active followers', some would have been shoulder-tapped by management, and so on. However, we all have one thing in common - we mostly learned from hard-earned experience and "winged" it, and to various degrees, we are still "winging" it some, or most of the time.

> *People already knew me due to my spreadsheet skills. From there it was a short jump to becoming a registrar.*

We have all seen examples of excellent clinical leadership but unfortunately we have also heard, seen or suffered under clinical-leadership-gone-bad.

While attending the Canadian Conference of Physician Leadership in 2011, I was exposed to a whole new world of fostering, training, supporting and recognising physician leadership. The Canadian Certified Physician Executive Program (CCPEP) was developed by the Canadian Medical Association and the Canadian Society of Physician Executives. The CCEP credential recognises physician leadership and excellence through a national, peer-generated, standards-based assessment process. Physicians awarded the CCPE have proved they have the leadership knowledge and skills needed to perform well and to direct and influence change in Canada's complex health care system.

Wow, a system that moves away from the accidental-clinical-leader-formula and changes the 70/20/10 model by increasing coaching, feedback and formal training! Physicians in clinical leadership positions no longer have to rely on experience 70% of the time. Standards are set and the Canadian certified physician executives are recognised for their qualification. In fact, it is asked for when applying for positions of leadership in the health care system.

Recently a thought hit me. If there is a generation of accidental clinical leaders, what does the managerial side of health care look like in New Zealand? What is the prevalence of accidental health managers? What training and qualifications do we accept and/or expect of a manager in health care? What does the career pathway of a health care manager look like?

Like clinical leadership, we have all seen examples of excellent managers but have all also heard, seen or suffered under management-gone-bad.

New Zealand has a health care budget of $14.5 billion. Whether we like it or not, we are also in the business of health care delivery. This business relies heavily on the skills, training, qualifications, strategy and foresight of its clinical leaders and health managers (hopefully supported by professional budgeting and business units which incorporates well trained and savvy accountants and business analysts).

The clinical leader/manager partnership should have a common purpose, or "why", which they share with their active followers. Unfortunately, and increasingly so, this common purpose and the "why" of health care delivery are pre-determined and orchestrated further and further away from the front line.

> *Those who lead are able to do so because others trust that the decisions being made have the best interests of the group at heart.*

I have total trust and a strong belief in my clinical colleagues across the whole spectrum of front line health care delivery. They work very hard on the shop floor. Their training, qualifications and performance are evaluated, re-evaluated and scrutinised on a recurring basis. They are expected to work harder, faster and safer, "at the top of their licence" and to adjust to a continuous stream of change, new initiatives and targets and at the same time do so within a relatively shrinking budget. Are they doing it with their blood, sweat and tears because they believe in the direction we are heading and because we all share a common belief…… or not?

Would it not be fair that they/we should expect a high level of training, qualification and evaluation of their/our clinical leaders and managers? Should there not be a structured training programme and recognised qualifications for clinical leaders and health managers? You might ask what the cost will be to the New Zealand health service to establish this? I ask you: "What is the cost of NOT doing it?"

It is time New Zealand's health care system invests a bit more of the $14.5 billion in supporting, fostering, coaching and formal training of clinical leaders and health managers to reduce the prevalence and degree of accidental clinical leaders and managers. This would make more sense than our current practice of spending money on high-flying external advisors who come in to our hospitals and clinical services, borrow our watches to tell us the time and then walk off with a nice slice of our budgets!

Hein Stander

West Coast efforts recognised

The hard work by ASMS West Coast Branch President Paul Holt and others has paid off with the Government's announcement it has finally signed off on the business case for funding of the Grey Hospital rebuild.

There were a lot of frustrating U-turns and dragging of heels over the business case, which caused unnecessary anxiety both for the senior doctors and other clinical staff working on the West Coast, and of course for local people wondering what health services they would end up with.

ASMS Executive Director Ian Powell praised Paul Holt's courage in speaking out against earlier attempts to reduce services on the Coast.

Dr Holt, meanwhile, says he's pleased the Government has listened to what doctors and other clinical staff have been saying about the level and type of services needed in the area.

"The feeling among people here is that the planned rebuild will adequately cater for health needs on the West Coast for the medium term," he says. "There's a strong sense of relief out in the community that we finally have some certainty.

"We do need to keep a watch on the Government's plans for Greymouth to make sure there is adequate space for consulting rooms, equipment, allied health and so on. We'll be looking at the detail of the Government's plans to make sure it's workable."

Paul Holt acknowledged the efforts of West Coast DHB Chief Executive David Meates and Programme Director Michael Frampton to get a good result for the region.

Paul Holt, right, talking to Canterbury Oral and Maxillofacial Surgeon Les Snape at last year's ASMS Annual Conference.

EXECUTIVE DIRECTOR

Drilling down on clinical leadership

The ASMS now has a much clearer picture of how each DHB is performing when it comes to providing time for non-clinical duties and distributive clinical leadership.

After two electronic surveys of DHB-employed members we have analysed the results for all of the 20 DHBs, supplemented by the insights provided by branch officers, our industrial staff and through the Joint Consultation Committees.

Our findings for each DHB are below, grouped by performance. The results must be qualified by the fact that in the first survey 63% of members said they did not have enough time for non-clinical duties to participate in 'distributive clinical leadership' activities (only 37% said they did). Overall, DHBs earned an E grade.

In the second survey only 30% of members believed their DHB was genuinely committed to 'distributive clinical leadership' in its decision-making processes, whereas 47% said it wasn't (23% didn't know).

How they performed

Pretty good ★★★

Lakes; Canterbury; West Coast

Lakes

One of the best but risks deterioration if rests on its laurels.

Ron Dunham

This Rotorua-Taupo-based DHB is the top ranked for provision of time and earned a B grade (although around one-third still did not have sufficient time). Lakes undertook a major job-sizing review a few years ago and, while probably somewhat out-of-date, did address time for non-clinical duties noticeably better than other DHBs.

It is also the second ranked DHB for its genuine commitment to clinical leadership in decision-making (and one of only two DHBs where 50% of SMOs responded in the positive). Both the chief executive and senior management (and also middle management) are also rated highly.

It takes a long time to build up collaborative goodwill and common purpose; it takes only a short time to lose it.

Lakes has been helped by having a committed and effective chief medical officer for many years and his successor is continuing in similar vein. However, a word of caution is appropriate. This year there have been signs of disengagement in important processes, including leadership appointments. Distance is emerging between SMOs and senior management. The chief executive will need to ensure that these incidents don't morph into a new direction and a deterioration of what has been an effective collaborative relationship for some years.

It takes a long time to build up collaborative goodwill and common purpose; it takes only a short time to lose it.

Canterbury and West Coast

Very good but always scope for improvement.

Like Hutt Valley and Wairarapa, these two DHBs separated by the Southern Alps have the same chief executive but (unlike their northern counterparts) separate senior management structures. But culturally and performance-wise these two DHB couplets are chalk and cheese. Both ranked in the top three for their commitment to distributive clinical leadership in decision-making processes (1st for Canterbury and 3rd for West Coast); their shared chief executive is ranked 2nd and 3rd respectively); while in senior management, Canterbury is 2nd while West Coast drops relatively to 9th.

They are less impressive on the provision of time, although once again in a survey revealing widespread non-performance. West Coast was a relatively credible 5th (but still 55% without enough time) while Canterbury was 9th (above average, just, but very low by its standards and the 'top of the E graders'). This demonstrates the significance of the differences between vacancies (positions that health bosses choose to advertise) and shortages (includes those many more positions that DHBs need but are not advertised with the result being an overworked workforce). There is scope for improvement here.

Could do better but showing promise ★★

Northland; Waitemata; Counties Manukau; Waikato; Tairawhiti; Hawke's Bay; Taranaki; MidCentral; Nelson Marlborough; South Canterbury

Northland

Promising but capable of doing much better.

In respect of provision of time for distributive clinical leadership, Northland is bang in the middle, both in ranking and percentages. There is nothing impressive about this and, as with other DHBs recording a similar result, Northland receives an E grade.

The DHB's performance is slightly worse on commitment to distributive clinical leadership in its decision-making processes. This is reflected in the rating of the chief executive's commitment although, as a relatively new appointment and with a positive attitude toward SMO engagement, this may improve over time. This ranking may also be skewed by a high proportion of 'don't

knows'. The rating is also similar for senior management. It does appear that members have rated management more harshly than our branch officers and national staff. Our dealings with human resources (HR) to resolve issues have also been positive.

Waitemata

Good potential but risk of encroaching top-down culture.

Waitemata came in 7th for providing sufficient non-clinical time but this has to be qualified by the fact 58% of respondents said that it didn't, earning it a D grade.

The DHB and the chief executive dropped very slightly in the rankings for their commitment to distributive clinical leadership. Of particular concern is the low ranking (14th) for the commitment of senior management, and middle management has also been found wanting. The ASMS has experienced some alarming conduct in the handling of reviews. There are elements of a top-down culture that need to be nipped in the bud before they become more extensive. The chief executive risks his relative popularity reducing if he does not take ownership of this challenge.

Counties Manukau

Good history but mixed performance. Good foundations to do much better.

This DHB received a mixed result, despite having a proud history of innovation. Its provision of time is graded by its senior medical staff as an E. On the other hand, it is ranked 7th for its commitment to distributive clinical leadership, ahead of its two neighbouring DHBs in metropolitan Auckland.

Its chief executive gets a low ranking on commitment to distributive clinical leadership but this has to be qualified by the fact that he is assessed more favourably than most of his counterparts in the 'no extent' category (7th equal best if the ranking was based on this category) and also this question attracted the highest proportion of 'don't know' responses (along with Capital & Coast). He may be a 'victim' of being seen as 'too big picture' and not operationally focused enough.

He has work to do but has good foundations to build on, including a likeable personality. On the positive side he has taken the initiative at our Joint Consultation Committee, asking for a list of SMO 'gripes' that need to be fixed and has responded positively to our request for a list of issues that he would like SMO help for. The commitment of both senior and middle management are ranked a little above the national average.

Waikato

Should be and could be doing a lot better.

Relatively speaking, Waikato is one of the better performing DHBs in respect of providing sufficient non-clinical time, ranked 6th with a D grade. But, on the other hand, the DHB's overall commitment to distributive clinical leadership is disappointing (only 23% thought it was genuinely committed). The chief executive's ranking was disappointing although over half of the respondents had a favourable view, his rating in the 'no extent' category was positively better, and one-third of the responses were 'don't know'. Both senior and middle management take a hammering, however. Some of this might be tainted by an approach from their from their employment relations unit which is seen by staff and unions as hard line.

Tairawhiti

Jim Green

Has done reasonably well but at risk of downward slide.

This Gisborne-East Coast-based smaller DHB is a good indication of national DHB failure. It is ranked well by members for providing time for non-clinical duties for distributive clinical leadership – 2nd behind Lakes – but again perspective is required with 60% answering 'yes' and 40% 'no'. When 40% of members in the second best ranked DHB respond in the negative to what is an essential requirement, it is difficult to think of a more powerful national message of DHB failure (how good really is second best, being a C+).

Senior medical staff are split right down the middle when ranking Tairawhiti's commitment to distributive clinical leadership in its decision-making process, with 37% saying it is genuinely committed and 37% saying it isn't. This mediocre result leaves the DHB ranked 6th.

The chief executive's commitment is ranked above average but senior management's plummets to 15th (possibly skewed by a high proportion of 'don't knows'). There are also recent signs of growing disenchantment among SMOs on the DHB's commitment, including among those in formal clinical leadership positions who feel unsupported. Management will need to work hard to ensure these signs don't become a trend.

Hawke's Bay

Improving overall; impressive senior management.

This DHB came out very poorly in the Robin Gauld (Otago University) 2010 clinical leadership survey of ASMS members, although the questions were different. This poor performance continues with its 19th out of 20 ranking, with just 26% of members agreeing that Hawke's Bay provided enough time to participate in distributive clinical leadership (74% saying they didn't).

Hawke's Bay does move up to middle of the pack for overall DHB commitment to distributive clinical leadership in its decision-making processes. There is a substantial improvement in rating (4th) for the chief executive's performance compared with the Gauld survey. That is despite a reputation for micro-management, especially in respect of targets. More impressive is the high rating for senior management (1st); largely attributable to Hawke's Bay's well performing chief operating officer.

Taranaki

Tony Foulkes

Mixed but good foundations; chief executive needs to be more visible.

Taranaki is perplexing, with mixed results, and based on the ASMS's interactions we were surprised with the disappointing rankings. On the positive side (relatively) it is ranked 4th for provision of time to participate in distributive clinical leadership activities, although again this has to be qualified similar to Tairawhiti above – what is good about the national picture when 4th out of 20 earns a D grade?

The ranking of the DHB's commitment to distributive clinical leadership in decision-making processes is below average while the chief executive's ranking is at the bottom. The latter is surprising because he appears to be genuinely liked and there are no signs of antagonism towards him. His style, however, is very 'below the radar' with less visibility than his counterparts in other DHBs. In part this may due to a long absence resulting from being the victim of a nasty traffic accident and also skewed by the highest number of 'don't knows'.

On the other hand, senior management ranks well (5th).

MidCentral

Middling but potential to do a lot better.

This Manawatu-Horowhenua based DHB is middle ranking in the provision of time but ranked much higher (5th) on its commitment to distributive leadership in decision-making processes. It is at the back of the middle pack in respect of the chief executive's commitment (despite a 'salt of the earth' engaging personality) and up a bit for senior management. The ASMS's experience is that this is a DHB that benefits considerably from the calibre of its chief medical officer and HR general manager.

Nelson Marlborough

Mixed, with potential.

This 'top of the south' DHB ranks well, relative to others, on the provision of time (3rd) but still with 46% responding in the negative its overall commitment to distributive clinical leadership plummets to a poor 15th, tempered by about one-third 'don't knows'. The chief executive's commitment is ranked average. His senior management team is ranked higher at 4th, although there is little difference when percentages are compared.

South Canterbury

Promising, but fixable problem to sort out.

The first of the two surveys is bad news for this DHB with a ranking of 18th and up to 70% of surveyed members saying they don't have enough time for distributive clinical leadership. On the other hand, there was a mixed result for South Canterbury's commitment to distributive clinical leadership – ranked in the top five in terms of positive respondents but with 50% of them believing their DHB was not genuinely committed.

Thereafter it gets interesting, rather like a tale of two managements. The (new) chief executive gets a very high rating on commitment (3rd and the only chief executive who no SMO answered in the 'no extent' option; even the impressive Canterbury and West Coast had 3% and 11% respectively for this response). In marked contrast, senior management came a poor 12th in the combined 'great' and 'some extent' category; 50% of respondents said senior management's commitment was 'to no extent', the highest level of all 20 DHBs. There is a challenge here for the chief executive to work through.

Need to really lift their game ★

Bay of Plenty; Whanganui; Capital & Coast

Bay of Plenty

Bordering on being in serious difficulties but some recent changes in senior management offers opportunities for improvement.

Bay of Plenty performs better than most DHBs on provision of time for clinical leadership activities (although it still receives a D grade). But it has serious problems in its overall genuine commitment to distributive clinical leadership in decision-making processes, with just 16% believing it was committed (17th). The chief executive's ranking was underwhelming - but for senior management it was disastrous (20th out of 20).

This is a DHB in difficulty, although recent changes in both senior management and clinical leadership in areas where there were serious problems may provide a stronger foundation for moving forward. But the DHB will have to listen to the messages. HR practices over fair process in some individual cases have been sub-optimal.

Whanganui

Signs of both improvement and regression.

Like Hawke's Bay, Whanganui was a poor performer in the 2010 Gauld survey and this continues. It received the lowest ranking for commitment to providing time to participate in distributive leadership positions (79% responded in the negative).

Relative to other DHBs, Whanganui is in the middle bunch on commitment to distributive clinical leadership in its decision-making processes (still with 54% saying no, however). The chief executive's and senior management's ranking is a little higher. Whanganui has improved somewhat since the Gauld survey but this is from a low base. There are, however, some worrying signs of hard-line attitudes emerging.

Capital & Coast

Debbie Chin

Should be doing a lot better; could go either upward or downward.

As one of New Zealand's largest DHBs including tertiary services, Capital & Coast's ranking is disappointing, beginning with below average on what is already a poor national assessment of provision of sufficient time and also for the DHB's overall commitment to distributive clinical leadership in its decision-making processes.

Its chief executive ranking is second lowest although this has to be qualified by the fact that as a recent interim appointment she is not well known among many senior medical staff. The result may also be tempered by the high number of 'don't know' respondents. Senior management ranks better in the surveys, but the results are not startling.

The possums in these DHBs need to get out of the headlights.

Like Hutt Valley and Wairarapa, Capital & Coast has been blindsided by a politically overhyped sub-regional service integration programme that is suffering through lack of purpose and direction, and an overabundance of confusion.

The possums in all three DHBs need to get out of the headlights.

There is some potential within Capital & Coast senior management, along with a responsive chief medical officer, but they need to line up their dots better. An important test will be how the DHB handles a review process for its laboratory service when, to date, it has managed to give confusing signals and is showing every sign of going down a destabilising path.

In serious difficulties

Auckland; Wairarapa; Hutt Valley; Southern

Auckland

Serious difficulties with a major leadership culture change required.

This DHB is in serious difficulty, with the emergence of a top-down micro-management culture. Auckland received a poor E grade for provision of time for clinical leadership (as do most DHBs, of course). The DHB's commitment overall and the chief executive's commitment, in particular, are judged poorly (16th and 17th respectively). This permeates down to both senior and middle management.

If ADHB is going to turn around, a major cultural change from its leadership is required.

The only 'shining light' is the respected and competent chief medical officer but she risks being dragged down in the mire.

Wairarapa and Hutt Valley

In serious difficulty; remedial action required.

These are separate DHBs, each with their own board but sharing both the same chief executive and senior management structure (this has proved to be an unwise politically driven decision). Both DHBs are in serious trouble.

They are ranked poorly on the provision of time (16th and 17th respectively), DHB commitment (20th and 19th), chief executive commitment (slightly below average in Wairarapa and 18th in Hutt Valley), and senior management commitment (respectable above average in Wairarapa but 19th in Hutt Valley). Some of this is due to ill-considered top-down restructuring but some is clearly due to a combination of poor leadership culture and performance. Remedial action is required. On the positive side, there have been recent informal indications that senior management at least is trying to take ownership of the problem and converting it into a challenge. But the recently announced resignation of the Chief Operating Officer is a setback.

Southern

Carole Heatly

In serious difficulties; needs to focus more on culture than structure.

Southern (the top-down merged Otago and Southland new DHB) inherited serious difficulties, part of which was revealed in a National Health Board report on systemic issues at Dunedin Hospital. These predated but were inherited by the current chief executive. This is a DHB in serious trouble, not helped by the chief executive mistakenly focusing on structural rather than cultural change, and failing to use the opportunity available to her as a new chief executive to completely rejig her senior management team.

For provision of sufficient time, the DHB ranked 15th (69% negative response). For its commitment to distributive leadership, Southern's overall ranking was very low (18th, with 68% believing there was no commitment at all). There is a sign of hope with the chief executive rated 12th but her senior management was a lowly 16th. The chief executive has an engaging personality but she needs to focus on culture and management performance if this situation is to be turned around. It is not too late but does require a new blood transfusion.

This is a DHB in serious trouble, not helped by a chief executive mistakenly focusing on structural rather than cultural change.

Ian Powell

ASMS RESEARCHER

The risks of fatigue for patients and doctors

The last issue of The Specialist looked at the need for recovery time. In this issue, we examine the effects of fatigue on hospital doctors and some of the ways this is being addressed.

More than 550 senior medical officers (SMOs) work 60 hours or more a week on average, according to workforce survey data from the Medical Council of New Zealand. Over 100 are working on average 70 hours or more, and over 30 are working 80-plus hours per week.

Working such hours exposes these doctors to the risks of fatigue, which has long been recognised as affecting cognitive and physical function. A study of workers in Germany found that after nine consecutive hours of work, the risk of unintentional accident increases exponentially with each subsequent hour.

Performance impairment after 17 hours of wakefulness has been shown to be equivalent to that of a blood alcohol concentration of 0.05%, which is the legal limit for driving in some countries and is the proposed new limit announced by the Government in November 2013.

In addition, the amount of sleep prior to work, the quality of sleep (eg, uninterrupted by call outs), and disruption of the circadian rhythm (working shifts) contribute to fatigue.

Aging reduces the capacity to recover from fatigue (45% of medical officers and 52% of specialists are aged 60 or over). And even relatively mild sleep debt can have a cumulative effect over a series of days. Research has shown that sleeping six hours or less per night over two weeks results in cognitive performance deficits equivalent to two nights of total sleep deprivation.

The Institute of Medicine (IOM) in the United States defines fatigue as "an unsafe condition that can occur relative to the timing and duration of work and sleep opportunities".

The IOM further states:

In healthy individuals, fatigue is a general term used to describe feelings of tiredness, reduced energy, and the increased effort needed to perform tasks effectively and avoid errors. It occurs as performance demands increase because of work intensity and work duration, but it is also a product of the quantity and quality of sleep and the time of day work occurs.

Several fatigue and alertness studies have demonstrated an increased risk of fatigue-related incidents in the early morning hours, coinciding with the circadian period of peak sleepiness. The circadian 'pacemaker' is resistant to change after a night of shift work. This is the main reason for the inability of people to readily adapt to shift work.

Fatigue among hospital doctors

Fatigue risk associated with the work schedules of hospital doctors is under increasing scrutiny internationally, though most of the research and regulatory focus to date has been on resident doctors.

However, because of the range of factors associated with fatigue, including the period of wakefulness, the circadian phase, prior sleep duration, sleep inertia and the state of an individual's health and wellbeing, evaluating the impact of fatigue in the medical workforce is not straightforward. There is no available metric for accurately measuring fatigue and its consequent effects on doctors and patient care.

> *Even relatively mild sleep debt can have a cumulative effect over a series of days.*

Findings from international studies have therefore been varied, and many studies have been found to have methodological weaknesses. Nevertheless, a major literature review focused on resident doctors, after screening out many flawed studies, found "there is reasonable consistent evidence" that working long hours, working the night shift compared with the day shift, increased shift length, working consecutive night shifts and decreased sleep are associated with poorer outcomes for doctors and their patients.

A paper summarising nine studies, mostly concerning resident doctors, found:

Fatigue leads to declined performance, attention span, and reaction time. Judgment becomes slow and precious time is lost in making critical choices. Decreased alertness and lapses in actions cause the provider to be more vulnerable to critical accidents and errors. Ageing, night calls, intense schedules, and long working hour shifts all are stressful and contribute to onset of fatigue. Various studies have shown that as sleep debt increases … energy decreases and simultaneously there is increased confusion, anxiety, depression, anger, and fatigue. As work hours are protracted or extended into night, mood is negatively affected.

Several reviews of the medical literature show that even a single night of missed sleep measurably affects cognitive performance. When adults do not sleep at least five hours per night, language and numeric skills, retention of information, short-term memory, and concentration all decrease on standardised testing.

Fatigue among senior doctors

The body of research specifically concerning senior doctors, though more limited, indicate that fatigue relating to, among other factors, long and irregular hours, can have adverse effects on both the quality and safety of care for the patient as well as the health of the doctor.

Well-controlled investigations that tested deficiency in performance secondary to fatigue, using reality simulators, found noteworthy reductions in the performance of sleep-deprived surgeons. Sleep deprived surgeons were slower, less accurate and more prone to errors.

An American study reveals an increased rate of complications among post-night-time surgical procedures performed by attending physicians who had slept less than six hours.

In New Zealand, 86% of the anaesthetists who responded to a survey admitted being involved in a fatigue-related error, while 58% felt that they surpassed their self-defined limit for safe continuous administration of anesthesia.

Another New Zealand study examined work patterns, sleep (actigraphy, diaries) and performance (psychomotor vigilance task, pre- and post-duty) of anaesthesia trainees and specialists across a two-week work cycle in two urban public hospitals. It was thought to be the first study to document sleep loss among specialist anaesthetists.

It found that, consistent with observations from experimental studies, the sleep loss of specialists across 12 consecutive working days was associated with a progressive decline in post-duty performance. However, this decline occurred with much less sleep restriction (< 1 hour per day) than in laboratory studies, suggesting an exacerbating effect of extended wakefulness and/or cumulative fatigue associated with work demands. For both trainees and specialists, robust circadian variation in performance was evident in this complex work setting, despite the potential confounds of variable shift durations and workloads.

Impact on doctors' health

A study involving 267 consultants from a wide range of specialties at Christchurch District Health Board in 2006/07 found one in five had symptoms of high burnout, with long work hours and low job satisfaction being key contributory factors. A quarter of the respondents reported working longer than 60 hours per week.

A study on the effects of long working hours on the health of senior hospital doctors and resident doctors in Germany found that excessively long working hours (defined as 10 or more working hours per working day, and six or more on-call shifts a month) were associated with an increased risk of health complaints.

A study of hospital physicians in Japan to determine the association of depressive symptoms with long and irregular work hours found the number of days of on-call and overnight work, lack of sleep and lack of time off duty were linked with symptoms of depression among some physicians.

Approaches to addressing fatigue

Prolonged and irregular working hours have for many years been recognised as a cause of accidents in industries such as aviation, where there are strict rules for maximum flying hours and mandatory rest periods between flying duties. In the United States, truck drivers, nuclear plant workers and train engineers have limitations placed on the hours they are allowed to work.

For the medical profession, regulation of work hours has focused mostly on resident doctors, with, for example, the 'New Deal for Junior Doctors' in the United Kingdom and the Accreditation Council for Graduate Medical Education approved standards in the United States. In New Zealand the current Resident Doctors' Association-DHB MECA (a new agreement was being negotiated at the time of writing) restricts duty hours to a maximum of 72 hours weekly and only 16 consecutive hours are permissible. The current MECA states: "The parties have a commitment to work back to a maximum of 60 hours per week."

The European Working Time Directive (EWTD), introduced to restrict work hours in order to protect the health and safety of the European workforce, gives EU workers, including senior doctors, a right to work no more than 48 hours a week. It also stipulates a minimum rest period of 11 consecutive hours in every 24, as well as a rest break during working time if they are on duty for longer than six hours. Workers are also entitled to a minimum uninterrupted rest period of 24 hours in every seven days. The EWTD also restricts excessive night work.

> *Fatigue related to long and irregular hours can have adverse effects on the quality and safety of care for the patient, as well as the health of the doctor.*

In the United Kingdom, the EWTD is implemented through the Working Time Regulations (WTR), which provides some flexibility in specifying that the 48-hour-per-week working limit is based on average hours calculated over 26 weeks. The WTR also allows individuals to opt out of the 48-hour limit to work longer hours, though they should not be obliged to do so by their employers and they may not derogate from the rest period requirements. (Resident doctors who opt out of the 48-hour limit requirement must still comply with the 'New Deal' limit of a 56-hour week.)

In Australia, after a consultation process supported by the Federal Government, the Australian Medical Association produced a *National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors*.

Because the "level of fatigue and the consequent effect on safety and work performance is complicated and is the product of a range of factors", the code does not contain absolute, enforceable limits on single elements such as the maximum length of a safe shift or the break required between episodes of work.

The range of risk factors is identified in the code, which contains a 'Risk Assessment Guide' and a 'Risk Assessment Checklist' to help assess the risk level of an individual's working hours. The code provides the tools to identify unsafe working hours and reduce the associated risk levels.

Your views

There have been calls for action – internationally and in New Zealand – to develop new tools and strategies for dealing with fatigue in the senior medical workforce.

We would like to hear your thoughts and comments on the contents of this article, or any other ideas or concerns you may have relating to fatigue. Please send your comments to your local industrial officer or directly to the national office at **asms@asms.org.nz**

Lyndon Keene

NOTE: This article, with a full set of references, is available on the ASMS website at www.asms.org.nz

EXECUTIVE DIRECTOR

A tale of political machinations

On 9 May I attended by invitation an all-day event in Auckland organised by Southern Cross in collaboration with Massey University, which they titled 'Tomorrow's Healthcare Think Tank.' It was called a 'think tank' because the participants were described as health sector 'experts'. It's fair to say I was flattered but unimpressed.

About 45 people attended the event, mainly representatives of private sector interests, some business and economics consultants, and a few academics. A small number of Ministry of Health (including the Acting Director-General) and Treasury officials attended. The only DHB attendees I noticed were a Board Chair and Chief Medical Officer. Compounding the unrepresentative nature of the gathering was the virtual absence of health professional organisations and unions. Additional to the ASMS I only noticed the NZMA and College of Nurses. Lawyer and former television journalist Linda Clark facilitated the event.

In an unusual move, with the exception of the keynote speaker (Sir Malcom Grant, Chair of NHS England) and the summing up session that followed him, Chatham House rules applied throughout the gathering. This limited any reporting to what was said but not who said it – which became particularly ridiculous when it applied to the Minister of Health in his address and to a panel discussion involving representatives of Labour, NZ First and ACT (Greens were unavailable). This appeared not to be due to any action by the various politicians, who seemed surprised to learn of it.

> *Chatham House rules applied, to the apparent surprise of the politicians present.*

As an aside, Sir Malcolm Grant (Chair of NHS England) spoke fluently but failed to address the ideological construct of the new UK Act that NHS England is required to act under or acknowledge the level of disruption and bureaucracy in the NHS today. Despite a nod to the Mid-Staffordshire tragedy, he indicated that ultimately it was addressing deficits that were the priority even ahead of safe staffing levels.

One could assume from his address that pressure to increase nursing numbers was one of the biggest challenges the NHS faced. But cutting nursing numbers was one of the significant contributing factors behind Mid-Staffordshire. His address was well executed but of limited relevance to the meeting's subject matter.

Presented to the gathering was a survey by the 'College of Health and Auckland Knowledge Exchange Hub' (Massey University) that was highly questionable. In particular, it was limited to 32 of the participants in a process where a private health insurer and hospital operator with obvious vested commercial interests had a significant influence in determining the interviewees.

Despite this, the survey results did not provide support for the position that the private sector and private health insurance should be more involved in publicly provided services. It did assert, however, that 44% of the people surveyed said New Zealand needed to 'revise current funding and allocation strategies' when asked what were the big issues facing the health sector. This had four sub-groups, including compulsory health insurance and introduction of user charges. It was sufficient mileage for vested interests to try to make hay with and embellish a dubious survey for commercial benefit.

There were three separate panel sessions, although the standard of contributions was variable and not well connected:

1. Health sector efficiency and quality (no-one from the DHBs).
2. Current funding and allocation strategies.
3. Public health promotion initiatives.

A session followed that struggled to pull things together and during which efforts were made by potential beneficiaries to put the case for private health insurance being part of the policy mix and private hospitals doing more or all of DHB electives, that would be developed by a new 'think tank'.

The purpose of this appeared to be to create a climate conducive to the promotion of the private health insurance market in which Southern Cross is the dominate player and also the increased use of private hospitals for electives – even to the extent of arguably doing all of them it seemed, leaving public hospitals with acute cases and chronic illnesses (ie, leaving them things that don't leave scope for profit maximisation). Funny that!

> *The purpose appeared to be to create a climate conducive to the promotion of the private health insurance market.*

Almost immediately after the meeting, Southern Cross released a media statement calling for the establishment of a 'think tank' with, no doubt, the interests of private health insurance and private hospitals at the all so discreet forefront camouflaged by noble aspirations and utterances. The ASMS, presumably alongside other participants at least, also received an invitation to join this august body.

For good reason when the ASMS National Executive considered this it decided to take no further action on this request. Funny that!

Ian Powell

ASMS 25 YEARS OF ENGAGEMENT 1989-2014

Diagnosing health systems and devel

One of the world's top thinkers on the challenges facing health systems will help senior special conference to mark the 25th birthday of ASMS.

Professor Martin McKee will be the keynote speaker at the commemorative birthday event at Te Papa, Wellington, on Tuesday 26 August 2014.

Other presenters include Dr George Downward, foundation President of the ASMS, who will reflect on the first 25 years of ASMS, and Dr Michael Chen-Xu, former President of the Medical Students Association, who will look at what lies ahead. They will be joined by a panel which includes business journalist Rod Oram, political commentator Colin James, and Professor Peter Crampton, Dean of the Otago University Medical School.

"It's going to be a day of reflection and debate, and a good opportunity to hear some of the best research and analysis available on the challenges for health care globally as well as for New Zealand," says Ian Powell, ASMS Executive Director.

"We're especially delighted to have someone of the calibre of Professor McKee join us as he has such strong international expertise in how health systems worldwide are coping with the task of delivering health care during periods of economic adversity."

Professor McKee qualified in medicine in Northern Ireland, with subsequent training in internal medicine and public health. In addition to his position at the London School of Hygiene and Tropical Medicine, he also co-directs the European Centre on Health of Societies in Transition and is research director of the European Observatory on Health Systems and Policies, which is a unique partnership of universities, national and regional governments, and international agencies.

He has published more than 740 scientific papers and 42 books, was an editor of the *European Journal of Public Health* for 15 years, and is an editorial consultant to *The Lancet*. In 2005 he was made a Commander of the Order of the British Empire (CBE).

During his week in New Zealand, in addition to the commemorative conference, he will also address the Branch Officers' workshop on Wednesday 27 August and meet with representatives from various government and health agencies to talk about his analysis of health systems.

Professor McKee is looking forward to talking to hospital specialists here.

Presidential talk

Effective leadership and a highly professional and active membership have been at the heart of ASMS' success over the past 25 years. The ASMS has been well served by its seven Presidents and its National Executive teams, and is in good heart as it embarks on the next quarter century.

"All the past National Presidents have brought impressive qualities. Their personalities have been different but all are underpinned by unquestionable integrity and commitment along with strong values that stand the test of time. It has been an honour to have worked for them," says Ian Powell, ASMS Executive Director.

We asked ASMS' past Presidents to comment on their time in the role. One former President, John Hawke (1995 – 1997), is deceased but the others provided the following observations. Their comments have been edited for space but the full interviews with each President is available on the ASMS website: http://www.asms.org.nz/Site/About_Us/National_Executive_and_Staff.aspx

George Downward, 1989 – 1991

What characterised your time as President?

The key challenge faced by the first National Executive and by me as the first President was simply that of ensuring the ASMS gained and maintained the credibility necessary to actually survive as a union representing a professional workforce.

The formative days of the ASMS predated 'launch day' by quite a period of time, with significant ground work required to develop, register and house a union while also keeping the potential membership informed and accepting of the need for change and the progress made. This work, undertaken by relatively few people, was facilitated by the very significant financial and administrative support provided by the NZMA, together with some additional funding provided by the Whole-time Senior Medical Officers Association and the NZ Association of Part-time Hospital Staff, both of which were wound up with formation of the ASMS. Many decisions had to be made along the way, amongst which one of the most important (and successful) was the appointment of Ian Powell as the Executive Director.

Happily the quest for membership was very successful and we were soon faced with the challenge of preparing for our first round of negotiations, no longer through HMOAC and the HSC but as a union, a new experience for all except Ian Powell.

In a sense the rest is history, with the ASMS gaining credibility both as a very effective union as well as a professional voice for the membership and the health system as a

oping a treatment plan: challenges and solutions

doctors take the temperature of New Zealand's public hospitals at a one-day

He says the biggest challenge for public health today is to press back against the dominant model of market forces, which has failed to provide significant increases in living standards and improvements in health for most people.

"This model is promoted everywhere, in politics and in the media, but the reality is that it is not delivering what ordinary people need, and we need to say so."

He says Europe's biggest problem is the maintenance of universal health care in the face of financial crisis, with austerity measures in Europe threatening the effective and equitable provision of health care. In addition, constant changes as part of the never-ending quest for greater efficiencies is destroying the institutional memory of organisations such as the NHS in the UK, and leading to 'reform fatigue'.

Professor McKee's address to the ASMS commemorative conference will be on *Health and Wealth: the argument for investment.*

Professor Martin McKee

"It's going to be a very relevant address for senior doctors and dentists in New Zealand's public hospitals who are working in an environment of financial constraint and ongoing challenges to do with workforce engagement, clinical leadership and entrenched shortages," says Mr Powell.

Branch delegates will be able to attend on the same basis as if it was the Annual Conference (including reimbursement of costs). Expressions of interest should be sent to ASMS Membership Support Officer Kathy Eaden at **ke@asms.org.nz.**

whole, albeit the latter in concert with the NZMA and NZRDA.

What do you think has changed?

The health sector has become more complex, and the membership and central office significantly larger, but the original focus and intent expressed in forming the ASMS has been sustained and enhanced through the commitment and efforts of a succession of Presidents and Executive Committee members. One key element of this success has remained constant, namely the fact that the face of the Executive Director hasn't changed, aging aside!

Do you think it's easier or harder to be a specialist working in a public hospital in New Zealand today?

I don't believe that it is any harder or easier to be an SMO or SDO working in a public hospital today, just a bit different, with some of the difference driven by the significant advances in health care, population growth etc, and some by the different expectations of today's world. There have been some very difficult times mostly associated with political whimsy with unfortunate rhetoric and sabre-rattling, but as a sector we are in relatively good shape at present.

Is there a particular ASMS gain or achievement that stands out for you?

Many of the gains achieved over the years have been incremental and although reflected in part in the back pocket, to my mind the most significant achievements of the ASMS have been based on an ongoing and unfailing recognition of the primacy of the needs of the patient. This is reflected both within the CEC and the day-to-day pronouncements of the ASMS.

Allen Fraser, 1991 – 1995

What characterised your time as President?

My four years as President was a time of consolidation and growth in the role of the ASMS.

A couple of things stand out for me. One of them was our efforts to educate members about the importance of superannuation. It wasn't good enough to leave something so important to the employer. We had to make sure we could retire when we wanted to, and that required a personal investment of time and effort. I remember saying in our talks with members around the country that there were many reasons for continuing to work after age 65 but that having to work was one of the worst reasons of all. We really raised the profile of superannuation as an issue, and got it onto the DHBs' radar.

We also had a very important role in the wider professional and political health sphere over that period. We made submissions on issues of real importance and concern, and were very actively involved. It was an interest of mine to ensure we took part in discussions about the wider health system and that we made sure the voices of hospital doctors were heard. That aspect was a very satisfying part of my time as President.

What do you think has changed?

The employment agreements are more secure, and we're seeing more people now negotiate individual contracts based on the collective agreement. That's a lot more common than it was back in the 1990s. There's also more recognition that a senior doctor should be involved in discussions and decisions about the provision of services. Doctors have good ideas and they should be listened to.

What is it like to be a specialist working in a public hospital in New Zealand today?

Overall I think it's probably harder to be a senior doctor in a hospital today, not because of the patients and their health needs but because of the requirements of the Ministry of Health. The Ministry has all sorts of hoops and jumps and so on, all these reporting requirements and yet it provides very little feedback to the people who supply the information.

Is there a particular ASMS gain or achievement that stands out for you?

The most significant achievement for me has been the way ASMS has managed to meld a strong industrial union with a professional group, without losing the focus on professionalism. The requirements of patients have never been forgotten in the pursuit of conditions and other things for senior doctors, and that's really important.

Peter Roberts, 1997 – 2003

What characterised your time as President?

We had, to some degree, headed off the privatisation agenda of the early 1990s but the managerialist manifesto/juggernaut steamed along throughout the era, and does still. The advisors to the Ministry of Health still believed they simply needed to let the market decide right up to the change of government in 1999.

Being National President was a delight for me because I was so ably assisted by the wisdom of Vice-President David Jones and the canny insights of National Secretary Brian Craig. The entire Executive Committee was an incredible brains trust, with each member bringing their expertise and experience to our deliberations.

Some of the most interesting items on our agenda over that period were the 'spots of bother' that would be brought to the Executive meetings as these often revealed the fundamental breakdown between the professional and managerial cultures within New Zealand's public hospitals.

Toward the end of my time as National President, our Timaru colleagues came to the realisation that a strike by senior doctors was needed to settle their grievances. I arrived in Timaru for a 9am meeting on the barricades (held in the tea-room). The room was empty except for an anaesthetist who obviously had no list at that point. After 45 minutes of waiting, several SMOs started to roll in after they had finished their 06.30am – 10am outpatient clinics and quick procedures carried out in the ED. They planned to return in the late afternoon for their next series of outpatient clinics outside of the 'work-hours strike'.

The anaesthetist said to me: "You see Peter, workaholics don't strike over money."

The strike was about the fact that the CEO didn't realise what a national treasure he was abusing. Unfortunately, many managers and even colleagues who take on management roles still don't recognise the value of our professional attitudes.

What do you think has changed?

The level of political interference continues unabated and the district health boards have not been allowed to be representative of their electorate. However, the manipulation of governance from below– managers "managing up" – has increased and there are only rare pockets of expertise that help us get our jobs done without more control modes being superimposed on the already struggling system.

Do you think it's easier or harder to be a specialist working in a public hospital in New Zealand today?

My son is training to be a doctor at medical school at the moment and I dearly wish that the humane values that have driven us will drive him as well. I have grave fears for the future while our culture continues to be dominated by those who would control and enforce efficiency over those who would cultivate, collaborate and nurture the workers of the next generation.

Is there a particular ASMS gain or achievement that stands out for you?

Our membership growth says so much about the effectiveness of the organisation. We made an incredible gain in getting reasonable CME funding throughout the sector, and this has been admired and praised throughout the world. This freed us up from depending on hand-outs from drug companies to go to meetings and has given us the opportunity to look further afield for better ways to serve our patients and further our art.

David Galler, April – July 2003

What characterised your time as President?

I was a member of the ASMS Executive team for a few years before becoming Vice-President for 2 years and eventually becoming President. I followed Peter Roberts in that role. He had made an enormous contribution to the ASMS so for me, it was a case of building on all that he accomplished. I had a very different style. I am a networker, someone who likes to bring people together on common ground. There is huge value from an investment in our senior medical staff and listening to what they have to say.

Back then, I remember my sense of disappointment with the lack of collaboration between doctors, DHB managers and the Ministry of Health. The Ministry seemed very removed from the realities of everyday work and my sense then (and now), was that we needed to create a health system that worked better for people; a system that was much more connected to meet the needs of its users.

What do you think has changed?

Working as a specialist back then was hard yakka, and of course it still is. I work at Middlemore Hospital as an Intensive Care Specialist and at the time, as well as being ASMS President, I was also in the middle of that devastating Meningoccal B epidemic. We were inundated with work, and acute patient presentations to our Emergency Department were increasing by nine percent a year. In many ways the underlying issues we were dealing with back then still exist today: the broader determinants of poor health and illness; problems attracting and retaining an appropriate skilled workload.

What is more evident now is the changing nature of our work. In the early 2000s we saw lots of acutely unwell people presenting for

the first time, but now we're managing more complex cases. We're realising more and more that the real task at hand is to manage or prevent chronic disease, and that's about changing people's attitudes, choices and behaviours, skills that doctors may not currently possess.

What is it like to be a specialist working in a public hospital in New Zealand today?

It is and always has been a position of great privilege. The standards of care are high and our staff highly skilled and successful in what they do. The pressure from Treasury and the Government to contain costs is an ever present and incredibly important challenge. That is a goal that will never be achieved by people like me alone. My challenge to government is to reorganise how they allocate and spend our precious resource to achieve the goals we want. The current simplistic and siloed approach to resource allocation might be the easiest way to spend our money but it does not reflect the complexity and messiness of real life issues we face or the problems we need to solve.

Is there a particular ASMS gain or achievement that stands out for you?

I think ASMS has done spectacularly well in the past 15 years, with the growth in membership and the way it responds to diverse views. We're a broad church, fundamentally an industrial organisation but with a wider role to play. I'd like to see the ASMS' influence grow, as it has the potential to contribute a great deal to the sector's discussions and decision-making.

Jeff Brown, 2003 – 2013

What has characterised your time as President?

A decade of change, while many things remained the same. When I started there was a climate of victimisation, of multiple jeopardy, of being done to, vilified, and in many cases a questioning of why we had chosen a career of striving to provide the highest quality care.

I set out to engage those who would help build a culture of leadership, of positive influence, to regain the helm of the health system. We achieved many advances, and suffered a few retreats and regressions into managerialism, especially as the financial screws tightened.

Despite some reversals and duplicitous dealings, we established sequential MECAs with many gains for our members. We have embedded clinical engagement with JCCs, workshops, revitalised branches, representation on national boards, and several victories for common sense against misguided administrators.

What do you think has changed?

Clinical leadership is now accepted as necessary for health care to perform at the top of its possibilities. Non-clinical time is now accepted as necessary for quality improvement and high functioning teams.

ASMS is seen, like it or not, as a protector of a high quality public health system. Your organisation is prepared to stand up for, lobby, and fight if necessary, to preserve a public health system we can all be proud of.

What is it like to be a specialist working in a public hospital in New Zealand today?

Expectations continue to exceed capacity to deliver, and as leaders of most health teams, specialists in public hospitals increasingly struggle with rationing. A hospital specialist now needs to consider how they can radically change their horizons and influence, how to provide care while not seeing patients, how to spread their wisdom and wealth of skills through others. The future cannot be addressed by the habits of the past, yet the best of what we have cannot be tipped out in the pursuit of change.

Is there a particular ASMS gain or achievement that stands out for you?

Adopting Toi Mata Hauora as our identity. It encapsulates where we have travelled in the decade I was President. We stand at the peak of health care, representing the many faces of clinical expertise, and preserve the public health system against the storms of opportunistic swings of mood and mandate.

Hein Stander, 2013 – Present

What is characterising your time as President?

We have two main roles as an association. Promoting the right of equal access for all New Zealanders to a high quality health service and as a union we represent our members in respect to their employment agreements. The next round of MECA negotiations is scheduled for 2016. This gives us a unique window of opportunity to concentrate on things other than MECA negotiations. I'm very keen for us to build relationships with like-minded organisations and to find common ground on health workforce issues.

What do you think has changed?

Health services have always been under pressure but the nature of that pressure is changing and increasing. There is a worldwide realisation that the current funding trajectory of health is not sustainable. We are facing escalating pressure on our services, exacerbated by the health problems associated with people living longer, diabetes, obesity, chronic disease etc. We are heading into the perfect storm if we do not alter our course now. The ASMS and its members are well placed to be a major player to help face the challenges ahead.

What is it like to be a specialist working in a public hospital in New Zealand today?

Hospital specialists are expected to work harder, faster and at the same time continue to improve quality and safety. This occurs against the background of a relatively shrinking health budget and a workforce that is growing at a rate slower than required. This creates a very challenging situation and I have respect for all of my clinical colleagues, who continue to be committed to delivering the best possible health care to the people in their communities. That is what we have been trained to do and provides us with job satisfaction.

Is there a particular ASMS gain or achievement that stands out for you?

We need to acknowledge and thank the leaders and those who played their part during the last 25 years. They have given us an ASMS that is in fantastic shape. They have established a culture of continued improvement and a belief that we can overcome the challenges the future holds.

MPS MEDICAL ADVISOR

Managing negative online feedback

With the growth of online forums it is not unexpected that consumers are increasingly expressing their opinions about the medical care they have received. Patients will commonly search online to research a doctor they will be seeing in secondary care. It is clear that this is not a passing fad, and for those working in healthcare, being rated and reviewed will become the norm as it is in other service areas.

Complainants have a right to express their views or complain online in the same way that they do directly to the health professional concerned, a practice, the HDC, the Privacy Commissioner, or regulatory bodies. The problem arises when this becomes inappropriate and/or unlawful comment. Unreasonable conduct may include abusive and threatening language, personal attacks, false allegations with the intention to humiliate or discredit, and posting personal contact details of the health professional so they can be targeted.

From time to time, MPS receives calls from members who have discovered a negative comment about themselves and seek advice on what options there are to manage this. This article describes an approach to monitoring postings, evaluating the content, and deciding whether and how to act, drawn from a manual published by the Office of the Ombudsman.[1]

Monitoring postings

You should monitor online postings and encourage staff to report any inappropriate online content which relates to you, your staff, or your organisation. There are a number of online tools, such as Google Alerts, which automatically monitor online postings referring to particular subjects, people or institutions.

Evaluate

Once content is discovered it needs to be assessed and a decision made on whether a response is necessary. This needs to be done as soon as possible as delays can increase the likelihood of the content being widely disseminated.

Content

- Does it contain constructive criticism or is it purely negative?
- Is it reasonable in its tone?
- Does it contain misrepresentations that could reasonably mislead others?
- Does it contain inappropriately obtained personal information about you?

Visibility and credibility

- Is the content on a website such as Facebook which is highly visible and accessible or an obscure website used by a relatively small number of people?
- Is the content so farfetched that no reasonable person would believe it?

Apparent purpose

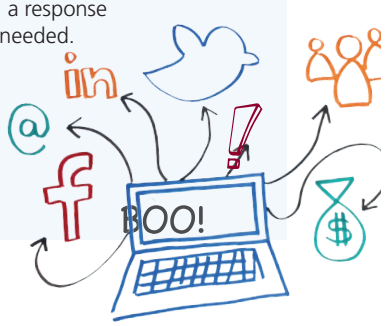
- Does the content incite others to engage in particular acts, such as targeting you, or to engage in unlawful conduct?
- Has it been created with the intent to embarrass or humiliate?
- Is it part of a smear campaign?

Impact

- Could the content significantly damage your reputation (where the damage is unwarranted or the content false)?
- What impact will it have on your workplace environment, relationships with colleagues and complainants, particularly if it is believed?
- Could the content be interpreted as a representation made by you?

Context

- Does the complainant have a legitimate issue? If so then take steps to rectify things.
- What is the timing of the content? For example, if it has been created at a time when you are already under unusual public scrutiny, a response may be needed.



Act

The decision on whether, and how, to respond needs to be carefully considered. As coming across negative, critical or abusive material can be very upsetting for the person concerned, it is wise to seek advice before taking any steps.

You may be more inclined to respond where there is a significant risk that the content could mislead others (especially if it appears credible), contains gross misrepresentations, or is highly misinformed.

Likewise where it is highly visible, having a significant impact on your workplace, or disclosing sensitive personal information, then you may wish to act.

Reasons for not responding may be that you feel that it would only encourage or incite the complainant, would create controversy and invite media interest, or is not located on a highly accessible website.

Some content may be relatively moderate (or even constructive) criticism which carries little risk, or so farfetched that it could not possibly be believed by a reasonable person. You may feel that it is unlikely to cause reputational or psychological harm, or affect the workplace environment in any significant way.

If a response is needed then this should be done promptly before the content has had a chance to be picked up and spread widely. Care must be exercised to ensure that the response is not inflammatory, inaccurate, a personal attack or unreasonable in its own terms. The response must also directly address the content otherwise the complainant may become increasingly frustrated, leading to further negative comments. If there is any concern as to the nature of the response, advice should be sought from MPS.

Members often phone MPS requesting assistance with removing negative postings. Our initial advice is often to approach the person who posted the content or the website administrator and ask that the content be taken down. Offer to address the complainant's concerns in a different forum, such as in writing, by telephone, or face to face.

While each case is different, it is often difficult to take legal action if the person refuses to remove the material. Defamation is the publication of something that wrongfully tends to lower someone in the estimation of others. There are several defences to an action in defamation including a disclosure which is true, and one which represents the person's honest opinion.

If your service hosts a website which allows feedback, or if there are comments appearing on general consumer review sites, then it is worth considering encouraging patients who have had positive experiences to post these online, thereby balancing the negative comments. If you make an online post then ensure that you exercise caution when publishing information which is accessible to members of the public.[2]

Follow up

Once the content has been responded to, continue to monitor the internet, in particular the website/blog where the content was located, to see if there is any additional content.

In cases where the content is legitimate, consider following up with the complainant several weeks later. This conveys a sense of approachability and increases the likelihood that they will contact you directly with further concerns rather than turning to the internet as the first port of call.

Andrew Stacey

1. Managing unreasonable complainant conduct. A manual for frontline staff, supervisors, and senior managers. October 2012, New Zealand Ombudsman; http://www.ombudsman.parliament.nz/system/paperclip/document_files/document_files/463/original/managing_unreasonable_complainant_conduct_manual_october_2012.pdf?1351456121

2. Statement on the use of the internet and electronic communication. New Zealand Medical Council. June 2013; para 12. https://www.mcnz.org.nz/assets/News-and-Publications/Statement-on-use-of-the-internet-and-electronic-communication-v2.pdf

ASMS
TOI MATA HAUORA

ASMS services to members

As a professional association we promote:

- 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 district health boards which ensures minimum terms and conditions for more than 4000 doctors and dentists, nearly 90% of this workforce;
- advise and represent members when necessary;
- support workplace empowerment and clinical leadership.

Other services

www.asms.org.nz

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 as it is vital in maintaining the site's professional standard.

ASMS job vacancies online www.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.

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ASMS email broadcast

In addition to The Specialist the ASMS also has an email news service, ASMS Direct. This is proving to be a very convenient and efficient method of communication with members.

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at **ke@asms.org.nz**

How to contact the ASMS

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Level 11, The Bayleys Building,
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F 04 499 4500
E asms@asms.org.nz
W www.asms.org.nz
P PO Box 10763, Wellington 6143

Have you changed address or phone number recently? We're updating the ASMS database and would be very grateful if you could email any changes to your contact details to: **asms@asms.org.nz**

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