THE SPECIALIST

THE MAGAZINE OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

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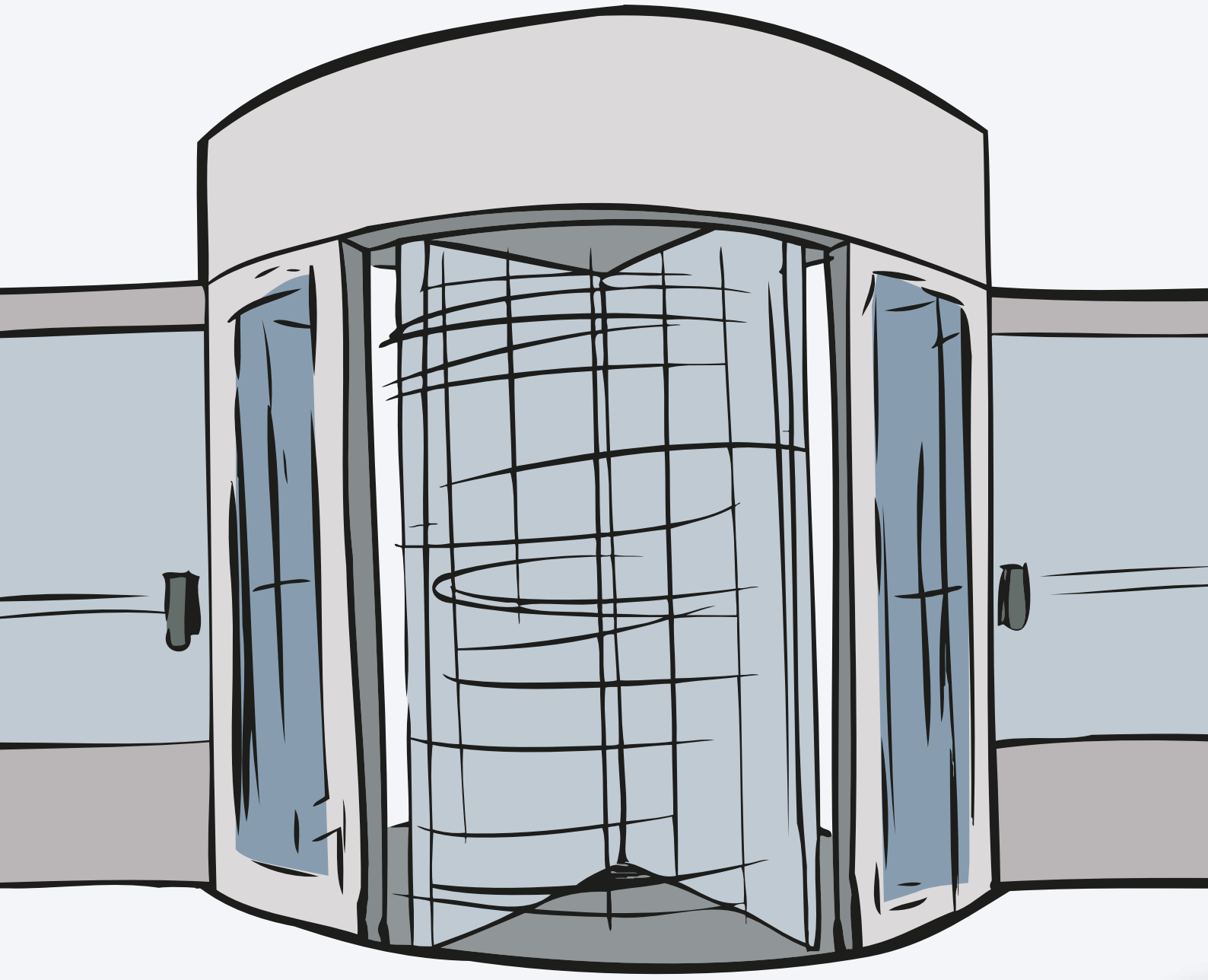

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INTERNATIONAL MEDICAL MIGRATION: HOW CAN NEW ZEALAND COMPETE AS SPECIALIST SHORTAGES INTENSIFY?

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

International competition for medical specialists will intensify over the next decade, with potentially significant implications for New Zealand. Despite efforts in many countries to become medically self-sufficient by boosting domestic training programmes, continuing shortages are forecast.

Data from the Organisation for Economic Cooperation and Development (OECD) show the United States (US), the United Kingdom (UK), Australia and Canada between them employ two-thirds of all foreign-trained doctors. About 55% of OECD foreign-trained doctors work in the US and the UK. The specialist workforce outlook for these countries is therefore especially important.

In the US, the number of overseas trained doctors increased by 14.5% in the four years 2010-2014 and the US is estimated to be facing a shortage of up to 90,000 physicians by 2025. Meanwhile, in the UK, New Zealand's main source of international medical graduates (IMGs), the National Audit Office reports that as at March 2014 there were 2330 National Health Service (NHS) consultants fewer than there were established positions, and the Royal College of Physicians reports 43% of consultant vacancies were unfilled in 2015, due mainly to the lack of suitable candidates.

In Australia, despite increased investment in medical workforce development, specialist shortages are forecast in many areas. And New Zealand specialists remain in demand. In 2012, that country was home to 624 New Zealand specialists – the equivalent of approximately 16% of the district health board (DHB) specialist workforce in that year. Within three years that had increased to 723 specialists who had gained their initial vocational qualification in New Zealand. This net loss of almost 100 specialists from New Zealand excludes those who had gained their vocational registration before working in New Zealand.

The forecasts of international shortages are due to multiple factors.

> ***As well as meeting the increasing health needs of growing and aging populations, and rising public expectations as technological advances introduce new treatments, diseases of affluence are causing further challenges.***

Medical workforces are aging. As a recent European report notes, the aging health workforce is leading to an 'upcoming massive replacement need, even with gradually growing workforce sizes'. The increasing proportion of women in the specialist workforces of Western countries, and the trend towards more work-life balance in both genders, add further to the need for greater numbers of specialists internationally.

The UK's uncertain future relationship with the European Union (EU) could also exacerbate medical workforce shortages there, given that over a quarter of doctors entering the UK medical register each year are from other EU countries. The British Medical Association warns of impending 'disaster' as a recent national survey it undertook of doctors who qualified in the EU shows more than 40% of them were thinking of leaving the UK because they feel less welcome; a further 23% were unsure. The uncertainties brought about by the 'Brexit' vote relate not only to the future employment arrangements for doctors but also the implications for future collaborative opportunities with other doctors in the EU and the employment and education opportunities for doctors' families.

PRESSURES ON SUPPLY

Additional competition for IMGs may also develop through a dwindling international source of supply of specialists, as many countries, including non-OECD countries, concentrate more on retaining their doctors to help meet growing workforce needs.

> ***New Zealand's high dependency on IMGs, coupled with its high rates of expatriation of doctors (we have one of the highest rates in the OECD on both counts) makes us especially vulnerable.***

As an OECD report noted, "New Zealand and, to a lesser extent Canada, Ireland or the United Kingdom, which receive and send lots of doctors and nurses abroad, may be at the mercy of sudden policy changes in other OECD countries which remain beyond their control."

New Zealand's source of IMGs is mostly from just half-a-dozen countries, particularly the UK, where the NHS has experienced unprecedented financial constraint, with numerous reports of a medical workforce under stress. While such circumstances may encourage doctors to move to places like New Zealand, it is notable that many do not stay here for long. A policy change that saw greater investment in the NHS could not only lead to stronger retention measures in the UK but also attract back even more doctors than is occurring now.

That scenario is reinforced in a recent study on UK-New Zealand migration which indicates a desire to leave the NHS has been a primary motivator for doctors deciding to move to New Zealand. Correspondingly, a change of policies which leads to improved working conditions in the NHS is a key reason given by British doctors to consider returning to the UK.

In India, the world's largest exporter of doctors by a large margin and the third-largest source of New Zealand's IMGs, the desire for better training and increased access to better technology and equipment are important reasons for migration. However, this is beginning to change with the growth of India's middle-class population, which is forecast by some analysts to more than double in the next 10 years. A burgeoning private health sector is also driving the rapid growth of a $3 billion health 'tourism' industry, estimated to grow to an $8 billion industry by 2020. While any future reduction in the supply of IMGs from India may not have a major impact on New Zealand directly, it may have a greater indirect effect if the supply to other countries is reduced, such as to the UK, the USA and Australia where, in each case, India is by far the most important source of IMGs.

OECD data show the inflow of doctors from India to OECD countries (especially the UK and the USA) dropped by 31% between 2010 and 2014. The extent to which this is due to increases in domestic medical graduates or an increasing tendency for Indian doctors to remain in India requires further study.

PRESSURES ON RETENTION

While New Zealand's specialist workforce is becoming increasingly dependent on IMGs, growing from 35% in 2000 to 43% in 2014 (and still growing), IMGs have poor retention rates.

> ***Currently about a quarter of IMGs are lost within three years of gaining vocational registration, rising to almost a third by the fifth year post-registration.***

The prospect of better working conditions, increased remuneration, better career opportunities, and 'family reasons' appear to be key motivators for doctors leaving New Zealand. In addition, many IMGs are employed on only temporary contracts. Whether that is because the conditions here are not attractive enough for them to want a permanent position, or whether it's because the district health boards (DHBs) can't afford them on a permanent basis – despite long-term specialist shortages – remains unclear. Either way, they are vital questions the DHBs should be addressing.

While health service employers may not be able to influence some factors concerning staff turnover (eg, family reasons), there are many factors that they can influence. The literature highlights the need for health service organisations to consider the reputation of their organisation as an employer and as a place to work, in order to create a climate that will attract and retain staff.

A major report on health professional mobility in Europe identifies three key factors that influence whether staff will stay or go:

- employment quality
- work quality
- organisational quality.

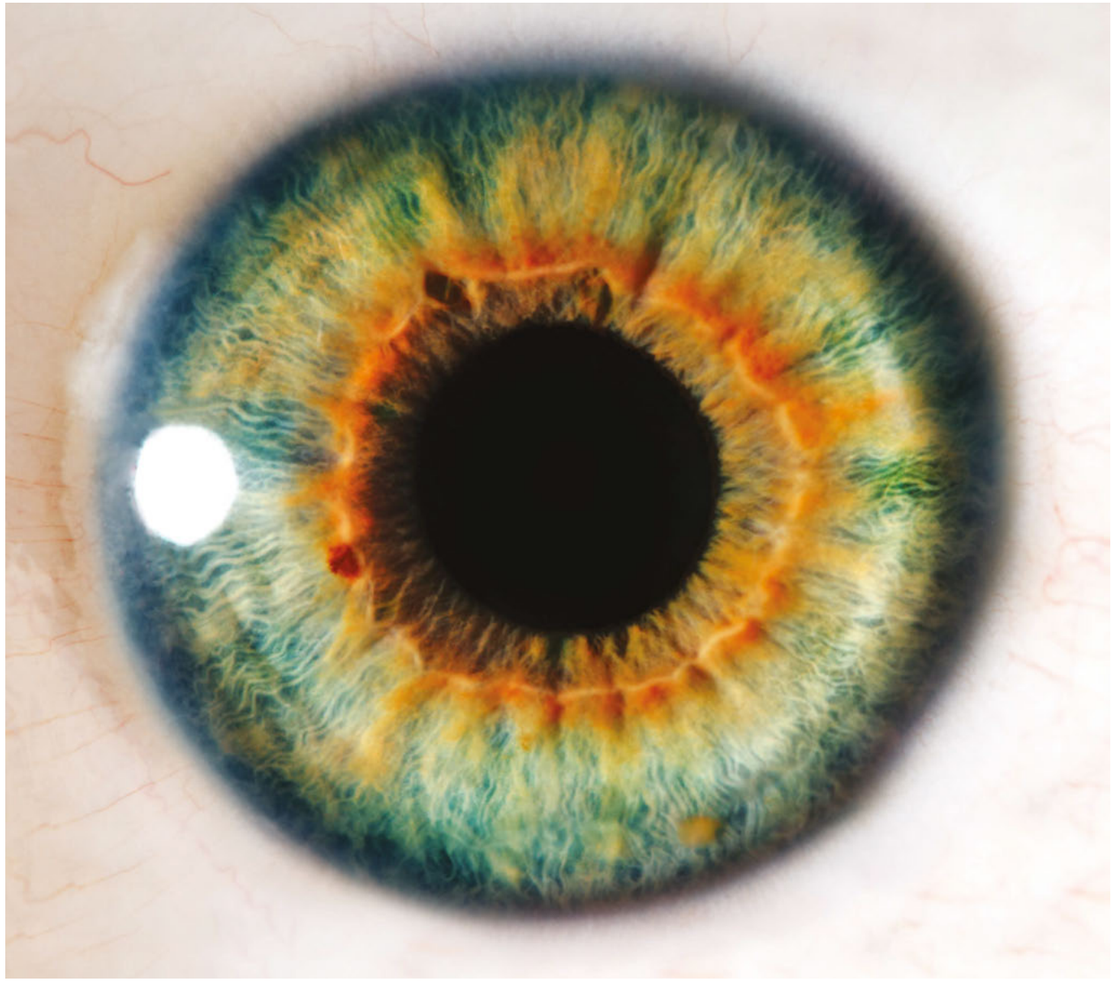
Employment quality relates not just to pay but also to terms and conditions, such as opportunities for flexible working arrangements and conditions that enable a reasonable work-life balance. Social benefits are also an important part of employment quality. Contractual relationships that allow for pension schemes, flexible retirement policies, childcare provisions, and so on have shown to be factors influencing job quality.

Work quality includes a number of variables around inappropriate or unsafe work. For example, high levels of administrative burden have been shown to have a negative effect on retention. In addition, many studies report negative effects of work-related stress in health care, particularly from high workload. Studies show that the consequences of continued high levels of stress for health professionals, including doctors, include not only reduced efficiency but higher error rates and higher staff turnover.

In relation to organisational quality the literature on retention has a particular emphasis on the relationship between leadership and staff satisfaction. Dissatisfaction with management styles has been shown to be a major driver in job dissatisfaction. On the other hand, participation in decision-making processes has been found to enhance job satisfaction.

Many of these issues are well recognised in our DHBs. The ASMS has reported on them regularly, most notably in the analyses and reports of recent national surveys of SMOs on 'presenteeism' and burnout and fatigue. Improvements in New Zealand's poor retention rates of medical specialists, particularly of IMGs, require these issues to be addressed.

The full ASMS *Research Brief* on international medical migration is available online at **http://www.asms.org.nz/wp-content/uploads/2017/02/IMG-Research-Brief_167359.5.pdf.**



OPHTHALMOLOGISTS CALL FOR URGENT GOVERNMENT REVIEW

DR SHENTON CHEW | AN AUCKLAND-BASED OPHTHALMOLOGIST, AND GLAUCOMA AND CATARACT SUB-SPECIALIST, A SPOKESPERSON FOR RANZCO, CURRENT CHAIR OF THE ADHB SMO COMMITTEE AND MEMBER OF THE ADHB OPHTHALMOLOGY STEERING GROUP

At the end of 2016, the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) launched an advocacy campaign calling for an urgent Government review of the current crisis that faces ophthalmology services across the nation.

The launch coincided with the release of the 2015-2016 adverse event report by the Health Quality & Safety Commission, which highlighted a noticeable increase in reported ophthalmology events, including delay in follow-up appointments, particularly in the Southern and Nelson Marlborough district health boards (DHBs).

We estimated that throughout the country there were 50,000 patients with delayed visits, and conservatively 1 in 100 of these patients (ie, 500 patients) had suffered significant visual loss.

> ***Funding is clearly insufficient to meet the growing demand for ophthalmology services due to the huge burden of resource-intensive chronic conditions such as glaucoma, age-related macular degeneration and diabetic eye disease, all of which can result in permanent blindness without appropriate care.***

A PATIENT'S STORY

Glaucoma patient David* nearly fell between the cracks in the ophthalmology crisis occurring around the country – and counts himself fortunate to still have his sight.

"It all started a few years ago when I was looking in a phone book and the numbers were a bit blurry," says the 75-year-old Auckland man.

"I thought, that's strange. When it didn't clear up, I went off and had my eyes checked. They did a few tests and then told me I had glaucoma."

He was referred to a private specialist who confirmed he had glaucoma and visually significant cataracts. David began treatment for his glaucoma and had cataract surgery to improve his vision.

David was told that he needed lifetime follow-up for his glaucoma and his care was transferred to the public hospital glaucoma specialist.

At one of his appointments, he was told that he should be seen in six months, but was not contacted. He's not sure why – whether he was lost in the system or if the lack of contact was simply due to delays caused by the crushing workloads in the ophthalmology service.

It's fair to say he was a bit anxious.

"Glaucoma runs in the family. My mum had it and she lost sight in one of her eyes. She nearly lost it in the other, too, so it's what I thought of straight away when they told me I had glaucoma."

Eventually David contacted the hospital. He says staff there apologised for the delay and promptly booked him in for an appointment with a specialist.

"Luckily for me there wasn't any damage done," he says. "I was one of the fortunate ones. I do understand that hospitals are under a lot of pressure but it was frustrating, and I was concerned."

** Not his real name*

DR SHENTON CHEW

Adding further pressure are government-enforced waiting time targets forcing DHBs to prioritise first specialist appointments (FSAs) within four months, as opposed to necessary follow-up appointments, or face reduced funding if these targets are not met.

RANZCO's call was for allowing clinicians greater responsibility to prioritise patients according to greatest need; to help us train allied health professionals such as specialist nurses, GPs and optometrists; and to increase funding to address the increasing needs of our aging population.

The Ministry of Health's initial response was disappointing. There remains a reluctance to move away from the rigid four-month target for FSAs, with the onus of managing the crisis placed back to the DHBs.

DHBs have already been proactive about managing the crisis with current resources, and despite this they are still struggling.

In one DHB, the number of patient visits increased from 50,000 to 90,000/year over the past five years, without significant additional resources. The department has had to streamline services provided, introduce virtual diagnostic clinics, run additional out-of-hours clinics and train specialist eye nurses who can take on more patient care, all without additional funding. Despite these measures, they are still struggling with cases of preventable blindness occurring due to lack of timely follow-up and management.

It is not just the individual impact of this that is devastating, but also the socio-economic implications, with a recent report from Deloitte, commissioned by Macular Degeneration New Zealand, suggesting that the cost of blindness from age-related macular degeneration is over $45,000 per person. This burden would be even higher in conditions like glaucoma, where blindness is truly absolute.

In consultation with other organisations, RANZCO determined that emergency funding would be required in the short term to address those critically overdue for follow-up and in the medium to long term an additional $5-10 million/annum would be required in the future.

After RANZCO presented the evidence supporting this position to the Minister of Health, the Ministry announced additional funding of up to $2 million nationally this year, which DHBs will use to start clearing through the backlog of overdue patients. RANZCO is committed to continuing to work with the Government to ensure that future funding for ophthalmology services is adequate to meet increasing demand.

Hopefully this change of stance from the Ministry represents a positive step forward in what will be a difficult future landscape for ophthalmology. The RANZCO NZ Branch Executive has been supported in this collective effort by its Fellows throughout the country, in particular those involved in DHB management, Ophthalmology NZ, the RANZCO leadership development programme, and Macular Degeneration NZ.

This is just the beginning of what will be ongoing engagement by ophthalmologists with the Ministry of Health, Government, and the DHBs. In the short term, RANZCO NZ Branch's intention, via a newly formed advisory group, is to collect data to monitor the situation and meet regularly with the Ministry of Health to deal with the current crisis. In the medium and long-term, they will work with the Ministry to develop further improvements, such as a nationally consistent approach to models of care and workforce modelling.

The goal is ultimately to save sight by stopping preventable blindness, and we will continue to advocate strongly on behalf of our patients to ensure this happens.

WOMEN IN MEDICINE NETWORK ESTABLISHED

ASMS has established a network for women doctors in New Zealand following ground-breaking research which showed women SMOs were significantly more likely to experience burnout.

A survey of ASMS members carried out last year suggested that women aged 30 to 39 had the highest rates of burnout, with over 70% of women in this age group scoring as having 'very high' burnout levels according to the Copenhagen Burnout Inventory (**http://www.asms.org.nz/wp-content/uploads/2016/08/Tired-worn-out-and-uncertain-burnout-report_166328.pdf**).

These findings and subsequent discussion with a number of ASMS members led to a broader meeting of women doctors at the ASMS Annual Conference in Wellington last November. This group supported the establishment of a network of women doctors and a Facebook page to encourage networking among women in medicine, whatever their age or stage of medical career.

As a result, the Facebook group 'NZ Women in Medicine' was set up at the end of January. Within a fortnight it had more than 3000 members from around the country (and the number is still growing). Members include senior doctors, medical students and GPs, as well as New Zealand doctors who have moved overseas but wish to stay in touch with their former colleagues here.

The Facebook page has been set up as a closed group, which means that only members can post or read what others have posted (although this privacy obviously depends on the behaviour of members). All membership requests are approved by a small group of 'admins', which involves checking names against the Medical Council where possible and messaging people to clarify their connection to New Zealand medicine when needed.

While the Facebook page has been set up by ASMS, it is not an ASMS page. Our role has been just to get it off the ground and to provide some technical support while it takes on a life of its own. That is already happening, with several other organisations supporting the fledgling network, including the New Zealand Medical Association and the New Zealand Medical Students' Association.

Other ways of developing and supporting a network of women doctors are also being discussed, as we are aware that not all women doctors use Facebook.

The Facebook group can be found at (**https://www.facebook.com/groups/womeninmedicinenz**) – please encourage women doctors you know to join the network. If you'd like to find out more about the group or have some ideas to support women working in medicine in New Zealand, please contact ASMS Industrial Officer Sarah Dalton at **sd@asms.nz**.

THE VALUE OF MENTORING

The need for good mentoring was raised by women doctors at last year's ASMS Conference, and we discuss that further here with two doctors at different stages of their medical careers – Brigid Connor is an experienced interventional radiologist at Auckland DHB, while Carmen Chan is the vice-president of the New Zealand Medical Students Association and a sixth-year medical student.

We asked them if they have ever been mentored, what it was like, and what qualities a mentor needed. If you, too, have memories of being mentored at a particular stage of your medical career, please contact Cushla Managh at ASMS (**cm@asms.nz**) so that we can include your story in a future issue of the magazine.

CAN YOU HELP?

In response to the high burnout scores for women specialists aged 30-39, principal analyst Dr Charlotte Chambers has recently applied for ethical review for a qualitative study that she hopes will go some way to explaining these trends.

The research will focus on the working lives of female specialists aged 30-39 who are members of the ASMS currently working in district health boards.

The research will involve face-to-face interviews away from the place of work for approximately one hour. Participation in the research will be strictly confidential and every attempt will be made to preserve participants' anonymity.

Dr Chambers is currently seeking expressions of interest from eligible women who might like to participate in this research.

Those who may be interested are encouraged to email her (**cc@asms.nz**) from a non-work email address or send her a personal message through the 'NZ Women in Medicine' Facebook page.

CARMEN CHAN

DR BRIGID O'CONNOR

CARMEN CHAN

Yes, I have been mentored. It's brilliant. I think it's added to my experience of medical school. It's like having a guide or a teacher that you can ask about the things that aren't taught in a formal medical curriculum. It's like having a big brother or sister.

When I was a fourth-year medical student starting my time in the hospitals, I remember finishing a particularly long week of long days on a surgical run, and feeling tired, uncertain and a bit isolated. The run was new to me and I didn't know what the expectations were or what my performance was like, or whether what I was feeling was normal for a medical student in terms of feeling a bit overwhelmed by the newness of everything.

I remember texting someone I had met earlier at a medical students' conference who was now an RMO. They had always told me to get in touch if I needed advice or someone to talk to. I organised a catch up so that I could just have a chat about hospital life. It was the first time I could talk to someone who was further along in training than I was and who had experienced what I was going through. I think it helped validate a lot of my concerns and it also gave me a sounding board to understand what I was experiencing and feeling.

Now that I'm in my sixth year of medical school, I've had the privilege to be able to do this for younger medical students who have come to me with their uncertainties. Being able to listen to their thoughts and feelings, and discuss our collective experiences on runs and share insights has been really valuable for them. Being able to do this with my seniors has been valuable for me as well.

It's easy to forget how medical students feel. Trying to get into medical school is a distant memory, and perhaps that's the case for senior doctors as well. Mentoring a junior doctor or medical student has reminded me what it was like, and I think it is helping me to develop more compassion.

A mentor needs to actively listen and to be present for a person. You have to be a companion for them and listen without judgement.

> *It's not about imposing one's personal experiences on another to work through a problem. It's about validating their experience and being alongside them as they work out how to address what's going on.*

Medicine as an apprenticeship model is about teaching each other and I would encourage every person – medical student, senior doctor – to be open to the idea of learning and to seek out mentors and to create a chance for yourself to grow personally and professionally through mentorship. You don't necessarily need a mentor for your entire professional life but there might be things you want to improve on, and having someone that you look up to and can learn from is a great way to learn.

If you find someone that you admire then it could be worth seeking out their mentorship. That way, we can collectively create a better health workforce and an environment in which medical students, new doctors and senior doctors can work together in a collegial, supported relationship.

BRIGID CONNOR

I've never had a formal mentor in the sense that it was a spoken, overt agreement, but there have been doctors that I have felt offered that degree of support and influence, and that I consider to be mentors. There have been a lot of influential people in my life through medicine at all levels, but those who have helped me in my transition to specialty and subspecialty training stand out.

The first was while I was a house officer trying to decide what to do with my career. I had been very keen on vascular surgery as a student but became less so as a house officer. I was working in Tauranga and a radiologist there, Jann Medlicott, spent a lot of time teaching the RMOs and was inspiring in terms of her knowledge and abilities. It made me look at radiology as a clinical specialty in a whole new way. She was generous enough to let me shadow her when I could find time, to get a feel for whether radiology would be a fit for me.

Then as a new radiology registrar I was taught by George Foote, an amazing radiologist who has probably forgotten more about radiology than I will ever know. He continues to inspire me – and when the word 'mentor' is uttered, he immediately springs to mind. I will never forget my sense of pride and achievement when, while working with him, he asked me for a second opinion. I thought: woo hoo, I've made it!

When I came across interventional radiology I suddenly felt I had found my niche. Our director of interventional radiology, Andrew Holden, is an ongoing source of support, advice and inspiration to this day. That someone as accomplished and respected as him believes in me is a huge confidence boost, and something I fall back on when having crises of confidence.

> *First and foremost, my mentors were available – for advice, teaching, moral support, and as a source of inspiration and role modelling.*

Friends, family and other colleagues are great but sometimes having someone outside of that close circle can be incredibly valuable. A mentor needs to be able to put themselves in the shoes of the other person. They need a level head and to be able to offer a cautious, considered opinion.

I don't think a mentor needs to be in the same area of medicine as you but that can add to their ability to help. While people of a similar seniority to you can have some of the qualities of a mentor, there is something about a mentor being more senior that adds an extra dimension to the relationship.

I haven't had a formal mentor relationship with anyone myself, and to the best of my knowledge there is no one that would refer to me as their mentor. Having said that, I would like to think that is a role I could take on one day.

SHOCKED? WE SHOULD NOT BE.

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

My story is not unique. In fact there are thousands of doctors with similar stories, not just in New Zealand, but across the globe.

My first appointment as a consultant paediatrician was in Grand Falls-Windsor, Newfoundland, Canada, 23 years ago. I joined another international medical graduate that was already in post. We shared the on-call commitment (one in two) between us.

After three months my colleague decided he would like to make Canada his home, and to do so he had to obtain full registration with the Newfoundland Medical Council. To achieve that he took up a fixed term contract at the Janeway Children's Hospital in St. Johns.

My on-call commitment suddenly became a 24/7 commitment, with the occasional locum relief for a weekend or annual leave.

They had an intercom pager system in the hospital: "Dr Stander, Dr Stander, please go to the children's ward." Mobile phones were not available yet, which meant that when I was outside the hospital I needed to be within striking distance of a land-line to respond to my pager.

> *You can imagine my joy when the first mobile phones became available. They were mobile in the sense that you could carry them around but you needed a shoulder bag to do so.*

It consisted of a big base station with a large handset connected to it. Although it was cumbersome, it meant I could now join my family for walks next to the beautiful Exploits River or visit the nearby Beothuk Family Park and lake. It gave me a degree of 'freedom'. Little did I know where this new technology would lead.

Mobile phones got smaller and smaller, and smarter and smarter. The initial device could only receive and make phone calls. Today, our smart phones fit in our pockets and keeps us connected 24/7 - not just to our family and social circles, but also to our employers.

Has my smart phone become a ball and chain? I can receive emails and text messages from my employer and colleagues (and occasionally from patients) at all hours, anywhere on the

globe, whether I am on call or not, at work or at play. This development did not happen overnight. Over the past 23 years it slowly became part of my life as the digital age evolved.

Volkswagen in Germany was one of the first companies that turned off their email servers after hours, preventing it from sending emails to the company-issued Blackberry phones. An agreement was reached with their trade union's employees that the servers would stop sending emails 30 minutes after an employee's shift finishes and restart sending emails 30 minutes before the next shift began.

Meanwhile, Daimler introduced a system of deleting all emails employees receive while on vacation. The out-of-office reply might read something along the lines of: "I am on vacation. I cannot read your email. Your email will be deleted. Please resend your email after I am back at work."

In 2012, Brazil was the first country to introduce a law that mandates over-time payment to employees who may receive work phone calls or emails outside office hours. On 1 January 2017 a new French law was enacted. This law bars after-hours work emails to employees. French legislator Benoit Hamon explained that employees "leave the office, but they do not leave their work. They remain attached by a kind of electronic leash-like a dog."

> *There is good research showing that workplace emails, and the expectation of receiving and the need to respond to after-hours emails, are a significant source of stress and a contributor to burnout.*

Even reducing the frequency of checking your emails throughout the work day can reduce daily stress (**http://www.sciencedirect.com/science/article/pii/S0747563214005810**).

Let us kick it up a notch. How about not just receiving after-hours emails and phone calls, but also being available to your employer who expects you to drop everything you are doing and rush back to work. It does not matter what time of day or night, where you are, whether you are awake or asleep, or what you are busy with.

When the phone rings or the pager goes off and more than telephone advice is needed, you have to return to your place of work. We casually refer to this as 'being on-call'.

I have done a conservative calculation of my on-call commitment over the past 23 years as a Senior Medical Officer.

> *Over a period of 276 months, I have been on-call (give or take) for 72 months or 2190 nights of my life. To look at it from a slightly different perspective, for 26% of the past 23 years I have been available to respond or return to work.*

Unfortunately, being on call does not just affect your life but also has an impact on everyone around you. It limits what you can do, where you can go and what activities you can participate in. Your family and friends share in your on call commitment. When the phone rings at 3am, it is not just you who is woken. Additionally, you are expected to go from deep sleep to being fully awake in a matter of seconds and then be able to have an intelligent conversation and make complex decisions while also being polite, friendly and understanding.

The expectation of receiving after hours emails and the need to respond to them adds stress to employees' lives and contributes to burnout. How much stress does being on-call add to our lives and relationships? How much does it contribute to burnout? The personal stress and strain on relationships is not reduced by the fact that we do on-call to care for our patients and support our colleagues. Being remunerated for on-call does not reduce the cumulative negative impact on our wellbeing.

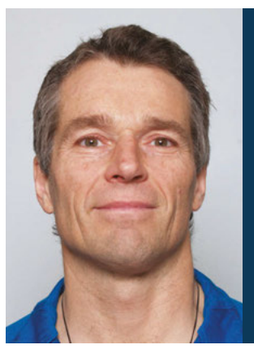
In the smaller DHBs and departments or subspecialties, it is nearly impossible to opt out of being on-call. For many of us, the reality is that we will have to participate in an on-call rota until the day we retire.

People expressed their shock at the findings of a recent survey of ASMS members. Fifty percent indicated that they were burnt out.

> *Shocked? We should not be. It is a surprise that not more of us are burnt out.*

However, the expectations of employees are changing. Brazil and France have recognised that being "attached by a kind of electronic leash-like a dog" to your work is increasingly unacceptable.

Being on call is part of the majority of ASMS members' contracts and work. It should be remunerated fairly and appropriately. However, is it fair to expect that most of us will have to participate in an on call rota until the day we retire (or burn out)? Are there ways to have a more flexible on-call system? This is something that needs to be further explored, sooner rather than later.

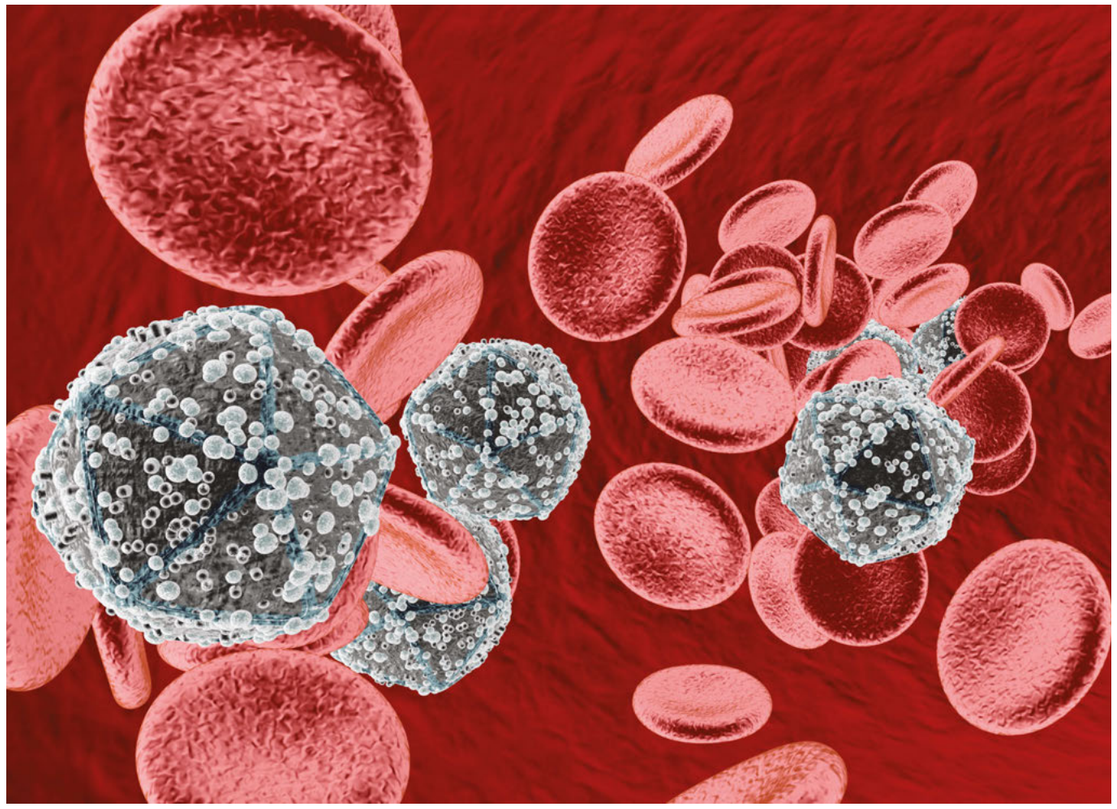


FAREWELL, CHRIS

ASMS was greatly saddened to learn of the tragic death of our Whanganui Branch President Dr Chris Cresswell at the end of last year. Dr Cresswell died suddenly while mountain biking on 31 December 2016.

He was the acting clinical director of the emergency department at Whanganui Hospital and was very popular among his professional colleagues and in the community.

He was a passionate and compassionate doctor, who demonstrated courage with his involvement in a range of broader issues, including Maori health, medical training, and the effects of environmental and trade policies on people's health and wellbeing. The special tribute at his funeral from local Iwi and emergency medicine colleagues was particularly moving.



FLAWED SEXUAL HEALTH DECISION LEAVES ASMS MEMBERS REELING

SARAH DALTON | ASMS INDUSTRIAL OFFICER

In December, *The Specialist* reported that Auckland District Health Board (ADHB) was about to deliver its decision on the future of specialist sexual health services across the region.

In late January ADHB finally released that decision – to cut sexual health SMO staffing by 1.7 FTE. The DHB has failed to make permanent appointments to SMO vacancies for some time now, so the actual cost in terms of specialist capacity is arguably even greater.

> *Sexual health staff are devastated by this decision – particularly coming at a time when HIV rates and case complexity are on the rise; and in the face of a notified syphilis outbreak.*

ASMS understand that due to delays from the DHB's planning and funding service, contact tracing is not underway, nor has ADHB provided resource staffing to manage the outbreak – despite multiple recommendations from SMOs in the commissioned public health report.

SMOs will continue to deliver specialist sexual health services on a business as usual basis, but predict that clinics located in the north, west and south of Auckland will most likely be severely reduced before the end of this year.

These reductions will place further strain on the service's ability to engage with primary providers; who will be expected to pick up the overflow of patients.

> *ASMS continues to support our members and will be working hard to turn this around.*

Under our national DHB collective agreement ADHB is required to endeavour to resolve serious clinical or professional concerns and, if this is unsuccessful, reach agreement with ASMS on a process for resolution. This is what ASMS is presently pursuing.

ADDRESSING BULLYING IN THE HEALTH WORKPLACE

LLOYD WOODS | ASMS SENIOR INDUSTRIAL OFFICER

Bullying, harassment and related unprofessional behaviour have been increasing in number and severity in recent years. Allegations of bullying towards members and by them now make up a serious part of ASMS' disciplinary work.

ASMS has looked for ways to address bullying while also supporting individual members who have either experienced or been accused of bullying and other unprofessional behaviour.

One of the first things we did was produce an ASMS Standpoint advisory in 2013 to warn and educate members about the situation (**http://www.asms.org.nz/wp-content/uploads/2014/08/ASMS-Standpoint-Bullying.pdf**). ASMS industrial officers have also made a point of attending conferences and other meetings to discuss bullying, and we have kept these issues high on our radar.

Our experience, however, is that most DHBs have been very poor in the way they have dealt with bullying complaints. Their responses have ranged from wilful blindness to trying to 'crack a nut with a sledgehammer'. Most in the past were tried as 'ambulances at the bottom of the cliff' but in fact, in many cases, turned into hearses.

> *Some DHBs are now improving their systems around complaints but this is 'patchy' to say the least.*

Bay of Plenty is very active and Nelson Marlborough, Southern and South Canterbury DHBs seem to be looking at merged models. While all DHBs have some type of policy to deal with bullying, none have yet developed best practice in our view.

The adoption of 'zero tolerance' policies has been particularly problematic due to the punitive nature of the subsequent complaints process. Research suggests that such policies actually increase bullying by instituting punitive processes that result in fewer people raising concerns or complaints.

In 2015, these issues gathered further momentum, due at least partly to a campaign by the New Zealand Resident Doctors' Association (NZRDA) as well as an investigation into bullying by the Royal Australasian College of Surgeons. A national medical taskforce was set up to address the problems, with representation from across the medical sector (including ASMS). A key challenge was to address differences between the parties over how to respond to bullying in ways that were both effective and fair. For example, ASMS is concerned about anonymous complaints which, in our view, allows for malicious or vexatious complaints, and denies the alleged bully natural justice.

> *We want to make sure bullying is dealt with but also ensure our members are heard and treated properly.*

Last year we decided to look further into an interesting initiative involving an anti-bullying programme at the Cognitive Institute at Australia's Royal Melbourne hospital, and we organised a cross-sector trip to Melbourne to find out more.

This cross-sector trip was, in itself, an achievement as it included representation from ASMS, the New Zealand Resident Doctors' Association, Public Service Association, New Zealand Medical Students Association, Auckland's medical school, New Zealand Medical Association, three DHB HR general managers (Waikato, South Canterbury, Nelson Marlborough), a CMO (Southern DHB) and a chief operating officer (second tier, Bay of Plenty). Representatives from the Ministry of Health and the New Zealand Nurses Organisation had also planned to attend but withdrew due to other circumstances.

> *As a result of our meetings in Melbourne, we concluded that the anti-bullying programme had real potential for New Zealand health settings.*

Under the Royal Melbourne anti-bullying programme, staff can report issues of concern involving any other member of staff right up to chief executive level. Concerns might involve anything from smoking on site, poor handwashing, in appropriate treatment and so on. All concerns will be dealt with, regardless of seniority and it is made clear that if concerns are being raised for vexatious or malicious reasons, disciplinary action will be taken.

The identity of the staff member is not passed onto the person they have raised concerns about; their identity is known to the system but not to the alleged perpetrator. All concerns go in confidence to a 'triage group' of people who have been trained in the programme. This group decides if the issue can be dealt with informally or if it needs to be sent through a formal human resources process. Almost all concerns will be dealt with informally.

Assuming that is the case, the issue is then forwarded to a trained 'messenger', who is someone of the same professional group and of sufficient mana within that group. ASMS understands this to mean that an SMO would only 'get the message' from another SMO. The messenger meets with the person informally and tells them a concern was raised by somebody about a particular issue. The messenger's role is simply to communicate the concern and not to suggest that it is true or not. There is no assumption of guilt and the message is not a disciplinary process in any way.

According to the Cognitive Institute, through research by Van Der Bilt University, this is usually the end of the process. Research shows that in about 80% of cases, someone who receives a message of this type will never require another visit. However, if further concerns are raised subsequent messages can be communicated, with the third or sometimes fourth message being passed on from the service manager. ASMS was told that non-compliance up to this level was very rare.

As mentioned, we were very interested in the positive approach being taken by this programme.

> *It offers an informal but still meaningful way to resolve most issues that arise without forcing people into stressful and difficult situations of a formal complaints process.*

We returned from Melbourne enthused about the programme and keen to see it implemented within DHBs. Unfortunately, progress appears to have stalled since the trip, but we are continuing to work with the other health unions and ASMS has also briefed various other organisations on our findings.

The Cognitive Institute provided a serious of briefings in New Zealand in March and we are expecting further action as a result. We are looking forward to assisting any DHB that chooses to implement this system that, in a nutshell, is not a fence at the top of the cliff but one a few hundred metres back from the edge.

We will keep you informed of progress on this issue.

Link to *ASMS Standpoint* on bullying in the workplace.

TIME TO JAZZ UP THE JCCS

IAN POWELL | ASMS EXECUTIVE DIRECTOR

Joint Consultation Committees are a creation of the very first multi-employer collective agreement (MECA) negotiated between ASMS and the DHBs, which took effect in July 2003. They provide for three meetings each calendar year between each DHB and ASMS.

The DHBs are represented by senior management, including chief executives, with chief medical officers usually attending also. ASMS is represented by local member delegates along with either myself as Executive Director or Angela Belich as Deputy Executive Director, and the relevant industrial officer responsible for the particular DHB.

The scope of what can be discussed is flexible. It can involve issues to do with the application of different provisions of the MECA to particular DHBs, but more likely subjects are broader involving either national issues that have an impact on DHBs or local (usually organisation-wide) matters.

> *Like many things in life the experience of JCCs since their inception has been mixed but generally positive.*

Sometimes they have addressed an issue of concern while on other occasions we have been able to gain traction on a matter that previously appeared stalled. The critical element has been membership attendance. The greater the attendance, the greater the impact on management.

SHARPENING THE FOCUS: WORKFORCE INTENTIONS

In 2017 ASMS has decided to sharpen the focus of the JCCs by using national concerns to drill further down in respect of each DHB.

Late last year we conducted a comprehensive survey of the workforce intentions of members employed by DHBs. We found a very high proportion of SMOs looking to leave DHB employment within the next five years. Note that this is not necessarily leaving medical or dental practice. Many of those leaving DHB employment still have opportunities in private practice, as locums or with other agencies not involving after-hours acute call such as ACC.

There are two obviously intersecting factors that help explain much of this situation – the general aging of the workforce and the high prevalence of after-hours acute rosters for most branches of hospital medicine.

In an effort to encourage senior management in each of the DHBs to be aware of the coming storm, ASMS is circulating the results for each particular DHB at our JCC meetings, with a view to discussing the impact locally of this national trend. We are expecting initial and follow-up discussion for at least two successive JCCs.

RESPONDING TO SMO BURNOUT

Last year another comprehensive ASMS survey of members employed by DHBs revealed the alarming fact of a 50% burnout rate among those who took part. After first using the JCCs to report on this 'shock wave', we are now using them to advise chief executives and other senior managers of ASMS expectations that they address SMO burnout (to be followed by asking them to advise us of their response to these expectations).

We expect that:

- DHBs should not require additional work from their staff without providing additional resources. If they do, they may be contravening their obligations to staff under the Health and Safety at Work Act.
- When a department or service has been job sized and staff shortages identified, in the absence of an agreed plan to fill these vacancies, this inaction may also be viewed as a contravention of the DHB's obligations of the Health and Safety at Work Act. ASMS will regard this situation as a risk requiring urgent action.
- DHBs should respond positively to SMO-led initiatives for minimum safety standards in their department or service.
- Departments and services should have agreed protocols to enable SMOs to take annual leave, sabbatical entitlements, and short and long term sick leave (including sick leave to care for dependents) if required.
- Departments and services should work to identify and support individuals who may be particularly at risk of burnout, for example, early career stage SMOs and those returning from periods of leave such as parental or long term sick leave.

A 'MID-STAFFORDSHIRE' IN YOUR DHB?

At last November's ASMS Annual Conference, in his Presidential Address, Dr Hein Stander spoke on the subject of whether a 'Mid-Staffordshire' could occur in DHBs. In part, this was influenced by the tragic outcome for several patients with chronic eye conditions who, following their first specialist assessments, had had their clinical follow-ups appointments significantly delayed. His message resonated strongly with delegates and as a result ASMS is now asking at the JCCs for each of the DHBs to answer the following three questions:

1. What are the DHB's good employer targets?
2. Is the DHB satisfied that they can meet what the Government wants from them with the funding provided without compromising their staff's health and safety?
3. What is the DHB's assessment of unmet patient need in their DHB in each department/service?

JOINT COMMUNIQUE WITH NEW ZEALAND MEDICAL STUDENTS ASSOCIATION

Last April, ASMS and the New Zealand Medical Students Association held a well-attended joint special conference on the specialist workforce in 2025. This led to a joint Communique being produced by the two associations (**http://www.asms.org.nz/wp-content/uploads/2016/12/Draft-Communique-ASMS-NZMSA_166026.2.pdf**).

ASMS is now using the JCCs to highlight the main points that arise out of the document, which are:

- The importance of rebalancing towards generalism in international context of increasing specialisation
- greater investment in current and future medical workforce necessary for quality of care
- *Patient Centred Care* important for quality and cost effectiveness but required medical practitioner time
- medical practitioner time required for strong clinical teams and integration and alignment between services.

DELAYED CLINICAL FOLLOW-UPS

Last year DHBs and public confidence were rattled by an alarming revelation with devastating effects on ophthalmological patients. In the context of a financially retrenched environment and rigidly applied targets (strictly speaking elective services performance indicators; a target with financial penalties by another name), first specialist assessments which are counted were taking priority over clinical follow-up appointments for chronic eye illnesses which are not counted. The net result was patient harm, including blindness.

Consequently, we are now asking at JCCs for each DHB to supply longitudinal data on FSAs and follow-up appointments for the past five years.

As a further contribution to the discussion about public health provision, ASMS has published four papers on patient centred care:

- **http://www.asms.org.nz/wp-content/uploads/2016/06/Patient-centred-care-improving-quality-and-safety-issue-1_165837.4.pdf**
- **http://www.asms.org.nz/wp-content/uploads/2016/06/Why-is-patient-centred-care-so-important-issue-2_165838.4.pdf**
- **http://www.asms.org.nz/wp-content/uploads/2016/09/The-time-barrier-issue-3_166514.1.pdf**
- **http://www.asms.org.nz/wp-content/uploads/2016/06/Making-time-for-patient-centred-care-issue-4_166668.2.pdf**

The first two papers were discussed at all the JCCs last year. We are now discussing the third and fourth papers – on time barriers and making time respectively – but probing further compared with the first two.

First, we are advising senior managers at the JCC that ASMS will be putting a sharper focus on more fully recognising outpatient clinics in job sizing under the MECA. Second, we are requesting longitudinal data on the number of patients seen in outpatient clinics to be provided for the next JCC.

ASMS is keen to see more membership involvement in JCCs and as much department or service representation as possible. I encourage all members who are not ASMS JCC delegates to consider this.

DR JOHN BONNING (CENTRE) WITH DR DOMINI MARTIN (LEFT) AND AND EMERGENCY MEDICINE NURSE SHERYL COULTON (RIGHT).

CHOOSING WISELY IN THE EMERGENCY ROOM

Waikato specialist John Bonning says the *Choosing Wisely* campaign to advise patients about low value or unnecessary tests, treatments or procedures is just as relevant in the busy emergency department environment as elsewhere.

"It can be a challenge to find the time to talk about these things in ED as it's time-pressured, and hectic and we don't have established therapeutic relationships with patients such as GPs and other practitioners do, but it's important to have quick conversations with patients about whether a test or a treatment is needed or not," says Dr Bonning, who's the clinical director of Waikato Hospital's emergency department (and a former ASMS National Executive member).

> ***"People often come in with a clear expectation that they need a needle, a test or scan. It's very rewarding when you can explain to them that not everyone needs a CT scan to diagnose a kidney stone because the clinical path clearly indicates that that's what they have."***

Choosing Wisely was launched in New Zealand in December to help patients be informed, make good choices and encourage health professionals to talk to patients about unnecessary tests, treatments and procedures. It focuses on areas where evidence shows that a test, treatment or procedure provides little or no benefit to a patient and could even cause harm.

The campaign is being run by the Council of Medical Colleges, in partnership with the Health Quality & Safety Commission and Consumer New Zealand, and with support from many health sector groups. More information is available in the December issue of *The Specialist* (p26, **http://www.asms.org.nz/wp-content/uploads/2017/03/11296-The-Specialist-Issue-WEB-v2.pdf**) or at the *Choosing Wisely* website (**http://choosingwisely.org.nz/**).

John Bonning says the campaign is patient focused and clinician-driven and is about rationalising time and resources, rather than rationing.

"In the United States, for example, there is no evidence for the benefit of surgical spinal fusion for degenerative back conditions including sciatica. 500,000 such operations are done per annum in the US, more than hip replacements (at a cost of $100k each). They could save $50 billion there if they didn't do this unnecessary surgery."

He says there is a misconception that tests and treatments are guaranteed to provide answers and benefit, where really there is a "chance of benefit and risk of harm" and there is the very real risk of over-diagnosis, especially within a low-risk population.

> ***"It's about being a better doctor by spending a few minutes talking to patients about the chance of benefit or the risk of harm of a particular test, procedure or treatment."***

"Some tests have the potential to be harmful by begetting further possibly harmful tests or treatments (for example, doing an unnecessary d-dimer in a patient at no risk of PE who then gets a CTPA (time, cost and radiation exposure) that might be incorrectly over-read as being positive subjecting them to unnecessary anticoagulants) so we need to get that across, not just to the patients but also to other doctors who may believe that they are good doctors by doing lots of tests when they may in fact be harming patients by doing so. The time and money used in doing these unnecessary tests can be allocated to other patients.

"Not every decision is time-critical and there's a need to provide reputable resources for patients so they can go and look up things themselves. This isn't about some mad crusade to cut costs. It's about being careful, rather than careless, and helping patients and doctors make the best decisions."

ASMS MEMBERSHIP SUBSCRIPTION INCREASE

Notification has been sent to all members advising of an increase in your membership subscription for the Association of Salaried Medical Specialists (ASMS) and to provide details of when this will take effect.

The upcoming subscription increase was detailed in the December issue of The Specialist by National Secretary Jeff Brown following the ASMS Annual Conference last November.

Delegates at the Conference voted overwhelmingly to increase subscriptions to $950 (GST inclusive) for the financial year 1 April 2017 to 31 March 2018. Many commented on the value of this payment in terms of industrial representation, negotiating your employment conditions, and strong policy and research activity that the ASMS is renowned for.

The practical effect is that on 1 April 2017, the annual membership subscription will increase to $950 or $36.53/fortnight if paying by salary deductions. The annual earnings threshold for eligibility for subscription reduction will rise to $95,000 pa. Members who earn less than $95,000 pa will have their subscription calculated at 1 per cent of their salaried earnings, the minimum being $100.00. Members who pay annually will be invoiced on 1 April or, if your ASMS membership is deducted from your salary, payroll will adjust the fortnightly amount appropriately.

Please contact Membership Support Officer, Kathy Eaden **ke@asms.nz**, if your circumstances have changed and you are either no longer eligible for ASMS membership or if your hours of work are different and you think that your subscription amount may need adjusting.

Once again, thank you for your ongoing support for the ASMS.

BURNOUT SCORES FOR ICU SPECIALISTS

In response to a query from a member, ASMS has decided to report the burnout scores for intensive care specialists. The 22 intensive care specialists who responded to the burnout survey were initially grouped into internal medicine because many ICU specialists are FRACP but there are also many anaesthetists. The disaggregated scores are as follows: 50% scored as having high overall burnout, 55% scored as having high work-related burnout and only 5% scoring as having high patient-related burnout.

VITAL STATISTICS

IN 2009/10...
Total core government spending was 32.3% of gross domestic product (GDP).

Core government health spending was 6.7% of GDP.

IN 2016/17...
Total core government spending is forecast to be 29.6% of GDP.

Core government health spending is forecast to be 6.2% of GDP.

SOURCES:
The Treasury, Half-Yearly Economic and Fiscal Update, December 2016.
The Treasury, Fiscal Time Series 1972-2016, December 2016.

CAROLYN FOWLER IS AN ANAESTHETIST AT AUCKLAND'S MIDDLEMORE HOSPITAL AND IS A MEMBER OF THE ASMS NATIONAL EXECUTIVE.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

I've had a deep interest in medicine from early childhood, from when I was six or seven years old. I thought I wanted to be a nurse, but my father encouraged me to think about medicine.

I belonged to the St John's brigade throughout my teenage years. While doing my 1000 hours community service badge, I spent time in the local hospital emergency department to finish it off, and I also nurse aided in an elderly person's hospital. From the time I was about 12 or 13, I was nurse aiding in the local geriatric hospital.

I was always more interested in science subjects at school. I went to Otago University and completed a degree in science first as I wasn't able to get into medicine. I did a degree with double majors in biochemistry and physiology. After that I got into medicine. I spent my pre-clinical years at Otago and then moved to Wellington for other training, and then onto Waikato Hospital for my house officer years.

> *The desire to be a doctor was just inside me.*

I always liked watching the medical TV dramas, but it wasn't really these that sparked my interest. I remember when my brother burnt his feet badly when I was young. We went to hospital to see him and I found it massively interesting.

I was going to get a job in radiology but then I did a senior house officer run in anaesthetics just to fill in the rest of that year. I'd previously found anaesthesia a struggle because I didn't have enough background knowledge at that point. But then off I went as a senior house officer to do three months in anaesthetics. For the first two weeks it was a nightmare, and then I woke up one morning and everything had just fallen into place. It was like – bang! I suddenly had the big picture. After that I was just really in love with anaesthesia. My husband got a job in Auckland and so I applied for the programme there.

I spent a year at Vancouver Hospital before returning to New Zealand for a job at Middlemore Hospital in 1999. I've been there ever since, and spend some of my time working in private practice as well.

WHAT DO YOU LOVE ABOUT YOUR JOB?

I love the mixture of 'doing' and 'thinking'.

> *The job can be very stressful but it changes so much and I love that.*

One minute it can be great and the next it can be hell on earth. I love it when it goes well for patients. I like to help people. My patients are very important to me, and that underlies my practice of medicine.

WHAT IS THE MOST CHALLENGING ASPECT OF PRACTISING MEDICINE?

The public's perceptions about medicine are not always accurate, which can be challenging. People expect us to be able to fix everything. In some ways, we're a victim of our own success. Some expectations are completely wrong! People watch stupid programmes on TV and think that nothing bad will happen to them, but of course sometimes they do.

Health is still under-resourced, which is a problem. It means we can't actually perform as well as we could if we had enough time and resources.

WHAT HAVE YOU GAINED OR LEARNT FROM YOUR ASMS INVOLVEMENT?

ASMS has been great in so many ways. On a personal level, it was massively helpful to me when it came to understanding my own employment terms and conditions. Like most SMOs, I never really read the contract so it's been good to learn what I am entitled to. I now help other people in the department understand these things. Every time someone new comes along, I can explain what they're entitled to.

> *In a wider sense, as a National Executive member, it has been good being able to contribute something to public health care in New Zealand by understanding the big picture and having input into these national discussions.*

It's given me a real insight into what's happening elsewhere around the country. In a big city hospital you can be very protected from the realities in other, smaller places, so it's important to talk to people in other hospitals and specialties.

DID YOU KNOW

DID YOU KNOW... ABOUT LEAVE ON FULL PAY AFTER AN ACCIDENT?

In the event of an accident, or any other sick leave, you are entitled to reasonable leave on full pay.

For many DHB employees this will be quite straightforward, with ACC paying 80% of earnings and the employer paying the balance of 20% to ensure you receive your usual full pay.

However, the actual ACC payment is capped and for most SMOs (and all full time SMOs) the capped ACC contribution will be much less than 80% of their salary. In these cases, the DHB is required by the MECA to make up the difference between the ACC payment and their full salary; in other words, to pay more than 20% if needs be.

It is very important that if you are on sick leave through injury that the ACC payment is topped up by the DHB to whatever amount is necessary to give full pay. You should check your pay any time you are "on ACC".

If you have any concerns, please contact your ASMS Industrial Officer for assistance.

DID YOU KNOW... WHAT CONSTITUTES PART TIME?

Under the MECA, a part-timer is defined as someone employed for less than 40 hours on average each week. This must be based on your total job size, not just your ordinary hours, and must include your rostered after hours on call duties.

For example, if you work 36 ordinary hours per week but are also paid an average of 4 hours each week for on call duties, your total job size is actually 40 hours per week and you are in fact a full time employee.

More information is available in the DHB MECA clauses 11.5 and 11.8 (**http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-one/clause-11/**).

DID YOU KNOW... ABOUT ADVICE FOR SENIOR DOCTORS ON TAKING UP FORMAL CLINICAL LEADERSHIP POSITIONS?

You should have a clear, mutually agreed job or position description with goals and objectives that are both reasonable and achievable. You should also have a separate allocation of time for any clinical leadership duties you may have that is sufficient to discharge those duties and responsibilities.

It is important to have an express agreement with your employer that you can revert to (or in the case of an outside appointee, take up) a clinical role if you leave or are displaced from your position, ie a 'parachute clause'.

MECA clause 36.6 provides for employees to receive leave with pay to participate in programmes, courses, conferences and other activities related to the development of professional or organisational leadership as approved by the employer. As this is a discretionary clause, you should make sure that you have an explicit agreement with your employer for the provision of such leave on full pay.

More information is available:

MECA clause 36.6 - **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-five/clause-36/**

MECA clause 48.2 (e) - **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-six/clause-48/**

ASMS Advice for senior doctors in formal clinical leadership positions (**http://www.asms.org.nz/wp-content/uploads/2016/04/ASMS-Advice-Senior-Doctors-in-Formal-Clinical-Leadership.pdf**)

HISTORIC MOMENTS

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

REFER ITEM 3/1 OF CHAIRMAN'S REPORT

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Collins Report

CONCLUSIONS AND RECOMMENDATIONS

The next twenty years are likely to be years of rapid change in health services. Public health, preventive medicine, primary health care, health education and occupational health will come to play a more important part in health services. Emphasis will shift away from medical care in hospitals and towards health care in the community. More health care will be team work requiring contributions from a widening variety of disciplines. Systematic evaluation of services in relation to specified objectives will become more generally accepted. Management performance will improve and cost containment efforts will continue.

Given such a prospect it is clear that medical manpower cannot be planned effectively in isolation from other health workers and from developments in health services as a whole. National health objectives and agreed strategies for health promotion and health service development are needed. These are absolute pre requisites for effective health and medical manpower planning. (22)

THE COMMITTEE RECOMMENDS THAT NATIONAL HEALTH PLANNING MECHANISMS BE DEVELOPED TO ENABLE MEDICAL MANPOWER TO BE PLANNED WITHIN THE BROADER FRAMEWORKS OF HEALTH AND HEALTH MANPOWER PLANNING.

Existing efforts to gather and analyse data, to disseminate information and to promote wide and open discussion on medical manpower planning issues must be expanded.

THE COMMITTEE RECOMMENDS THAT THE MEDICAL COUNCIL BE ENCOURAGED TO IMPROVE AND DEVELOP ITS ANNUAL MANPOWER DATA COLLECTION.

Both the studies of specialist medical manpower and of the availability and distribution of general practitioners described in Chapter 6 are seen by the Committee as being of particular importance. Of prime concern is the general practice study because of the urgent need to find workable solutions to the problems of providing adequate national coverage of primary health care services. A full study of this complex issue will take time but the Committee hopes to provide information and recommendations in an interim report which could be the basis for early action.

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GOOD MEDICAL RECORDS

DR ANDREW STACEY | MEDICAL PROTECTION MEDICAL ADVISOR

Good medical records, whether electronic or handwritten, are essential for the continuity of care of patients. They enable you or someone else to reconstruct the essential parts of each patient contact without reference to memory. They should therefore be comprehensive enough to allow a colleague to carry on where you left off.

Good medical records not only help to ensure better care for patients, but can also become vital when responding to a complaint or investigation; they provide a window on the clinical judgment being exercised at the time. They enhance care in a number of ways, including facilitating continuity of care where other health professionals are involved, providing a complete record of patient care, assisting with the making of diagnoses and decisions, and clinical governance and risk management.

WHAT MAKES A GOOD MEDICAL RECORD?

Medical records should summarise the key details of every patient contact. On the first occasion a patient is seen, records should include:

- relevant details of their history, including important negatives
- examination findings, again including important negatives
- differential diagnoses
- details of any investigations requested and any treatment provided
- follow-up arrangements
- what you have told/discussed with the patient.

On subsequent occasions, you should also note the patient's progress, findings on examination, monitoring and follow-up arrangements, details of any telephone consultations, details about chaperones present, and any instance in which the patient has refused to be examined or comply with treatment. It is also important to include your opinion at the time regarding, for example, diagnosis.

MEDICAL COUNCIL'S EXPECTATIONS

The Medical Council of New Zealand expects that doctors will keep clear and accurate patient records that report[1]:

- relevant clinical information
- options discussed
- decisions made and the reasons for them
- information given to patients
- the proposed management plan
- any medication or other treatment prescribed.

ALTERATIONS

These records should be made at the time care is provided or as soon as possible afterwards. If for whatever reason it is necessary to add further information at a later date, then it is essential that any additions or alterations to the existing clinical record should be overt. Any suggestion that a doctor has covertly altered notes to cover up a deficiency in care will be met with severe consequences. To avoid this, ensure that the retrospective entry is clearly labelled as such.

HDC CASE

There may be a number of reasons why medical records are not as detailed as they ought to be; a doctor may be too busy, distracted by interruptions, believe that a complaint is not likely or that it is fine to continue writing notes as they always have. The following case illustrates the importance of keeping good notes[2].

A 69-year-old patient (Mr B) was admitted to the ward following an episode of haematemesis. The following morning (Sunday) he was reviewed by the consultant physician (Dr A). A house-surgeon wrote the notes during this post-acute ward round. Dr A was of the opinion that an upper GI bleed was the most likely diagnosis and a gastroscopy was arranged for the following day. Mr B's observations remained stable for the rest of the day; however, he was noted to be experiencing severe back pain and vomiting.

Mr B was reviewed by Dr A again on Monday. Despite the notes recording ongoing vomiting, Dr A continued with his initial diagnosis and plan. Dr A considered that other differential diagnoses were unlikely, and that surgical review was not necessary.

Mr B began to deteriorate Monday afternoon. It was considered that he might have aspiration pneumonia, and the gastroscopy was deferred. Early on Tuesday morning, Mr B collapsed, suffered a massive haematemesis and, sadly, died. A post-mortem was not performed and the exact cause of the haematemesis remains unknown.

Unfortunately for Dr A there was no record in the clinical notes of a physical examination, consideration of differential diagnoses, or other clinical investigations during the post-acute ward round.

The House-Surgeon's notes simply stated:

> ***"On losec for last 3-4 months***
> ***Hiatus hernia***
> ***Started on statins + aspirin by GP 3 days ago***
>
> ***Being monitored by GP for elevated LFTs/fatty liver***
> - ***[previous] malaria***
> - ***[previous] + [alcohol] intake (not for last 5 yrs)***
>
> ***Started vomiting then > haematemesis***
> ***initially frank then coffee ground.***
>
> ***Pain in lower back, sub-sternal.***
>
> ***[Impression] ? ulcer***
>
> ***Plan***
> ***i) needs to be on Losec lifelong***
> ***ii) Gastroscopy – acute list (team to arrange)***
> ***iii) Able to [eat and drink] today***
> ***iv) [nil by mouth] from 0200 tonight."***

Dr A acknowledged that the amount of written information documented for the post-acute ward round on Sunday was very brief and incomplete. He stated that he "accept[ed] that the notes ought to have recorded the full examination that was undertaken, [his] differential diagnoses ... and the plan for gastroscopy. They also ought to have included that the result of the assessment [was] discussed with the patient and his wife and plans and options explained." Dr A also advised the HDC that this case had reinforced to him the need to review notes taken by junior staff and to verbally reinforce discussions to ensure the notes clearly reflect the patient's condition and what is to occur.

The HDC's expert was of the opinion that it is accepted practice that the house officer documents consultations during senior medical officer ward rounds; however, the responsibility for the content of what is written in the notes remains with the senior medical officer. It would be unusual for a house officer not to record any of the physical examination or discussion.

Dr A found to be in breach of the Code of Rights with the Commissioner opining that:

[The] HDC has made numerous comments in previous reports stressing the importance of the accuracy of the medical record. In Patient A v Nelson-Marlborough District Health Board, Judge Baragwanath noted that it is through the medical record that doctors have the power to produce definitive proof of a particular matter. As previously noted by this Office, doctors whose evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted.

In this case, I consider that the lack of documentation of a physical examination, consideration of alternative diagnoses, and discussion with Mr and Mrs B, likely indicates that these did not, in fact, take place. My conclusion on this point is also reinforced by Mrs B's lack of recollection of any such discussion.

THE IMPORTANCE OF A COMPREHENSIVE RECORD CANNOT BE STRESSED ENOUGH

Ensure that comprehensive records are made for patients under your care. Certain situations may necessitate notes to be even more detailed than usual; such as where the need to write a report or respond to a complaint is anticipated, there are differing opinions amongst clinicians, the patient is very unwell, or a decision that has been made needs to be justified e.g. NFR status.

Patients have a right (subject to a limited number of exceptions) to access their medical records under the Health Information Privacy Code. If a complaint arises or a response to one of the various regulatory or judicial bodies becomes necessary, the records are likely to be examined closely by experts, the HDC, Medical Council or Coroner. Inadequate records that fail to address the key issues will create a poor impression, particularly if they include inappropriate comments about the patient, and ultimately make it more difficult for you to justify the clinical care provided.

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- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists.

As a union of professionals, we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

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