THE SPECIALIST

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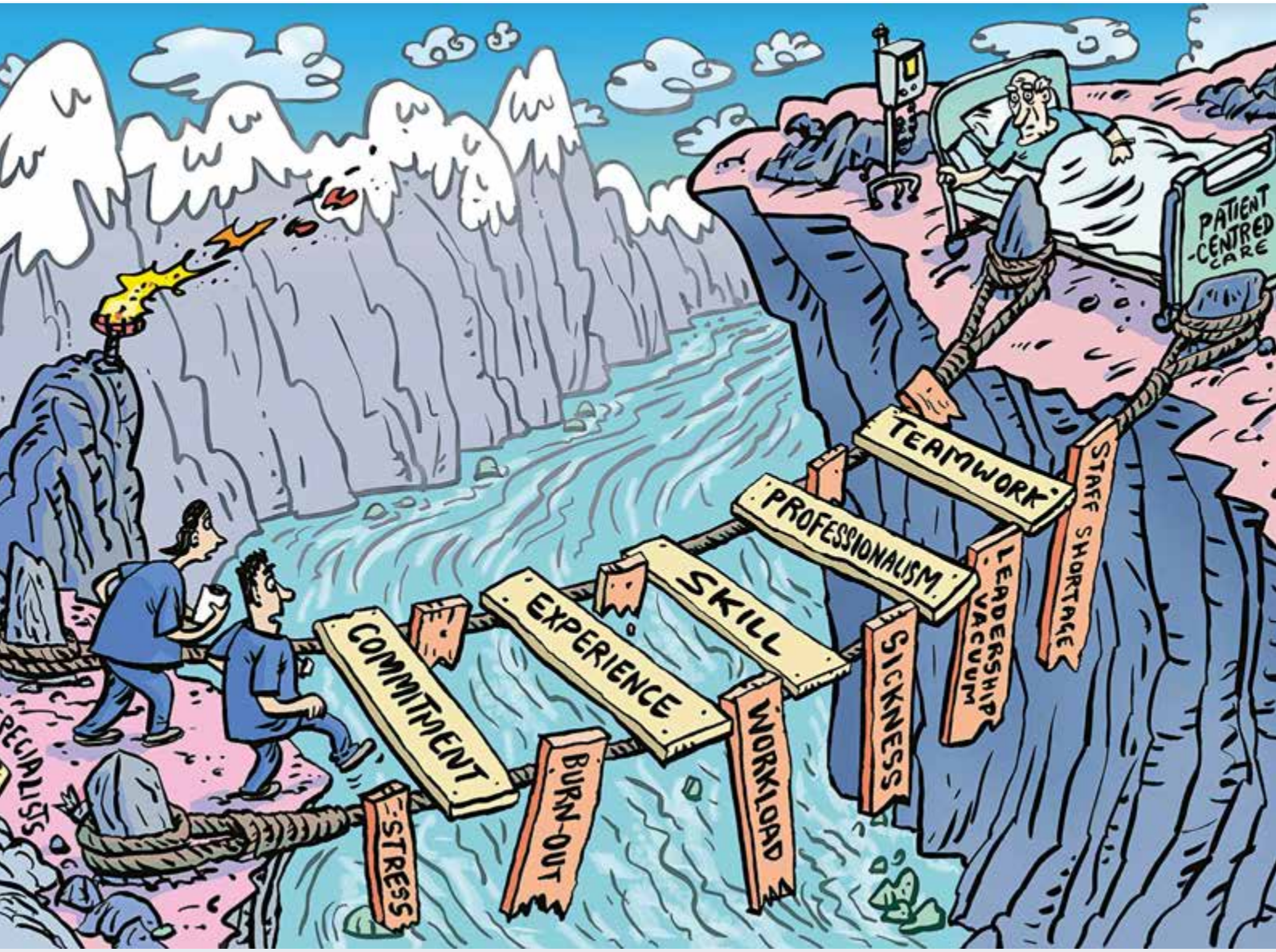

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CARTOONS BY CHRIS SLANE

PATIENT CENTRED CARE AT THE HEART OF MECA NEGOTIATIONS WITH DHBS

IAN POWELL | ASMS EXECUTIVE DIRECTOR

The national multi-employer collective agreement covering Association members employed by the 20 DHBs expires on 30 June 2016. It ran for three years from 2013. The significance of this expiry date is that it is the legal trigger point for re-negotiation. Under the Employment Relations Act neither the ASMS nor DHBs can formally initiate bargaining for a new MECA until 60 days from the expiry date (ie, not until early May). This does not preclude, however, informal discussions which have already commenced. This includes the setting of initial formal negotiation dates from early May through to mid-July.

The expiry date does not mean that the current MECA comes to an end on 1 July. It continues in force for members currently covered by it until a replacement MECA is negotiated. Further, DHBs are required by statute for a further 12 months to offer the 'expired' MECA to new appointees subject to them joining ASMS. This obligation continues beyond 30 June 2017 by written agreement between ASMS and the DHBs until a replacement MECA has been negotiated.

PROCESS AND CLAIM

For the last two MECA negotiations the ASMS team has been relatively small – me as advocate, Deputy Executive Director Angela Belich, and the 10 National Executive members. For this negotiation we have significantly increased the number in the team (including the number of branch presidents and vice presidents) in order to strengthen our representativeness and combativeness. The full team includes over 25 members.

Further, the National Executive has decided to adopt a broader approach to our claim compared with recent negotiations. Base salary scales are at the centre of the claim but they will also include, for example, enhancing the penal rate for working on after-hours call rosters (and shifts), strengthening the rights of those working on shifts, increasing CME expenses reimbursement, increasing paid parental leave, recovery time, long service leave (two weeks after every 10 years), and providing experienced medical officers (non-vocationally registered) who work with nominal supervision access to placement on the specialist scale.

> *But outside remuneration, the most important claim is to introduce a new clause enabling (with some teeth) members to shape the minimum safety standards, including staffing levels and mixes, in their service or department.*

The National Executive has considered at its first meeting of the year a draft claim which, with some revisions, will be considered by a day-long planning session

of our negotiating team on 8 April before being finalised by the Executive at its next meeting on 14 April.

RELEVANCE OF PATIENT CENTRED CARE

Patient centred care is much more than a nice sounding slogan. Its dimensions are:

- respect for patients' preferences and values
- emotional support
- physical comfort
- information, communication and education
- continuity and transition
- coordination of care
- the involvement of family and friends
- access to care.

But why is this relevant to our MECA negotiations? The scene for this is nicely set by the Government's health workforce advisory body, Health Workforce New Zealand, which recognises the vulnerability of the senior medical workforce in DHBs. In November 2014 it publicly stated that the most important issue currently is the impact of a prolonged period of medical labour shortages on the workloads, wellbeing and productivity of DHB-employed senior doctors.

This dire situation is summarised by the following underpinning features of the current state of the senior medical workforce in DHBs:

- growing unmet need of patients due to factors such as population growth, aging and increasingly entrenched poverty
- entrenched specialist shortages (high undersupply of specialist positions) as distinct from advertised vacancies
- capacity (numbers to generate the time necessary to achieve distributive clinical leadership throughout each DHB)
- welfare of senior doctors, including health and safety, presenteeism, burnout and fatigue, with consequential increasing risks for patients.

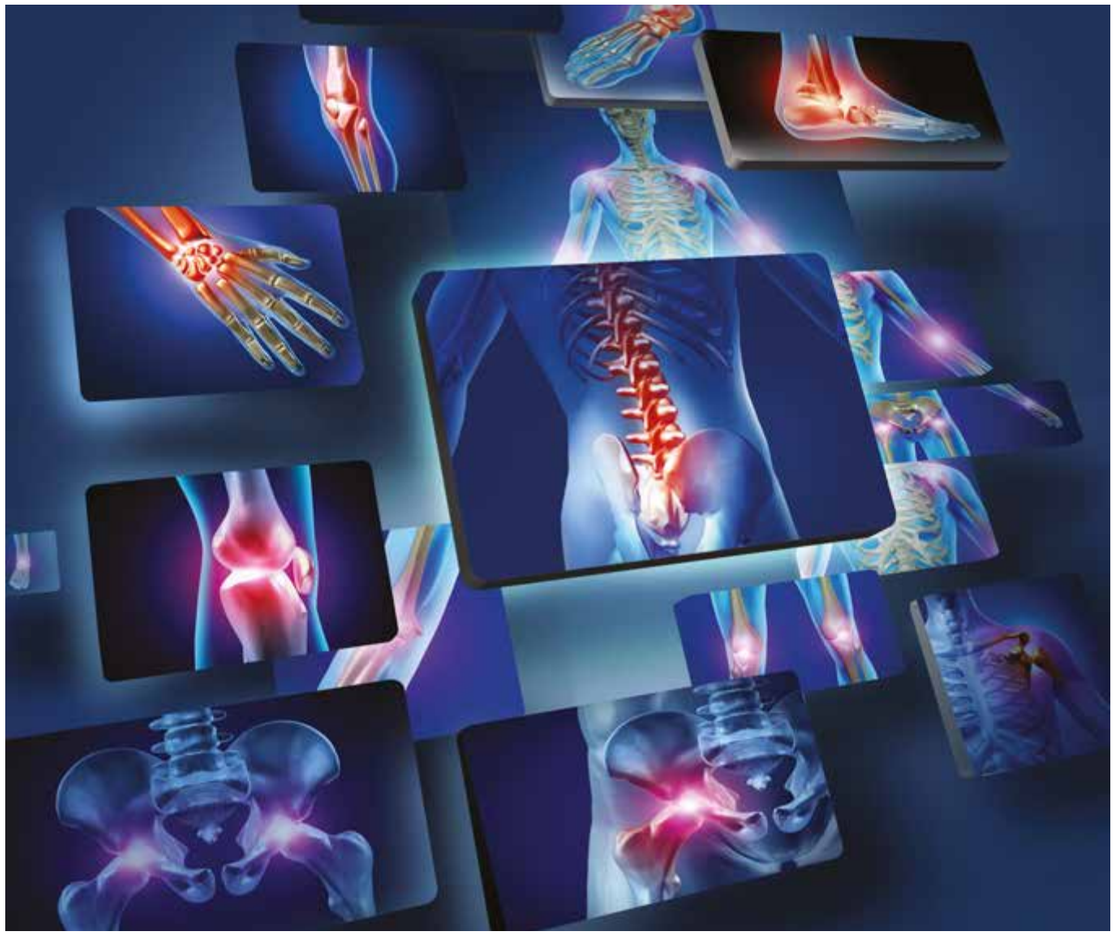
This is all very laudable but what does the MECA have to do with this? Quite simply, health delivery is labour-intensive, and senior doctors and dentists are at the core of achieving patient centred care. The MECA both provides and enables the wherewithal to achieve patient centred care. DHBs need to be able to recruit and retain a significantly larger and sufficiently stable senior medical workforce that includes the capacity to provide realistic time for non-clinical duties (ie, duties not directly related to the care of an individual patient).

For this level of increased recruitment and retention, the MECA requires competitive remuneration and other conditions of employment.

But it also needs sufficient teeth to ensure there are robust minimum standards for achieving patient centred care. Already the MECA requires DHBs to provide the necessary resources to enable senior medical staff to undertake their duties and responsibilities. Further, it expects that senior medical staff will provide the lead role in service delivery, configuration and provision with management in a support role. These are important provisions despite often being ignored by too many DHBs to one degree or another.

But more is required in the MECA, including senior doctors being able to organise a stocktake of what the minimum standards for patient safety care in their service should be, including staffing (not just medical or dental), equipment and accommodation. The MECA needs to require DHBs to be responsible for providing the necessary information and data for this stocktake. Finally, we need a dispute resolution process in situations where there are difficult blockages in achieving these standards; the patient safety clause (41) of the current MECA could be used for this purpose.

> *This journey of using the MECA to achieve substantive and comprehensive patient centred care will be a long one but one that is worth ASMS fighting for.*



RHEUMATOLOGY WORKFORCE SHORTAGE

CUSHLA MANAGH | ASMS DIRECTOR OF COMMUNICATIONS

The frustration is evident in rheumatologist Fiona McQueen's voice as she recounts how, a couple of weeks earlier, she saw a 30-year-old man with long-standing back pain and discovered he had a severe rheumatic disease that could be treated.

But that's good news, right?

"He'd been suffering with this condition since his late teens," she says. "A treatment has been available for a number of years and he really should have been seen by a rheumatologist at least three years ago."

Hence her frustration, borne out of long-standing shortages in the public hospital rheumatology workforce.

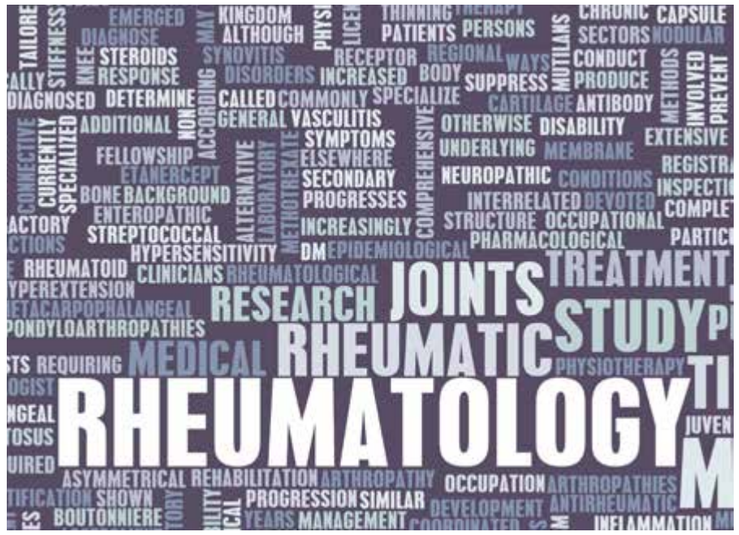
"Getting money out of the DHBs is like getting blood out of a stone, but this is having an impact on patients," she says. "There's a lot of people we can't get to see, which leaves them reliant on their GP, who may be very good but obviously isn't a specialist in this area. It's a real concern for rheumatologists."

Dr McQueen moved to Invercargill last year to take up a part-time (0.4 FTE) position with the Southern DHB, after spending most of her working life as a rheumatologist in Auckland. She also works part-time (0.1 FTE) as a Professor of Rheumatology at Auckland University, and is President of the New Zealand Rheumatology Association.

She's been at the sharp end of rheumatology service provision and training for more than 20 years, and says improvements are needed to provide the level of rheumatology treatment New Zealanders require.

"We need more publicly funded rheumatology positions, probably another 5 to 8 FTE, and we need to incentivise

DR FIONA MCQUEEN



DR DOUGLAS WHITE

jobs in the regions where they're desperately needed."

Estimates of how many rheumatologists are needed vary across countries, but have been conservatively benchmarked at one rheumatologist for every 100,000 people. The most up-to-date figures available show wide variations across New Zealand, with shortages in two places in particular standing out: in 2012, Northland had just 0.64 FTE per 155,800 people (one full-time rheumatologist to 243,438 people), while Nelson-Marlborough had 0.5 FTE per 136,800 population (one rheumatologist to 273,600 people) over the same period.

And even in regions that appear to be doing well by comparison, the situation is less than rosy, according to Fiona McQueen. For example, patients covered by the Southern DHB face a unique set of hurdles in getting to see a rheumatologist; they need to travel great distances, and in this region there is very limited private rheumatology provision.

Rheumatologists diagnose and treat a range of conditions such as arthritis, autoimmune connective tissue disease, systemic inflammatory diseases such as vasculitis, spinal and soft tissue disorders, certain metabolic bone disorders, and chronic musculoskeletal pain syndromes. After graduating from medical school it takes at least seven years to train as a rheumatologist (longer if additional PhD or other study is involved), with advanced rheumatology training undertaken through the Royal Australasian College of Physicians (RACP). By the time the finish line is in sight, many of the new specialists have families and are feeling very settled in their current locations.

"Trainees don't necessarily want to move or to work in the provinces," says Fiona McQueen. "Positions there can be seen as dead-end jobs – which they're not – and people can be very reluctant to move out of the bigger centres. There might be less support from other specialties in small areas, which can be a real issue. It means that jobs in Auckland are being snapped up, but it can be harder to recruit in other places. We need to incentivise those positions."

There's also the lure of Australia – Fiona McQueen says rheumatologists crossing the Tasman are able to earn significantly more money and have more access to resources and support.

Issues with the rheumatology workforce and service provision have been well documented. Hutt Valley DHB rheumatologist Andrew Harrison analysed the provision of rheumatology services in New Zealand over a decade ago and subsequently reported his findings in the *New Zealand Medical Journal* (23 April 2004). He concluded that access to rheumatologists varied markedly, depending where patients lived, and that the shortage of rheumatologists appeared to be worsening. Waiting lists were often used as surrogate indicators of the adequacy of service provision, he wrote, possibly because they were easier to measure than true unmet need.

> *"Waiting lists, however, do not take account of the unmet need of patients who, due to lack of access to rheumatology services, are referred to a less appropriate specialty or managed in general practice."*

More recently, a review of the musculoskeletal workforce and service published by the Ministry of Health in March 2011 **(http://www.health.govt.nz/system/files/documents/pages/musculoskeletal-workforce-service-review.pdf)**, while not specifically about rheumatology, highlights a number of broader issues that affect rheumatologists. These include the growing number of people with conditions such as arthritis, the need to better integrate GP training within orthopaedic and rheumatology clinics, and existing barriers to improved provision of care, which include the DHB funding model and inconsistent use of clinical team members across hospitals.

The report argues for more consistency in managing patient referrals, and that's a message that's been picked up in rheumatology by Waikato DHB rheumatologist Douglas White and a team of other clinicians. They have developed a triaging tool that involves a short set of three questions to be answered by the referring GP and a further three questions for the triaging rheumatologists. It's early days but they think that using the tool electronically can reduce the turnaround on referrals from five days to one day.

Their research has been published in the international *Journal of Clinical Rheumatology* (August 2015) and also won an award for excellence in health improvement at last year's APAC Forum in Auckland **(https://www.1000minds.com/about/news/health-improvement-award)**.

"This project is about streamlining the process," says Douglas White.

"As a country we have fewer rheumatologists per head of population than many other countries. We can't provide the same service that rheumatologists do in other countries so we have to be selective about the patients we see. The shortage of rheumatologists is driving the need for work-arounds."

RHEUMATOLOGY SPECIALIST WORKFORCE AS AT 2012*

DHB	2012 FTE	FTE PER POPULATION
NORTHLAND	0.64	243,438
AUCKLAND	3.16	139,589
WAITEMATA	2.4	220,208
COUNTIES MANUKAU	3.26	147,761
WAIKATO, BAY OF PLENTY, LAKES, TAIRAWHITI, TARANAKI	5.55	148,468
HAWKE'S BAY	1.4	109,929
MIDCENTRAL	1.3	127,692
WHANGANUI	0.6	105,333
WAIRARAPA, CAPITAL & COAST, HUTT VALLEY	2.5	188,280
NELSON-MARLBOROUGH	0.5	273,600
CANTERBURY, WEST COAST	2.625	203,657
SOUTH CANTERBURY	0.4	139,000
OTAGO, SOUTHLAND	2.3	130,609

Source: Andrew Harrison, from a presentation at the 2012 New Zealand Rheumatology Association Annual Scientific Meeting.

* Service provision may have changed since these figures were compiled.

‘CONSULTATION’ OR PUBLIC RELATIONS?

LYNDON KEENE | DIRECTOR OF POLICY AND RESEARCH

A surge of government activity in the health sector over the past year has included a plethora of reviews, consultations and proposed legislative changes. The opportunity to have input into proposed government policies is of course welcome, but there is a disturbing tendency for consultations to occur over unreasonably short timeframes, and often involving complex issues.

For example, just over five weeks were allowed for formal feedback on the draft updated New Zealand Health Strategy. Much of the substance of the draft strategy lies in a number of other documents, including the Productivity Commission’s 300-page-plus report on More Effective Social Services, and the Director-General of Health’s Capability and Capacity Review and Health Funding Review. They cover a broad range of sometimes multifaceted and controversial issues. The Health Funding Review, for instance, proposes radical changes that resemble policies of the failed health ‘reforms’ of the 1990s. To allow little more than a month for consultation on the draft strategy is insufficient time to enable a proper analysis of what is being proposed. This is made worse by the fact that the Government’s position on these particular documents remains unclear.

Virtually two weeks were allowed for feedback to the Ministry of Health on the Draft District Health Board Planning Guidelines 2016/17. The ‘consultation’ was intended for DHB staff to ‘use as appropriate’ to assist in the development of a DHB ‘Planning Package’, which includes planning guidance for the Annual Plans, Regional Service Plans, Māori Health Plans, Public Health Unit Annual Plans, updates to the Crown Funding Agreement schedules incorporating the Operational Policy Framework, Service Coverage Schedule, and health targets and performance measures. It is unrealistic to expect any organisation, let alone DHB staff members, to fully consider these documents and the additional documents associated with this package. We have to question, therefore, the meaningfulness of this consultation.

The ASMS learned of the draft Mental Health and Addiction Workforce Action Plan a week before it was publicly announced by the Minister of Health in mid-December, yet even then we had barely five weeks to provide comment by the 20 January deadline, not taking into account that many people take their holidays over this period. The timeframe and the timing of this consultation prompted the ASMS to write a letter of protest to the Director-General of Health. At the time of writing, no response had been received.

ALLOWING ENOUGH TIME FOR FEEDBACK

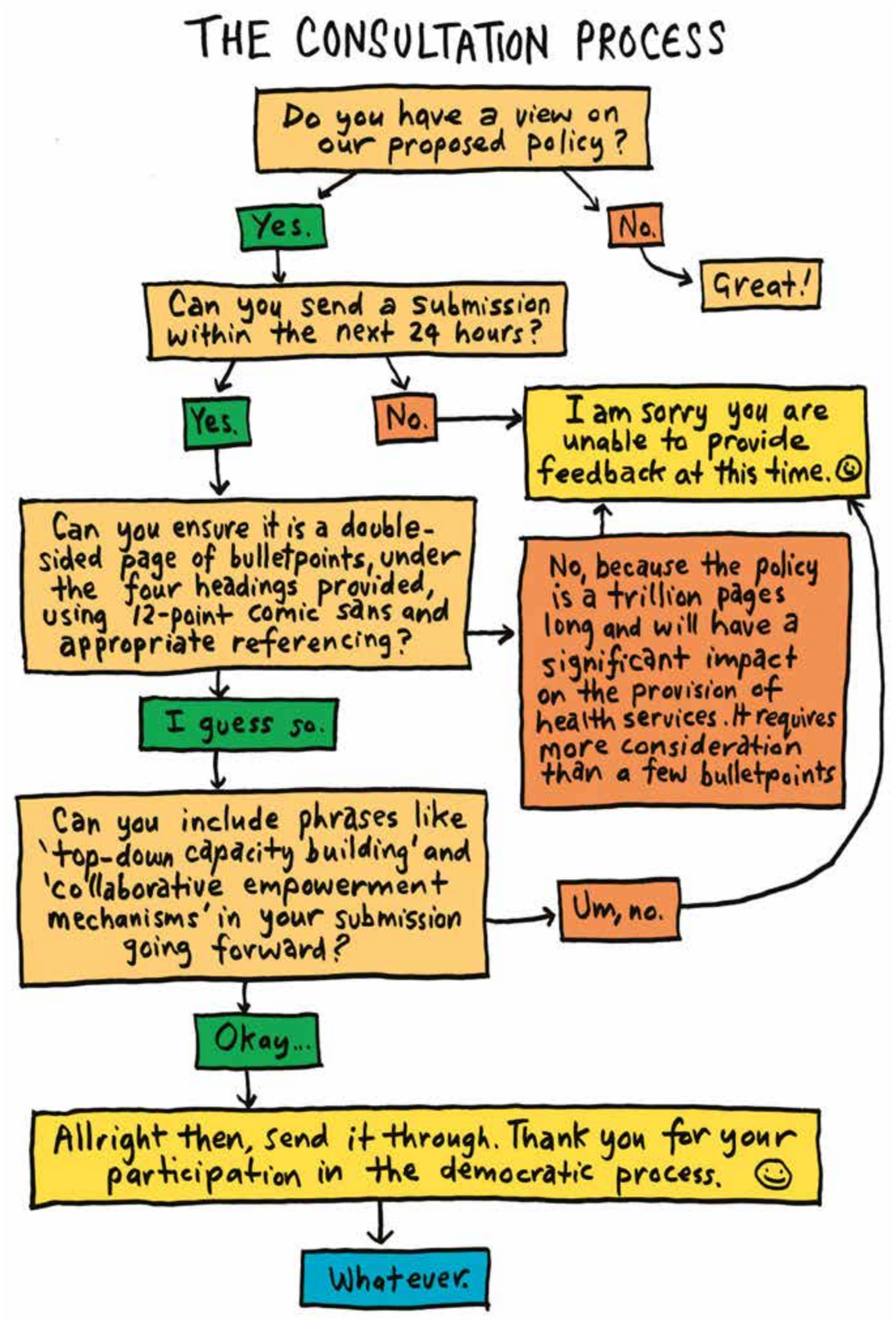
The need to ensure adequate time is allowed for feedback on proposed policies and law changes, including time for membership organisations to consult internally, has been well recognised overseas. The 2008 Government Code of Practice on Consultation in the United Kingdom, for example, set a 12-week minimum standard for public consultations (unless there were good reasons for a shorter period).

The code stated: “If a consultation exercise is to take place over a period when consultees are less able to respond – eg, over the summer or Christmas break, or if the policy under consideration is particularly complex, consideration should be given to the feasibility of allowing a longer period [than 12 weeks] for the consultation.” The code was effectively an acknowledgement that many non-government organisations possessed a wealth of knowledge and practical experience to inform good policy and legislative development. A 12-week standard time limit for replies to public consultations was seen as striking a reasonable balance between the need for adequate input and the need for swift decision-making. The minimum 12-week timeframe would “help enhance the quality of the responses”. Moreover, effective consultation was considered essential for upholding those often-stated virtues of good democracy such as ‘transparency’, ‘responsiveness’ and ‘accountability’.

For essentially the same reasons, since January 2012 the European Commission has also adopted a 12-week minimum period for open public consultations.

The UK Government came under widespread criticism when it began watering down the 2008 code, turning it into a set of more evasive ‘principles’. The House of Lords Secondary Legislation Scrutiny Committee summed up public feelings in its comment: “It is essential that contributors should be assured of genuine engagement, and that consultation should be capable of influencing Government policy and not become a mere public relations exercise.”

This is also the case in New Zealand. The public needs to be assured of good processes and practices around government decision-making, as the results will have a significant impact on the provision of health and other services in this country. Improvement is needed.



ASMS SUBMISSION ON THE DRAFT UPDATED NEW ZEALAND HEALTH STRATEGY

LYNDON KEENE | DIRECTOR OF POLICY AND RESEARCH

In December 2015 ASMS made a submission to the Ministry of Health on the draft updated New Zealand Health Strategy. This was made more challenging than it should have been due to the tight timeframe provided for feedback on a very complex document with far-reaching consequences.

Much of the substance of the draft updated health strategy lies in a number of other documents, including the Productivity Commission report, the Capability and Capacity Review and the Health Funding Review. These documents cover a broad range of complex and controversial issues; for example, the Health Funding Review proposes radical changes that resemble policies of the failed health 'reforms' of the 1990s.

ASMS expressed support for the proposal to retain the seven principles of the original New Zealand Health Strategy. We also supported the proposed additional principle of collaborating across sector to improve New Zealanders' wellbeing.

SERIOUS CONCERNS ABOUT THE STRATEGY

That said, there is much in the substance of the draft updated strategy which we do not support and have serious concerns about. While the draft updated strategy is presented as representing "the common view of where we want to go" (Minister's foreword), it is in fact largely a reflection of current government policy. In essence, the 'update' is an exercise in reframing the original New Zealand Health Strategy within the Government's current policy agenda.

The updated strategy fails on a number of important points. It fails to acknowledge the efficiency and quality of New Zealand's health system relative to comparable countries that spend more on health, it fails to acknowledge the extent of New Zealand's current health need compared with other similar countries, and it fails to acknowledge significant health inequality that is related to poverty.

On the other hand, the challenges relating to future health spending have been overstated to the point of being alarmist, and these are used as the rationale for introducing 'significant change' to the current health system model. Government health spending has actually been falling as a proportion of gross domestic product, a trend that is likely to continue under current policies. This will exacerbate difficulties in accessing care in both primary care and secondary care.

> *The draft updated strategy misses an important opportunity to improve the cost-effectiveness and efficiency of our health services by giving a stronger commitment to distributive clinical leadership.*

We think this is a critical oversight, and we have called for this to be remedied in the final document.

The draft strategy acknowledges challenges such as the ageing workforce, but no responses or potential responses are suggested. It also acknowledges New Zealand's medical workforce is highly dependent on overseas recruits, many of whom do not stay long. However, its suggested solution – "we need to continually invest in training" – is inadequate. Nor does it recognise the importance and urgency in addressing specialist shortages in DHBs.

While the draft strategy focuses on people 'living well, staying well, and getting well', 'dying well' is also of critical importance and needs to be included in the document as part of a genuine patient centred care approach to health care (which requires greater investment in the senior doctor workforce). At the other end of the lifespan, a greater investment in 'starting well' is also critical. In short, whole-of-government policy should ensure every baby should be born to a healthy mother and grow up in a healthy home.

The full ASMS submission can be read on our website at **http://goo.gl/laJq3y**

MEMBERSHIP SUBSCRIPTION INCREASING

Delegates at the Annual Conference in Wellington last November voted overwhelmingly to increase ASMS membership subscriptions by $100 for the coming year (1 April 2016 – 31 March 2017). The National Executive's recommendation was for a $50 increase but, on the urging of delegates from the Conference floor, this was amended to $100.

The subscription has not risen for the past four years, but an increase is now needed to fund the expansion of the industrial team with an additional industrial officer and the establishment of a new principal analyst position for policy and research (witness the presenteeism survey as a result of the latter) in the middle of last year. It also funds the further two additional officer positions which commenced in February this year. All these decisions are to ensure ASMS can provide the level of support our members require.

Further, the past four years have been funded by increased membership numbers. However, while ASMS is maintaining the same density of permanently employed DHB senior medical staff (at least 90%), the rate of increase in the number of DHB employed SMOs has declined, making this no longer an option.

WE NEED TO RELIEVE THE PRESSURE TO PREVENT THE DAM WALL FROM BREAKING.

ENOUGH IS ENOUGH

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

The end of 2015. The New Year's Honours list. The names of two doctors appear on the list, recipients of the New Zealand Order of Merit: Mr Kevin Pringle, Professor of Paediatric Surgery at the University of Otago, Wellington (**http://www.stuff.co.nz/national/health/75510307/founding-paediatric-surgeon-made-an-officer-of-the-new-zealand-order-of-merit**) and Dr Simon Allen, Palmerston North, Director of Palliative Care and President Elect of the Australasian Chapter of Palliative Medicine (**http://www.stuff.co.nz/manawatu-standard/news/75529092/doctors-work-helping-others-at-the-end-of-their-lives-recognised**).

While reading the two newspaper articles outlining the working lives of each of them, I thought: "It is well-deserved and right and proper that they get recognised in this way." A short paragraph toward the end of one of the articles drew my attention: "It had been a demanding career, Pringle was often on call 24 hours a day, leaving Carol to look after the three children." This struck a chord with me.

How many of us have experienced that tension between work and family life?

It is different from the tension created by trying to achieve a work–life balance. It is more specific, more immediate and often more unpredictable. It can lead to significant friction in family dynamics whereas work–life balance is more akin to a life philosophy. The tension between our commitment to family life and work always seems to be present. Sometimes it is barely perceivable and at times very immediate and acute. Occasionally it becomes chronic and very destructive.

How does this compare to tension at work itself? We are all running the gauntlet.

> *On the one hand we need to deliver better quality, faster and safer health services and we need to achieve this with relatively decreasing resources and higher patient expectations. On the other hand we risk burnout and/or compassion fatigue.*

We need more time and resources.

BOLSTERING THE HEALTH SYSTEM

There are only 24 hours in a day. No one can create more time but many of us 'make more time' to see patients. Against our better judgement and at the risk of our own health and the detriment of our family lives, we consciously or subconsciously:

- work longer hours than we are job-sized for
- do extra clinics or theatre lists, using our non-clinical time
- don't take annual leave or take it when it suits our booked clinics/theatre list/health target/manager – and instead of taking a well-deserved two or three week break, we end up taking a few days here and there
- put off taking a sabbatical or never take one at all
- turn up to work when we are too unwell to actually be at work.

There are many reasons why we end up doing this.

> *In the end we are all trying to do the best for our patients and bolster a health system that is under tremendous pressure.*

We are trying to keep the sky from falling on our public health service (while risking burnout and at the expense of our health and family life). Unfortunately there is just so much any one of us can do. Occasionally the sky does fall on individual patients or groups of patients who end up not being seen in a timely manner or being turned away from our public health service. They join the ever-increasing group of patients whose health needs are not being met.

I was struck by the recent case of Koby Brown (**http://www.odt.co.nz/news/dunedin/369451/staff-asked-man-be-patient-he-went-blind**), a patient who hassled Southland Hospital for his overdue ophthalmology appointment because his eyes were hurting. What he didn't realise was he had permanently lost the sight in one eye while waiting for his overdue follow-up appointment. He was diagnosed three years ago with juvenile glaucoma and was reviewed every six months but due to pressure on the system his follow-up appointment was pushed back by five to six months, and by the time he was seen he was told that he had lost vision in his right eye. An underfunded, understaffed and under pressure health system has failed Koby Brown despite the best efforts of the front line health care workers involved.

We are all aware of the ever increasing unmet health need. These are the patients that the public health system has turned its back on. Their health needs are not being met and as a consequence their quality of life may suffer, some may lose their ability to live independently and, even worse, they can lose their sense of self-worth.

As a country we have an increasing unmet patient need, an ever increasing number of New Zealanders who are denied access to the health services they need. The system is neglecting to address their health problems. (If you haven't done so already please watch Associate Prof Phillip Bagshaw's presentation (**https://youtu.be/x4jMtwLmBig**).) How do we as senior front line health care workers respond to that? When do we say: "enough is enough"? When do we make a stand and, like the wizard Gandalf in *Lord of the Rings*, shout "You shall not pass!"? To here and no further.

SPEAKING UP FOR PATIENT CARE

It is time to make a stand and speak up. Do we have the right to speak up? The DHB MECA clearly allows for this. The New Zealand Medical Council indicates that we have an obligation to speak up. The publication *Statement on Safe Practice in an Environment of Resource Limitation* (**https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Safe-practice-in-an-environment-of-resource-limitation.pdf**) states the following:

- 09. Doctors have a responsibility, as advocates for their patients, to seek the provision of appropriate resources for their patients' care and report any deficiencies to the appropriate authorities. Where these deficiencies are serious the report should be made in writing.
- 10. Doctors must try to ensure that services are provided in a timely manner.
- 34. Doctors, like everyone else, have a right to reasonable quality of life outside their profession and to participate fully in the lives of their families. Within this context, it is reasonable for doctors to strive for efficiency so that they can provide more services, but not at the expense of lowering the quality of those services or putting their own health and quality of life at risk.
- 35. Doctors can be at risk of burnout. Burnout is particularly likely when a doctor's excessive workload lasts for an extended period of time. Doctors should be aware of the warning signs of burnout in themselves and their colleagues.
- 36. When doctors are unable to provide services that are both safe for themselves and safe for their patients, they should bring their concerns to the attention of management or primary health organisation (PHO) before taking any other action and should also seek advice from an appropriate agency such as a peer, their College, Association of Salaried Medical Specialists, New Zealand Medical Association, or the Rural GP Network

> *I have very little doubt that the time has come for us to draw a line in the sand.*

Realistically, though, will we achieve much by doing that? Surely it has been done before and the problems continue?

We need to engage with the chief executives of the 20 DHBs and work with them to find solutions. You might say we have tried that. I think it is worth another try at both an individual DHB level as well as at a national level, with the ASMS continuing to raise the profile of the problems. If that fails, it is time to engage the public. The public has a right to participate in this debate. Our message should be clear: "We have a safe public health care system but the biggest problem is accessing it."

Realistically we will never be able to treat everyone, but we should be able to open the flood gates on the large pool of patients with unmet health needs and relieve the pressure to prevent the dam wall from breaking. If we don't, we risk the system being completely flooded and failing.

Associate Prof Phil Bagshaw's presentation to the ASMS Annual Conference 2015

Medical Council statement on safe practice

'KNOW YOUR MECA' WORKSHOPS

LYDIA SCHUMACHER | ADMINISTRATION OFFICER (COMMUNICATIONS)

How well do you know your entitlements under the DHB MECA?

Leave, on call, lieu days, CME, retirement, gratuity, sabbatical – these are just some of the topics up for discussion at the 'Know your MECA' workshops being run around the country by ASMS Senior Industrial Officer Lloyd Woods and Industrial Officer Sarah Dalton.

They say the workshops help members understand what they are entitled to under the MECA and also aim to clear up any common misunderstandings.

"They're proving really valuable both as a way to meet with ASMS members and to answer questions about the MECA," says Lloyd Woods.

> *"We're finding that there are entitlements members didn't realise they have and also reminding them of things they can use.*

"Members are often pleasantly surprised by what comes out of the workshops."

So far workshops for members have been held at Waitemata DHB (both North Shore and Waitakere hospitals), Capital & Coast, Hutt Valley and Wairarapa DHBs), and at all South Island DHBs. Branch Officers and National Executive members also attend where possible.

Sarah Dalton says the workshops take place in an informal environment and involve a presentation followed by a discussion.

> *"It's a good environment in which to have a chat, build up your knowledge of the MECA and to put it into a wider perspective," she says.*

ASMS has had very positive feedback about the workshops, which are run at times to suit as many members as possible (early morning, lunchtime and after work).

If you would like a workshop at your DHB or site, please contact your industrial officer at ASMS, 04 499 1271 or **admin@asms.nz**.

More information about the DHB MECA is available at **http://www.asms.org.nz/employment-advice/agreement-info/**

Information about other collective employment agreements covering ASMS members is available at **http://www.asms.org.nz/employment-advice/advice/**

RETURN OF THE EMPIRE BY STEALTH?

IAN POWELL | ASMS EXECUTIVE DIRECTOR

It is difficult to avoid the conclusion that the Government is stealthily returning to the failed market approach to health that was tried and failed in the 1990s. In that decade the Government used the lever of new health legislation to achieve this objective. Public hospitals became state-owned companies governed by competition law, and were expected to compete with each other and with the private sector.

The consequences included:

- setting back workforce planning and development several years because it did not fit in with market theory
- obstacles to critical collaboration between public hospitals including information technology (DHBs are still suffering the results of this folly)
- incentivising short-term decision-making at the expense of medium to longer term service planning
- introducing an alien and disintegrating artificial divide between the funding and provision of services
- cherry-picking of clinical services by the private sector while leaving public hospitals with the same fixed costs
- encouraging an eroding culture among health professionals of working to contract rather than to professional standards and patient care.

SIDLING BACK TO MARKETS

Regrettably, although we now have new legislation more consistent with the values of a universal accessible public health system that has continued under successive governments, the current Government appears to be sidling back to a market-driven approach to the provision of public hospital services at least. It is all happening in the background and largely below the radar. This is of great concern, and warrants active scrutiny.

For example, when we look at the Ministry of Health executive (second tier) restructure announced recently, ASMS noted that the functions of the apparently disbanded National Health Board (currently comprising about half of the Ministry of Health) appear to be reduced. Certainly the brand name 'NHB' is out the door.

But, of greater significance, there is an increased emphasis on market mechanisms such as tendering through commissioning, and the language of the market – clients and customers. Those driving this restructure appear oblivious to the huge problems with commissioning in the English National Health Service.

There are also signs of a return to the failed market health experiments of the 1990s in the updated draft New Zealand Health Strategy first developed in 2000. This strategy is required by legislation but does not require legislative amendment to change it. The lever for constructing a 'competitive health market' shifts from legislation in the 1990s to a strategic document enabled and required by legislation today.

The Government's health funding review, whose controversial recommendations were leaked to the media last year, underpins the draft updated health strategy. This review clearly points to a competitive market model of health service provision. At the extreme, in the context of the Trans Pacific Partnership Agreement, it also opens the doors to more involvement of multi-national health insurance companies.

REINTRODUCING A HEALTH MARKET

The review group's most prominent author is Murray Horn, an unashamed marketer who genuinely believes in the 1990s ideology, a former head of Treasury, a member of the now disbanded Business Roundtable, a banker, and influential in government circles. Asking him to review health funding systems guaranteed an ideological pro-market outcome.

Proposals currently being considered by the Government include opening up DHB services to competitive tendering, with indications that funding will be dispensed only if planned 'milestones' are achieved. If they are not, then funding will go to another public or private provider. A leaked document from the funding review suggests that these milestones will include tighter financial targets.

The proposals also suggest separating DHBs' funding and providing roles, with the funding role eventually being carved off and given to some other unidentified organisation. This was tried and failed in the discredited market experiment of the 1990s.

Doing that would be all about creating a structure more suitable for market mechanisms. It's not about providing the best care for patients and a decent clinically-led working environment for people employed by DHBs. It's about awarding contracts to the lowest bidder.

Particularly if they have multi-national company backing, private business can afford to make loss-leading bids to secure a contract, with the aim of making a profit over the longer term by cutting costs. As a country we really don't want to be going down that track. The wrong move could prove very costly for New Zealand because once well-resourced companies get their hooks into our public health service contracts, they may be very difficult to dislodge.

It is not just fans of the *Star Wars* films who should be concerned with the threatening return of the Empire.

Q&A FLEXIBLE WORKING ARRANGEMENTS

All employers (including DHBs) are required by statute to consider an employee's request for more flexible working arrangements. This includes a request to change hours of work, days of work, or place of work.

This right is set out under Part 6AA of the Employment Relations Act 2000.

Last year the Government made it easier for employees to request such changes. Previously flexible working arrangements only related to the need to care for somebody. No such restriction now applies. You may simply want to change your hours of work for a better work-life balance.

Your employer is obliged to consider your request within one month and can only reject your request for operational reasons such as an inability to reassign duties or recruit additional staff (a full list of permitted reasons can be found at Part 6AA of the Employment Relations Act 2000).

Your request needs to specify for how long the requested change in hours would apply (including if permanent), when you wish the change to take effect, and explain what changes the employer may need to make if your request is approved.

The rationale behind the Government extending access to more flexible working arrangements is to support greater participation in the labour market, by encouraging employees to stay in the workforce when they might otherwise feel compelled to withdraw completely because of their employer's inflexibility over alternative arrangements.

WHAT KINDS OF WORK ARRANGEMENTS CAN I REQUEST BE CHANGED?

You can request changes to hours of work, days of work, or place of work. A comprehensive list of examples of flexible working arrangements can be found here: **http://employment.govt.nz/er/bestpractice/worklife/flexibleworkguide/index.asp**

DOES A CHANGE ONLY MEAN A REDUCTION IN HOURS?

No. A request could be for an increase in hours (or a change in work days).

WHAT INFORMATION DO I NEED TO INCLUDE IN A REQUEST FOR A CHANGE IN WORKING ARRANGEMENTS?

As a minimum:

- your name
- the date on which the request is made
- that the request is made under Part 6AA of the Employment Relations Act 2000
- for what period of time you want the change to apply, including if it is a request for a permanent change
- the proposed commencement date for the change (and end date if for a fixed period of time).
- an explanation, in the employee's view, of what changes, if any, the employer may need to make to the employer's arrangements if the employee's request is approved.

DO I HAVE TO GIVE A REASON FOR WANTING TO CHANGE MY HOURS?

No, you don't, and not giving a reason is not sufficient reason for the employer to turn down your request. Nevertheless, an application that explains why you need or wish to change your working arrangements may be helpful.

CAN THE EMPLOYER REFUSE MY REQUEST?

Yes. But only for one of the following grounds:

- an inability to reorganise work among existing staff
- an inability to recruit additional staff
- a detrimental impact on quality
- a detrimental impact on performance
- insufficient work during the periods the employee proposes to work
- planned structural changes
- the burden of additional costs
- a detrimental effect on ability to meet customer demand.

The employer must provide an explanation as to why these grounds apply.

HOW LONG WILL IT TAKE FOR MY REQUEST TO BE CONSIDERED?

The employer must accept or decline your request as soon as possible but within one month of your application.

WHAT HAPPENS IF I AM UNHAPPY WITH THE EMPLOYER'S DECISION?

If you believe your request has been unfairly rejected, you may contact a member of the ASMS industrial team for further advice. There are mechanisms available to ensure all requests for flexible working arrangements are properly considered.

IS THE PART 6AA PROCEDURE DIFFERENT FROM THE RIGHT IN THE MECA TO REQUEST A CHANGE IN HOURS FOLLOWING PARENTAL LEAVE (CL. 28.1(F))?

Yes. The MECA provision covers the specific circumstance of a request for reduced hours following a return from parental leave. The statutory Part 6AA process covers this and many other circumstances where flexible working arrangements are necessary or desirable.

DOES THE PART 6AA PROCEDURE COVER THE SAME CIRCUMSTANCES AS DOMESTIC LEAVE?

No. Domestic leave is leave on full pay in the event of the illness or accident of a close family member. On the other hand, the Part 6AA procedure may lead to a variation in your hours of work (temporarily or permanently) and would normally result in change in salary.

DIANNE VOGEL

IAN WEIR-SMITH

ASMS INDUSTRIAL TEAM APPOINTMENTS

Two new faces have joined the industrial team at the ASMS national office in response to the increasing growth in our membership and the need for more advice and representation on employment and professional issues.

DIANNE VOGEL has been appointed an Industrial Officer with the ASMS. She holds a Bachelor of Laws from Victoria University and a Graduate Diploma in Business Studies (Dispute Resolution) from Massey University, and has provided advice and representation for a union previously. She is also a former nurse, and has a private practice background in employment, family and general civil litigation.

IAN WEIR-SMITH has also joined the ASMS as an Industrial Officer. He is a solicitor with extensive experience in employment law in South Africa, and has advised and litigated for the Public Servants Association in that country. He has experience in collective bargaining, mediation and representation. Ian moved to New Zealand with his family in 2015, and holds a Bachelor of Arts (with majors in law and psychology), and an LLB from the University of the Witwatersrand in South Africa.

They are currently undertaking an induction programme that includes attending our Joint Consultation Committees in the DHBs. Later on they will be allocated their specific DHB responsibilities.

DR MITHRA VIJAYASENAN

LONG-SERVING ASMS MEMBER RETIRES

One of the founding members ofthe ASMS, Dr Mithra Vijayasenan (Vijay), has retired after many years as a psychiatrist in the Hutt Valley and Wellington region.

Dr Vijay saw his last patient at the end of February, stepping aside from both public and private practice after a long career which began in India and concluded half a world away.

He has been a familiar face at the ASMS Annual Conferences over the years (attending the founding conference in 1989), and takes pride in his ASMS membership.

"ASMS has done a lot of good work raising important issues over the years, and it represents us well," he says.

Dr Vijay was inspired to take up medicine by his parents, especially his mother, who was an early graduate of a medical college for women in India.

"When I graduated she said to me: 'Don't forget to do good for fellow human beings to improve their lives. You must always remember that' – and I have. It's what I have tried to do over the years."

After training in both occupational medicine in India and then psychiatry in the UK, he arrived in New Zealand in 1976, impressed by what he'd heard of the opportunities here. His career since has included posts as a consultant psychiatrist, clinical lecturer, and registrar and intern supervisor in Wellington, Hutt Valley and Palmerston North where he was the Chief Psychiatrist. He was involved in setting up the new psychiatric unit in Hutt Hospital.

He has seen significant changes – and progress – in the treatment of mental health over the years.

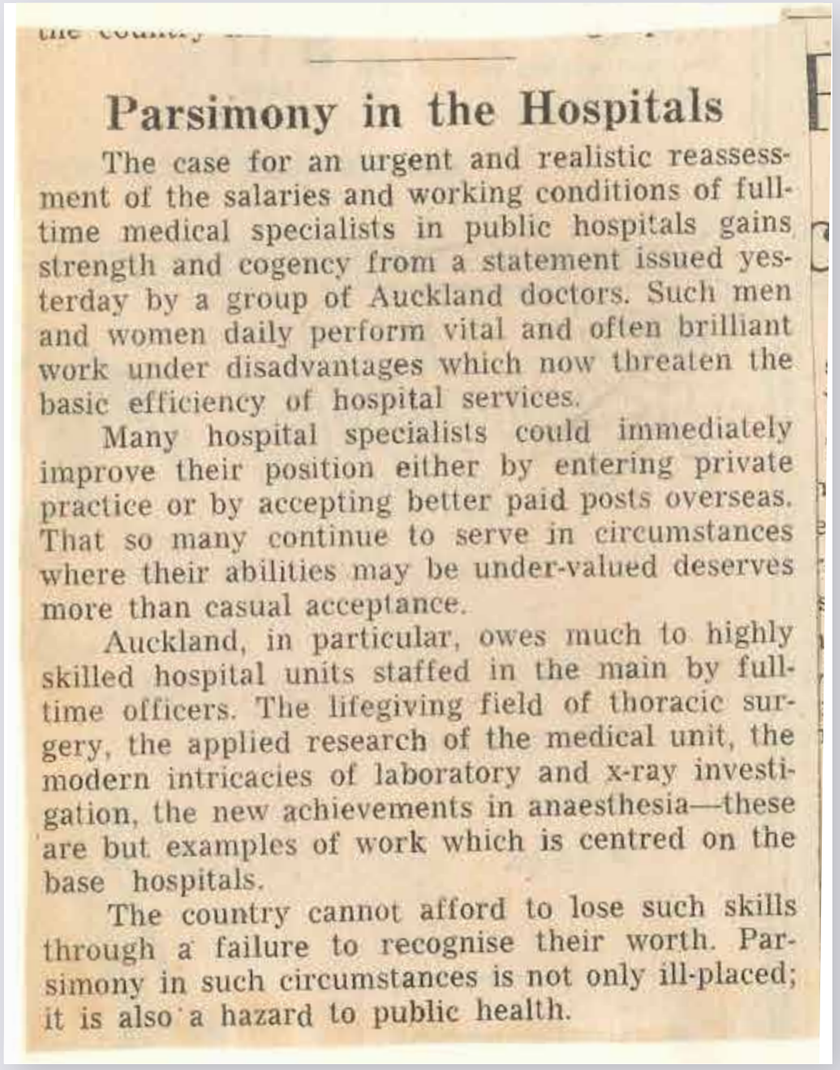
"We have come a long way in recognising that the mind and body is inter-connected, and that we have to concentrate on the wellbeing of both."

Dr Vijay plans to spend more time with his family, do some lecturing, provide community health advice and indulge his love of music (harmonica, guitar, accordion and double bass).

"I have a very supportive family and now I will have more time to spend with them," he says.

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'.



Parsimony in the Hospitals

The case for an urgent and realistic reassessment of the salaries and working conditions of full-time medical specialists in public hospitals gains strength and cogency from a statement issued yesterday by a group of Auckland doctors. Such men and women daily perform vital and often brilliant work under disadvantages which now threaten the basic efficiency of hospital services.

Many hospital specialists could immediately improve their position either by entering private practice or by accepting better paid posts overseas. That so many continue to serve in circumstances where their abilities may be under-valued deserves more than casual acceptance.

Auckland, in particular, owes much to highly skilled hospital units staffed in the main by full-time officers. The lifegiving field of thoracic surgery, the applied research of the medical unit, the modern intricacies of laboratory and x-ray investigation, the new achievements in anaesthesia—these are but examples of work which is centred on the base hospitals.

The country cannot afford to lose such skills through a failure to recognise their worth. Parsimony in such circumstances is not only ill-placed; it is also a hazard to public health.

A NEWS MEDIA ITEM FROM THE 1960S.

FIVE MINUTES

WITH ALASTAIR MACDONALD

ALASTAIR MACDONALD WITH HIS GRANDCHILDREN JACK (FRONT) AND CHRISTIAN

RETIRED RENAL PHYSICIAN AT CAPITAL & COAST DHB AND FORMER ASMS NATIONAL EXECUTIVE MEMBER.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

Funnily enough, I think it was the esteem that the local GP had. They had a certain standing. I lived in a comfortable part of town in York, these were all guys in tweed suits and our GP was just a nice, avuncular person. Having said that, my family also has a very strong medical and nursing background. My father was a psychologist and my mother and sister were nursing Sisters, my aunt was a Matron, and my uncle was Major General WC Paton who was in command of India's medical service before the partition in India. He was a surgeon, and a pretty impressive person.

Really I wanted to do history or archaeology or languages, that sort of thing, and that was politely acknowledged by my family and then we moved on… I wasn't someone who said: I must do medicine. I kind of drifted into it, and to be honest it was more about having a really good time at Edinburgh University. If you wanted to know where the parties were, I was the man. After all, this was the 1960s.

After training at Edinburgh University, I went to the United States. Initially I wanted to be a psychiatrist but after some time in New York I realised that all the people with real psychiatric problems were being hammered with large doses of tranquilisers and everyone else with mostly imagined problems were off seeing expensive psychoanalysts. I changed my mind!

I worked at a Kings County Hospital in Brooklyn, New York, for two years. I was 24 when I went there and it was the hardest work I've ever done. Every day I was dealing with drug overdoses, alcohol and violence. I was shot at and even attacked with an axe. One time I was trying to give someone with the DTs an injection and I went to get an orderly, but the orderly was busy shooting up, so I had to wrestle with the patient on my own to get him onto an x-ray machine. I had to do all of my own lab work. It would take me about five hours to do an admission and I was on call every other day for two years. I worked an average 100 hours a week. It was a big shock after the cruisy life I'd had in Edinburgh.

You didn't get any sympathy from your seniors, either. The attitude was: well, we've done it so you can. It was inhumane, really. I guess the good thing I got from it was resilience. I was the shyest person out at the start but I learned that I was actually pretty strong.

I was going to stay in the States and in fact I was offered a really good job in San Francisco but decided it wasn't worth it, because the price of citizenship at that time would have meant being drafted to Vietnam, and I didn't want that. So I went to Canada for a couple of years and did research work, studied transplantation in rats, then studied the genetics of fruit flies. I then gave up medicine altogether. Eventually my father, who was a very parsimonious Scotsman, said: look, I didn't spend all this money on your medical education to have you collecting fruit flies. So I came back to London and sat the exam for membership of the College of Physicians, and somehow passed.

After that I went to a party, met New Zealander and future wife Jan and followed her out to New Zealand. I ran out of money after a few weeks so I organised a couple of references and brought the letters into Wellington Hospital to see if I could get a job. The next day I was on duty!

I worked as a renal registrar for about four years, then went to Nelson to work as a GP for a year and then as a physician for another four years. After that I went to Iraq with an Irish private company that was contracted to a hospital by the Ministry of Health in Baghdad. It was fantastic. We did two transplants a week, and there were just two of us. It was like: oh it's Tuesday, we must be doing a transplant. It was so efficient. I learnt Arabic so I could write my prescriptions and carry on a conversation. People would come on a 20-hour bus ride just to have a 15-minute consultation with me, and they'd say it was no problem. I was there for four years, including the Iran–Iraq war. I was on holiday the day Saddam Hussein invaded Kuwait, and I decided not to return!

So I came back to New Zealand and worked as the Director of Family Planning in Wellington for a while before returning to Wellington Hospital to work as a renal physician. I've stayed there ever since and have finally managed to settle down!

About 10 years ago I started looking at clinical ethics, and five years ago managed to set up a clinical ethics group. I'm absolutely passionate about this. Everybody thinks it's a very lofty abstract pursuit, but it's much more than that. I'm retired now and my focus is on getting the Clinical Ethics Network New Zealand up and running.

WHAT DO YOU LOVE ABOUT MEDICINE?

It's about helping people and being trusted. As doctors we are the bridge between science and humanity. We are able to interpret things so that people understand it. It's about being patient and dealing with a lot of different approaches to life, asking the right questions and taking your time.

The challenging aspects of practising medicine can be reduced to a couple of things. I've been absolutely shocked by the pervasive influence of bullying, for instance. It's just unacceptable. I've seen it on ward rounds or in other areas and I haven't hesitated to say: 'actually this is a public space and you are giving me a bad name as a doctor so can you stop this, please'. I'm very proud of the profession so this behaviour appals me. I know of two cases where people killed themselves in which I think bullying was involved. I was the RMO liaison officer for about 10 years at one point and RMOs would come to see me and burst into tears, and we'd just work through it. I've always believed in the pastoral approach.

The other thing that concerns me is to do with stewardship of our public health services. We need to avoid waste and use all of our resources wisely. It's our responsibility to take care of what we have so that there's enough to go around now and in the future

WHAT HAVE YOU GAINED FROM YOUR ASMS INVOLVEMENT?

I was on the National Executive of the ASMS for six years. I didn't have the strategic knowledge that a lot of people had but I was passionate. I saw myself as a representative, rather than a leader, and it was about putting forward the concerns of local ASMS members.

ASMS has done so much good work. In the late 1980s and 90s, for example, ASMS managed to preserve the central concept of professionalism. Professionalism is our raison d'etre. This is the basis of our individual and collective legitimacy. We're a union, but it's much more than just pay and conditions. It's also about ensuring the survival and more importantly the sustainability of our public health service. No matter who we are, we will all need to be cared for at some time in the future!

THE ART OF GIVING EVIDENCE

SEAN O'SULLIVAN | PARTNER AT LAW FIRM DLA PIPER, ON BEHALF OF MEDICAL PROTECTION

Increasingly health professionals are required to appear before courts and tribunals to give evidence of both a factual and expert nature to help them reach the appropriate decision and outcome. The situations where this can arise are varied, including at Coroners Court, Criminal and Family Court proceedings.

There is a clear distinction between providing factual evidence and giving an expert opinion. A fact witness is a person with knowledge of what happened in a particular situation. The witness' testimony consists only of the recitation of facts and/or events. This will often include the provision of the contemporaneous patient notes made at the time and other relevant material in the patient's file.

This is in contrast to an expert witness whose testimony consists of an opinion. It is based on formal training or experience that allows them to form an expert opinion on matters associated with that subject.

It is fundamental to the role of an expert that you understand that you have an overriding duty to the court or tribunal and need to be impartial and objective. There is now a standard code of conduct for expert witnesses in the Judicature Act 1908 that you will invariably be provided with and asked to read and confirm on oath that you have read it and will abide by it. If this isn't provided to you by the party that engages you, you should ask for it.

YOUR BRIEF OF EVIDENCE

By all means have a draft of your evidence prepared by a solicitor setting out the relevant areas and topics that need to be covered. However, make sure that you prepare the brief in your own words and that it is expressed from your own point of view, as this will prepare you for giving evidence on the stand.

BEING CROSS EXAMINED – FRAMING YOUR ANSWERS AND THE GOLDEN RULES

It is natural for you to be apprehensive about giving evidence and especially the prospect of being cross-examined on your evidence. The following will provide you with some useful advice on how to best deal with the 'dreaded' cross examination phase of the hearing and to prepare appropriately for it.

It is useful to always keep in mind that you are probably the most knowledgeable person in the room in the area of your expertise, certainly more so than the opposing lawyer or indeed the judge. Be comfortable in that knowledge but don't allow it to make you to appear arrogant or over-confident.

You are there to provide advice to the court and support the process to ensure that the court makes the right decision about what occurred and gets to the most appropriate outcome for the parties who are involved. These are some of the golden rules to assist you:

1. Understand the question. Always listen carefully to the question. If you are unclear or do not understand it, ask for clarification. Take your time. Good witnesses think before they respond.
2. Use the 'golden triangle'. You need to engage with the people who are making the decision. Make eye contact with the cross-examiner when he or she is asking the question, but address the court/tribunal with your answer.
3. Plain speaking. The best witnesses give short concise explanations in a straightforward way to the court. Wherever possible give a yes or no answer. If you believe that you need to expand you can answer in this manner:

   The answer to your question is yes, but I should expand on that...

   If the cross examiner stops you from clarification the court may intervene, and if it does not your lawyer will be aware of the need to address this in re-examination.
4. Treat each question on face value. Don't overthink the question or treat each one as a smoking gun. Don't try to predict where the line of questioning is heading. Focus on answering that question only. Do not volunteer other information beyond what is asked. Some cross examiners will remain silent to get you to expand. Do not feel obliged to fill in that silence. Simply sit quietly and await the next question.
5. Take your time. The evidence is often being transcribed. Use this as an opportunity to pause and collect your thoughts. There is no rush. You will not be criticised for taking time to consider and answer your questions.
6. Keep calm. Your credibility may be affected by your composure and professionalism. You are not an advocate, you are an expert. A skilled cross examiner may try to unsettle you and some can be aggressive and at times bordering on insulting. Remain calm and stay focused.
7. Make concessions. Don't be concerned if you have to make a concession. Be prepared to do so. It often enhances your credibility rather than harms it. It confirms that you understand your role as an expert witness. This can include modifying previous answers to questions if you subsequently become aware that they might be erroneous.
8. Defend your opinion. While it is appropriate to be objective, you are there to defend the opinion that you have provided to the court. You should be robust in your opinion and not allow a cross examiner to undermine it with vague assertions and contrary opinions.
9. Wait for an 'open question'. A skilled cross examiner will try to control your answers by asking you closed questions which require only short answers or even yes or no responses. Cross examination is an opportunity to put your position before the court again and an open question allows you to do that. It is an opportunity that should be seized upon by you when you are absolutely confident of your position and you are only restating the evidence you have already provided.

CONCLUSION

There is no substitute for preparation. The mantra 'prepare, prepare and prepare again' should play over and over in your mind prior to any occasion where you are required to give evidence in a formal court or tribunal setting. Make sure you have all relevant documents collated and easily accessible. When giving your evidence remember the four golden rules and write them on a pad while you are giving evidence:

1. deflect to the golden triangle.
2. make sure you understand the question.
3. answer the question as concisely as possible.
4. then stay quiet.

Bear in mind that lawyers are not infallible and are often as nervous as you. These excerpts, apparently from real trial transcripts, attest to this:

Lawyer: *"How many autopsies have you performed on dead people?"*

Doctor: *"All my autopsies were on dead people."*

And:

Lawyer: *"Doctor, did you say that the deceased was shot in the woods?"*

Doctor: *"No, I said he was shot in the lumbar region."*

And finally:

Lawyer: *"Now Sir, I'm sure you are an intelligent and honest man."*

Doctor: *"Thank you. If I weren't under oath, I'd return the compliment."*

DID YOU KNOW

MECA clauses that you may not be familiar with are highlighted in each issue of *ASMS Direct* sent regularly to ASMS members. These clauses are also promoted on the ASMS website (**www.asms.nz**) and are reprinted here for your information.

...ABOUT CME TRAVEL TIME ON TOP OF CME DAYS

That the MECA provides for CME travel on top of your CME days? Clause 36.2(a) provides for 'reasonable travel time' as needed to undertake approved CME activities. Many DHBs have travel time guidelines in place – it's sensible to check these when you apply and to agree on travel time before you leave. **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-five/clause-36/**

...ABOUT OVERPAYMENTS

That overpayments do happen from time to time and, should this occur, in most cases you will have to repay some, or all, of the money? If you are concerned that there may have been an overpayment you should alert payroll straight away. If you are notified of an overpayment you have the right to seek advice (ring your industrial officer), to have your pay history checked, and to negotiate how/when repayments are made. DHBs do not have the right to recoup an overpayment without your consent. Find out more at: **http://employment.govt.nz/er/pay/paymentanddeductions/index.asp**

...ABOUT TIME IN LIEU OVER PUBLIC HOLIDAY

That time in lieu for working a public holiday can only be claimed once? That means, where a public holiday is Monday-ised, if you work both the actual day and the Monday, you can only claim one alternative (or lieu) day. You will be paid at the appropriate rate for all days you work, but one public holiday only generates ONE alternate day of leave. **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-24/**

...ABOUT SECONDMENTS

That MECA clause 36.4 means you can apply for a secondment of two weeks, every three years? Secondments must be to a recognised unit for the purpose of your professional development and to upgrade your skills. Most DHBs have an application process similar to that for sabbaticals. **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-five/clause-36/**

...ABOUT THE STANDARD NOTICE PERIOD

That the standard notice period for resignation or retirement in the DHB MECA is three months? This period may be changed by agreement between you and your employer. If you are considering a resignation (or retirement) it is well worth contacting your industrial officer to discuss other ramifications. **http://www.asms.org.nz/employment-advice/agreement-info/retirement-redundancy-and-termination-of-employment/**

...APPLYING FOR A SABBATICAL

That under clause 36.5 of the MECA you can apply for a sabbatical after six years' DHB service? Usually you need to follow DHB policy and application procedures, and typically need to give 12 months' notice. Some departments factor SMO sabbaticals into their annual planning and staffing projections. Learn more in a recent issue of *The Specialist* (December 2014, pp 20–23). **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-five/clause-36/**

ASMS SERVICES TO MEMBERS

As a professional association we promote:

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

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in 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 jobs.asms.org.nz

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

Substantial discounts are offered for bulk and continued advertising.

ASMS Direct

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

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

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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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