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The Specialist

The newsletter of the Association of Salaried Medical Specialists

A most flexuous process: planning begins for next MECA negotiation

The adjective flexuous is a good word to describe our multi-employer collective agreement (MECA) with the 20 district health boards. It means "full of bends or curves, sinuous, full of turns or crooked". It is an interesting example where the suffix changes the implication of the word; unlike the more common word flexible, which means "capable of being bent" because of the suffix -ible, flexuous has the suffix -ous meaning "full of."

Even though the MECA negotiations between the ASMS and the DHBs have concluded with a new settlement reached and signed and the new MECA expiring on 28 February 2013, the process never ceases. Given the relative shorter nature of this settlement (the two previous MECAs were for three year terms), the ASMS National Executive spent much of its two day meeting last month planning its preparation for the next flexuous negotiations.

Even though the MECA negotiations between the ASMS and the DHBs have concluded … the process never ceases.

This was particularly appropriate given the acrimonious circumstances of the last negotiations and the unsatisfactory nature (and unresolved issues) of the outcome. Our specialist workforce crisis in public hospitals remains unchanged despite the best political efforts of government to make it go away with its 'spread-sheet' doctors (the disingenuous misleading 800 extra hospital doctors' claim). Much of what is discussed below is what the Executive is contemplating rather than has determined.

Timeframes for negotiations

Timeframes for collective bargaining are set by legislation and impose some constraints on when we can do certain things. Under Section 41 of the Employment Relations Act the union rather than the employer(s) has the first opportunity to initiate bargaining for the negotiation of a new collective agreement. The "union must not initiate bargaining earlier than 60 days before the date on which the collective agreement expires" (in the case of employers it is 40 days).

Our specialist workforce crisis in public hospitals remains unchanged despite the best political efforts of government to make it go away with its 'spread-sheet' doctors

In other words, the ASMS can't initiate before 31 December this year (an awkward time of the year). This means realistically that negotiations would probably not formally commence until early next year. However, this would not preclude informal discussions with the DHBs later this year if both parties considered it useful.

This provides an opportunity for our claim to be finalised as late as the 28 November National Executive meeting with the further opportunity for endorsement at the ASMS Annual Conference over the following two days. The Executive could approve the claim earlier than this but, given the limitation of the legislative timeframe and the opportunity provided by the Annual Conference, this may not be wise. This is still being considered by the Executive.

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Lessons of the last collaborative process with DHBs

In the last MECA negotiations (2010-11) the ASMS and DHBs embarked upon a new approach which was intended to be much more collaborative. The intention was to develop a joint understanding and narrative of the state of the DHB-employed senior medical/dental officer workforce, with a focus on recruitment and retention, from which solutions as part of the MECA settlement would flow. This included a series of joint workshops culminating in the agreed Securing a Sustainable Senior Medical and Dental Workforce in New Zealand: the Business Case in November 2010.

This was the mode of the negotiations in 2010 and for the early part of 2011. The failure of this approach has been previously discussed (including the December 2011 issue of The Specialist). In essence it involved a systemic failure in the ability of the DHBs to function nationally compounded by changes in the national leadership of the DHBs, some individual acts of dishonestly and government unhelpfulness.

Consequently the level of collaborative work with the DHBs in the next negotiations is unlikely to be anymore than would normally be the case in our negotiations. It will be for the ASMS to shape the narrative of these negotiations rather than doing it jointly with the DHBs as attempted last time.

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There was a strong message from Conference delegates (and other membership feed-back) that the Association should not give up on the *Business Case*, at least in respect of its principles. They are too important and too invaluable to the future sustainability, quality and cost effectiveness of our public health system.

Similarly there was a strong message that the specialist workforce crisis in DHBs still remains unabated and it is important that this remains our focus. This includes the negotiation of terms and conditions of employment and recognising that we are in an Australian medical specialist labour market in respect of both recruitment and retention.

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The narrative

The ASMS needs this year to shape the narrative in the lead up to the development of our claim and the commencement of negotiations in order that the true picture emerges, rather than that of government and DHB spin doctors. The National Executive has already decided to produce a publication consistent with the *Business Case* principles. It would not replicate the *Business Case* but adapt and update it as appropriate.

The *Business Case* was a joint document which inevitably limited, from the Association's standpoint, what could be said and the way it was said.

Further to the above point, a theme of the narrative might be the effect of the crisis on senior medical staff working in DHBs (over-worked, over-stretched, 'clinical creep' and lack of time for non-clinical activities, burn-out, and lack of time for distributive clinical leadership and the lost opportunity for financial savings and improved cost effectiveness). This would also lend itself to greater use of the telling of stories of actual experiences through, for example, visual productions and the website.

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In the last negotiations, due to the unusual opportunity that presented itself at the time with the joint business case initiative, we tried to address the competitive salary scale in one go (over a three year period). This was justified, but ambitious, influenced by what appeared at the time to be a genuine recognition by DHBs and the Health Minister of the specialist workforce crisis and a genuine commitment to address it. This situation will not present itself again and certainly the Minister of Health will not be an ally as once previously thought.

Further to the above point, it should be noted that in the past our advances have been based on a gradualist building-block approach, sometimes contrary to the prevailing trends at the time. One example is our achievement of subsidised superannuation. This commenced in the mid-1990s, following the closure of access to then government superannuation schemes, initially at Nelson-Marlborough and then Counties-Manukau, at a time when there had been a strong political and employer drive against subsidised superannuation based on the argument that it was an individual rather than state or employer responsibility. While further advances were made in the following years completion was not achieved until the first MECA settlement (2003-06).

Another example is the gradual implementation of penal rates for after-hours call duties again starting in the mid-1990s with what was then Western Bay of Plenty. This was another case of going against the dominant trend which, in this case, was removing penal rates.

…in the past our advances have been based on a gradualist building block approach, sometimes contrary to the prevailing trends at the time.

The recognition of time for non-clinical duties as an express part of job sizing was also a gradual process that predated the first national MECA beginning (in the late 1990s) with mere references to the Association's position.

Some of the issues

The current salary scale structures (step numbers), particularly the specialist scale, is not sustainable in terms of the next MECA negotiations because of the impact of relativity on those on the lower and middle steps (above the first step) and the growing number and proportion on the top step (as well as the overall lack of competitiveness of the specialist scale). Membership feed-back on this has been received loud and clear from many members.

Salary scale restructuring should only be contemplated if it is sufficiently beneficial in terms of addressing our recruitment and retention crisis and creating the workforce capacity to deliver on the principles of the Business Case. Something similar to the outcome in the current MECA based on tinkering with the salary scales will not do.

We will also have to be mindful of the recent settlement for nurses between the Nurses Organisation and DHBs. Over a three year period nurses will receive salary increases in each of these years of 2%. 1.5% and 1%.

Salary scale restructuring should only be contemplated if it is sufficiently beneficial in terms of addressing our recruitment and retention crisis and creating the workforce capacity to deliver on the principles of the Business Case.

Consideration needs to be given about continuing the focus on base salaries, the specialist and medical officer scales in particular, and whether we should extend this to further enhancing subsidising superannuation. This sentiment came through in some of the Conference small group feed-back. While the former is the most critical the latter is also where we fall behind Australia although the differences between the systems are more pronounced (Australia does not require a matching employee contribution).

Let the flexuous journey commence (again).

Ian Powell
Executive Director

EXIT SURVEY

If you are resigning DHB employment please contact ASMS

The ASMS conducts an ongoing exit survey of those who resign their positions with district health boards. The most recent update of this survey considered by the National Executive revealed that around 30% have taken up positions elsewhere in New Zealand, with a similar proportion leaving the country (mainly Australia). The remainder are largely complete retirements, retiring from DHB employment but continuing some private practice, and working in private practice only.

This information is very useful for the Executive but would offer much more if more members participated. "Consequently the ASMS requests and encourages members who resign their employment to advise us of their action and provide a current email address so we can improve participation and the utility of the information provided in this survey.

The contact person is:
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PRESIDENT'S COLUMN

The Charge of The Health Brigade

This poem was written to memorialise a suicidal charge by light cavalry over open-minded terrain by ASMS forces in the Battle of *The Business Case* in the MECA War (2010-2011). 373 of the 800 more in the charge survived the inflation. ASMS entered the war, which was fought by DHBs against Turkeys, because CEOs sought to control the Dardanelles. DHB control of the Dardanelles threatened New Zealand health routes.

Many best know of this war today because of Florence Nightingale, who trained and led nurses aiding the wounded during the war in a manner innovative for those times. The War was also noteworthy as an early example of the work of innovative and collaborative health correspondents.

The Charge of The Health Brigade

by Fred, Lord Nineson

Memorialising Events in the Battle of MECA, 2010 to 2011

Half a league table, half a league table,
Half a league table onward,
All in the valley of Health
Rode the eight hundred:
'Forward, the SMO Brigade!
Charge for the targets he said:
Into the valley of Health
Rode the eight hundred.

'Forward, the SMO Brigade!'
Was there a doctor dismay'd ?
Not tho' the Executive knew
Some one had blunder'd:
Theirs not to make reply,
Theirs not to reason why,
Theirs but to vote & sigh,
Into the valley of Health
Rode the eight hundred.

Vacancies to right of them,
Shortages to left of them,
Locums in front of them
Volley'd & thunder'd;
Storm'd at with short-term outputs and she'll-be-right,
Boldly they rode and well,
Into the jaws of Health,
Into the mouth of Joint Quality and Safety Improvement Plan
Rode the eight hundred.

Flash'd all their scalpels bare,
Flash'd as they prescrib'd in fear
Sabring the funders there,
Charging an arm and a leg while
All the world wonder'd:
Plunged in the spreadsheet-smoke-and-mirrors
Right thro' the bottom-line they broke;
Cossack & Russian
Reel'd from the restructuring-stroke,
Shatter'd & sunder'd.
Then they rode back, but not
Not the eight hundred.

Vacancies to right of them,
Shortages to left of them,
Locums behind them
Volley'd and thunder'd;
Storm'd at with short-term outputs and she'll-be-right,
Off to Aussie hopes & private tills,
They that had fought so well
Came thro' the jaws of Health,
Back from the mouth of MECA negotiations,
All that was left of them,
Left of eight hundred.

When can their glory fade?
O the wild charge they made!
All the world (or NZ at least) wonder'd.
Honour the charge they made!
Honour the SMO Brigade,
Noble, but not eight hundred!

Politics and the use of financial penalties and incentives

Most members are probably aware that Health Minister Tony Ryall was heckled at the ASMS Annual Conference last November. The issue was his insistence that since becoming minister, there were 800 extra hospital doctors in DHBs. This statement was made to an incredulous audience who struggled to relate it to their own workplace.

This was not the only point of contention, however. He was also challenged by a delegate over the use of financial penalties for DHBs who fail to meet government requirements for electives.

The Minister's response was to dispute that this was happening, something that also left many Conference delegates incredulous. The ASMS then started raising this issue in our Joint Consultation Committees in the DHBs to see what the facts are. The facts prove the delegate who boldly asked the question correct.

Recent past history

In those DHBs where we have mentioned the Minister's assertion, they first resort to the Tui advertisement 'yeah right' and then refer to the financial penalties that incur when ESPI requirements are not complied with.

There is also the threat and consequences of being placed on 'intensive monitoring' (not only for electives). This means that DHBs would receive their funding at the end rather than the beginning of each month with implications for interest income. Further, DHBs can be forced to pay their capital charge to government monthly rather than six monthly which also adds to their costs.

The government's reduction of the six month maximum waiting time for electives (first specialist assessment and operation or other treatment) to five months next year and four months in 2014, is expected to place extra pressure on DHBs (according to what they tell us in JCCs). This will particularly be the case if, as expected, the government yet again increases the service volumes it requires from DHBs and, also as expected, it does not address the workforce capacity needed to achieve this. On top of this the government is removing the 5% 'buffer' it has for meeting the maximum from July this year.

On the other hand, the government is also putting in place, from this July, a financial incentives fund for those DHBs who fully comply with the maximum waiting time.

Targets are one thing; financial penalties and incentives are another

There is an argument for targets that are developed by those who have the clinical expertise to know what works (and what does not) and what is unlikely to produce detrimental unintended consequences (and what is likely to produce them).

Financial penalties and incentives are another thing. They are much more likely to create unintended consequences. You risk getting what you incentivise (or threaten with penalties) and that is all you get. While targets can provide a sharper focus on particular services, incentives and penalties encourage a focus primarily on those things that are incentivised or at risk of penalty, and yet so much of what is done in public hospitals is not counted and so much is driven by professionalism and goodwill.

"You risk getting what you incentivise (or threaten with penalties) and that is all you get."

This might make sense in a narrowly focused organisation not dealing with complexity. But DHBs are not like this owing to their unique features (including being highly integrated and complex, highly labour intensive and dependent on workforce capacity and morale, dependent on a high level of inter-disciplinary collaboration, and being large 24/7 organisations of necessity). In these sorts of organisations incentives and penalties designed to affect behaviour can be counter-productive, unravelling what should remain ravelled and risking less than optimum delivery on those things neither financially incentivised nor at risk of being financially penalised.

"…so much of what is done in public hospitals is not counted and so much is driven by professionalism and goodwill."

Having a focus on electives is a good thing for reasons of early intervention, reducing the likelihood of increased pain and suffering, and cost effectiveness. But these are not the only reasons why the government is so strongly behind them. They make productivity figures look good. Productivity in the health sector is only what can be counted and is predominantly discharges. Treasury, who report productivity, acknowledge (rarely that prominently) that what is counted is only around 35% or so of what DHBs actually do in healthcare. But it makes good PR to be able to report productivity growth even if it is in the relatively less complex part of what public hospitals do. Further, it tends to be electives that attract the negative publicity when patients are frustrated over, for example, waiting times.

The previous Labour-led government self-inflicted a severe wound upon itself by its second 'actively monitoring' list which, as the ASMS said at the time, was a form of data cleansing. The National-led government has learnt from this and knows full well that the greater the elective volumes, the less the risk of negative media.

But when electives become the focus of financial penalties and incentives they risk being the area DHBs over-focus on at the relative expense of others. Public hospitals veer more towards stretching the workforce more and more and of increasingly

becoming mere production lines; a concern we increasingly hear from affected members. Clinical creep erodes non-clinical time necessary for supporting professional activities, organisation-wide systems improvements and quality initiatives.

> *"…when electives become the focus of financial penalties and incentives they risk being the area DHBs over-focus on at the relative expense of others."*

Extending into models of care and employment

The above leads into serious concerns over a "new model of care" planned for Waitemata DHB's new elective surgical centre (ESC), currently being built in front of North Shore Hospital. There are no concerns with the concept of an "elective surgical centre". On the contrary, the experience of Counties-Manukau DHB with its 'super clinic' confirms that significant benefits and efficiencies may be achieved with a separation of acute and elective surgery and doing each set of procedures on different sites.

The concern is over an agenda among some in the DHB's leadership to introduce remunerative financial incentives in order to drive the ESC's model of care. They argue that it will improve productivity but what they are referring to is throughput. Counties Manukau's dedicated electives facility has high throughput but remunerative incentives were not necessary to produce them.

The absurdity is that what you can count (about 35% of hospital activity including electives) becomes worth more remuneratively that what you can't count (eg, chronic illnesses). Further, what you can do faster because it is less complex (electives) becomes worth more remuneratively than what takes longer because it is more complex (eg, acutes).

Why should elective surgery alone attract financial incentives to increase throughput? Why should other clinical services be discriminated against in the "productivity stakes" (eg. acute surgery, diagnostic services, psychiatry, ED admissions and ICU) and be offered no incentives?

There are no good answers to these questions. Inevitably this unfairness and discrimination will result in a high level of workforce dissatisfaction across the organisation (including by nurses who are also important to improved throughput). That dissastisfaction will undermine the strong culture of collaboration and team work that is at the heart of the ethos of public hospital healthcare delivery.

> *"Inevitably this unfairness and discrimination …will undermine the strong culture of collaboration and team work that is at the heart of the ethos of public hospital healthcare delivery.*

Professionalism, not financial incentives, for models of care

I was struck by an article in the NZ Medical Journal (16 December 2011) about a trial on the use of non-contact first specialist assessments at (NCFSA) Palmerston North Hospital ('Safety and efficiency on non-contact first specialist assessment in neurology', Pietro Cariga, William Huang and Annemarei Ranta).

It concluded that a "significant proportion (around 20%) of new referrals to a neurology clinic can be treated safely as NCFSA. This may not only improve the capacity for non-urgent appointments, but also increase resources and reduce waiting time for more urgent referrals."

A new or revised model of care equivalent to a clinic a week arising out of this in Palmerston North Hospital would be a worthy achievement. Financial incentives did not drive this; professionalism did. What would make this sort of model of care any less valuable for a DHB than one shaped by remunerative financial incentives?

Ian Powell
Executive Director

Introducing the Joint DHB/ASMS Quality and Patient Safety Improvement Plan

In November 2011 the ASMS and the 20 DHBs reached agreement on a joint document called the *Quality and Patient Safety Improvement Plan*. While not formally part of the national DHB MECA resolved and ratified late last year, it did arise out of the MECA negotiations. The Plan can be downloaded from the ASMS homepage **www.asms.org.nz** (see *Core Documents*).

Download The *Plan*:

Members are strongly encouraged to download *The Quality and Patient Safety Improvement Plan* from the ASMS homepage **www.asms.org.nz** (Core Documents section).

The origin of this document goes back to the agreement between the DHBs and ASMS that the much discussed *Business Case* agreed between us in late 2010 needed a supplementary operational document. Good progress was made on developing this document in early 2011 (up to April) but it was derailed due to the DHBs U-turn and unprincipled behaviour and misrepresentations. It was picked up again later in the year in the resumed negotiations, tweaked a bit more, and then agreed. There is no reference to the *Plan* in the MECA but it is referred to in an accompanying document called the 'Terms of Settlement'.

The *Plan* is based on the view that, SMOs and DHB management can work more effectively together to achieve sustained improvements in clinical quality and patient safety. Reducing waste and improving productivity will free up funding and clinical time meaning more resources are available to invest in activities that will deliver better quality and safer services. Chief Executives are responsible for championing the *Plan's* direction and taking the appropriate approach in the context of their DHB.

The *Plan* is built on the principle of distributive clinical leadership. Its success will depend on strengthening the relationship between DHB management and senior medical staff, as well as other clinical groups.

Context

The *Plan* recognises that the capacity of the existing senior doctor workforce in DHBs is facing mounting pressure due to generational and gender-linked shifts in lifestyle aspirations, opportunities abroad, and ageing. Workforce sustainability is also at risk due to population growth, expectations from government, and changes to resident medical officer training. Recruitment and retention of sufficient senior medical and dental officers is therefore critical.

The potential that could be realised is recognised in the *Plan*. Integrated models of care and improvements in quality and safety result in better patient experience, safer, more satisfying clinical practice, and reduced wastage. Consequently a paradigm shift towards working together is needed to achieve this. Allowing SMOs the time and opportunity to achieve these objectives within the current environment often proves difficult, but also offers the beginnings of a pathway to see these issues addressed.

This *Plan* has three pillars – the *Time for Quality* agreement between the DHBs and ASMS (2008), which endorses a partnership between health professionals and management to improve the quality of healthcare delivery; *In Good Hands* (2009), from the government, which provides a framework for strengthening clinical leadership, giving health professionals a greater role in decision-making at all levels, from bedside to boardroom; and Securing a *Sustainable Senior Medical and Dental Officer Workforce in New Zealand: The Business Case*, jointly developed

Suggested Time Framework (2012-13)

The expectation is that the *Plan* will begin immediately following the settlement of the MECA.

By when	What	Who
3 months	Communicate details of plan	Chief Executives and ASMS
	Agree date for quality improvement DHB/ SMO workshops at each DHB	Each Chief Executive and ASMS at each DHB
6–12 months	Hold first quality improvement DHB SMO workshop at each DHB	ASMS and Chief Executives, SMOs
	Identify possible projects (at quality improvement engagement workshops)	
	Form project teams	
	Develop project plans	
	Agree resources	
	Set dates and key measures	
	Identify data sources – plan for data collection	
12–18 months	Projects well underway	Project teams
	Report-back to local ASMS DHB JCC and ASMS - DHBs NCC	
Ongoing	Monitor, support and share successes	Local JCC and National JCC

by the DHBs and ASMS in November 2010, which outlines the problem of an inadequate SMO workforce in DHBs facing increased demands over the next ten years, sets targets for SMO recruitment and retention, and proposes an investment and reinvestment strategy explicitly connected to potential quality and patient safety improvements.

Confidence is expressed in the *Plan* that there are many improvement initiatives that have a greater success rate and are more sustainable ***if*** clinical leadership amongst senior doctors and dentists is embraced to a greater degree than now. With the right investment in SMO recruitment and retention, and with the right paradigm shift, SMOs will be able to take on that role. These ifs are central to the *Plan's* success or otherwise.

Strengthening Clinical leadership

Central to the *Plan's* model is *distributive clinical leadership* at all levels of the senior medical/dental workforce. Clinical leaders have the skills necessary to effectively identify process improvements needed on the frontline and to lead improvement initiatives to address these. Specific clinical leadership positions are not the entire solution, rather the establishment of distributed clinical leadership at all levels of care. Clinical leadership offers opportunities for SMOs that can be expected to attract and retain the specialist workforce needed to deliver the improvements. Literature is increasingly reflecting the critical role that frontline clinicians have in spreading best practice, in innovating and introducing new systems and processes.

However, shifting to a model of clinical governance (and clinical leadership as part of that) is not always easy. DHBs are at different stages of engaging with the clinical leadership approach and SMOs role in it. The reasons for this are many, reflecting the major shift in culture and behaviours that clinical leadership requires of management and clinicians alike. Clinical leadership challenges the distinction and divide between clinical and management roles that have become common in recent decades.

The *Plan* recognises that clinical leadership is critical for frontline -lead improvements in quality and patient safety, which has flow-on effects for

Three interconnections for acheiving Distributive Clinical Leadership

Clinical Leadership Quadrant

The *Plan* on Reducing Clinical Variance

"Variability is an accepted part of clinical practice, reflecting the fact that all individuals are different. Variation due to patient factors or clinical condition can lead to appropriate variation in practice. However, variation due to doctor preference or deviation from acknowledged best practice is neither inevitable, nor desirable. In general, for common high volume conditions, it is possible to limit the variation in practice for 80 percent of patients. Using agreed standard practice for these cases will reduce variation, risk of error, and unnecessary costs due to duplication. It will also free clinical time to focus on those 20 percent of patients that, for disease or individual reasons, need different levels of care."

reducing waste and unlocking resources in the system. It is also an important contributor to recruitment and retention of the SMO workforce.

The challenge, as developed in the *Plan*, lies in ensuring that the investment – time, space, training support, financial resources and culture- exists to enable SMOs to develop as clinical leaders and to lead the quality and safety agenda within their own DHBs. At the same time, there needs to be concerted effort to ensure recruitment and retention of SMOs is of the scale and sustainability to provide the workforce necessary to deliver the desired results.

The *Plan* factors in the interdisciplinary nature of the delivery of health services and acknowledges that while clinical leadership by SMOs may be a necessary component of the improvements sought, it will not be sufficient in itself, as other clinical professions will need to be engaged in, and contribute to, the success of these initiatives. How this will best be achieved will need to be considered on an initiative-by-initiative and DHB by DHB basis.

Some of the improvement initiatives, if they are to be realised to their fullest extent, may challenge individual practice, and may give rise to significant consequences and challenges for the organisation and delivery of health services at a broader level.

The *Plan* also promotes the reduction of clinical variation by identifying the best possible practice for the 80 percent of treatments and strengthening the apprenticeship model for training the future medical workforce. This model inevitably requires more SMO time to supervise and train RMOs. It also requires a shift from SMO-led to SMO-provided services in order to free up training time for RMOs.

Implementation

The *Plan* envisages that DHB chief executives and ASMS will jointly facilitate special purpose DHB SMO engagement workshops to bring together senior medical staff and management to consider collaboratively planning and agreeing on quality and patient safety projects and engaging SMOs in them.

Elements to be included in Project Planning

Five key elements should be condered during the planning stage

Planning element	Questions to answer
Problem identification	What is the 'problem'? What evidence do we have that this is a problem in our healthcare setting?
Outcome identification and goal setting	What is the outcome we are seeking? What are the specific objectives of the project we are proposing, including savings?
Intervention logic	What is the intervention being proposed? What is the rationale for this intervention? Is there an evidence-base to support this intervention achieving our objectives?
Implementation plan	Who are the relevant stakeholders who need to be engaged in this project? What are the steps we are going to undertake? Who will be responsible for each step/action? When will we do them (or finish them)?
Measurement (see 'Monitoring' in the next section for further details)	What is our baseline on this issue? What will our targets for improvement be (against our objectives)? How will we know we: – are on track? – have succeeded?

Improvement initiatives to release resources for investment

The *Plan* identifies 12 areas (not exhaustive) where improvement initiatives could release resources for reinvestment. These are:

- improved theatre utilisation
- improved SMO recruitment and retention
- reduced length of stay (to the national average)
- reduced SMO locum costs
- diagnostic tests
- reduced adverse drug events
- reduced falls
- reduced pressure injuries
- reduced central line associated bacteraemia (CLAB)
- surgical site infections
- other Hospital Acquired Infections
- identification errors
- venous thromboembolism (VTE)

Health Minister to DHBs – do more with less

This year Minister of Health Tony Ryall has sent at least two 'Letters of Expectation' to DHBs. The first was the standard annual 'Letter' for the 2012–13 year, the other sets out expectations on access to services up to 2014. Together the letters show a view that "doing more with less" is a strategy that the government expects to work if not indefinitely, then certainly in the medium term. Both letters are available on the ASMS website **www.asms.org.nz.**

Letter of Expectations 2012–13

The picture is the familiar one of the Government wishing to return to surplus in 2014/15 and therefore constraining new funding and expecting DHBs to stay in budget. Specific mention is made of constraints around capital and the expectation that capital projects are funded internally. The letter has three sections.

Under the sub-heading **Integrated Care**, Mr Ryall sets out his expectation of increased integration between secondary and primary care, reliant mainly on care pathways designed by hospital and community clinicians. Clearly there is an expectation that developments are stepped up (there are three priority areas; unplanned and acute admissions, long term conditions and wrap around services for older people). The area of particular concern for ASMS members is the primary care 'direct referral to diagnostics' which may mean added pressure on hospital funding and workforce.

Health of older people focuses on keeping people at home particularly after discharge, as well as on dedicated stroke units and dementia.

Regional integration is to continue delivering on IT and capital but also regional workforce objectives that have already been set. Normally these workforce objectives will have been well discussed with our members, however it is of concern that there is not really an obvious way for ASMS to ensure engagement with SMOs regionally in the same way we can on a DHB or national level. Strong clinical leadership is 'pivotal' but the letter this year is silent on monitoring.

Shorter waiting times are dealt with in the second letter and changes to the health targets have apparently already been advised.

Expectations around improved access to services 2012–13 and beyond

This second letter sets steadily more challenging elective surgery targets for the next three years. Currently the target for the maximum waiting time for a first specialist appointment and, if applicable, elective surgery is six months. The Minister is requiring this maximum to reduce to five months by 2013 and to four months by 2013. Already some comment has been made at ASMS-DHB Joint Consultation Committees (JCCs) about the practicality and usefulness of the 2014 target. Lifting thresholds or removing patients from waiting lists are specifically ruled out by Tony Ryall as mechanisms to reach the target. A Tui advertisement 'yeah right' has been the response to us by several senior DHB managers!

Work is being done to set targets for diagnostic tests including collecting data on how long patients are currently waiting. Direct referral by GPs is raised approvingly as a mechanism already used by some DHBs to reduce waiting times and increase efficiency.

There appears to be a further letter dealing in more detail with waiting times for cancer treatment. Radiation treatment and chemotherapy treatment will now have to be delivered in four weeks.

A further target is foreshadowed requiring 80% of young people to be seen by an addiction heath professional within three weeks.

ASMS members at JCCs have commented that the six month maximum target for electives has in some services led to a clean up of waiting lists and greater focus on working with GPs on referrals. Similar gains cannot necessarily be assumed to follow even shorter waiting times. Targets have to be clinically meaningful and already very efficient services will not find making further gains easy.

Angela Belich
Assistant Executive Director

National Executive endorses Memorandum of Understanding with Medical Protection Society

For many years the ASMS and Medical Protection Society have worked together to advise and represent members facing medico-legal or professional complaints that have sometimes threatened the member's continued employment.

Over this period ASMS industrial officers and MPS medico-legal advisers and barristers have developed close professional relationships to the mutual benefit of our joint members. Both organisations have become very good at assessing the nature and possible implications of the complaints and professional or industrial issues that might arise from them. With the member's consent, this will often result in ASMS and MPS staff consulting one another soon after an initial enquiry is received by one or other organisation; occasionally this may lead to a joint meeting with the member concerned and perhaps even with management, if the ASMS and MPS advisers consider such a meeting is appropriate and would serve the member well.

As a sign of our close working relationship ASMS and MPS have recently entered into a Memorandum of Understanding ("MOU") to underpin that relationship and to provide a formal framework for members and staff of both organisations to refer to as we continue to work closely together, supporting members in the range of medico-legal and employment-related matters they contend with in their professional lives. The Memorandum was endorsed by the National Executive at its meeting on 9 February 2012.

The MOU is reprinted here for members' information. It is open ended but may be reviewed at the request of either party and as circumstances may warrant. It is not intended that the MOU will change the way we work together and it is not a commercial relationship; the ASMS does however gratefully acknowledge that MPS has sponsored our annual conference dinner for more than ten years.

Henry Stubbs
Senior Industrial Officer

Memorandum of Understanding between the Medical Protection Society (MPS) and the Association of Salaried Medical Specialists (ASMS)

Many doctors in New Zealand are members of both ASMS and MPS and from time to time, faced with a complaint or professional concern of some kind may seek advice and perhaps representation. The question then arises, Which of the two organisations should they turn to for that advice or representation? MPS or ASMS? This Memorandum of Understanding has been developed to assist MPS and ASMS answer that question and to ensure their members receive sound advice from the most appropriate organisation. It is anticipated that the MOU will also reduce the possibility of a member of both organisations seeking advice from both MPS and ASMS on the same matter.

The purpose and spirit of this Memorandum between MPS and ASMS is that their Medico-Legal Advisers and Industrial Officers will work closely together to ensure their respective members receive appropriate and effective advice and support on a collaborative basis, or from whichever of the two organisations is better placed to provide it.

Requests for assistance to either organisation by a member on a matter that might be better managed by the other should be referred to the other organisation by the MPS Medico-Legal Adviser or the ASMS Industrial Officer who received the call for assistance.

Where the matter relates largely or entirely to the interpretation, application or operation of the member's employment agreement it is unlikely that MPS will become involved. The ASMS industrial officers have particular knowledge, skills and experience in these areas and will ordinarily be better placed to assist members resolve concerns in these areas.

Similarly the ASMS will usually be better placed to deal with complaints or other matters that an employer is processing or investigating under their internal disciplinary policies or procedures.

The ASMS would ordinarily also deal with workplace issues and employment disputes that are or may appropriately be dealt with under employment legislation, including the Employment Relations Act, the Health & Safety in Employment Act and Human Rights Legislation

Where the matter is a complaint or concern of a clinical or professional nature, or involves an agency such as the Coroner, the Medical Council, the Health and Disability Commission, Accident Compensation Corporation, Privacy Commission or the Police, MPS would usually be the sole or principle provider of advice, support and representation to the member.

When an employer raises concerns about the health or competence of a member the matter may be dealt with completely internally or by both the employer and the Medical Council. In such circumstances ASMS is usually better placed to assist the member until such time as contact is made with the Council or such contact is thought to be inevitable, at which point a collaborative approach between both ASMS and MPS is indicated.

Where it is reasonably anticipated that a matter being managed by one organisation is likely to extend into an area better managed by the other, there will usually be contact between the MPS Medico-Legal Adviser and the ASMS Industrial Officer to discuss and facilitate services to the benefit of the member. Members of both ASMS and MPS will be encouraged to co-operate with such a collaborative approach.

MPS and ASMS will review the operation of this Memorandum at the request of either party and as circumstances may require.

Date: 21/03/12

Dr Brendon Gray
Head of Medico-legal Services
Medical Protection Society

Ian Powell
NZ Executive Director
Association of Salaried Medical Specialists

Growth in SMO numbers: The big growth was between 2007 and 2008

During the last election campaign one of the achievements that the government referred to was 800 extra doctors that had been employed by DHBs since they took office at the end of 2008. At the ASMS conference delegates made very clear that this had not been their experience and the Minister of Health was left in no doubt that the SMOs present disputed this claim.

The ASMS has tried to follow these figures up with the National Health Board which has said that their figures are based on a conservative interpretation of 'full-time equivalents' (ftes) but have yet to provide these figures to us.

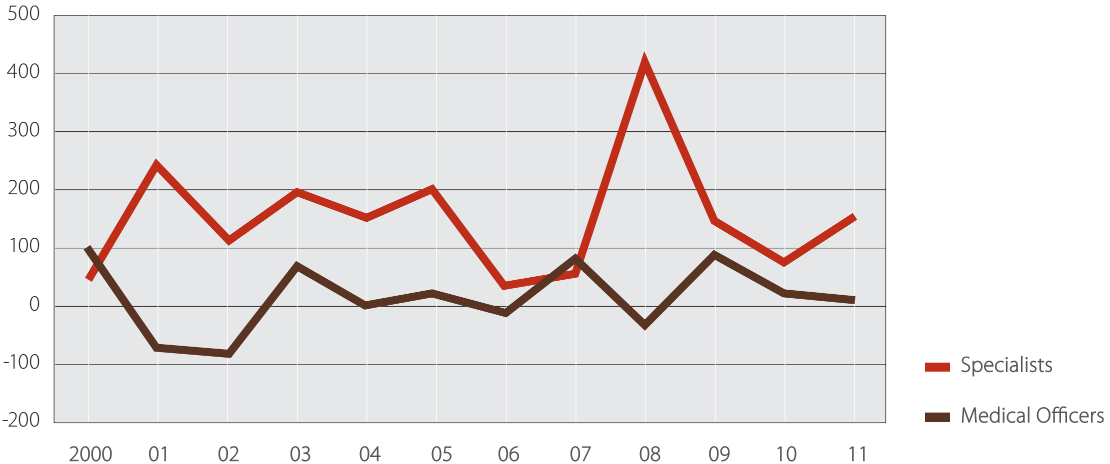
We do have a data series from DHBs, however, which we have collected for our annual salary survey as at July each year which gives figures for "bodies" rather than ftes and shows the growth in SMOs over the last eleven years.

The notable feature of the data is the big leap in numbers of specialists between 2007 and 2008. What is embarrassing for the Minister of Health is that the number of specialists increased more in the three years before he took office compared with the three years after.

Fluctuations in the number of medical officers (formerly MOSSs) may have something to do with the locum market for general registrants and the shifting of these doctors between employment and contracts for services.

Angela Belich
Assistant Executive Director

Change in numbers employed from the previous year



Total Employee Numbers – all DHBs

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Specialists	1,912	2,151	2,259	2,459	2,609	2,811	2,845	2,894	3,312	3,457	3,533	3,685
annual change	47	239	108	200	150	202	34	49	418	145	76	152
annual % change	3%	13%	5%	9%	6%	8%	1%	2%	14%	4%	2%	4%
Medical Officers	483	410	327	389	388	404	396	474	431	522	548	565
annual change	102	-73	-83	62	-1	16	-8	78	-43	91	26	17
annual % change	27%	-15%	-20%	19%	0%	4%	-2%	20%	-9%	21%	5%	3%

Successful Bargaining Fee Ballot outcomes in all DHBs

The bargaining fee ballot of all medical and dental officers eligible to join the ASMS in each of the 20 DHBs that was held as part of the recent national DHB MECA settlement has resulted in a bargaining fee option being available in every DHB. This is a good result for ASMS members because it means that SMOs who have not joined ASMS and are covered by the MECA still have to share the costs of bargaining. They pay an amount equivalent to the ASMS membership fee each year. Bargaining fee payers are not entitled to any of the other benefits of ASMS membership such as individual representation, including union enforcement of the MECA, and our publications.

As it did for the last MECA that process made some SMOs aware that though they thought they were ASMS members they were not. The process has meant a surge in membership.

We are still pursuing DHBs to complete the data by telling us the number of invalid votes cast (if any) and number of votes distributed.

Ballot Results

DHB	Distributed	Counted	For	Against	Invalid
Northland	150	67	60	7	
Waitemata	414	131	123	8	
Auckland	875	347	319	28	
Counties Manukau	423	147	126	21	
Waikato	327	168	145	23	
Bay of Plenty	180	90	85	5	
Lakes	71	49	43	6	
Taranaki	86	49	41	8	
Whanganui	47	32	29	2	1
Hawkes Bay	126	72	68	4	
Tairawhiti	48	26	23	2	1
Wairarapa	31	13	13	0	
MidCentral	153	95	88	7	
Capital & Coast	350	120	109	11	
Hutt	140	80	74	6	
Nelson Marlborough	149	49	41	3	5
West Coast	34	20	18	2	
Canterbury	483	225	210	15	
South Canterbury	39	11	9	2	
Southern Otago / Southland	265	114	104	10	

Angela Belich
Assistant Executive Director

The Medical Council On Line Survey: What do specialists who leave New Zealand really want?

The Medical Council of New Zealand (MCNZ) undertook a survey via email between 1 April 2010 and 30 June 2011 to find out why doctors chose to leave New Zealand and what might encourage them to return.[1] Participation was invited from all doctors requesting a Certificate of Good Standing and who had indicated they were leaving New Zealand (330 doctors).

The full details of the survey have not been released but the Medical Council has put a generally positive gloss on the findings. The ASMS engaged free lance health researcher Lyndon Keene to examine the MCNZ's analysis. He not only found serious issues of concern but also raised questions about the position the MCNZ has taken with regard to medical workforce policy matters.

Approximately 55% (182 doctors) responded to the survey. Of those, 88 doctors (48%) had a general scope of practice while 65 doctors (36%) had vocational registration and the remainder had provisional general/vocational or special purpose registration. Of the 65 vocationally registered doctors, 28 were in general practice, meaning approximately 20% (37) of the survey respondents were vocationally registered doctors excluding GPs.

Just over half of the respondents were doctors whose primary medical qualification (PMQ) was gained overseas, and almost half of those were from the United Kingdom.[2] No information is available on the numbers of these doctors by scope of practice.

Purpose of the Survey

While the stated purpose of the survey was to find out why doctors chose to leave New Zealand and what might encourage them to return, virtually no quantitative data is provided on the responses to those questions. Most of the quantitative data released concerns the characteristics of the respondents, such as their scope of practice, years of practice, areas of medicine, and intended length of time away, but this information is not linked with the responses to the two key questions. This means, with a couple of exceptions, no figures are provided detailing how distinct medical groups – vocationally registered doctors, those with overseas PMQs, and those with general registration – responded to the questions on why they were leaving and what encourages doctors to return.

Instead, there are a few selected general descriptions of how some groups responded. For example:

> *The data showed a trend of doctors with overseas PMQs [primary medical qualifications] returning to the country where they gained their qualification to undertake further training. (p 25)*

> *Many [doctors who gained their PMQ overseas] noted that they enjoyed their time in New Zealand and expressed a desire to return in the future…(p 22).*

Hence the typical doctor who gained their PMQ overseas is described as …

> *by and large sad to leave New Zealand as they had a good experience. (p 28)*

The analysis explains that the responses to the two key questions were such that "the data could not easily be derived in a statistical format". Nevertheless, while some of the responses listed at the end of the document do not allow for clear categorisation, the vast majority do.

A tally of the 178 listed reasons for leaving New Zealand, leaving aside a few that are ambiguous, shows approximately 45 (25%) were related to training, 34 (19%) were related to income, 34 (19%) concerned family, 21 (12%) were about gaining overseas experience, and 20 (11%) related to doing locum work, with the remainder covering a variety of other reasons.

The analysis contains some inconsistencies and it is often hard to reconcile some of the analysis statements with what is actually said in the listed responses. For example:

- The earlier example of the departing doctor who gained their PMQ overseas typically being "by and large sad to leave New Zealand as they had a good experience" is not supported by the responses. Of the responses to the question "Why are you leaving New Zealand?" only three mention having a positive experience in New Zealand. While of the responses to the invitation to make general comments, a dozen of the 86 responses make similar positive comments. There are many more responses describing negative experiences.
- The analysis states that "most respondents identified multiple reasons" for leaving New Zealand. However, the list of responses shows that only approximately 30% of respondents gave two or more reasons.
- The analysis states "an overwhelming number of New Zealand medical graduates leaving for overseas indicated they wished to

1 MCNZ (2011). Doctors leaving New Zealand: Analysis of Online Survey Results, MCNZ, September 2011

2 Up until now known as international medical graduates (IMGs).

go in order to seek further training…". The "overwhelming" number is 40% of respondents with a general scope of practice (as stated on page 15 of the document), minus an unknown number of respondents that were not New Zealand graduates. The latter could be a significant proportion, given the stated "trend of doctors with overseas PMQs returning to the country where they gained their qualification to undertake further training" (p 25).

What were the Survey findings?

Key points from the analysis are quoted below in italics, followed by comments:

On the question: "Why are you leaving New Zealand?

> *The main reasons identified as factors for leaving New Zealand related to the desire for training opportunities and work experience in overseas settings, particularly fellowship training. The intention to earn a higher income than what was available in New Zealand was the next largest indicator for leaving. (Executive summary, p 2)*

The first sentence, most of which was used to highlight the primary point in the MCNZ's media statement, is ambiguous. In the absence of supporting figures, it could be construed to mean many doctors – or even most doctors – left New Zealand for training opportunities and overseas work experience. As shown above, around 25% of respondents said they left for training reasons, while about 11% left for overseas experience. Only one or two of those respondents cited both reasons, meaning close to two-thirds of the respondents cited reasons other than training or overseas experience.

Despite this, and because of the emphasis given to training and overseas experience, an extended TV3 news item (8 February 2012) began its piece with the line: "A survey has shown that training opportunities and work experience are enticing our doctors offshore."

> *When broken down by scope of practice, the data reflects that doctors registered in different scopes of practice leave for different reasons. (p 15)*

The details would be useful to know, but the only figures provided on this point related to training:

> *Doctors on general scope were more likely to identify further training as a reason for leaving New Zealand compared to doctors on a vocational scope (approximately 40% of doctors on a general scope compared to 26% of doctors on a vocational scope).*
>
> *Doctors on a vocational scope tended to respond to the question citing increased remuneration and further training as their reasons for leaving New Zealand whereas for doctors on a general scope, the most common reason mentioned was clearly further training. (p 15)*

Given that increased remuneration was the second most common reason given by doctors overall but more common for those with vocational registration, increased remuneration may have been the most common reason given by the latter.

Further summary descriptions of responses to this question (pp 24-27) indicate training as a common reason for leaving for both New Zealand graduates and doctors with a PMQ gained overseas. Family reasons were also common for the latter group, whereas a desire for higher incomes and better working conditions tended to be more common among New Zealand graduates.

> *The issue of seeking a higher income was common amongst respondents; however this is an issue which is unlikely to be addressed in the current New Zealand healthcare system with a pressure on resourcing. Focus instead should be around identifying what factors encourage doctors to stay in New Zealand for reasons other than income and work to ensure that these outweigh the financial incentive to go elsewhere. (p 26)*

The MCNZ has taken what is essentially a political position here, which is strongly reiterated in comments on the responses to the next key survey question.

On the question: "What would encourage you to stay/return to practise in New Zealand?"

> *For the large majority of respondents who had gained their PMQ in New Zealand, the offer of a higher salary in the New Zealand job market was provided as a reason that would encourage them to return home. (p 22)*

A figure is not provided to indicate the size of the "large majority" but an examination of the total 177 responses to this question shows 63 (36% of the total responses) cited better income. These are likely to be mostly New Zealand graduates, given the analysis indicates that higher salary was not cited as such an issue for doctors with PMQs gained overseas. The percentage as a proportion of New Zealand graduates is therefore likely to be much higher than 36%. Whether or not that could equate to a "large majority", the higher salary factor was by far the most common response to this question and appears to be the most common response above all others in both questions concerning reasons for leaving and incentives for returning.

This response, nevertheless, is not mentioned in the MCNZ's media release, nor in the executive summary of the analysis. Nor does the analysis offer any substantial discussion on the matter. Instead it repeats the (political) affordability argument:

> *Mention of a desire for a higher income appeared frequently in responses. This factor, whilst frequently mentioned, does not have any real solutions. Therefore focus must be given toward ensuring other factors outweigh this and encourage retention in New Zealand. (p 30)*

And:

> *Offering comparable salaries to those available in Australia and other countries is not an option that is available, this therefore requires creative solutions to identify what other factors would encourage doctors to want to live and work in New Zealand that would outweigh the income level in other countries. (p 31)*

On the question: "How long are you intending to be away from New Zealand?"

> *The good news from the survey findings was that the majority of doctors leaving New Zealand intend to return.* (Media release)

The MCNZ appears to have set the bar very low on what measures up as "good news" on this issue – which raises the question as to how many doctors New Zealand has to lose permanently overseas before it becomes "bad news".

The survey results show 9% of respondents intended to leave permanently, 9% intended to stay away for more than three years, and 27% did not know how long they would be away.

The results are similar for those with general registration. For those with vocational registration, 5% intended to leave permanently, 9% for more than three years and 25% did not know how long they would stay away. However, the small number of respondents – eg 65 with vocational registration – means a difference of just three doctors either way would give a swing of 5%.

In addition to the nearly one in 10 departing doctors who intend to stay away for good, realistically a question-mark hangs over many of the 36% who indicated they did not know how long they would be away or would be away for more than three years.

For those leaving for more than three years (a very open-ended indicator), which may include some approaching retirement age, how many intend to eventually return to New Zealand to practise? For those who are uncertain about how long they will be away, how many are leaving to practise overseas "to see how things go", leaving their options open?

It is worth noting that earlier surveys of New Zealand registrars' intentions regarding future employment show 13% of respondents stated Australia as their preferred destination (the main destination of respondents to the MCNZ survey), while twice that amount of the same cohort (26%) were working there seven years later.[3]

Summary of results from the separate IMG survey

The analysis report includes a brief section summarising the results of a separate MCNZ-commissioned survey, undertaken between October 2009 and March 2010, concerning the question of why international medical graduates (IMGs) were leaving New Zealand. All IMGs who had applied for a Certificate of Good Standing (CGS) before leaving New Zealand were invited to complete the survey (the number has not been published); 51 responded.

As with the more general survey, the details of this survey have not been publicly released so it is not possible to make any detailed comparisons between the two.

The most common reasons IMGs gave for leaving were family reasons (24%), professional opportunities or higher training (22%), and higher remuneration (16%). That appears to be reasonably consistent with the results indicated in the analysis of the general survey. However, the IMG survey found 41% of respondents were leaving New Zealand because they had intended to stay in New Zealand for only a short period of time at the time of arrival. In contrast, the general survey analysis does not record any doctors leaving New Zealand for that reason.

From an examination of the list of responses to the general survey, at least 14 doctors appear to be leaving because they were on a short-term visit. That would amount to approximately 15% of the IMG respondents to that survey.

The results of such surveys can be significantly influenced according to what proportion of respondents are practising in New Zealand on a temporary basis. There is a case for separating these doctors from the rest when reporting the responses.

What's wrong with the Medical Council report?

A principle of all scientific work is that it should be open to scrutiny, assessment and possible validation. The reasoning behind that principle applies no less to the publication of survey findings.

The MCNZ's analysis of this survey is scant on the details concerning the two main questions: "Why are you leaving New Zealand?" And "What would encourage you to stay/return to practise in New Zealand?" It appears to have been selective in the details published.

For example, it reports "further training" was given as a reason for leaving New Zealand by 40% of general registrants and 26% of vocational registrants, but omits providing similar details on responses concerning income. Yet income appears to have been the most significant single factor in vocationally registered doctors' decision to leave, and the most significant factor given by respondents to the question of what is needed to encourage doctors to return.

The importance of gaining a better understanding of these matters – so they can begin to be addressed – is underscored by the fact that in recent times close to 300 New Zealand doctors each year have moved to Australia on a permanent or long-term basis,[4] and an estimated 29% of New Zealand's doctors are working overseas – most of them in Australia[5].

In addition to the lack of detail, the credibility of this survey analysis is not helped by the MCNZ taking a position on what is affordable in our health system, and without any supporting argument. The affordability of our health system is, of course, a matter rightfully decided through the country's political processes. The Medical Council is in a strong position to assist those processes with its potential for gathering valuable intelligence on medical workforce trends, and to report its findings in such a way as to enable properly informed debate.

Of further concern is the Council's assessment that: "This report finds there is no single factor or particular issue that causes concern in relation to the movements of doctors from New Zealand overseas". The survey analysis confirms that income is a key factor for many doctors and raises some big, still largely unanswered questions about the extent of the long-term and permanent loss of doctors from this country.

3 Moran E, R French R, Kennedy R, (2011). "A comparison of anaesthetic trainees career outcomes with previously expressed intentions". Anaesth Intensive Care. 2011 Sep;39(5):946-50.

4 ASMS 2010. Medical Workforce Trends: Australia. A paper prepared for the joint ASMS-DHBs workshop as part of national DHB collective agreement (MECA) negotiations on 18 May 2010

5 PZurn P, Dumont J-C, Health Workforce and International Migration: Can New Zealand Compete? OECD Health Working Paper No 33, 2008.

NOW IN SEPTEMBER 2012

40TH ANNIVERSARY OF UNIVERSITY OF OTAGO, CHRISTCHURCH

(formerly Christchurch School of Medicine)

5–7 SEPTEMBER 2012

In 1973, the first intake of Fourth Year medical students enrolled at Otago University, Christchurch (then the Christchurch School of Medicine).

In September 2012, the school will celebrate 40 years of teaching and research.

The celebrations will also be an acknowledgement of the impact of Canterbury earthquakes on staff and students, recognising our bright future.

Celebrations will include:

A series of social functions in Christchurch, beginning with a keynote address by Sir Michael Marmot, world-renowned health inequalities researcher and advocate.

- Wednesday 5 to Friday 7 September: Scientific Sessions.
- Thursday 6 September: Alumni Reception.
- Friday 7 September: Anniversary Dinner.
- The publication of a book covering the school's highlights and its future direction.
- The establishment of a research trust to fund fellowships and scholarships on the Christchurch campus.

If you would like to be part of the celebrations register your interest by completing an online form at www.otago.ac.nz/christchurch. There is a 40th anniversary button on this page.

For more information you can email:

Virginia Irvine
virginia.irvine@otago.ac.nz

or Kim Thomas
kim.thomas@otago.ac.nz

24th Annual Conference

29–30 November 2012

Mark it in your dairy!

Working with limited resources

Working in environments with inadequate resources can pose risks to patient safety. It can also lead to medico-legal risks for doctors. Dr Alan Doris from the Medical Protection Society (MPS) explores what your responsibilities are as senior doctors

MPS has received calls from many hospital consultants and specialists who are concerned about the medico-legal risks associated with the lack of available resources and the patient safety issues that this poses.

During their careers, most doctors will have experienced potential conflicts between rising patient expectations and finite resources. These are likely to become increasingly frequent with the rising costs of healthcare, pressure to control costs and staff shortages as some areas of the health sector struggle to recruit and retain highly skilled doctors.

Basic Principles

Doctors are not responsible for the overall resourcing of healthcare in New Zealand, though they are often responsible for allocating some of those resources, either in general terms or to groups of patients or individuals.

In clinical practice a doctor must make care of his or her patient the first concern and provide the best possible care within the resources available. However, doctors also have a duty to the community at large to use resources efficiently and so must balance the care of the individual patient with the needs of the community. [1]

Doctors should participate actively in discussing how resources are allocated so that this is based on scientific evidence of need and maximal benefit.

Doctors should advocate for the proper provision of resources for their patients by funders and commissioners of services.

Doctors' clinical responsibilities

Doctors are accountable for their clinical decisions. When resources are limited, they must do their best in the circumstances, and be prepared to justify their decisions and demonstrate their reasoning.

The Health and Disability Commissioner's Code of Rights states that patients have the right to services of an appropriate standard, though it does not guarantee access to healthcare. Clause 3 of the Code states that a provider who establishes that he or she took "reasonable actions in the circumstances" will not be found in breach of the Code.[2]

Where rights cannot be met, the onus will be on the provider to show that it was reasonable in the circumstances not to have done so. Should a doctor face a complaint, the circumstances in which they are working will be taken into account, which includes the resources available.

As managers

Doctors can have many roles and responsibilities. When acting as a manager, doctors have a duty to the wider community, the organisation in which they work, and their colleagues. However, a doctor's primary consideration should always be the interests and safety of patients.

Decisions about resources should be based on all the available evidence. Where managerial duties conflict with primary clinical duties then doctors should declare the conflict and seek advice from colleagues; raise their concerns with senior management and external professional bodies. Discussions and communications about these issues should be carefully recorded.

As employees

Employees must act in good faith, carry out their duties to a reasonable standard, and follow reasonable instructions from their employer. This would not include instructions to act illegally or unlawfully, nor should doctors act in breach of their professional and ethical obligations. Where there is any doubt, consult with colleagues, professional colleges or the Medical Council.

Employees are not responsible for organisational resources - only to make the best use of them and ensure any patient safety concerns are identified and brought to the attention of the District Health Board or other employer.

If resources are so limited as to endanger patients, doctors are expected to take further action, and either take steps to put matters right, or draw their concerns to the attention of their employer or contracting body. It is important that these concerns are clearly conveyed in writing, backed up by evidence and preferably after discussion with colleagues and relevant bodies such as professional colleges. It is helpful to indicate what strategies for providing care the doctor will be employing to try to ensure best possible services despite the restricted resources and seek comment from the employer about this.

If possible, the preferred treatment option must be explained to the patient, why this is not available and what the next best option is. If the preferred treatment is available privately, or through some other source, then the patient should be informed of this.

MPS is able to advise doctors working in situations of limited resources how best to limit their legal vulnerability and members are encouraged to call on **0800 225 5677.**

Useful links

Medical Council of New Zealand http://www.mcnz.org.nz/

Health and Disability Commissioner, Code of Rights http://www.hdc.org.nz/the-act--code/the-code-of-rights/the-code-%28full%29

1 Medical Council of New Zealand, Statement on safe practice in an environment of resource limitation, August 2008

2 The HDC Code of Health and Disability Services Consumers' Rights Regulation 1996

jobs.asms.org.nz

The ASMS endeavours to help fill senior doctor and dentist vacancies in New Zealand, especially DHBs, through the job vacancy page on our website.

jobs.asms.org.nz is a one-stop-shop for those seeking positions in New Zealand as it has a comprehensive list of NZ vacancies and provides direct links to key employment information and agreements.

The ASMS encourages members to recommend to their DHB or employer that they seriously consider using jobs.asms.org.nz when advertising SMO vacancies. Employers can get information about our advertising rates and volume discounts from our website or by contacting **admin@asms.org.nz.**

Support service for doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members an important support service.

The support service provides access to a free professional counselling service. Doctors seeking help can call

0800 225 5677 (0800 Call MPS)

The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling or support.

The service is completely confidential.

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 around 3,000 doctors and dentists, over 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

Other services

www.asms.org.nz

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

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

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

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

Substantial discounts are offered for bulk and continued advertising.

ASMS email broadcast

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

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

How to contact the ASMS

Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
Cnr Brandon St & Lambton Quay, Wellington

Telephone	04 499-1271
Facsimile	04 499-4500
Email	asms@asms.org.nz
Website	www.asms.org.nz
Post	PO Box 10763, Wellington 6143

We pay our advisers commission in nice round figures.

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Zero commission is not the traditional remuneration model for the financial services sector. But then, MAS is hardly your traditional financial services provider.

Zero commission. It's just one more way MAS acts with your best interests in mind.

Hayley Sturt,
Adviser, MAS Hamilton Branch

Call us today
0800 800 627
Email **info@mas.co.nz**
Visit us online at **www.mas.co.nz**