THE SPECIALIST

THE MAGAZINE OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

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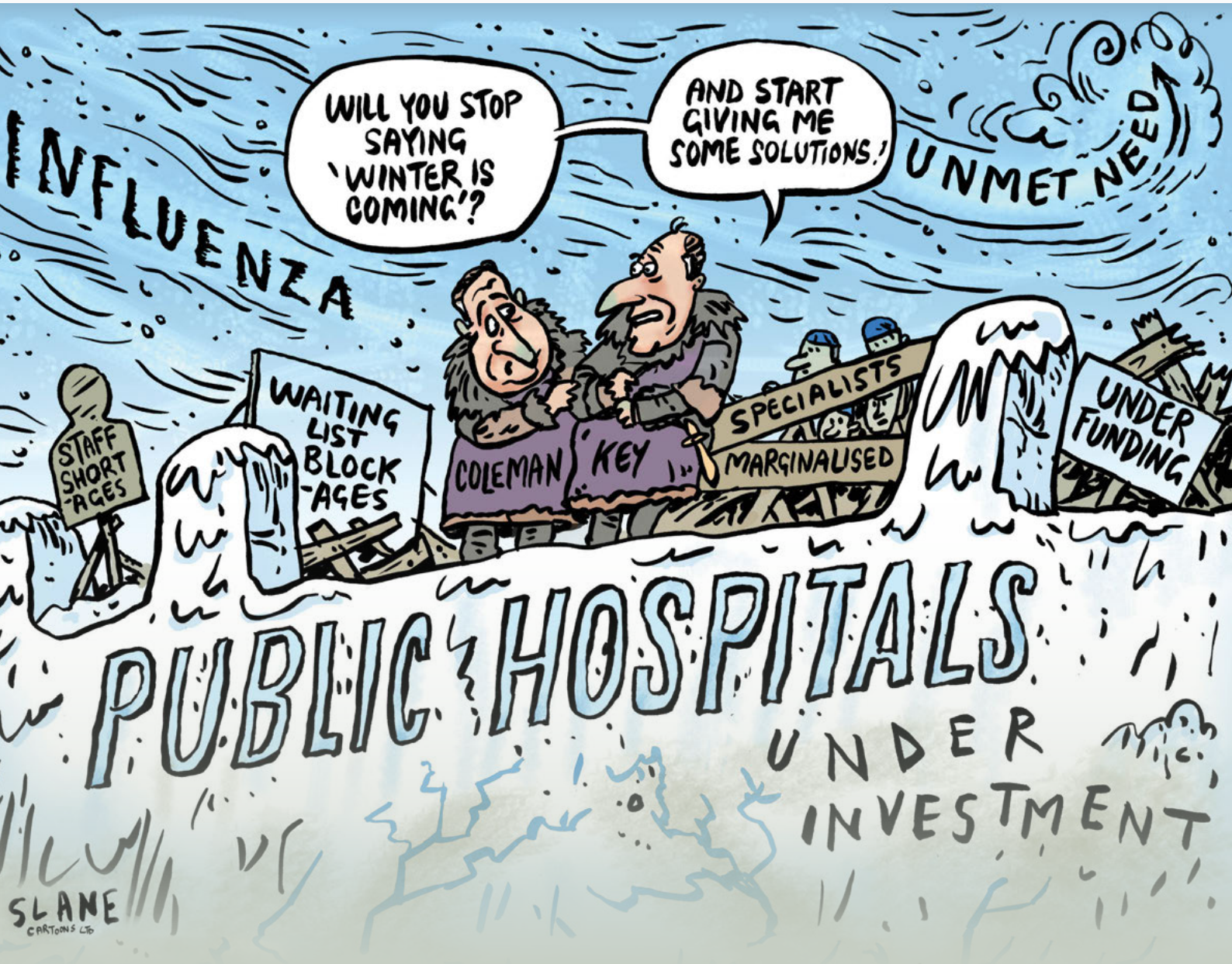

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USING QR CODES

You'll notice QR codes are used for the first time in this issue of *The Specialist*. For those unfamiliar with them, they are a type of sophisticated barcode that an application on smart phones can recognise. If you don't already have a QR reader/scanner on your smart phone, you can download one for free from your phone's app store (eg, google play on Android or the app store on Apple phones). It's simply a matter then of pointing the QR reader at the QR code on the page of the magazine and then clicking through to the website link that appears.

The QR codes in *The Specialist* will take you to website links that will provide more information about the topic at hand, or through to videos that ASMS thinks you might like to watch.

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LYNDON KEENE | DIRECTOR OF POLICY AND RESEARCH

FATIGUE – TACKLING AN INVISIBLE WORKPLACE HAZARD

Definition of fatigue: A physiological state of reduced mental or physical performance capability resulting from sleep loss or extended wakefulness, circadian phase, or workload (mental and/or physical activity) that can impair a person's alertness and ability to work safely and efficiently - *International Civil Aviation Organisation (2011).*

Previous issues of *The Specialist* have discussed the effects of fatigue in the senior medical workforce and possible measures for dealing with it, including the introduction of a 'recovery time' clause in the MECA. This would allow shift employees or those on the on-call roster to have agreed breaks or periods of rest between shifts, or before commencing their next day's duty following a period of on-call.

The expected passing of the Health and Safety Reform Bill through Parliament later this year makes this an opportune time to consider not only how to ensure adequate recovery time but also how to best develop broader strategies to address fatigue in the workplace.

As with the current legislation, the Bill recognises fatigue as a health and safety hazard.

The Bill sets out a general duty of care for employers to provide and maintain a safe and healthy workplace, "so far as is reasonably practicable". This obligation applies not only to employees and contractors but also to "other persons" (eg, patients) who may be involved in or affected by work carried out as part of the employer's business or undertaking.

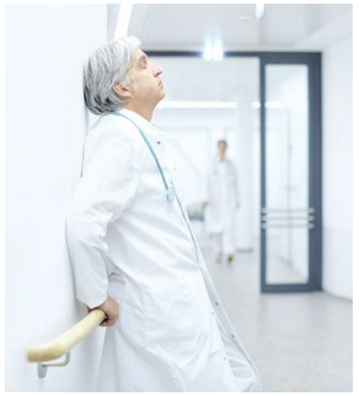
DUTIES OF CARE

Employers are required to:

- provide and maintain a safe system of work (eg, work scheduling)
- provide adequate information, training, instruction and supervision to employees (eg, hazard information and emergency preparedness training)
- consult with employee representatives on health and safety at work (eg, changes to work systems or introduction of new equipment)
- monitor the health of employees and workplace conditions for the purpose of preventing illness or injury (eg, concentrations of airborne contaminants)
- provide adequate facilities for employees (eg, washrooms, lockers etc).

Employees have a duty to take reasonable care for their own health and safety, and for the health and safety of others who may be affected by the employees' acts or omissions at the workplace. They also have a duty to cooperate with their employer's efforts to provide a safe and healthy workplace (See box 'Health and Safety Reform Bill - Employee duties' – p6).

For a better understanding of how fatigue as a workplace hazard might be managed, it is useful to look at the situation across the Tasman (see box 'Australian Medical Association's Code of Practice' - p5) and also understand the findings of a Massey University report on rostering and shiftwork (see box 'Massey University report' – p6).



NEW ZEALAND'S SITUATION – QUESTIONS TO CONSIDER

In order to develop a code of practice similar to the Australian Medical Association's, perhaps taking into account the critique by Massey University's Sleep/Wake Centre, some important questions need to be considered.

- To what extent has the code contributed to the decline in identified risks in Australia?
- What are the 'industrial' implications for introducing such a code?
- Would it be feasible – or desirable – to develop an SMO-specific code or should it include all hospital doctors?

To be effective, a broader strategy would be needed in New Zealand, including – in the AMA's words – "an education and awareness programme to change the current individual and organisational beliefs and culture that support working hours and patterns that would be considered unacceptable in most other industry sectors".

Not least, it should be remembered that the increased focus on employers' health and safety responsibilities will see a similar increased focus on employees' responsibilities.

That such an awareness-raising programme is needed – for both clinicians and management – is illustrated in the findings of a survey published last year on 'presenteeism', where 82% of doctors surveyed at one DHB reported turning up to work when they were sick, many with infectious illnesses. The researchers commented that similar results would most likely be found in other DHBs.

It is clear that properly addressing health and safety in health services in this country is far from straightforward. It throws up many challenges, and it requires additional resources. However, the importance of health and safety cannot be overstated. When issues such as 'presenteeism' have become the 'norm' and, as with fatigue in the workplace, are linked to entrenched staff shortages, which have also become the 'norm', health and safety is a critical ethical issue needing urgent attention.

This is work in progress for the ASMS, and we will be conducting surveys shortly on fatigue and presenteeism. In the meantime, we welcome members' views on the matter.

AUSTRALIAN MEDICAL ASSOCIATION'S CODE OF PRACTICE

In Australia, after a consultation process supported by the Federal Government, the Australian Medical Association (AMA) produced a National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors, issued in 1999. The code, which applies to all hospital employers and salaried hospital doctors, was prepared in recognition of the responsibilities of employers and employees under Australian legislation, on which the New Zealand Health and Safety Reform Bill is based.

It is one part of a broader education and awareness programme to change the current individual and organisational beliefs and culture that support working hours and patterns that would be considered unacceptable in most other industry sectors.

The code's scope is limited to hazards related to shiftwork and extended working hours, and the effect on the health and safety of individual doctors and impact on patient care.

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. Instead, the Code contains a Risk Assessment Guide and a Risk Assessment Checklist to help identify fatigue and assess the risk level of an individual's working hours. It then provides tools to lower the risk. The model is essentially: (a) hazard identification, (b) risk assessment and (c) risk control.

(A) HAZARD IDENTIFICATION

The AMA says hazard identification should be part of a hospital's business planning and be regularly reviewed as circumstances change.

Information on hazards can be collected from various sources, including:

- absence and sick leave records
- incident and injury records associated with extended working hours
- views of doctors collected through hospital surveys, complaints or disputes involving extended working hours
- reports or advice from specialists in work scheduling, shiftwork and fatigue
- research findings into the impact of extended hours on work performance and health and safety.

Hazard identification needs the active involvement of doctors through consultative arrangements.

Common hazards associated with shiftwork and extended hours include:

- excessive consecutive hours worked in any one period
- lack of rest within and between work periods
- inappropriate speed and direction of shift rotations
- Irregular and unpredictable work schedules
- night shift or extended hours that lead into night shift
- type of work and additional workloads.

(B) RISK ASSESSMENT

Assessing the likelihood and impact of injury or illness for those exposed to an identified hazard can be done in a range of ways, depending on the hazard. For example:

- use of specialist expertise in scheduling and shiftwork
- use of techniques that enable calculation of potential sleep deprivation and fatigue risk factors
- consultation with staff on "best fit" schedules and on individual orientations to different work schedules
- use of available research on shiftwork and extended hours.

A risk assessment checklist and a guide (see sidebar 'Risk Assessment Guide') have been produced to help with assessment, and the recommended standards should form the basis of any work scheduling for doctors.

The checklist includes questions such as: "Do doctors work more than 14 consecutive hours in any one period (including overtime and recalls) at least twice a week?" "Is the minimum period of rest between scheduled work less than 10 hours?" "Are the total hours worked in a 7-day period more than 70 hours (including overtime and recalls)?" "Is there less than a 24-hour break free of work in a 7-day period?" and so on.

Because the hazards associated with shiftwork and extended hours are complex and interrelated, doctors should be fully involved in the process from the beginning to ensure a good result.

RISK ASSESSMENT GUIDE (BASED ON A 7-DAY PERIOD)

LOWER RISK*	SIGNIFICANT RISK*	HIGHER RISK*
Less than 50 hours worked	50 to 70 hours worked	More than 70 hours worked
No more than 10 consecutive hours in any one period	Up to 14 consecutive hours in any one period	14 or more consecutive hours worked at least twice
Scheduled shift hours worked	Scheduled shift plus part of next shift worked	A full shift cycle worked of at least 24 hours
Three or more short breaks taken during shift	One or two short breaks taken during shift	No short breaks taken during shift
Little or no overtime	More than 10 hours overtime	More than 20 hours overtime
Rostered for on-call less than 3 days in 7 days	Rostered for on-call duty 3 days or more in a 7-day period	Rostered on-call continuously for more than a 7-day period
No night shift or extended hours into night shift	At least 2 night shifts or extended hours into night shift	At least 3 night shifts or extended hours into night shift
Minimum 10 hour breaks between work periods and 2 days free of work	Minimum 10 hour breaks between work periods and 1 day free of work	Less than minimum 10 hour break on at least two work periods and no full day free of work
Forward shift rotation and predictable cycle	Forward shift rotation but changed cycle	No stable direction or speed of rotation
No changes to roster without notice	Changes to roster through overtime and recalls worked	Roster changed so much because of overtime and recalls so as to be unpredictable
Maximum opportunity for sleep to be taken at night including two full nights of sleep	About two-thirds of sleep able to be taken at night including one full night of sleep	Less than half of sleep able to be taken at night and no opportunity for one full night of sleep

*Risk assessment is based on a simple scoring system where each lower risk element scores 1, a significant risk scores 2, and higher risks score 3.

(C) RISK CONTROL

The effectiveness of controls at the individual and organisational levels depends on shared ownership of the protocols and arrangements to control risks.

Risk controls for shiftwork and extended hours cannot be set out as a series of stand-alone solutions that will be effective in all cases. A series of strategies should be used, including:

(i) Design principles for schedules
Scheduling the work of doctors in hospitals to eliminate or minimise the risks to their health and safety and to those affected by their actions is the key control measure. The following performance-based principles should underline the design of work schedules, which should be designed to:

- minimise the occasions on which doctors are required to work more than 10 hours in a period
- ensure that minimum breaks between shifts enable doctors to have a minimum of 8 hours continuous sleep before resuming duty
- ensure that any period of extended hours is compensated with a longer break before resuming a shift
- use a forward shift rotation to minimise individual adaptation problems
- avoid rapid shift changes such that at least a 24-hour break is provided before rotating to a new shift
- ensure doctors have regular time (a minimum of 24 hours) free of work in a 7-day period in which unrestricted sleep is possible
- minimise consecutive night shifts in order to limit reductions in performance levels caused by circadian rhythm imbalances
- ensure that longer breaks between and following night shift are provided
- account for "covering" contingencies caused by sickness or absences
- maximise the opportunity to take breaks within shifts.

In some cases these design principles will not accord with current practices, and hospitals should ensure that any risks are appropriately managed.

(ii) Information, supervision, consultation and training
Doctors should be provided with training and all appropriate information relevant to health and safety hazards and how they are addressed.

(iii) Facilities and services
An essential control strategy is to provide suitable facilities in which doctors can have short or extended breaks during shifts, or short naps within long shifts.

(iv) Monitoring and review
Because of the nature of work scheduling and unanticipated workloads in hospitals, the system of risk controls needs constant monitoring and review.

The process of monitoring should be done on a single shift basis, over 7, 14 and 28-day periods to establish potential risk exposures and to actively manage known risks in the upcoming period.

STATUS OF THE AUSTRALIAN CODE OF PRACTICE

This is a voluntary code. It does not have evidentiary status but has legal status like all other guidance in that it contributes to 'the state of knowledge' about a particular hazard or risk and the ways of mitigating that hazard or risk. It provides recommendations for duty holders to consider in meeting their legal obligations.

An Approved Code of Practice (approved by the Minister), on the other hand, has evidentiary status and may be used in a prosecution to demonstrate a failure to meet a duty.

MONITORING FATIGUE RISKS

In a separate exercise, the Australian Medical Association has conducted three national surveys (2001, 2006 and 2011) of doctors' working hours to assess the fatigue risks of their current working arrangements.

The results indicate a sustained decline in the risks of fatigue, based on the proportion of doctors that fall into the significant and higher risk levels. However, many hospital-based doctors are still working rosters that potentially impair their performance.

MASSEY UNIVERSITY REPORT

In New Zealand, the report, *Best practice Rostering, Shift Work and Hours of Work for Resident Doctors: A Review,* produced for the Resident Doctors' Association by Massey University's Sleep/Wake Research Centre, found there are no magic bullets for rosters to cover 24/7 services.

However, Fatigue Risk Management Systems (FRMS), which integrate scientific knowledge on sleep and circadian physiology with modern safety management practices for each workplace, offer a scientifically defensible approach to meeting the requirements of health and safety legislation.

A FRMS is based on a data-driven process that in many respects is similar to the Australian Medical Association's voluntary Code of Practice. For instance, it:

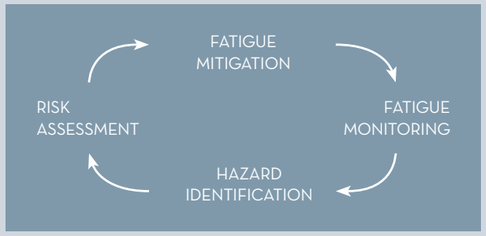
- identifies where fatigue is a hazard
- assesses the level of risk that a given hazard represents
- where necessary, puts in place controls and mitigation strategies, and monitors to ensure they manage the risk at an acceptable level. These include organisational strategies (including good rostering), and personal strategies
- routinely monitors fatigue levels.

These processes are a 'closed loop', because the effectiveness of current mitigation strategies is measured by ongoing monitoring of fatigue levels.

A criticism of the AMA's voluntary Code of Practice was that while it provided for recommendations for monitoring and review of work scheduling and unanticipated workload and incident reporting and investigation, and record keeping, it did not explicitly link the recommended fatigue risk assessment and mitigation strategies together with these processes - and so it did not 'close the loop'.

Properly implemented, these processes would meet current health and safety legal requirements for employers to adopt a systematic approach to identifying, assessing, and controlling fatigue hazards at work. The Health and Safety Reform Bill does not change those requirements.

THE FRMS PROCESS:



A key part of FRMS is fatigue monitoring. Collecting data is not sufficient – it must be analysed and acted on as needed. This requires commitment of resources from district health boards.

There are two kinds of data that are typically used for fatigue monitoring:

- Routinely collected organisational information (such as rostering and payroll data, sick leave data etc)
- Information provided by staff, either in voluntary reporting systems (staff are required to report fatigue hazards they encounter at work), or by doctors agreeing to complete surveys or participate in fatigue monitoring studies where there is particular concern relating to a group. Guidelines for an effective safety reporting culture have been developed in commercial aviation, encouraging open and honest reporting of fatigue hazards.

HEALTH AND SAFETY REFORM BILL - EMPLOYEE DUTIES

As noted in the AMA code, while employers have the primary duty of care, there is an employee duty to assist the employer in meeting health and safety obligations and to take reasonable care not to put themselves, or others, at risk.

Translating this duty to shiftwork and extended hours, the AMA suggests an employee would be expected to:

- Participate in training provided to gain an understanding of the hazards of shiftwork and extended hours.
- Ensure that breaks provided within and between shifts are used for rest and recuperation.
- Report incidents arising from hazards related to shiftwork and extended hours.
- Recognise signs of sleep deprivation or fatigue and the impact on themselves and others.
- Report to supervisors on circumstances in which fatigue and lack of sleep is impacting on individual wellbeing and patient care.
- Understand the implications of voluntarily seeking additional hours, both at the hospital and elsewhere, that may increase risks to health and safety and patient care.

The AMA also recommended that hospitals develop with doctors and their representatives a policy on work readiness covering such matters as drugs and alcohol, extracurricular commitments, including other jobs, and education and training commitments.

WELLINGTON HOSPITAL LABORATORIES DECISION - A MINEFIELD OF RISKS

DR JEANNETTE MCFARLANE | CONSULTANT PERINATAL AND PAEDIATRIC PATHOLOGIST, ANATOMIC PATHOLOGY, LABPLUS, AUCKLAND HOSPITAL

The recent decision to place the future of the Wellington region's hospital and community pathology laboratory services in the hands of a single private company, Southern Community Laboratories (SCL), which is owned by Healthscope, effectively cedes control of a critical part of health care to the private sector and is likely to have far reaching consequences for patient treatment and safety for many years to come.

If this had been written as an episode of the British satirical comedy *Yes Minister,* Sir Humphrey Appleby would have described the DHB's actions as courageous - "That's a courageous decision, Minister", but in reality it is a highly risky strategy.

Local pathologists and laboratory scientists, who have been cynically and deliberately excluded from the decision to privatise, have expressed serious concerns that there are many potential consequences that may have been ignored or not considered. It is unclear why the Health Minister, Jonathan Coleman, has approved the decision to proceed, especially in light of his stated commitment to clinical engagement and leadership.

There is now a very short time scale for implementation of the new contract but, at the time of writing, the DHBs have been unable to answer the pathologists' questions about how the changes will be implemented and have not provided evidence of a proper transition plan. The existing staff have no confidence that the new service will be able to deliver the same quality of service as at present, or that it will have the additional capacity to cope with impending initiatives such as the cancer treatment pathways and the prostate cancer awareness programme.

> *Existing staff have no confidence that the new service will be able to deliver the same quality of service as at present.*

The experience in the Auckland region has been that SCL's parent company Healthscope were highly effective in making a low tender bid to secure the contract for the community laboratory services but were subsequently unable to deliver on their promises. The Auckland transition process has taken more time and money than budgeted for and also incurred hidden costs, such as the extensive support required from DHB staff.

In order to accommodate the new service, SCL will have to build a new laboratory on the Wellington Hospital site, which will not be ready before the start of the contract. The latest proposal is that Wellington Hospital's Anatomic Pathology and Microbiology departments are to be moved offsite until the new laboratory is ready - this is likely to be disruptive to service delivery and there are obvious issues such as specimen transport, but there are other intangibles such as the effects on communication between the labs and their end users, and potential effects on the hospital's accreditation for registrar training in other disciplines, such as surgery and anaesthesia for which an onsite Anatomic Pathology department is a specific College requirement for training accreditation.

The plan does not make any provision for registrar training in the pathology disciplines, and the Wellington Hospital pathologists play an important part in teaching trainees from other disciplines.

The University department of Pathology is one of the major academic pathology centres in Australasia, with a strong research and publication record. If one of the effects of the new contract is to diminish the academic focus of the pathology service, this will affect the reputation of the Medical School and the University.

In terms of other unintended consequences, it is unclear whether the DHB managers considered the broader implications of privatising the mortuary services of Wellington Hospital as part of the new contract. This mortuary services the hospital, but it is also the regional centre for the National Forensic Pathology Service. If for any reason the new SCL run service is unable to provide the level of service and out of hours cover required for forensic post-mortems, the Ministry of Justice will need to make alternative arrangements.

The whole process of the Laboratory Services Strategy has been a top down exercise, which we believe has seriously underestimated the complexity of the services and could prove a costly mistake for the DHBs if the privatisation fails, or as previously raised by the ASMS, the single provider, once locked in, uses its monopoly position to renegotiate its contract on more favourable terms.

This is the biggest privatisation of a public hospital clinical service in the 26-year history of the ASMS – bigger than the privatisation of the hospital laboratories of the former Otago and Southland DHBs in 2007, and with greater risks than Healthscope's takeover of community laboratories in Auckland.

Wellington region pathologists are now in the uncomfortable position of being treated like chattels which the DHB can simply transfer to another employer that they have not chosen to work for. The DHBs are essentially gifting the region's intellectual laboratory expertise to Healthscope – the same intellectual expertise that will be needed to monitor contract performance and assess how good a job the new company is doing after the first five years.

From our past experience none of the managers who made the decision will ever have to take any personal responsibility for their actions and it is likely that by the time major issues come to light they will have moved on, leaving the pathologists to sort out the mess.

> *The whole process has been a top-down exercise which could prove a costly mistake for the DHBs.*

Has anyone actually thought this through?

HOW TO GUIDE MINISTERS TO MAKE THE RIGHT DECISIONS...

Sir Humphrey: If you want to be really sure that the Minister doesn't accept it, you must say the decision is "courageous".

Bernard: And that's worse than "controversial"?

Sir Humphrey: Oh, yes! "Controversial" only means "this will lose you votes". "Courageous" means "this will lose you the election"!

FATIGUE ON THE FRONT LINE

Imagine having dinner at 11pm and it's not a fun thing, it's not something you've chosen to do because you've been partying, or you were so busy reading you just forgot to eat, or you're in another country (Spain, hola!) with a different time zone. No, it's because you're in the emergency department of a hospital in New Zealand, you're working, and you're rushed off your feet. You're one of the people that the hordes of sick and injured who arrive at odd hours with broken bones or heart attacks or babies that can't breathe properly need to see. They're out there in the waiting room RIGHT NOW and you don't have time for a proper meal break so you eat your salad and sandwiches as fast as you can, and then you get back out there.

CUSHLA MANAGH, ASMS DIRECTOR OF COMMUNICATIONS

CLOCKWISE FROM TOP: JOHN BONNING; GARRY CLEARWATER; CLIVE GARLICK.

Because the sooner you get back to it, the more people you'll be able to help.

Clive Garlick, Medical Officer, Nelson Hospital's emergency department: "You come on shift and you're working from the get-go. You may be the most senior person on so you're taking phone calls from GPs, you're seeing the most critical cases, working them up or keeping an eye on them, discussing cases and checking x-rays with junior staff, and so on. You just don't get a break."

John Bonning, Clinical Director of Waikato Hospital's emergency department: "Weekends are unimaginably busy and stressful, to the point of people questioning their career choice. There's no down-time at all in ED, you can never sit down and say that it's under control. There are always patients streaming in and waiting. It's relentless."

Garry Clearwater, ED specialist, North Shore Hospital: "Shift work is the big thing for people working in ED. People say they feel a lot more tired, for longer, after doing a late shift. Working shifts is hard on families, childcare arrangements, socialising and so on. It can be very disruptive."

These are experienced doctors who have been working in emergency medicine for many years, and they know about fatigue and the need for recovery time. All medical specialties have their stressful times, they say, but for people working in ED, that's the norm.

It's not that they don't love their work, it's just that there's so much of it.

"70,000 people pass through Waikato Hospital's ED every year," says John Bonning. "The pressure is always on. Sunday is now the second-busiest day in ED, yet both ED and the hospital generally operate with significantly fewer staff and facilities on the weekends."

> *"I'm totally fatigued right now," says Clive Garlick. "I worked on Monday night until 1am, got to bed about 2am but was then called up at 5.20am. That kept me busy until 8am when I had to grab a coffee and then go and do a fracture clinic all morning."*

All of them value the need for recovery time after shift work, the ability to rest and regroup, to recharge their batteries.

Clive Garlick says the worst shifts involve weekends and evenings, and it's almost impossible to have enough time to recover after working these. Doctors are increasingly juggling their clinical and non-clinical time, and trying to make both parts fit into their working week.

"Our rosters are planned two months ahead but then we start getting invitations to attend meetings," he says.

"We're often doing a full nine-hour shift in the evening until late, then doing non-clinical work the following day. That's normal for us. Management give lip service to the concept of recovery time but as soon as you mention it, they just look blank and then they go ahead and schedule meetings that destroy your recovery time."

Garry Clearwater wonders if having ED doctors work 40 hours a week, when it involves shift work, is actually a sustainable model for the specialty.

He was the sole Australasian-credentialed emergency medicine specialist to be employed at North Shore Hospital when he took up the role of clinical director of ED there from 2000 until 2005. Prior to his arrival, he says ED was staffed mostly by non-specialist medical officers and house surgeons, and the shiftwork required of staff was really taking a toll.

"At one point, about 50% of senior nurses and medical officers turned over within 12 months," he says.

One of his first tasks was to look for ways to make the newly-minted specialty sustainable.

"When I started, medical officers were working a roster of seven nights on and then seven nights off. This was really difficult. We looked into this to see what was manageable and we found that people could tolerate three nights in a row but after that, their body clocks started to acclimatise to a different pattern and it was then harder to return to a normal routine."

He worked to limit the number of nights people could work in a row and improve the time allocated for recovery after a night shift.

"Young, enthusiastic RMOs see the shift work as a temporary state of affairs that they just have to go through, at the end of which their lifestyle will be much more reasonable," he says.

"It's harder when you're in your 50s and older. You're finishing work at two or three in the morning, quickly having something to eat and drink, driving home, trying to unwind and then getting to bed about four in the morning."

That's echoed by Clive Garlick: "You can't slouch through the day. You can't say that you're not up for it. I'm 62 now and I'm not a spring chicken. I enjoy the variety and the people I work with, it can be deeply satisfying, but I do find that my tolerance for working past midnight is less than it used to be."

John Bonning says for a number of years now he has staffed the emergency medicine desk at the PGY1/2 careers choice evening at Waikato Hospital.

> *"Each time a substantial portion of young doctors come up to me and say they don't want to do emergency medicine because it involves shift work. I tactfully suggest to them that health care is becoming more 24/7 with after-hours work and shifts being required in a wider range of specialties, not just emergency medicine."*

Garry Clearwater says many senior medical officers look for alternatives to shift work because they find it too disruptive in their lives. They seek non-clinical roles to reduce the number of clinical shifts they do, or they start working part-time.

"I'm a good example of that. Technically, I now work 0.35 FTE, which gives me an opportunity to pick up other shifts and fit them around my existing commitments."

Being physically active, keeping an eye on their health and taking part in enjoyable activities helps them cope with the concentrated nature of ED work and the exhaustion of shift work. They all enjoy walking or cycling. John Bonning takes part in a range of sports, and Clive Garlick likes to fire up his guitar in a band called the Mighty Clouds of Joy.

All three ED doctors welcome the spotlight being turned on the issue of fatigue. After all, it's such a big part of their lives.

A SINKING LID ON HEALTH FUNDING

LYNDON KEENE | DIRECTOR OF POLICY AND RESEARCH

Each year since 2010/11 the Council of Trade Unions has analysed the health budget and over the past two years this has been done in partnership with ASMS.

Our analysis indicates that the Health Vote in the 2015 Budget is an estimated $245 million behind what is needed to cover announced new services, increasing costs, population growth and the effects of an aging population.

While the Budget listed services that will receive more funding and new initiatives, such as for hospice and palliative care services and the move to enable children under 13 to have free access to primary health care, there is a smoke-and-mirrors element about how they will be paid for.

> *Ultimately, funding for these initiatives will need to be paid for by cutting funding to other services.*

Even the well-publicised $30 million of 'new funding' earmarked for the under-13s policy is subject to some creative accounting, with $11.9 million of that to be paid for from district health board budgets. Technically that money has been transferred to the DHBs, but we estimate the total DHB budgets are $133 million short of what they need to keep abreast of inflation and demographic changes and provide the expected additional services.

Elective surgery has tended to do relatively well over a number of years, compared with other services, and this year received an additional $23 million to provide additional surgery. Yet even here, in an area with a high-profile health target, we estimate that to keep up with rising costs and demographic changes and provide the expected additional surgery, the elective surgery budget is $16 million short.

PATTERN OF FUNDING SHORTFALLS

The funding shortfall in this year's Budget follows significant shortfalls in each Health Vote the CTU has analysed since 2010/11. Data are not available to enable an accurate assessment of how much money has been saved over those years through genuine efficiencies and how much has been 'saved' through service cuts and increases in user charges. With that qualification, taking into account the new services and claimed savings in each Budget, and actual expenses, CPI, population and average wage increases, we estimate an accumulated funding shortfall of $0.8 billion between the 2009/10 and 2014/15 financial years. This year's funding shortfall would make that more than $1 billion.[1]

Another way of viewing the funding comparison over this period is to compare Vote Health expenditure as a proportion of GDP. Figures provided in the Estimates show in 2009/10 Vote Health operational expenses were 6.32 percent of GDP, which had dropped to 6.01 percent of GDP (forecast as $239.771 billion) by 2014/15. For Vote Health expenditure to match 6.32 percent of GDP in 2014/15, it would have needed a further $0.75 billion.

> *More widely, for core government health expenditure to match 6.72 percent of GDP in 2014/15, it would have needed a further $1.03 billion. And in 2015/16 it would need an additional $1.2 billion, based on Treasury's forecast GDP.*[2]

It is often argued by Government that spending more on health would be at the expense of other government expenditure. However, Treasury's figures show that while core health expenditure has risen from 19.5% of core government expenditure in 2010/11 to 20.6% in 2014/15, the main reason has been a 4% drop in core government expenditure as a proportion of GDP – from 34.6% of GDP in 2010/11 to 30.5% in 2014/15.

The conclusion from this is that the Government's overall priority of reducing expenditure has led to a substantial funding shortfall for health services and an even greater shortfall for combined other government services.

BARRIERS TO ACCESSING HEALTH SERVICES

The effects of year-on-year funding shortfalls of public health services are largely hidden from public view because they are not currently measured and reported. There are, however, clear signs of a health system that lacks the capacity to meet growing health needs. It is well recognised in the sector that there is hidden unmet need across a range of health care services, such as primary health care, dental health, mental health, sexual health, disability support and primary services for disadvantaged communities, as well as medical and surgical specialties, with much of the media attention focused on the latter.

There are numerous reports of increasing barriers to accessing 'elective' surgery.

> *Patients have to be in more pain to access elective surgery now than ever before.*

Treatment thresholds are getting further out of reach every year. As the New Zealand Medical Association put it, the gap between the patients who meet the clinical threshold for surgery, but fall short of our hospitals' financial threshold, is widening.[3]

Recent reports indicate Taranaki DHB has seen a 142% increase of people needing a first specialist appointment for orthopaedic surgery being referred back to their GP. In the Bay of Plenty there has been a 396% increase; while the West Coast DHB sent out 200 letters of decline for orthopaedic first specialist assessments in 2013/14, up from 11 in 2011/12.[4, 5]

A further recent report revealed more than a quarter of ear, nose and throat patients who need surgery are being turned away from the overloaded Dunedin Hospital department.[6]

As ASMS President Hein Stander says in his column in this issue of *The Specialist*, whichever way you turn, you find 'treatment thresholds' which are being used as a tool to ration care, created by the ever-present 'financial threshold'. While the Government is so focused on reducing expenditure to pay off debt (which it could have avoided if it had not decided to make tax cuts), it is in effect borrowing New Zealand health dollars from the 'Population Health Bank'. And the interest is building.

The CTU's 2015 health budget analysis is available on the CTU website (www.ctu.org.nz).

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PHIL BAGSHAW IN THE MAIN OPERATING THEATRE AT THE CANTERBURY CHARITY HOSPITAL TRUST HOSPITAL. PHOTO TAKEN BY ADRIAN MALLOCH AND PUBLISHED IN NORTH & SOUTH MAGAZINE; REPRINTED WITH PERMISSION.

THE CANTERBURY CHARITY HOSPITAL TRUST AND UNMET HEALTHCARE NEED

CHRISTCHURCH SURGEON PHIL BAGSHAW WRITES ABOUT THE WORK OF THE CANTERBURY CHARITY HOSPITAL TRUST (CCHT) IN PROVIDING HEALTH CARE TO PEOPLE WHO WOULD OTHERWISE STRUGGLE TO RECEIVE IT.

Until his retirement at the end of 2010, Phil was Associate Professor of Surgery at the Christchurch School of Medicine, University of Otago, where he practised as a specialist General Surgeon, taught undergraduate and postgraduate surgery, and did surgical research.

During his clinical career, he was President of the New Zealand Society of Gastroenterology, Chair of the New Zealand National Board of the Royal Australasian College of Surgeons, and Chair of the Council of Medical Colleges in New Zealand.

Phil initiated the CCHT project in 2003 and is Chair of the associated board of trustees. He continues to work there as a volunteer General Surgeon. In 2008 he was North & South magazine's New Zealander of the Year.

As Ian Powell described in a recent article, the New Zealand health reforms implemented in 1993 were ill-conceived and had disastrous consequences, some of which persist today.[1]

A large group of senior doctors in Christchurch attempted to mitigate these consequences through many avenues, including: (i) appealing to our hospital staff association, regional and national ethics committees, local politicians, and our medical colleges; (ii) promulgating public statements; (iii) producing documentation and issuing a legal challenge, which resulted in The Stent Report;[2] and, (iv) joining our DHB governance board.

Collectively these avenues slowed the deterioration but failed to reverse it. We were therefore left with a situation where managerialism was on the ascendancy, secondary elective healthcare was on the decline, and universal access was no longer a core principle of our public health care system.[3]

> *We try to fit in the gap between the public and private healthcare systems, through which too many people fall.*

It was at a workforce conference in Melbourne in 2003 that the possibility of a future revival for charity hospitals was raised by a visiting speaker.[4] In pondering this possibility, some of us in Christchurch were reminded of the adage of 'thinking globally but acting locally'. The Canterbury Charity Hospital Trust (CCHT) was therefore formed in 2004, with the primary objective of providing free elective health care for some of those patients who slip through the gaps in the system by being refused care in the public hospitals, not eligible for ACC, having no health insurance and being unable to pay for private care.

THE IMPORTANCE OF THE WORD 'CHARITY'

It was determined that funding would be solely by public charitable giving and our hospital would be staffed by volunteers, with only two paid employees.[5] It was decided to include the word 'charity' in the name of the hospital to clarify how we intended it to always function. This label should make any future slide into privatisation or government ownership, as happened with other hospitals in Christchurch, impossible.

Thanks to the immense generosity of our local community, we acquired and renovated premises in Bishopdale, Christchurch, and our volunteer workforce started treating day patients there in 2007. We have since expanded into adjacent properties and now offer a wide range of elective day care services to adult patients of all ages including general surgery, gynaecology, dental surgery, counselling, colonoscopy, orthopaedic & hand surgery, podiatric surgery, sasectomy, etc.

The range of services we provide is governed by what our DHB is not offering and what resources we have at our disposal to address the unmet need. We try to fit into this gap between the public and private health care systems, through which too many people fall. The nature of the gap changes regularly and we endeavour to respond to these changes. When the DHB winds down a service, we try to provide it, and vice versa.[6]

We currently have 285 active volunteers including clinical, administrative and support staff, who do a fantastic job of helping many people who would otherwise have to live with correctable diseases and disabilities.

The patients we see are mostly referred by their GPs with often chronic, disabling conditions untreated for years. They usually have a letter from the DHB saying their condition is not currently treated by the public hospital. They often express strong feelings of resentment towards, and abandonment by, the public health system and are extremely grateful for any help we can give. It is clear to us that there are many people around Canterbury and throughout New Zealand who are in this predicament. There are good reasons for believing that the size of the problem is growing.

Although we currently perform between 1,000 and 1,500 treatments each year, regrettably we are increasingly unable to treat all the patients referred to us. Furthermore, there are now other organisations such as the Auckland Regional Charity Hospital[7] and the Taranaki Community Health Trust[8] which have emerged to deal with some of their unmet health care need.

Aside from our expanding services in Christchurch, the CCHT has, since its inception, had a concern about the level of unmet secondary health care need around the country. Last year we put in a great deal of effort, and achieved some level of success, in bringing the issue to public attention.[9 - 13] This year it is our aim to have the level of unmet need independently measured on a regular basis in order to assess the success (or otherwise) of changes to the public health system and the adequacy of its funding.

> *To those who deny the existence of a large and expanding quantum of unmet healthcare need, come to any of our outpatient clinics and discuss your views with those patients who are waiting there for treatment.*

MEASURING UNMET NEED

To this end, we have convened an expert senior academic panel from around the country. They have constructed a pilot study to look at the most accurate and cost-effective way to measure it. This will involve community surveys and other methods to dig out the unmet need, which has been buried under accumulating barriers to treatment accessibility. In response to rising public pressure, the last Minister of Health ordered a national survey of 'referred unmet need'.[14] This will overlook a large part of the problem and will be essentially a political exercise. Interestingly, the lexicon has changed - the Ministry of Health now refers to the issue as 'referred unmet demand'.[15]

We are greatly indebted to all our supporters, and feel privileged to be in a position to help so many needful people and to fulfil some of our Hippocratic responsibilities. The atmosphere at our hospital is excellent and the rewards for working there are immense.

To those who deny the existence of a large and expanding quantum of unmet health care need we say – (i) come to any of our outpatient clinics and discuss your views with those patients who are waiting there for treatment – and, (ii) if your mind is open to the possibility that our claims might have substance, please support our call for an independent, scientifically robust process for the regular measurement of the size of the unmet need problem. Only with such meaningful data will it be possible to truly inform the public on the performance of the health system and the decision makers on the effects of their policies.[16]

If universal access to secondary health care can be restored to the people of Canterbury and New Zealand, it will be our great joy to be able to close our charity hospital and hang a sign outside saying "Closed & no longer needed – the public health care system will look after you". We wait in hope, if not expectation, that this will happen one day.

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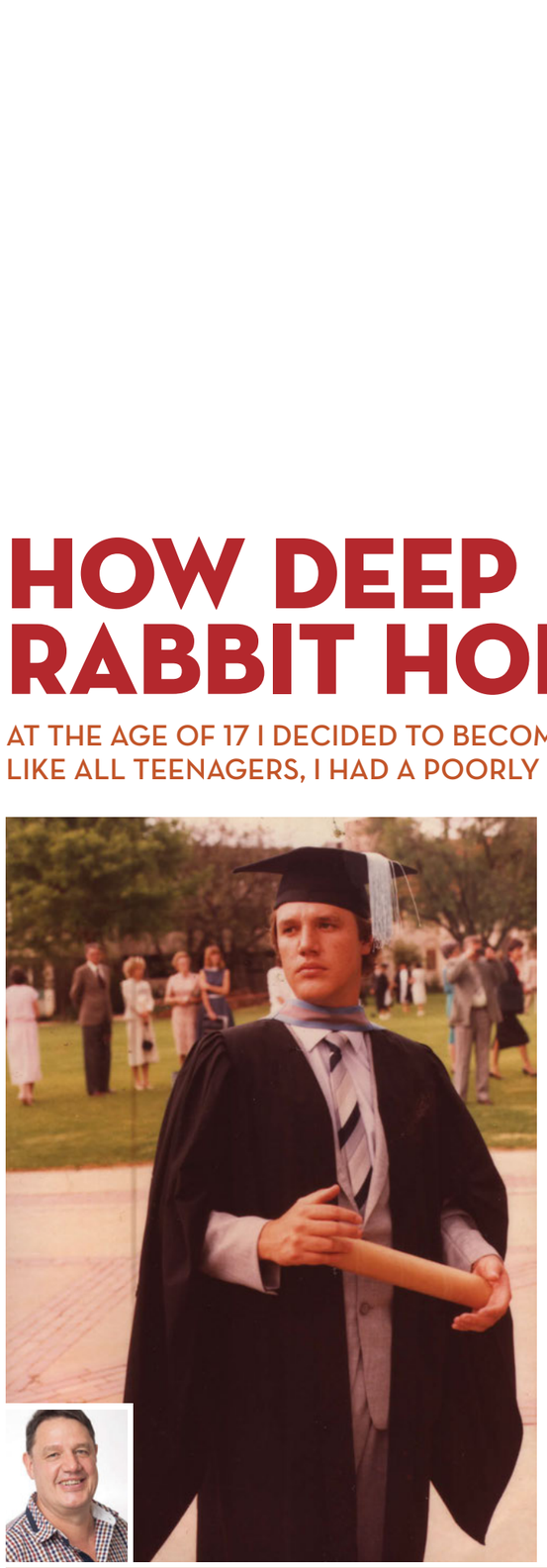
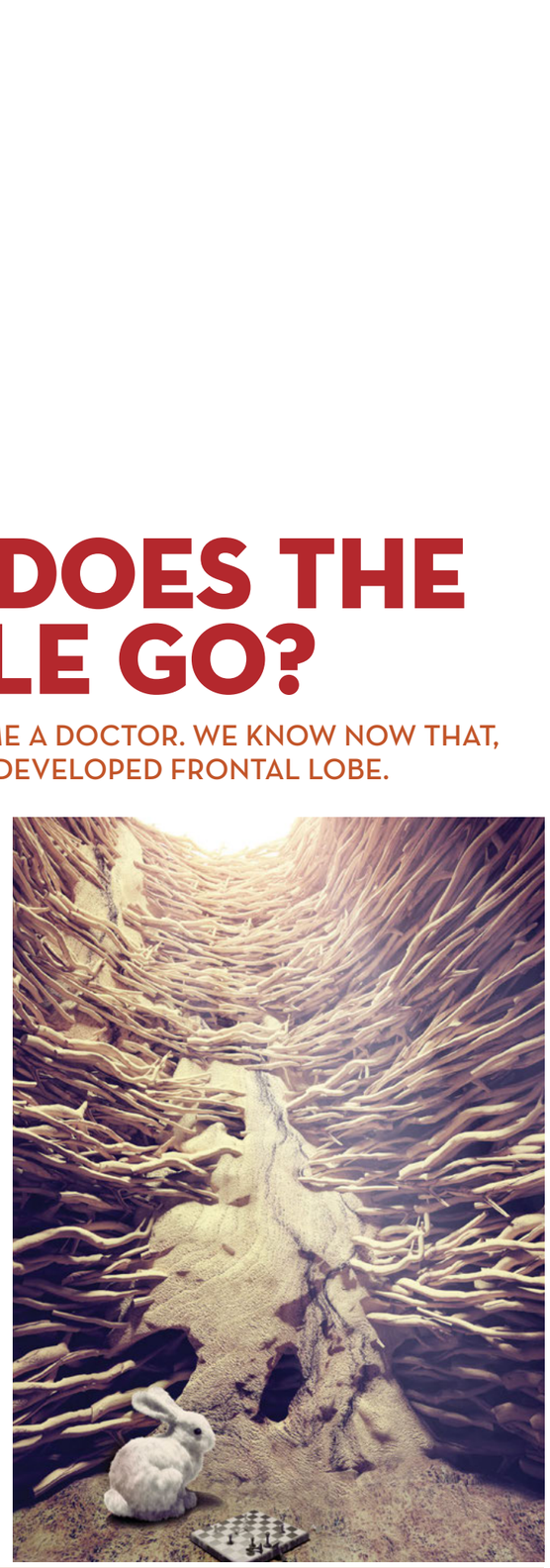
HOW DEEP DOES THE RABBIT HOLE GO?

AT THE AGE OF 17 I DECIDED TO BECOME A DOCTOR. WE KNOW NOW THAT, LIKE ALL TEENAGERS, I HAD A POORLY DEVELOPED FRONTAL LOBE.





DR HEIN STANDER | ASMS NATIONAL PRESIDENT

ABOVE: HEIN STANDER AT HIS GRADUATION

My decision was based on the fact I wanted to help people and make a difference. At the same time I did have enough insight to realise I would have a high degree of job security, a decent income and a vocation that could be practised internationally. I was not familiar with the Hippocratic Oath. I did not think it through much further and had no idea, and was not prepared for what lay ahead.

Studying and training increased my knowledge and skill, while my frontal lobe matured quietly in the background. I started to develop an interest in the deeper meaning of life and my career choice. I read about the Hippocratic Oath and the Declaration on Geneva (http://www.wma.net/en/30publications/10policies/g1/).

One paragraph in the Declaration of Geneva bothered me:

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.

It was 1984 in South Africa and, barring an unforeseeable academic disaster, I was about to qualify as a doctor. I needed to decide where I was going to do my houseman year and apply my fledgling knowledge and skills. As far as I was concerned, there was only one option.

LEARNING TO PRIORITISE CARE

I decided to work in the public health system and specifically applied to do my houseman year in one of the then "black homelands hospitals". I was placed at Edendale hospital in Kwa-Zulu Natal, where I stayed for five years. It was hard, but very rewarding work: long hours and often 1-in-2 on call. I learned and experienced team work and camaraderie. I learned how to prioritise care. The 10%-plus dehydrated and shocked baby was treated before the one with a skin infection.

> *I had a very clear understanding of what prioritisation meant, and my triage and prioritisation skills improved daily.*

Back to the present, and I am no longer in a situation where I need to prioritise 20 to 30 acute patients in a waiting area. Although I still provide acute care, the demand for my prioritisation skills in an acute setting has diminished significantly. Nowadays, my colleagues and I use our skills to prioritise "electives". *http://www.health.govt.nz/our-work/hospitals-and-specialist-care/elective-services.*

Prioritisation is now based on electronic referrals from GPs, who have assigned their own triage categories: routine, semi-urgent or urgent. We then prioritise on the information they have provided.

We have no interaction with the patient in question. We are expected to use 'tools' (if available) to assist us, so called Clinical Priority Assessment Criteria or CPAC.

There is a whole set of terminology and steps that goes with the process: Treatment threshold or TT, Financial Sustainability Threshold (FST) or Funding Threshold (FT), Commitment Threshold (CT)... and the list goes on.

Professor Philip Bagshaw outlined this process very well in a newspaper article *http://www.stuff.co.nz/national/health/10105817/Unmet-need-a-national-disgrace.*

Patients need to pass each of these 'threshold tests' before they are given a commitment to treatment and are placed onto a four-month waiting list.

The Ministry of Health website explains the process in a flow diagram: *http://www.health.govt.nz/our-work/hospitals-and-specialist-care/elective-services/how-electives-process-works.*

You will notice there are several 'pressure release' pathways or 'get out clauses' for DHBs in this flow diagram.

THESE INCLUDE THE FOLLOWING POINTS:

1. A specialist appointment is not available.
2. Public treatment is not available to people with your priority score.
3. Your priority score is close to the threshold so you are re-assessed in six months.

In the first two instances the patient is not moved further back on the waiting list. Instead, they are taken out of the 'queue' and referred back to their GP or other primary care practitioner.

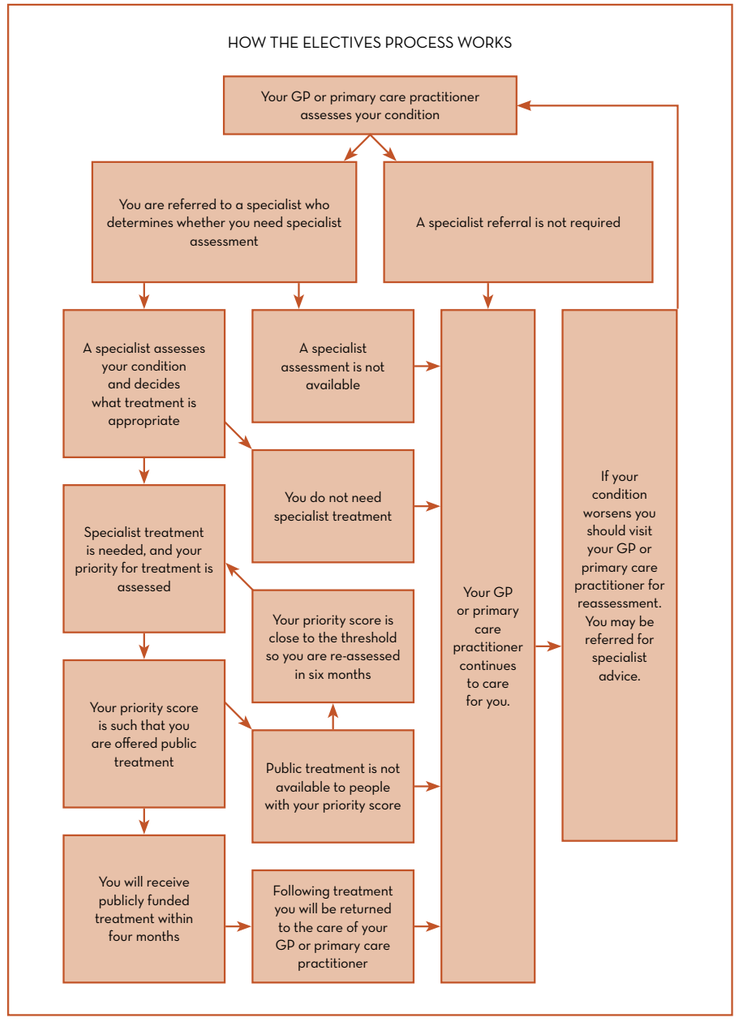
PRIORITISATION OR RATIONING?

In that situation, can it truly be said that their need has been prioritised? Or is this in fact rationing of care?

- Prioritise: to list, rate or arrange in order of priority.
- Rationing is the controlled distribution of scarce resources, goods, or services, or an artificial restriction of demand.

> *I was never taught, and have never been asked, to be an 'agent' to ration the provision of health care - but I believe the system now demands it.*

My conscience is being soothed by euphemisms and rhetoric: "There is not enough money to treat everyone" so "you need to prioritise care", "patients are still receiving care by their GPs" or "they are on an Active Review list".



Another 'trick' is to dehumanise the process for clinicians (and managers, chief executives and hospital boards).

1. The prioritisation process is done with a piece of paper in front of us (no patient in sight).
2. The term 'elective services' has over time morphed into the patients being referred to as 'electives'.
3. The patients who are not seen by specialists and instead are returned to their referrers without treatment then join the big pool of 'unmet health need'. We don't refer to them as John or Jane who are suffering with their hernia or hip joint, etc. Collectively we refer to them as the 'unmet health need'. In my opinion, this term is a dehumanising euphemism for real people suffering while their health problems are not being fixed.

We are also given permission to delay treatment or helping the patient even when we find they do in fact have a significant health problem. From the MOH website: "Elective Services, or Electives, are medical or surgical services which will improve quality of life for someone suffering from a significant medical condition, but that can be delayed because they are not required immediately".

So that is going to make me sleep better tonight? Yeah, nah.

WHAT ACTIVE REVIEW REALLY MEANS

Back to the flow diagram: "Your priority score is close to the threshold so you are re-assessed in six months".

This moves a patient onto the Active Review List. Here the patient waits for six months to be seen again and re-evaluated to see if they can now move through all of the thresholds and make it onto the four month waiting list. The Active Review List, in real terms, is a euphemism for a six month waiting list: "and cunning is the nose that knows, an onion that's been called a rose". Wendell Johnson, or I am missing something somewhere?

A bit of online research quickly made me realise other organisations also feel uncomfortable with this system. The Medical Council of New Zealand has previously published the 'Statement of safe practice in an environment of resource limitation' in 2005 https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Safe-practice-in-an-environment-of-resource-limitation.pdf. This document clearly indicates what our individual responsibilities are towards our patients, the public health system and, also importantly, to ourselves as individuals and to our family life. Please take the time to read it if you haven't done so recently.

Also in 2005, the National Ethics Advisory Committee of New Zealand commissioned a report by the Centre for Health Planning and Management, University of Keele, Staffordshire, United Kingdom to investigate the published material and the ethics of our 'electives booking system': http://neac.health.govt.nz/system/files/documents/publications/bookingsystemselectiveservices.pdf.

Some of the points made in the 59-page report:

- Section 3: The NZ booking system, with its: GP referral guidelines, ACA, CPAC, aTT, CT, TT and AR, is undoubtedly complex.
- They continue to summarise the key aspects of the system in relation to the ethical issues identified through a literature scan, and conclude:

"The literature describing research and booking system developmental work reveals strengths and weaknesses, benefits and harms, associated with the booking system in practice. It also reveals many gaps in our completed research – gaps, which if filled, would help us to better understand the system and, most importantly, the impact on the system for patients throughout NZ. Conceptually, the booking system promised advantages (national consistency, certainty and equity) for NZ patients over the former waiting list system. To date, the booking system has not functioned in practice as originally intended. Additional consideration of the reasons for such failure-in-practice and strategies to address any ethical issues raised by the booking system in its current guise is now required."

I cannot find any evidence that the questions raised in this report have been addressed or researched since. If they have been, the subsequent work has remained hidden from the all-seeing 'Eyes of Google'.

THE SCARY REALITY

A few weeks ago I was walking down a hospital corridor when a very harassed looking member of the Information Services department entered from a side corridor. He had a large and heavy looking laptop bag hanging over one shoulder.

We greeted and I asked: "How's life?"

He sighed deeply and replied: "Frustrating. Barely keeping our heads above the water."

"How so?" I asked.

He told me there are lots of important but smaller IT problems that needs sorting out but they seldom get around to them because of all the big problems and new systems that need to be implemented and fixed. Then some of the smaller things that have been put off suddenly become critical, and require urgent attention. They need to drop what they are doing to fix them and then try to pick up where they left off (and now fell behind on) with the larger work programme.

It suddenly struck me: Information Services has a Treatment Threshold. They also have a Funding Threshold.

And then I was falling down the rabbit hole, not knowing how deep it goes or what I will find when I get to the bottom. While I was falling I had time to think. How deep does the treatment threshold go into our public health system? What about services other than electives and information services? Out-patient FSAs, allied health services, etc? What other thresholds have we created or which have been forced upon us while trying to 'live within our means'?

It certainly does not stop at hip and knee replacements and hernia repairs. We have maintenance thresholds, new equipment thresholds, FTE cap thresholds, staff training thresholds... The list goes on and on and on.

Whichever way you turn, you find 'treatment thresholds'. The major driver for the creation of thresholds are the ever present financial threshold. While the Government is trying to get back into a surplus and borrowing less money, they are still borrowing New Zealand health dollars from the 'Population Health Bank'. I predict the interest rate is going to catch up with us sooner or later, and at what cost to the health of New Zealanders?

I am still falling down the rabbit hole and I sincerely hope that when I reach the bottom I do not find a health care system where Treatment Threshold has become part of the culture: "this is just how we do things around here". We need to do everything in our power to prevent that from happening.

We need an enthusiastic workforce not prepared to compromise, and willing and able to innovate and shift the Treatment Threshold to the benefit of patients.

We need to continue to lobby for a public health service that does not have to ration care.

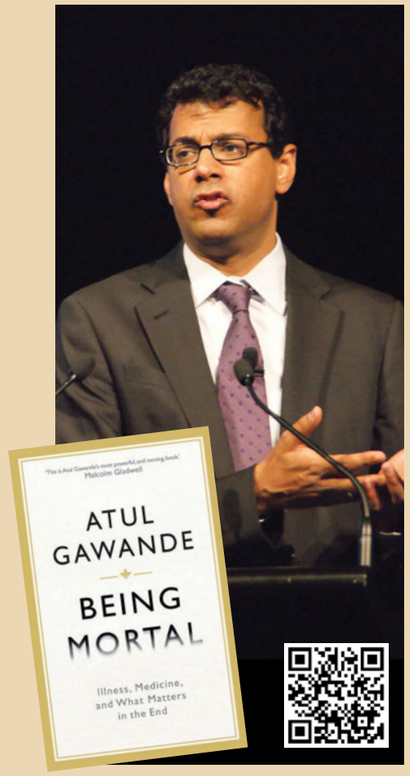


PHOTO: ETHAN TUCKER, HQSC

ATUL GAWANDE

ON THE QUALITY OF END-OF-LIFE CARE

Nearly 500 doctors and other health professionals, policymakers and health leaders gathered in Wellington recently to hear from one of the of the world's leading thinkers on health improvement and end-of-life care, American surgeon and writer Dr Atul Gawande.

Dr Gawande is the author of several highly acclaimed books, including 'Being Mortal: Illness, Medicine and What Matters in the End', which looks at the quality of end-of-life care. He practises general and endocrine surgery at Brigham and Women's Hospital, and is a Professor in both the Department of Health Policy and Management at the Harvard School of Public Health, and the Department of Surgery at Harvard Medical School.

An interview with him about the choices available to patients at the end of their lives, and why these choices matter, can be viewed at https://www.youtube.com/watch?v=K1Rsk-3mVKs&t=44. His presentation in Wellington was organised by the Health Quality & Safety Commission.

"We can reduce suffering now to a degree that is unprecedented," he told the gathering, before talking about the need to focus on systems and quality rather than the delivery of medicines and treatment. He gave the example of his mother's recent hospital stay, which involved three days on a ward followed by three days in rehabilitation. He counted the people with different names who entered her room to either make decisions about her treatment or to carry it out: 63 in total.

"The most expensive places for health care in our country and in the world are not the places that get the best results. Many of the places that are in the middle or at the bottom of the curve are getting better results – by not having complications, by not having things go wrong. Where care is more like a system is where that care is more successful."

The past 50 years had been an experiment in "medicalising mortality", he said.

"Disease-directed care is focused on the disease. This is less effective than goal-directed care, which is focused on the patient. What we want to do is show that a good life is in fact possible for people all the way to the very end."

PROFESSOR MARTIN MCKEE

One of the world's leading thinkers on health systems, Professor Martin McKee from the London School of Hygiene & Tropical Medicine, made a return visit to New Zealand recently for a series of presentations to senior medical and dental staff in several district health boards.

His visit was hosted by the ASMS in partnership with Waitemata District Health Board and followed his very successful series of addresses to ASMS members last year as part of our 25th anniversary commemorations.

"He's one of the world's leading authorities on the workings and complexities of health systems and has a remarkable ability to pull together many diverse strands of research and analysis into a coherent overall picture," says ASMS Executive Director Ian Powell.

Professor McKee's presentations to ASMS members and senior managers at Waitemata, Northland and MidCentral DHBs in April were well attended and well received.

A video of Professor McKee's Northland presentation can be viewed online at https://www.youtube.com/watch?v=WWTeVc2UkpM or via the QR code included here.

DR ERIK MONASTERIO

ASMS members in several DHBs had an opportunity in May to hear from Dr Erik Monasterio about the implications of the Trans Pacific Partnership Agreement (TPPA) for health care in New Zealand.

Dr Monasterio is a consultant in forensic psychiatry, Deputy Clinical Director with the Department of Forensic Psychiatry at Hillmorton Hospital, Christchurch, and a senior Clinical Lecturer with the University of Otago, Christchurch School of Medicine.

He spoke eloquently about the potentially disastrous implications of the TPPA at the ASMS Annual Conference last November and he also wrote about the TPPA for the March issue of *The Specialist*.

A video of his 2014 conference presentation can be viewed online at https://www.youtube.com/watch?v=FYXndJVJbm8 or via the QR code included here.

His presentations to ASMS members in Blenheim, Wairarapa and Rotorua in May this year were very well received.

YOUR NATIONAL EXECUTIVE

THE ASMS NATIONAL EXECUTIVE HAS BEEN CONFIRMED FOR THE NEXT THREE YEARS.

HEIN STANDER (ASMS NATIONAL PRESIDENT)

Hein graduated in South Africa and his first consultant position was in Newfoundland, Canada, where he worked for two years. He then moved to the UK and worked there as a paediatrician for eight years. He moved with his family to Gisborne 11 years ago. He became Clinical Director of Women, Child and Youth a year after taking up his position as general paediatrician at Tairawhiti District Health Board. He resigned as Clinical Director in April last year. Hein joined the ASMS at the first opportunity he had when he started work in New Zealand. He became an ASMS Executive member in 2010. He became National President two years ago and started his second term this year.

JULIAN FULLER (ASMS NATIONAL VICE-PRESIDENT)

Julian was born in England, gained medical qualifications in South Africa and has lived in New Zealand since 1992. He has been an Anaesthetist at North Shore Hospital since 1997. He has been on the National Executive and held the position of National Vice-President since 2011. While completing his vocational training in Anaesthesia, he also followed his passion for yacht racing, competing in two trans-Atlantic races as well as two Whitbread Round the World races.

"I am old enough now to be able to sit back and reflect on what makes an exciting and interesting job that I love, along with the wisdom to be able to unravel simplistic debates about public versus private health care."

JEFF BROWN (ASMS NATIONAL SECRETARY)

Jeff has been a paediatrician at Palmerston North Hospital for 23 years. Locally he pushes joined up care, nationally he is involved in resuscitation and life support training, and also the education, assessment and accreditation of future paediatricians as Chair of the RACP Paediatrics and Child Health Division and as a senior examiner. He has served on the National Health Board since 2009. He led a decade as ASMS National President from 2003 to 2013, and has been National Secretary since 2013.

"If we can get our health and welfare systems working for the best outcomes for our youngest citizens, the rest of us will admire the places we live well, get well and stay well."

SETON HENDERSON

Seton has worked in intensive care since 1989 and is currently the clinical director of intensive care at Christchurch Hospital. He was President of the Canterbury ASMS branch from 2011 to 2013, when he joined the ASMS National Executive.

"I'm committed to the practice of high quality medicine within the current complex environment of continual change, fiscal restraint and increased accountability. I believe in the collective strength of our profession and the need to maintain attractive working conditions with good remuneration, continuing medical education, study and training."

TIM FRENDIN

Tim is originally an Australian medical graduate (UNSW 1980) but has long worked in the New Zealand health system. After several formative years as a medical registrar in Christchurch he returned to Sydney, initially to complete training in cardiology. However, an interest in broader general medicine and a strong public health system saw him return to Hawke's Bay in 1992, where he has since worked as a general physician and geriatrician.

"I remain committed to our public health service within New Zealand and have been a member of the ASMS National Executive for the past six years during which time, amongst other activities, I have been intimately involved in our last two SMO MECA negotiations. SMOs remain at the heart of delivery of excellent care within our hospital system. Major challenges ahead for us include the empowerment of clinical leadership, more appropriate targeting of increasingly scarce health resources and the accommodation of changing demands that our aging population places upon our health system. ASMS and our members have a vital role to play in ensuring public health for New Zealanders."

PAUL WILSON

Paul has been an anaesthetist at Tauranga Hospital since 1995 and clinical director of the hospital's pain service. He is on the after-hours roster at the local hospice, and helps facilitate an integrated care model for the hospital pain service and the hospice. He has been on the ASMS National Executive since 1999.

"The breadth of my clinical work across primary, secondary and tertiary clinical care gives me insight into the challenges confronting our members working in district health boards, large and small, and in the growing non-DHB salaried sector."

CAROLYN FOWLER

Carolyn is an Otago graduate (1987) and has been an anaesthetist at both Counties Manukau Health and in private practice since 1999. She has been involved in all the MECA negotiations and, prior to that, collective negotiations for CMDHB. She has been a member of the ASMS National Executive since 2011.

"While I feel that the ASMS' role in continuing to maintain and improve our members' terms and conditions of employment is crucial I also believe that we have a duty to the wider community. As the largest organisation representing specialists in New Zealand, we have a strong voice for both defending our public health system and in leading important conversations for its future direction."

MURRAY BARCLAY

Murray is an Otago graduate (1984) and has been a gastroenterologist and clinical pharmacologist at Christchurch Hospital since 1997. He is also Clinical Professor with the University of Otago. He was an ASMS representative in Canterbury prior to the national MECA and has been on the National Executive since 2013.

"New Zealanders deserve to be treated by well-trained, compassionate specialists withtime to think, which requires sufficient specialists, and working conditions and salary thatare competitive internationally. There is a long way to go to achieve this but ASMS is working on it!"

JEFF HOSKINS

Jeff is a neuroanaesthetist and anaesthetist at Waikato Hospital. He has a long history of representation of doctors nationally serving on the RDA National Executive while a registrar and has been on the ASMS national executive since 2013.

He agrees with Murray's comments and couldn't say it better himself.

JEANNETTE MCFARLANE

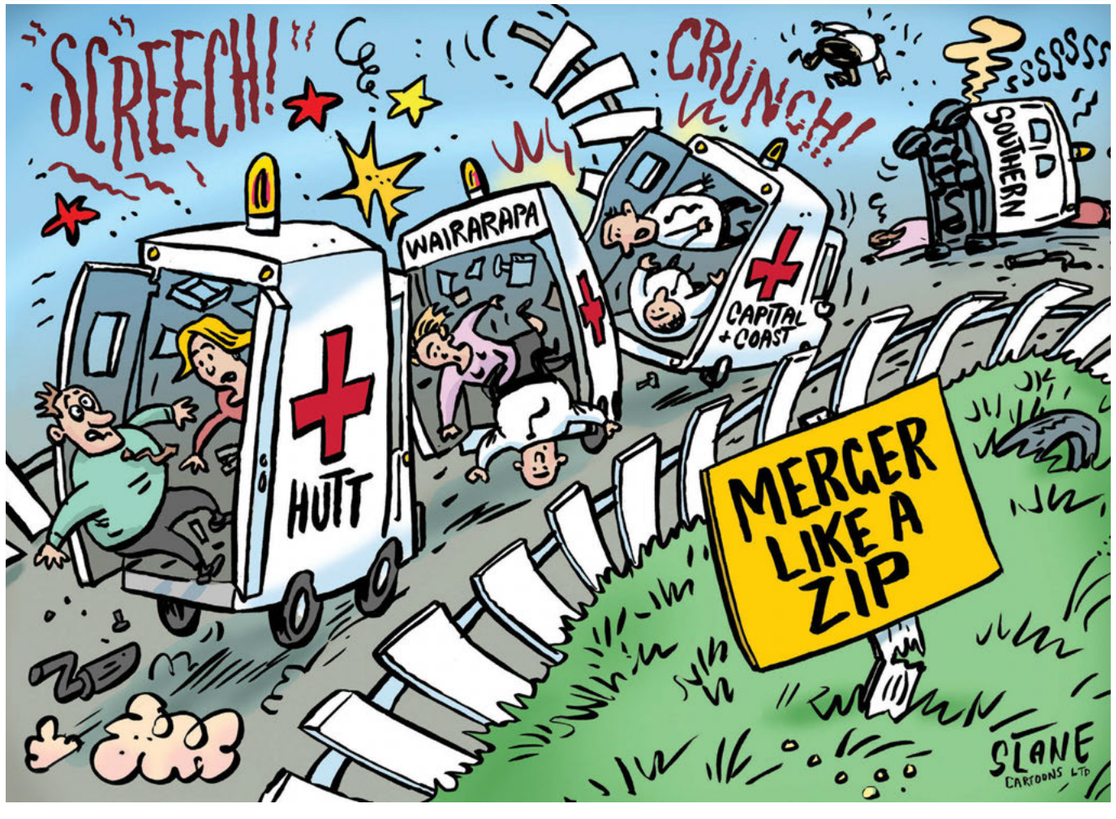
Jeannette is a paediatric pathologist at LabPlus, Auckland Hospital. She qualified in the UK in 1983 and trained in pathology in Yorkshire, London and the North West of England. After working as a consultant forensic pathologist in Glasgow for 11 years, in 2002 she chose to retrain in paediatric pathology. Jeannette has been involved with the ASMS since arriving in Auckland in 2005 and served two terms as Auckland DHB Branch President prior to being elected to the National Executive this year.

"As medical specialists we have a privileged position and voice. We need to use that influence in support of our public health care system and value the good work that is being done across the country by all groups of staff."

MOVING AWAY FROM MERGERS AND MERGER STEALTH

THREE DISTRICT HEALTH BOARDS ARE LIKE MAGNETS FOR TROUBLE, CHAOS AND DISENGAGEMENT: SOUTHERN (THE FORMER OTAGO AND SOUTHLAND DHBS), CAPITAL & COAST AND HUTT VALLEY.

IAN POWELL | ASMS EXECUTIVE DIRECTOR



The latter two are linked by a '3D' branding (which also drags in the hapless Wairarapa DHB).

Poor leadership, a top-down decision-making culture and, as a consequence, weak engagement cultures characterise the Southern, Capital & Coast and Hutt Valley DHBs. Structural change continues to drive their evolving models of care, rather than the other way around. They share another factor; they have all moved in the merger direction. Southern DHB completed its merger journey some time ago while the other two have been getting closer to being a single entity. In each instance, the pressure to 'merge like a zip' has become a major distraction, creating uncertainty and confusion among their workforces.

Mergers require government approval. Under former Minister of Health, Tony Ryall, there was an informal preference for mergers in the mistaken belief that structural change at the top drove system improvement change. The process was carried out by stealth to avoid explicitly debating the merits or otherwise of mergers. Stealth was achieved by taking a number of what were, in effect, interim decisions that then made an eventual merger a logical consequence.

IT BEGAN WITH AN ACCIDENT

Southern DHB began with an accident.

Once upon a time the then Chair of the former Southland DHB, an honest likeable 'salt of the earth' personality, found himself with a problem. Despite being an impressive competent chap he had sheer bad luck appointing chief executives and having to part company with both, and eventually diagnosed himself as having a condition known as the Midas touch in reverse in respect of chief executive appointments. So he looked a little further north and managed to arrange for the Otago DHB chief executive, a nice bloke called Brian, to become chief executive for both boards.

> *Structural change continues to drive their evolving models of care, rather than the other way around.*

This began the age known as the 'Life of Brian'. He established a combined senior management structure and then, even though they didn't get on, managed to persuade a bloke called Tony that a merger was the next logical step, it would save bags of money, and that this structural change would lead to improved patient services. What was missing from the decision-making process was the buy-in from senior medical staff, at least, that structural change of this magnitude was a good idea.

The merger was not based on strengthening clinical relationships (it assumed these would logically follow) and it ignored the challenge of providing health services to such a huge geographic mass with widely dispersed populations. After a while Brian moved on to the joys of the South Australian health system (briefly), to be replaced by a nice Scotswoman called Carole who discovered she had inherited a mess of an organisation acting as two DHBs with one letterhead. Part of the inherited mess was a senior management culture that was disengaging and at times toxic. However, instead of addressing cultural change, Carole thought she could restructure her way through it. This compounded the underlying problems, increased alienation between the leadership and health professional workforce, and saw the financial position deteriorate further.

This has reached a point where in many quarters, including its own staff and government, this new DHB is considered an embarrassment in need of 'regime change'. This would have made a wonderful Monty Python script.

IT BEGAN WITH A BRAND

The second was an attempted merger by stealth in the three lower North Island DHBs – Capital & Coast, Hutt Valley and Wairarapa – under the brand name of '3D'. This included two DHBs sharing the same chief executive, senior management teams and chief medical officer (Hutt Valley and Wairarapa) and two sharing the same Board Chair (Capital & Coast and Hutt Valley).

Very quickly '3D' became tainted and eventually, for many, a toxic brand. It was directionless, chief executives and senior managers were unable to effectively explain its purpose, and it was seen as top-down decision-making. It was damaging for what should have been a compelling case for strengthening clinical service collaboration, through networks at least, between the three DHBs.

> *It was obvious to almost all that the objective was to merge all three DHBs, but the approach was to deny it whenever raised.*

A review of the mental health services was forced to first determine the new structure before agreeing on the model of care that it was to be based on. And then there was the extraordinary disengaging, top-down laboratories restructuring, leading to one of the biggest inept and irresponsible decisions in the health system for many years.

What also became clear in the lower North Island is that the DHBs' staff don't like decision-making by stealth. It offends them. It was obvious to almost all that the objective was to merge all three DHBs, but the approach was to deny it whenever raised. People saw through this disingenuous tactic. The obvious conclusion in the assessment of many was this was the objective of the Chair of Capital & Coast and Hutt Valley Boards at least, with the 'nod is as good as a wink' from Health Minister Tony Ryall.

Eventually some sanity crept in. In response to strong specialist opposition, the new Health Minister, Jonathan Coleman, halted a move toward one chief executive for all three DHBs. Next (inevitably under the influence of the Minister), the decision for two of the DHBs to have the same chief executive and senior management team was reversed. The expectation is that the next step will be for the two DHBs sharing the same Board Chair to revert to having separate Chairs. Further, the '3D' brand is expected to be quietly jettisoned.

BACK TO BEFORE THE RESTRUCTURING STARTED

As an aside, the Canterbury and West Coast DHBs are the only ones to now share the same chief executive, and this is working reasonably well by contrast. Why? The answer, at least in part, is to do with the stronger history and culture of clinical service collaboration between the two DHBs (and their predecessors) for around a century. In addition, both have a level of effective clinical engagement that many other DHBs would envy, and their leadership is superior by a country mile to the three culprits discussed above.

It is now clear that within the Government (including the Ministry of Health) there is less appetite for mergers. If imposed in a top-down way they are more trouble than they are worth, waste an enormous amount of time, effort and money, disengage their health professional workforce, and are major distractions.

Let's try something truly innovative and focus on clinically-led, rather than bureaucratically-driven, process and system improvement. How long will it take – and how many poor decisions will the health system have to go through – before this lesson is learnt?

ASMS BRANCH OFFICERS

ASMS BRANCH OFFICERS HAVE BEEN CONFIRMED FOLLOWING RECENT ELECTIONS, WITH JUST A FEW POSITIONS STILL PENDING. BRANCH OFFICERS WILL MEET AS A GROUP ON FRIDAY 14 AUGUST IN WELLINGTON TO DISCUSS ISSUES RELEVANT TO YOUR WORK.

BRANCH	PRESIDENT	VICE-PRESIDENT
Northland	Ian Page	Lisa Dawson
Waitemata	Jonathan Casement	Ywain Lawrey
Auckland	Brigid Connor	Julian Vyas
Counties Manukau	Helen Frith	Sylvia Boys
Waikato	Annette van Zeist-Jongman	Annie Abraham
Rotorua	David Silverman	To be confirmed
Tauranga	Matthias Seidel	Rod Gouldson

BRANCH	PRESIDENT	VICE-PRESIDENT
Whakatane	Richard Forster	Guy Rosset
Taranaki	Campbell White	Allan Binnie
Tairawhiti	Angela Freschini	Mary Stonehouse
Hawke's Bay	Kai Haidekker	Jenny Corban
Whanganui	To be confirmed	Mark Van De Vyver
Palmerston North	Andrew Spiers	To be confirmed
Wairarapa	Bob Sahakian	Naser Abdul-Ghaffar
Hutt Valley	Neil Stephen	Jeffrey Suen

BRANCH	PRESIDENT	VICE-PRESIDENT
Wellington	Justin Barry-Walsh	Sinead Donnelly
Nelson	Clive Garlick	Andrew Munro
Marlborough	Prieur du Plessis	Jeremy Stevens
West Coast	Paul Holt	Stuart Mologne
Canterbury	Anja Werno	Geoffrey Shaw
South Canterbury	Matthew Hills	Peter Doran
Otago	Chris Wisely	John Chambers
Southland	Timothy Mackay	Roger Wandless

NEW ASMS STAFF APPOINTMENTS

Following the National Executive's decision to establish new positions, we are pleased to welcome two new staff members to the ASMS National Office. Charlotte Chambers joins us as Principal Analyst – Policy & Research, working with Lyndon Keene, and Sarah Dalton joins the industrial team as an Industrial Officer.

DR CHARLOTTE (CHARLIE) CHAMBERS is the new principal analyst (policy and research) for the ASMS. Charlie is a former lecturer in human geography at the University of Otago and holds a PhD and MSc from the University of Edinburgh. Prior to joining the ASMS, Charlie worked as a stay at home Mum to her two children, Harry and Xanthe, for nearly four years. She returned to the paid work force to work six months for Russel Norman in Parliament. Charlie is looking forward to applying her skills in research and analysis to the issues facing the membership of the ASMS and the health sector.

SARAH DALTON is the new industrial officer at ASMS. A former secondary school teacher, Sarah has a MA (hons) in History from Victoria. Prior to joining the ASMS, Sarah worked at the NZ Post Primary Teachers Association as an advisory officer and, most recently, field officer (industrial). After 20 years in education, Sarah is looking forward to working in the health sector, and to meeting and working with ASMS members around the country.

DID YOU KNOW

Specific MECA clauses that you may not be familiar with are highlighted in each issue of *ASMS Direct*, a national e-newsletter sent out to all members at regular intervals. These clauses are also promoted on the ASMS website (www.asms.org.nz) – and reprinted here for your information.

...ABOUT THE BASIS OF REIMBURSEMENT FOR COLLEGE AND OTHER PROFESSIONAL FEES?

Reimbursement for your college fees, Annual Practising Certificate etc must be based on your job-size, not just your ordinary hours. For example, if you work 32 normal hours per week but you are also paid an average of 4 hours each week to be on-call, then your job-size is 36 hours per week and that is the basis for reimbursement.

Reimbursement is full for those part-timers who have no other income from medical practice.

More information is available in the DHB MECA:

- Clause 13.2: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-13/
- Clause 21: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-21/

...ABOUT A PARTNER'S ENTITLEMENT TO PARENTAL LEAVE?

Clause 28.2.b of the DHB MECA says the partner of a primary caregiver is entitled to two weeks' paid leave around the birth of your child.

This leave needs to be taken within a particular period of time, and this is spelt out in detail in the MECA clause: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-28/

...ABOUT PAYMENT FOR PUBLIC HOLIDAYS?

If you would normally work on a public holiday, you are entitled to a day off on full pay. If you actually work or are on call on "any part of" any of these days, you are entitled to a day-in-lieu on full pay at a later date, plus your usual pay for the day worked, plus a load of 50% of your "relevant daily rate" for every hour worked on the public holiday.

If you are a shift worker, eg, in ICU or ED, and you are rostered off, you are entitled to a day-in-lieu on full pay on another mutually convenient day.

More information is available in

- Clause 24.2(b) and 24.3(c) of the DHB MECA: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-24/
- Section 50(1) of the Holidays Act 2003: http://www.legislation.govt.nz/act/public/2003/0129/latest/DLM237128.html

....ABOUT THE INVOLVEMENT OF STAFF ASSOCIATIONS IN APPOINTMENTS?

Clause 52 of the DHB MECA describes the process required for the appointment of senior medical and dental officers, including clinicians appointed to leadership roles.

Clause 52.2(b) says the Senior Medical Staff Committee (or equivalent body agreed with the ASMS) must be invited to appoint at least one member to the appointments committee, who shall be from the same or similar discipline to the position that has been advertised.

More details are available at http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-six/clause-52/

....ABOUT PRIVATE PRACTICE AND CONFLICT OF INTEREST?

Under the DHB MECA, you have the right to engage in private practice but not in such a way that would give rise to a conflict of interest. Where a conflict might exist, you are expected to consult with your employer in an effort to avoid a conflict and reach agreement.

More information is available in clause 46 of the DHB MECA: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-six/clause-46/

...ABOUT THE EMPLOYER SUBSIDY FOR YOUR SUPERANNUATION?

Clause 17.1 of the DHB MECA specifies that your employer will make the required employer contribution in respect of any of the superannuation schemes operated by the National Provident Fund or the Government Superannuation Fund to which you belong. If you do not belong to one of these, then Clause 17.2 of the MECA entitles you to a 6% employer subsidy matching your contribution to an approved superannuation scheme, and ASMS encourages members to take advantage of this.

More information is available at http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-17/

SHORTAGE OF PAEDIATRIC SURGEONS

NEW ZEALAND FACES AN ONGOING STRUGGLE TO TRAIN AND RETAIN ENOUGH PAEDIATRIC SURGEONS TO KEEP UP WITH THE LEVEL OF NEED, SAY ASMS MEMBERS SPENCER BEASLEY AND BRENDON BOWKETT.

LEFT: SPENCER BEASLEY; RIGHT: BRENDON BOWKETT

They're two of this country's small pool of paediatric surgeons, and they say more of these specialists are urgently needed.

"We're currently down about 20% on the number we need," says Spencer Beasley, a paediatric surgeon at Christchurch Hospital and also Clinical Professor of Paediatrics and Surgery at the University of Otago.

"Each of the four centres – Auckland, Hamilton, Wellington, Christchurch – has been advertising for someone or is about to advertise."

He says there's a worldwide shortage of paediatric surgeons, most markedly in developing countries, but also in countries such as New Zealand.

That's echoed by Brendon Bowkett, a paediatric surgeon at Capital & Coast District Health Board, who says New Zealand has 12 or 13 paediatric surgeons but needs more – at least four surgeons in each centre but ideally slightly more than that.

> *"Many paediatric surgeons, including myself, would like to be involved in preventative and rehabilitative work," he says.*

"Paediatric surgeons in many countries are deeply involved in that kind of work. It's an essential area as that's where many of the recent advances in improving child mortality and morbidity have occurred.

"With the current numbers, the opportunities to do that are pretty much non-existent."

He says many children are treated in an adult environment in New Zealand, and surgeons need more time to lobby and support governance structures to facilitate appropriate standards of care for children.

"The 20 DHB model has focused a lot of resources on structures which are removed from child health and patient care. For example, despite the clinical risk, it appears to take several years for jobs to be advertised and filled."

SHARED TRAINING PROGRAMME

New Zealand and Australia share a training programme, with trainees selected on merit by a single body. There's no quota of trainees from each country – and Spencer Beasley says that's an issue for New Zealand.

"New Zealand trainees have to do some of their training in Australia and because they tend to be very good, they then get offered jobs in Australia," he says. "It's a very attractive option for them because the centres are bigger and better resourced, they will be doing less on-call work and they have the ability to earn more."

Spencer Beasley and the country's other paediatric surgeons are doing their best to convince trainees and new graduates that the opportunities they're seeking are available on this side of the Tasman, too. It's a tough job: so far just three of the last nine New Zealand trainees who have gone through the Australasian programme have returned to New Zealand to work, with most opting to stay in Australia.

Brendon Bowkett says that in the past year, seven people have been taken onto the advanced paediatric surgery training scheme but six people have left or been removed from the programme.

"So we have a net gain of just one person."

Paediatric surgeons, like other specialists, are also grappling with issues of workload, fatigue and stress, he says.

"Work stress is such that I am now aware of three paediatric surgeons who have fallen asleep or crashed their cars because of tiredness when on intolerable rosters."

Spencer Beasley says it has proven hard to recruit and also difficult to get locums for the roles.

"There are about three or four New Zealanders in training at the moment but they're at different stages of their training so they're not immediately available."

ATTRACTING PAEDIATRIC SURGEONS TO NEW ZEALAND

Part of the challenge for Spencer Beasley and Brendon Bowkett and their colleagues is to get across the message to trainees and new graduates that New Zealand also has some very strong attractions.

"There are only four paediatric surgical units in New Zealand so we all know each other and work very well together," says Spencer Beasley. "There are also opportunities to do a broader range of surgery here, whereas in a bigger centre in Australia, the opportunities may be narrower. And of course there are the benefits of living in New Zealand, too. That's very attractive to many people, to return here to live and work."

He sees two possible solutions to the current situation – either introducing a quota for New Zealand trainees that matches our anticipated needs, so that an appropriate number can be accepted onto the Australasian programme, or to allow New Zealand trainees to do all of their training in New Zealand.

He says a review of tertiary services in 1998 looked at paediatric surgery but there is a real need for Health Workforce New Zealand to carry out a separate review of the specialty to see what is needed now and in the future.

"What happens at the moment is that the four surgical units get the complex and rare conditions, but probably the greatest contribution they can make is for simple things like hernias, which require good clinical judgement and expertise.

> *"When I go to Greymouth once a month, the patients there receive the same quality of care that they get in Christchurch or Melbourne. We travel a lot to provide care for families close to their homes, but overall we're struggling to provide adequate support to some other DHBs. We need to entice people back to work here."*

Brendon Bowkett is not convinced that providing all of the training in New Zealand will solve the problems with recruitment and retention, as there are still issues to do with public funding of child health, facilities and coordination.

At the end of the day, he says it's simply about providing the best possible service for the children who need it.

"You need to keep up to date in order to provide the best care, and it's difficult to do that with limited numbers of paediatric surgeons."

FIVE MINUTES

WITH GEOFF LINGARD

IN HIS SPARE TIME, GEOFF LINGARD IS A KEEN FISHERMAN.

WHAT INSPIRED YOU TO BECOME A DENTIST?

It was really due to the headmaster of my high school in Christchurch, Terence McCombs, who had previously been a Cabinet Minister and was the first principal of Cashmere High School. In our final year at school he delivered a series of career talks and I was particularly taken by the way he talked about dentistry. As a profession it seemed to him to offer a good combination of academic and technical skills, an opportunity to work with people as well as providing a reasonable income. I looked at all of that and thought: that's interesting. Most of my friends were going to do science or teaching. I had been thinking of a chemistry degree myself, but dentistry stood out as being different.

I trained as a dentist at Otago University in the 1960s. I then worked as a lecturer at the School for Dental Nurses in Christchurch for two years, then as a Dental Registrar at Christchurch Hospital's Dental Department for another two years. After that I went to the UK and worked in a private practice for 15 months before doing my Master's degree in paediatric dentistry at the University of London. I returned to New Zealand in 1976 to work at Christchurch Hospital as the First Assistant Dental Surgeon and Specialist Paediatric Dentist and during that time established a part time private specialist paediatric dental practice.
I eventually decamped to Nelson in 1986 to take on the role of Principal Dental Officer to the newly formed Nelson Area Health Board.

I started attending the grand rounds at Nelson Hospital and following discussions with medical colleagues, realised there was a total lack of dental input into the hospital. So I went and talked to the Medical Superintendent. These days if you want to achieve anything you have to have a business case and it's all very complex, but back then the medical superintendent and I walked around the hospital and we found some space and he said, well, you can have that if you like, we will fund the alterations if you can fund the equipment through the School Dental Service budget.

Eventually I also started a dental department at Wairau Hospital in Blenheim. We now have seven dentists working for us, all part-time, as well as a visiting OMF surgeon and Prosthodontist.

WHAT DO YOU LOVE ABOUT YOUR JOB?

When I considered this as a career, I thought it seemed interesting, and it is. I like dealing with people and helping them. I have a lot of variety in my role, a good mix of clinical work, administration and management. I also enjoy interacting with staff, both in the dental department and in the wider hospital.

There's a reasonable amount of complexity in this role. One of the challenges of doing paediatric dentistry is that you have to communicate successfully on at least three different levels more or less at the same time – with your patient, who's a child, but also with their parents who might be anxious, and with your dental assistant about the work you're both doing.

Dentistry can be a stressful occupation. You're working with patients who, on the whole, prefer to be somewhere else. You're trying to make the experience as comfortable as possible for them. One nice thing about working in a hospital environment is that it does allow you more options, especially in paediatric dentistry and if all else fails , I always have the option of working under a general anaesthetic if that's going to be best for the patient. The really fun thing for me is that if a child enters our clinic and they're clearly apprehensive, it's really satisfying to see them leave later on feeling confident and comfortable.

WHAT IS THE MOST CHALLENGING ASPECT OF PRACTISING DENTISTRY?

For me, in terms of hospital dentistry, it's ensuring that we have enough staff, adequate facilities and an environment which is pleasant to work in which enables us to provide quality care for our patients.

We are also seeing an increasing number of patients, especially those who are older, who are basically unwell and have a range of medical issues which then complicate the dental treatment they require. For example, some patients are on IV Bisphonphonates that can cause Bisphosphonate related osteonecrosis of the jaw. This is rare but it's very distressing when it does happen.

A further challenge is caring for dependant older people. In days past, a high percentage of these older people would have dentures. However, today it is not uncommon for people in their 80s and 90s to retain some or all of their teeth. As they become less independent they struggle to care for themselves, the carers are often not educated with regard to oral health and these teeth and periodontal tissues can deteriorate rapidly resulting in infection and painful abscesses.

Access to hospital dentistry varies throughout New Zealand. It's very uneven. Most hospital dental departments have access criteria. The core patients we treat here, for example, are those who are medically compromised in some way, or with an intellectual or physical disability, those under the care of adult mental health services, and people who are very ill and have been referred to us by our specialist colleagues. If we can, we also treat low income patients who can't afford private dental care.

WHY DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH THE ASMS?

I've been involved with the ASMS for quite a long time. I was at a senior medical staff meeting many years ago, sitting next to a physician who was retiring as the branch secretary. He volunteered me for the role and since there were no other takers, I was it. The main job in those days was to be involved in the local negotiations.

I really enjoyed the negotiations process and later on I became involved in a couple of national MECA negotiations as well. It was a great pleasure to learn the art of negotiation, to understand the mechanisms by which you could negotiate and what you can do if you find yourself at an impasse. I learnt a lot about employment law and the MECA. I enjoyed working with members and supporting them. When members have a problem you certainly listen and try to help them to resolve it. It wasn't always easy. Sometimes you got the resolution you wanted, and sometimes you compromised. That was the reality.

I stood down as an ASMS branch officer in 2010 as I had been involved at executive level with the New Zealand Dental Association for some years and in 2011 I was elected their President.

WHAT HAVE YOU LEARNT FROM YOUR INVOLVEMENT WITH THE ASMS?

I believe we need a strong and viable industrial voice, and ASMS provides that. What I particularly like about ASMS is that that voice is accompanied by a very good knowledge of health and the ever changing political climate. ASMS has the ability to look beyond the industrial issues, the pay and rations, and to explore the creation of a much better working environment for doctors and dentists, with the ultimate aim of benefitting patients. For example, the concept of clinical leadership isn't exactly new but ASMS has really helped to reinvigorate and advocate for it. While not all DHBs embrace it as fully as we like, without ASMS' continued advocacy it would pretty much be just a distant memory.

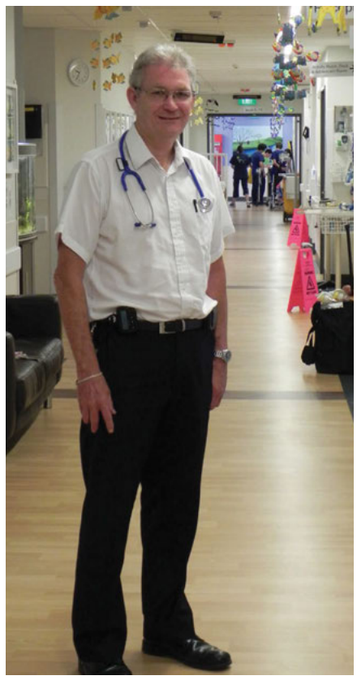
ASMS is more than a union. It's much wider in its philosophy and culture, and it's a good voice for senior doctors and dentists.

HISTORIC MOMENTS

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

THIS ISSUE: A PHOTOGRAPH OF THE 1989 ASMS ANNUAL CONFERENCE.

COLLABORATIVE APPROACH ESSENTIAL FOR NEW ROLE



HUGH LEES

Hugh Lees is quite clear about the importance of collaboration, clinical engagement and good working relationships in his role as Chief Medical Advisor (CMA) at Bay of Plenty District Health Board.

"It's all about building relationships with the people you work with, with managers and with the ASMS," he says.

"Each of us sees issues through a slightly different lens but we're all working towards the same thing – what's good for colleagues and patients and for the hospital. When we can find common ground on issues, it's a win-win."

He says he learnt a number of years ago that developing a good working relationship with the ASMS was fundamental to the success of his role, and that remains true in his position as CMA, which he took up last year.

"Issues often come up that are controversial," he says. "Being able to ring your ASMS representative and have a discussion about the issue beforehand goes a long way toward smoothing the process when it comes to meeting around the table."

Fortunately for Hugh Lees, he has many years of collegial working relationships to draw on.

He joined Tauranga Hospital in 1984 as one of two paediatricians in a pool of 30 to 40 SMOs. Today, the DHB employs 140 SMOs across its Whakatane and Tauranga hospitals. Over the years he has moved through various clinical and leadership roles, including becoming the medical leader for the women, children and family service about eight years ago.

He says he has grown with the DHB, and he's not the only one.

"SMOs are often the constant factor in an organisation like this, helping to maintain and carry forward the ethos and history of the organisation. It's not just about where you're heading to but also about where you have been, what your history is.

"Paediatricians work with a wide range of other hospital specialties so I like to think I have a good working relationship with all of the other specialties in the hospital. I know everyone pretty well, and that's really helpful."

Steve Hurring, the ASMS Industrial Officer covering BOP DHB, acknowledges the contribution Hugh Lees has already made in terms of the relationship with ASMS.

"We have been able to move expeditiously on a number of issues that were previously stuck, and have made good progress," he says.

JUDY BENT'S LONG SERVICE TO ASMS ACKNOWLEDGED

JUDY BENT

ASMS NATIONAL PRESIDENT HEIN STANDER HAS PAID TRIBUTE TO THE LONG SERVICE AND CONTRIBUTION OF AUCKLAND DHB ANAESTHETIST DR JUDY BENT TO THE ASMS NATIONAL EXECUTIVE.

Dr Bent joined the National Executive in 1997 and left following this year's elections for the Executive.

"She has always made a significant contribution to the Executive and been a very active participant," says Hein Stander. "Judy has been on the ASMS negotiating team for all of our national DHB MECA negotiations since 2003 (the right to national collective agreement negotiations was regained in 2001. Further, she also represented members in pre-MECA collective negotiations with Auckland DHB from the early 1990s).

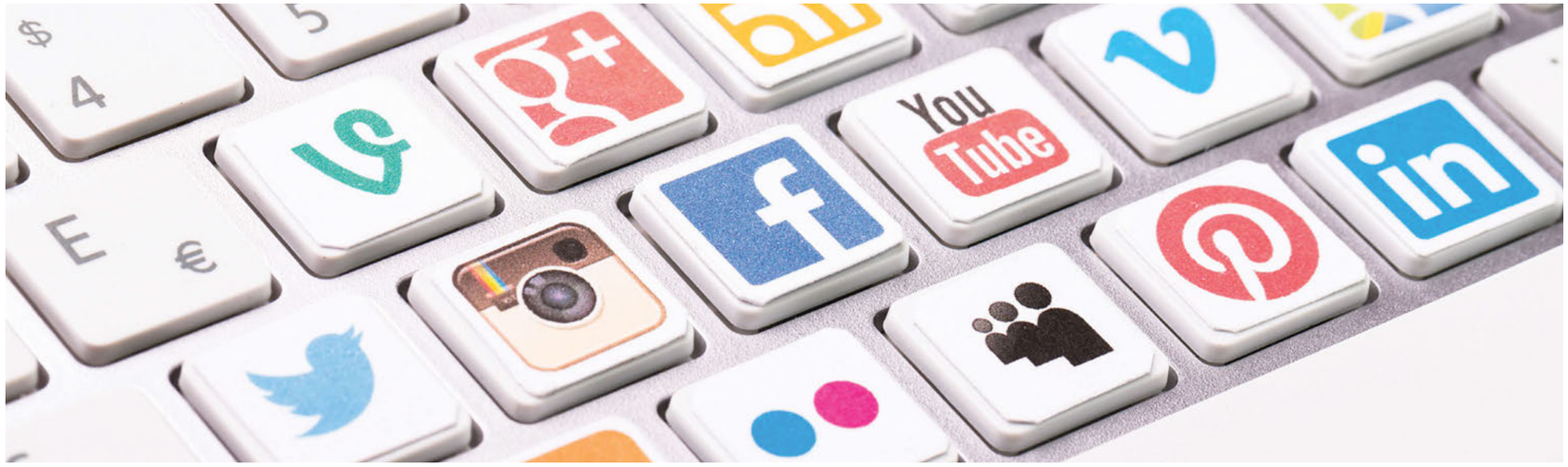
"She has also regularly attended the National Joint Consultation Committee meetings involving ASMS and the DHBs. Through the NJCC we engaged with HBL which led to her being appointed to HBL's Clinical Council."

Hein Stander says Judy Bent introduced the concept of 'Executive-only' time at the start of each National Executive meeting, which had proved to be very useful, and she had volunteered to attend meetings of the New Zealand Medical Association on ASMS' behalf, reporting back on items relevant to members.

"She will be particularly remembered for her sharp attention to detail, her keen understanding of the organisation's finances, and her strong principles," he says.

ASMS National Secretary (and former National President) Jeff Brown added:

"In my 10 years as National President, Judy was the touchstone for any resolution or change in direction. Her wisdom and experience applied an invaluable measure of opportunity and risk, and whether to test one or the other. Her service to ASMS and to its members was visible to a privileged few, her legacy will serve many for years to come. Thank you, Judy. Enjoy the future of your anaesthetic and tennis aspirations."



HOW TO STAY SAFE WHEN USING SOCIAL MEDIA

DOCTORS ARE INCREASINGLY USING SOCIAL MEDIA AND VIDEO CHAT WEBSITES SUCH AS FACEBOOK, TWITTER, SKYPE AND GOOGLE+ TO COMMUNICATE WITH EACH OTHER AND WITH THEIR PATIENTS.

While this has clear advantages in being quick, easy and accessible, the blurring of professional boundaries in the virtual world of the internet can lead to potential problems, according to the Medical Protection Society (MPS).

Dr Rob Hendry, Medical Director at MPS, highlights his top tips for doctors regarding the use of social media.

BE SECURE

Maintain strict security settings and be vigilant with your standards.

Use the most secure privacy settings on social networking sites, but remember this is not failsafe and not all information can be protected on the web. Identities can be traced so be careful you don't inadvertently post comments about your work, patients or your hospital or practice.

Declaring that you are a doctor adds weight and credibility to your views; however, with that privilege comes a responsibility not to undermine public confidence in the profession. If you are providing medical opinion and are happy for it to be professionally held to account then you must identify yourself as a doctor.

A social network is not an appropriate place to raise a concern. Even 'doctors only' forums have risks as they may be accessed by members of the public, employers, or friends of friends may pass on information attributable to you.

RESPECT CONFIDENTIALITY

Your duty of confidentiality applies online as well as offline.

Doctors are afforded a privileged position by their access to patients and information divulged in communication with them. To abuse this is to erode trust and confidence in the doctor-patient relationship.

It's important to be aware that the Health Information Privacy Code 1994 and the Code of Health and Disability Services Consumers' Rights apply to the health sector and to electronic communication. You should therefore ensure you consider issues around privacy, security and the sensitivity of information when interacting with patients online – just as you would in a face-to-face situation.

Posting inappropriate comments/photographs or describing a patient's care on a social media website could damage your reputation, lead to disciplinary action and attract unwanted media attention.

Even if you do not mention a patient's name they may be identifiable from information written about them, especially if the case is reported in the local press.

ACT PROFESSIONALLY

As doctors, you are not only representing yourself but the hospital or practice you work in. You have a responsibility to act professionally at all times and not bring the profession into disrepute.

Consider who may be able to access photographs of you on your personal accounts and whether there is information you would not want your employer to see. Derogatory or flippant comments about patients can be damaging to the public perception of doctors and their trust in the profession.

MAINTAIN BOUNDARIES

It may be flattering to receive online contact or a "friend" request from a patient with whom you have a good rapport, but conversing with patients online is inadvisable. Relationships should be kept strictly professional and the doctor-patient boundary should not be blurred.

Be cautious about online contact with colleagues too so as to maintain the distinction between your personal and professional lives.

CRITICISM: THINK BEFORE YOU TYPE

Once you post a comment or photograph online you relinquish control of that information, so think carefully before hitting 'send' or 'upload'.

Although critical comments patients make about your care online may be upsetting, potentially damaging to your reputation, or even defamatory, avoid giving a knee-jerk reaction when responding.

It is important to keep a cool head and look at the issues objectively.

Consider treating the comment as a formal complaint. Using the appropriate formal complaint channels will allow you to explore and investigate patients' concerns and provide an explanation and apology where appropriate.

Doctor–patient confidentiality can prevent you from directly challenging negative feedback; however, such comments can be diffused creatively with a positive response. For instance, if a patient comments "my appointment was late and my doctor seemed in a hurry to get me out the door", you could reply by stating "we are sorry that you are unhappy with the service on this occasion. As the only practice offering this service in the area, we pride ourselves on serving as many patients as possible."

Should a user's feedback reveal a genuine deficiency, use it as an opportunity to improve your policies and/or procedures. Invite the patient to discuss their concerns and provide a point of contact, demonstrate that you have listened to their concerns and are addressing them. The patient may even reply with a positive comment online.

IF YOU ARE STILL UNSURE

If you are still unsure about how to tackle a tricky situation online, talk to your employer, supervisor, medical school or contact MPS or your medical defence organisation to discuss the best way forward.

Taking care to avoid these potential pitfalls will help you make the most of social media, which offers exciting new ways to communicate in the ever-changing world of medicine, and has become an integral part of our lives.

ASMS
TOI MATA HAUORA
www.asms.nz

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

ASMS job vacancies online www.jobs.asms.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*.

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

How to contact the ASMS

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

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F 04 499 4500
E asms@asms.nz
W www.asms.nz
www.facebook.com/asms.nz

Have you changed address or phone number recently?

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

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KiwiSaver
2013

KiwiSaver
2014

CANSTAR awarded our Growth and Aggressive Portfolios five-star ratings for outstanding value in both 2013 and 2014.

Switching to the Medical Assurance Society KiwiSaver Plan is easy. Call us today or email **info@mas.co.nz.**

Call us today:
0800 800 627
Visit us online at **mas.co.nz**
Or email us at **info@mas.co.nz**

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