THE SPECIALIST

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FINDING MEANING IN LIFE

DR HEIN STANDER | ASMS NATIONAL PRESIDENT (OUTGOING)

She returned two days later. She had a simple request. She wanted to sit next to the now still, empty incubator. She previously visited daily and stayed for many hours, sitting next to her son. He passed away two days earlier at the age of five weeks.

She spent about an hour there that day. Quietly sitting by herself, tears rolling down her cheeks. She politely turned down offers of tea and coffee. Then she got up, gave each of us a hug and left. He was born by an emergency Caesarean section performed under a general anaesthetic at 26 weeks gestation. The first time she met him was in the neonatal intensive care unit, and this is where she held him as he breathed his last breath.

As health care workers, we touch people's lives on a daily basis. What we don't always realise is how our patients touch our lives and change or influence us, our thinking and how we experience and view life. I was a junior registrar then and on that day in the neonatal unit I seriously questioned the meaning of life... and I still do today.

THE SEARCH FOR MEANING

Humanity has been searching for an answer for a very long time trying to establish what the meaning of life is. Scientists, theologists and philosophers have all speculated over the years and shared their thoughts and answers to the question. What it all comes down to in the end is whether death is the last chapter in our lives or whether there is a life after death. My Dad believed that he lives on in the genetic material he passed on to his three sons. Others believe that there is life after death. In short, the meaning of life depends on what you believe in.

Consciously or subconsciously, we are all also searching for a meaning in life. The difference between the two questions, what is the meaning of life and what gives my life meaning, are subtle but the answer to these two questions can be very different. As Einstein put it: "If I had an hour to solve a problem and my life depended on it, I would use the first 55 minutes determining the proper question to ask, for once I know the proper question, I could solve the problem in less than five minutes."

In fact, our lives do depend on finding the answer to both these questions. The answers will be unique to each individual. However, there is a noticeable shift in what the senior medical workforce in New Zealand value in life. How much does our work or vocation contribute to giving our lives meaning? How much does our vocation impact on the rest of our lives and how much does it tax our health and well-being? How much do we value our life and activities outside of work?

The following is advice the American Academy of Family Physicians gives to candidates contemplating a career as a doctor: "Choosing to pursue a career in medicine for prestige or financial rewards will likely be disappointing, as most physicians find that medicine is a vocation that requires a commitment to service, lifelong learning and the dedication to practice competently and compassionately."

WORK-LIFE BALANCE

However, there is a shift and a realisation of the importance of our lives outside of work. Family, friends, hobbies etc. all contribute to give our lives meaning. Each of us will have a different work-life balance but the importance and desire of achieving your balance is very similar.

The ASMS' own research published in 2016 (**https://www.asms.org.nz/wp-content/uploads/2016/11/Demographic-and-attitudinal-change-in-the-NZ-specialist-workforce-research-brief_166927.1.pdf**)

"As health care workers, we touch people's lives on a daily basis."

highlighted the increasing awareness and need to have a healthy work-life balance. "The importance of work-life balance across all age groups in the medical workforce is illustrated in a survey of Australian and New Zealand hospital doctors which found 81% of respondents want a better work-life balance by having more flexible working arrangements" (Australian Medical Association (AMA). AMA Flexibility Survey, 19 June - 30 July 2007, 2005).

Achieving a work-life balance is important but it is equally important to experience joy in your work. We know that burnout is affecting 50% of our SMO workforce. Burnout robs us of the joy that we should be getting from our vocation and the contribution that, that makes towards giving our lives meaning. The underlying causes and drivers that lead to burnout (and I include bullying and negative workplace behaviours) needs to be addressed to help restore joy in the workplace.

IMPROVING THE WORK ENVIRONMENT

The ASMS remains committed to improving our work environment, and in the new MECA there are several clauses that empower us to achieve that:

Employee well-being clause:

The employer and the employee agree to take reasonable steps to protect employees against harm to their health, safety, and welfare by eliminating or minimising risks arising from work and to promote employees' well-being.

Clause 13.6 Recovery Time:

By the expiry of this agreement, services that operate an after-hours' call roster are expected to have agreed arrangements in place that allow an employee to have an adequate break without deduction from full pay before commencing work following periods of on-call related work where the employee is too fatigued to safely undertake their next scheduled activity.

Clause 1.3 Patient-Centred Care:

Patient centred care was the central "theme" and driver for our most recent MECA negotiations. We did not reach an agreement with the DHBs on our proposed clause but that does not mean that we have forgotten about it. The last word on this topic has not been spoken.

Action from bullying and negative behaviours publication:

The ASMS Industrial officers are actively working with each DHB to help address this. Each and every one of us has a role to play, on a daily basis, to promote professional behaviour in the workplace.

This is my last President's column and I want to leave you with a few final thoughts. We manage patients every day but sometimes we forget how important our own health and wellbeing is, and how fragile life can be. We are not immortal. It is important not to postpone or wait for the future to start to make the changes necessary to address your work-life balance, experience joy in the workplace and find the answers to the question of what gives your life meaning. Philosophers tell us that the past has come and gone and there is nothing we can do to change that. Neither can we predict what the future holds for us. What we do have is today.

Master Oogway, the Kung Fu master in the DreamWorks movie, "Kung Fu Panda", summarises this beautifully: "Yesterday is history, tomorrow is a mystery but today is a gift. That is why it is called the present."

I wish you all the best and leave you with this final thought: "Don't wait for the perfect moment. Take the moment and make it perfect." ~ Unknown.

"There is a shift and a realisation of the importance of our lives outside of work."

DR JEFF BROWN AT HIS FAREWELL FROM THE ASMS NATIONAL EXECUTIVE

CONFESSIONS OF A SERIAL OPTIMIST – PART TWO

DR JEFF BROWN | ASMS NATIONAL SECRETARY (OUTGOING)

Excerpts from a book that may be written one day, reflecting on 19 years on the Executive including 10 as President and 5 as National Secretary. My first National Executive meeting was on 29 April 1999 at which there were 4 national office staff. I step down on 31 March 2018 from an Executive still with 10 members, and an office with 17 staff, humbled by a farewell that brought tears.

PROLOGUE

We used to be junior doctors. We worked over a hundred hours a week. This equated to an hourly rate of less than two dollars an hour. Some runs were constructed so that more hours on duty led to negative gearing of pay. After many gripes and grizzles, at last a semblence of organisation led to threat of strike. This was averted on a Saturday morning, with a central determination that exceeded any claim and still resonates some 30 years later. I was peripherally involved through heated discussions in the 'mess' at Auckland Hospital as a Paediatric Registrar. This exposed me to the power of collective action, spearheaded by Jeremy Cooper. Life as a junior doctor aka RMO was never to be the same again.

E kore e hekeheke, he kākano rangatira.

A noble heritage will never perish.

CHAPTER THREE: 1990S 'HEALTH REFORMS' – YEAH RIGHT

Soon after starting as a Paediatrician in Palmerston North I had the dubious pleasure of attending a lecture from Simon Upton on his Green and White Paper. As a newbie Consultant, little did I realise what he was proposing, and what ramifications it would have for the place I worked. We entered a brave new world: CHEs (crown health enterprises - state owned companies) competing for patients, doctors not allowed to share ideas on best practice, patients charged for outpatient clinic appointments, massive growth in administratium. We saw individual employment contracts to reward some with bonuses, which were meant to inspire others to compete harder. All well illustrated by Ian Cowan in his novel 'Not Our Problem'. The only positive I saw for SMOs was ratcheting from one CHE/HHS to another as only ASMS knew what each was offering, and could use this as the basis for invidual negotiations. Clinical practice was only preserved by doctors breaking rules and talking to each other. I saw that sharing, and collective action, was the only way to preserve our public health system from the rapacious jaws of overseas insurance companies, and the role of ASMS in this fight. I succumbed to the suggestion to put myself forward as Region Three representative.

CHAPTER FOUR: TASTE OF ACTION

Peter Roberts, then President, asked me to join him in a presentation to the Ministry of Health, at that stage in a battle for relevance against the RHA.

He supported me to conduct a role play to tease out the reality of medical resourcing. In a room full of policy wonks, we played out a scenario of truancy and glue ear. It became quite apparent that those in the room had no understanding that if more grommets were needed, the lag time to produce more ENT surgeons exceeeded the political cycle by a factor of five, and the job security of political graduates in esoteric modelling by even more. Peter convinced me that the vast gulf in knowledge between the Ministry boffins and those at the coal face needed individuals such as myself to fill in the gaps. I decided to stay on as Region Three representative, and was asked to help with the New Zealand Health Strategy in 2000.

Waiho i te toipoto, kaua i te toiroa.

Let us keep close together, not far apart.

CHAPTER SIX: ACCIDENTAL PRESIDENCY.

Phone call in Hannover from David Galler (Peter's successor). I was preparing to umpire at the first Indoor Hockey World Cup in Leipzig 2003. "Just fax this form so that David Jones can rejoin Executive". I did what was asked and accepted the role of Vice President to support both Davids. Walking down Lambton Quay a short time later, the shorter David is embraced by Annette King. Within weeks he is chief adviser to her, and I am acting President of ASMS. Sought counsel from several, and against advice of some that it would consume me, I took on the Presidency.

Early on found myself hosting both the Prime Minister Helen Clark and the Deputy Prime Minister Michael Cullen at the same Annual Conference. Baptism of fire, but exhilirating. And exhausting.

CHAPTER EIGHT: STOPWORK MEETINGS IN 2007

MECA negotiations stalling. Toxic relations stoked by their advocate. He was a great tool – for organising our side. (Read that again). Huge preparation. Huge anticipation. First stopwork meeting in Waitemata at North Shore Hospital. Five minutes before the scheduled start and three of the five SMOs present get up to answer their pagers. Tension. Potential disaster. Then floods of SMOs in white coats, in theatre scrubs, in civvies, all having checked on their patients before turning up for a meeting they have never experienced. Stunning support. Amazing activism. All with patients at the centre and the health system in the spotlight. Subsequent gatherings in Waitakere, Gisborne, Christchurch, Auckland which I fronted, and every other DHB through the country, reinforced the passion and pride in our public health system which we were not going to let a DHB advocate undermine nor a Minister abdicate responsiblity for.

CHAPTER ELEVEN: NATIONAL HEALTH BOARD

Invercargill, late 2009 evening after a bitterly cold summer day as technical officer at hockey World Cup Qualifier. Phone call from Minister of Health asking me to join National Health Board. I said I was likely to be conflicted as President of ASMS. He and chair of NHB rang back and convinced me to accept the appointment. Next six years opened my eyes to the machinations within the Ministry, and the priorities of the agencies the Ministry deals with in doling out 14 to 17 billion dollars each year.

One success was to abort a scheme to put posters in every GP surgery, and every hospital clinic, stating that your doctor could be rorting the health system, and it was your responsibility as a patient to dob them in. All because one phone call had not been passed on to a high ranking official. Pointing out the undermining of patient-doctor confidence and therapeutic relationships required much stronger argument than I ever believed would be necessary, but was eventually successful. To this day I do not know whether the posters were already printed, or we were merely shown some mockups.

In the end, the Ministry managed to scuttle the NHB Board by avoiding papers, sidelining recommendations, and ignoring advice. The Board was getting in the way of internal reforms and power plays to drive disruption and Uber-ise our health system. The Minister had no choice but to disband it.

He rangi tā matawhāiti, he rangi tā matawhānui.

A person with narrow vision has a restricted horizon; a person with wide vision has plentiful opportunities.

CHAPTER THIRTEEN: MECAS

Filibuster from Ian on May Day 2003 kicked off the first MECA negotiation. I have been heavily involved from the first national MECA to the fifth signed in 2017. The approaches varied from joint business case, to attempts at retrenchment and clawbacks. Outsourced advocates have lectured us on how important we are to the health system, whilst painting us as the greedy bastards who undermine everthing managers do to improve productivity. The most egregious has been Nigel Murray who lectured us on the morals of doctors, on the disgusting habits of SMOs who bleed the system, on the rorting of CPD and leave arrangements. He attempted to pound a wedge between the Executive and the Executive Director, to which we responded with derision. We withstood his bluster threatening legal redress for libel, for pointing out his actions and words. Subsequent events in British Columbia, and Waikato, have shown who has the true moral high ground.

I have lost count of the hours, days, weeks spent around tables in Wellington and other venues, getting to know our negotiating team very well, and the machinations and restricted options of DHB representatives operating with their fiscal arm tied into a straitjacket, which doesn't fit. I have learned that it may take more than one MECA to achieve a goal, especially if it is a very important one, that it is critical to have at least one eye on the long game. The fifth MECA built on the successes of the previous four and has achieved the greatest gain for the greatest number of our members.

Ko te pae tawhiti, whāia kia tata; ko te pae tata, whakamaua kia tīna.

Seek out distant horizons and cherish those you attain.

CHAPTER FOURTEEN: MINISTER OF HEALTH'S OFFICE AT 3AM

Ian and I had met with Minister David Cunliffe and DHB representatives. He was clearly pissed at lack of integrity of DHBs in negotiating, but made sure we were in the backwash. He gave a strong message to get it together, which led to the Time for Quality agreement. However, the subsequent inability of their advocate to read the tea leaves led to the Minister declaring a make or break gathering in the Beehive. Our team in one room, theirs in another, Minister as go-between. Started in the evening, went on into small hours. I suspect that doctors being more used to hard calls in the early hours of the morning was in our favour. A deal was finally completed by 3am. Shared a whiskey with Minister before a couple of hours sleep, then Executive meeting. That meeting endorsed our decision, and one diehard CMO critic instantly signed up as member at the news of a $10,000 lump sum.

Ko te kai a te rangatira he kōrero.

The food of chiefs is dialogue.

CHAPTER SIXTEEN: TOI MATA HAUORA

Despite its centrality, and its pinnacle place in medical politics, ASMS did not have an indigenous identity. This troubled me, as much as not knowing how to address the problem. Seeking counsel from many within and without ASMS, it became obvious that we needed to both seek an identity, and to seek it the right way. Working with Te Huirangi Waikerepuru of Ngāti Rauru and Taranaki led to his gifting of 'Toi Mata Hauora', and our reciprocal koha to Te Kōpae Tamariki Kia Ū Te Reo, his kohanga reo in New Plymouth. This respectful and long process has left a treasure, and responsibility, of which I am immensely proud.

Kia ū ki te pai.

Cleave to that which is good.

CHAPTER SEVENTEEN: NATIONAL RADIO AND TV

Alarm going off at 5am to get up in time to await telephone call, set up the night before, to be interviewed. Pre-recorded allows leniency for editing, but the risk of a convenient sound bite out of context. Voyage into studio for live recording, taking risk of on camera meltdown or

"I have learned that it may take more than one MECA to achieve a goal, especially if it is a very important one, that it is critical to have at least one eye on the long game."

"Outsourced advocates have lectured us on how important we are to the health system, whilst painting us as the greedy bastards who undermine everthing managers do to improve productivity."

even minor hiccough, but advantage of the moment with their only recourse to terminate after I have said my piece (or in the middle of it all).

CHAPTER NINETEEN: MEMBERSHIP IDEALS

Most managers come to work to do good. A few carry huge chips on one or both shoulders and seek every opportunity to knock doctors off an imaginary pedestal. There are an equal number of doctors who perceive their narrow view of medicine as the only true path to nirvana. These individuals consume an inordinate fraction of ASMS and DHB time to sort their peccadillos. I have come to see that there are many SMOs who passionately believe in their cause, but have been selected by high school, medical school, and postgraduate excellence, to see the universe in one dimension. I have struggled to represent these wonderful technicians while propositioning distributive leadership, with the accountabilities and responsibilities this demands. There are a few who reckon if they demand an action or concession, especially at the end of frustrating negotiations, that it can be achieved. The reality of months of tense to and fro, of offer and counter, of trading off possibilities for probabilities, can seem lost to their singularity of purpose.

He manako te kōura i kore ai.

Wishing for the crayfish won't bring it.

While celebrating what ASMS has done for individual SMO/SDOs, and for the preservation of our public health system, I wonder if we have the right balance. Do we call out our colleagues who are clearly in the business for their own advancement? Do we call out our representatives for trumpeting SMO power at the cost of collegiality? Do we honestly support our peers who bravely engage in leadership roles at the risk of denigration and ridicule?

My hope is that many of the more than 4000 SMOs and SDOs in our wonderful public health system will put their hand up to lead. By example in their daily job. By example in the practice of their profession. By joining local and national groups focussed on quality improvement. By seeking roles in ASMS, and other organs of power, to advance the notions of equity, fairness, and brilliance, to ensure that all citizens of Aotearoa enjoy the best possible health care.

CHAPTER TWENTY: SUCCESSION

A wise man told me there were two ways to get out of a job – do it badly so you are sacked, or find someone who really wants to take on your yoke. He later told me if you are doing a half-decent hack the latter will be hard to find. I never sought the Presidency, and certainly not a decade of it. But every time I thought I was lining up a possible successor they found other avenues for their skills. I was not prepared to just up and leave an institution that was part of my breathing. Fortunately I found another Paediatrician who agreed to consider taking the reins, on the condition I stayed on to guide – but in reality I only needed to be a sounding board. Hein has more than succeeded me, he has taken the Presidency to greater heights and the organisation into uncharted waters, with skill and courage beyond measure.

Māku te ra e tō ana; kei a koe te urunga ake o te rā.

Let mine be the setting sun; yours is the dawning of a new day.

EPILOGUE

The Association – Toi Mata Hauora – has consumed almost two decades of my professional life. Life without it will never be the same. I have seen it grow, seen it fight for individual members, seen it fight for our public health system, seen it fight itself. I believe I have grown with it, and it has grown me. It has afforded me opportunities to meet fantastic persons in politics, in health policy, in other health professions, and in our own membership. I have seen how good people can be driven or squeezed into doing bad things. I have seen a few bad people. I have mostly seen good people struggling to be better at what they do, and mostly succeeding. Due in no small way to the support of those they work with at the coalface, and the collective wisdom and authority of the Association when things get tough. It has been an honour to lead, to sit at the top table, to be a servant for so long. I have learned and gleaned far more than I have given, and that is lots. Thank you for reading my words, in prose or poems. Thank you for listening. I trust you all to support our leaders in the waka of the future.

Ehara taku toa i te toa takitahi, he toa takitini.

My strength is not as an individual, but as a collective.

ABOUT THE GIFT TO JEFF BROWN PICTURED ON THE FRONT COVER OF *THE SPECIALIST* AND ON PAGE 5 – HEIN STANDER SAYS:

This ātanga taonga was commissioned from Master Carver Paul Graham. It was gifted to Jeff Brown on 15 February 2018 on his retirement from the ASMS National Executive. Jeff has made an exceptional contribution, over many years of service, including 10 years as National President (2003 to 2013) and 5 years as National Secretary (2013 to 2018). Jeff played a pivotal role in the ASMS being gifted our Maori name (26 March 2013): Toi Mata Hauora.

When Paul was given the background of the multi-dimensional person he was creating the piece for, he proposed enhancing the 'circle of life' design, adding layered dimensions to depict the many aspects of health care Jeff has influenced and the many connections he has made over the years. Jeff will continue his journey in life as a long-serving paediatrician in Palmerston North and as the next President of the Royal Australasian College of Physicians, discovering and rediscovering the ways in which he will have a positive impact on health care in New Zealand.

THE PYGMALION EFFECT AND SELF-FULFILLING PROPHECIES

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

The effects of doctors' 'unconscious bias' on the treatment outcomes of Māori health service users is among the topics explored in the latest Health Dialogue: Path to Patient Centred Care, included with this issue of The Specialist.

In the education sectors, teacher attitudes towards students and their impact on student outcomes have been researched over many years around the world. A seminal study undertaken more than 50 years ago highlighted the powerful impact of teacher expectations on student achievement.

It took place in an American elementary school where they had students take IQ 'pre-tests'. In order to create an expectancy among teachers, they were told the test was the 'Harvard Test of Inflected Acquisition', which served as a measure of 'academic blooming'. After the results were scored, the researchers informed the teachers that five students in their class had unusually high IQ scores and would probably be 'late bloomers' – that is, they would most likely out-perform their classmates later in the year.

In truth, no late bloomers were identified; rather, these students were selected randomly. Nevertheless, the same test undertaken later in the year showed the five 'late bloomers' performed much better than the other students.

This study, which has become known as 'Pygmalion in the Classroom', was acclaimed when published in 1968 for its demonstration of how teachers' expectations determine, to a large part, students' educational outcomes. Simply put, when teachers expect students to do well and show intellectual growth, they do. Conversely, the experiment showed when teachers do not have such expectations, students' performance and growth are not so encouraged and they tend to perform relatively poorly.

Subsequent studies have produced similar results.

PYGMALION EFFECT

The 'Pygmalion effect' – or perhaps more aptly the opposite 'Golem effect' in which lower expectations placed upon individuals lead to poorer performance by the individual – is paralleled in health care. There is significant international evidence that health care providers hold stereotypes – often without being consciously aware of it – based on patient race, class, sex, and other characteristics that influence their interpretation of behaviours and symptoms and their clinical decisions.

In New Zealand this 'unconscious bias' in health care providers is a contributing factor among the multiple causes of health disparities between Māori and non-Māori. Studies have consistently demonstrated that some doctors treat non-Māori differently from Māori, to the detriment of the latter.

Examples include an analysis of data suggesting bias against Māori receiving cardiac revascularisation procedures even though the clinical need is much greater. Similar evidence of bias is available for outcomes following stroke, obstetric intervention, and asthma. General practitioner consultation times have been found to be shorter with Māori, and they are referred less often to further investigations than Pākehā.

Another recent study shows that significant inequities in timely access to surgical treatment for breast cancer exist, with Māori and Pacific women having to wait longer to access treatment than New Zealand European women. Overall, a high proportion of women did not receive surgical treatment for breast cancer within the guideline limit of 31 days.

And a study examining diagnostic and treatment pathways for Māori and New Zealand European men with prostate cancer found poorer outcomes for Māori men may not only be related to later stage at diagnosis but differences in treatment modalities may also be a factor.

A qualitative study exploring the experience of Māori patients with ischaemic heart disease compared with the experiences of the health professionals treating them found compliance to prescribed treatment, or perceptions of compliance, to be a key issue in the relationship between receivers and providers of care.

CULTURAL COMPETENCE

On the one hand, providers often held a generalised view of Māori patients as being non-compliant. On the other hand, Māori patients revealed a range of rational explanations for apparent non-compliance and also a wide range of health-seeking practices strongly congruent with what their clinical counterparts regarded as compliant behaviour. The researchers suggested the findings reflected "service providers' limited cultural competence to deal with the specificities of Māori health care".

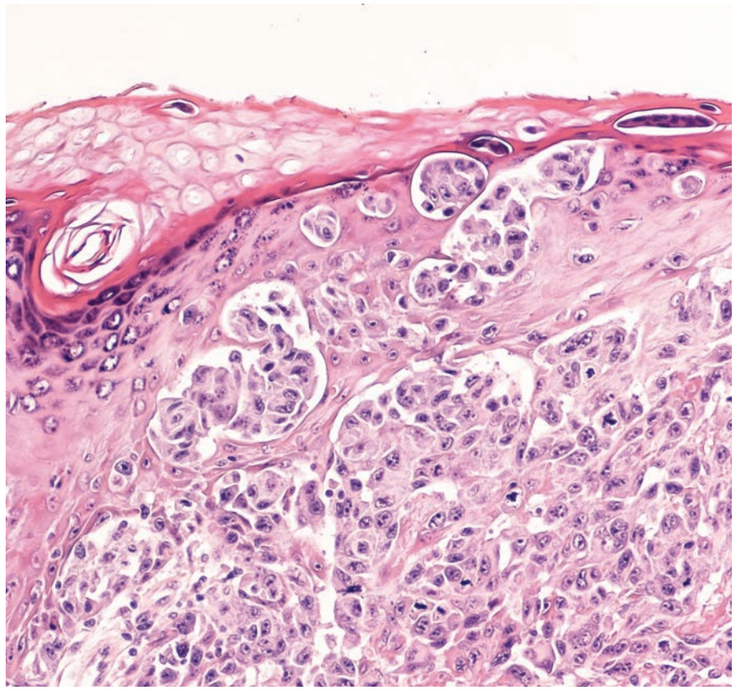
The Medical Council of New Zealand's approach to addressing cultural competency is to improve integration of cultural and clinical competence through recertification and continuing professional development processes, including Council-approved programmes which must include audit, peer review and team-based assessments to verify that individual practitioners practise competently and have an understanding and respect of cultural competence.

But how cultural competence is best learned and implemented in clinical settings remains a matter of debate. The literature suggests that whichever approach is taken, it is an ongoing process. Information components are generally well-received and can be developed over a relatively short period of time, but changing attitudes and sensitivities requires gradual and progressive engagement and effort – and, importantly, making time for self-reflection.

A study examining how doctors learn in the workplace suggests the kinds of endeavours needed for developing cultural competence requires protected time, away from the direct demands of patient care, to undertake 'deliberate practice' – a focused effort to reflect and develop performance aspects that need improvement. Hence the importance of full access to time for continuing medical education and the availability of relevant programmes.

Senior doctors also have an important role in instigating attitudinal change in their workplaces by leading by positive example in a model of distributive clinical leadership.

Note: References for studies mentioned here are available in the Health Dialogue: Path to Patient Centred Care.



PAUL JARRETT, MD. FRCP. FRACP.

THE FUTURE OF PUBLICLY FUNDED DERMATOLOGY SERVICES IN NEW ZEALAND: IT'S SPARTAN

PAUL JARRETT, MD. FRCP. FRACP. | DERMATOLOGIST, COUNTIES MANUKAU DISTRICT HEALTH BOARD AND PRESIDENT OF THE NEW ZEALAND DERMATOLOGICAL SOCIETY

At the battle of Thermopylae (480 BCE), a small number of remaining Spartans and Greek hoplites mounted a final, last-ditch defence against the invading Persian forces. The Spartans were strategically placed in a mountain pass. They held on as long as they were able but the final outcome is well known. There were none left at the end of the day. Hopefully publicly funded dermatology will not share the same plight. I will return to the Spartan theme later.

The problems for publicly funded dermatology are well known and nicely summarised in the Health Workforce New Zealand (HWNZ) report published in 2015.[1] Like many considered and well-constructed reports, it has been filed and no action taken. I am reminded of Neville Chamberlin arriving at Heston Aerodrome in 1938, "here is the paper…" This aspirational report for publicly funded dermatology proposes that "Health Workforce New Zealand, business units of the Ministry of Health and district health boards develop a cohesive plan that provides a sustainable, public sector dermatology service and workforce in New Zealand for 2020". A gentle reminder, that at the time of writing this article, 2020 is only 25 months away.

Where is publicly funded dermatology right now in 2018? The total full-time equivalent (FTE) public dermatology, documented by the HWNZ report, in 2014 for the nation was 16.4, giving a ratio of 1 FTE public dermatology to 274,146 of the population. This is a third-world statistic in a first-world country. The New Zealand population estimate in 2014 was 4.3 million but in 2017 that has risen to 4.79 million. A current estimate for 2018 is that there may be approximately 18 FTE dermatology nationally. There are various models for the ideal FTE:population ratio for public dermatology services. HWNZ suggests 1:100,000 for New Zealand, which is too high in my opinion. However, by way of contrast, in the UK in 2014 the actual ratio was 1:85,124.

"Many New Zealand hospitals do not have easy, or may have no, access to SMO-led dermatology services."

"Trying to obtain additional FTE is a Sisyphean task in the current funding climate for district health boards when other services are also in desperate need."

THE IMPORTANCE OF PUBLICLY FUNDED DERMATOLOGY

Does publicly funded dermatology matter? The New Zealand public rightly expects that if there is significant organ failure, somewhere close within a reasonable distance, an experienced SMO will manage that failure, be it cardiac, respiratory, marrow, etc. Unfortunately, this is not the case with skin failure as many New Zealand hospitals do not have easy, or may have no, access to SMO-led dermatology services. Approximately 2% of all New Zealanders have psoriasis, 20% of New Zealand children will suffer atopic dermatitis, and New Zealand, with Australia, has the highest rate of melanoma in the world. New and exciting therapies such as the third-line biologic agents for psoriasis need skilled advocates in New Zealand for their introduction and use. Quality of life issues for those unfortunate New Zealanders with significant skin disease are profound, as well as the loss of economic activity.

What about training and supplying new dermatologists to New Zealand? In 1979 there were six dermatology training positions when the total population was approximately 3.1 million. In 2018 there are five training positions. Trying to obtain additional FTE is a Sisyphean task in the current funding climate for district health boards when other services are also in desperate need. Integrating dermatology departments within established divisions of medicine with a supportive management, a practice that works exceptionally well in my own district health board, is a useful model. The Ministry of Health needs to recognise the value that hospital-based dermatologists can bring to patient care. In my previous life as a solo, hospital-based dermatologist, the manager said that "dermatology is not a priority"; hardly an attitude to engender enthusiasm.

DERMATOLOGY OUTLOOK

Could the outlook for New Zealand dermatology get worse? It is not the ASMS' role to comment or engage in the private sector, but in reality many SMOs successfully combine a public and private appointment. The two intersect to a degree. Approximately one third of New Zealanders have private health care insurance. It is expensive and unaffordable for many and the costs of premiums increase with age. Insurers don't always help. For example, one insurer is attempting to restrain their costs and exposure by trying to constrain contracts to dermatologists working in the private sector and additionally by offering lower remuneration rates to newly qualified specialist SMOs. This approach to the newly qualified, which I am informed is to be enacted by the insurer in all disciplines, further limits the options for SMOs. The mortgage and food bills need to be paid, so why train or work in New Zealand if there is no substantive employment?

The HWNZ report on the dermatology workforce is a useful framework, but now is the time to act. I am encouraged by my first attempts to engage the Ministry of Health in a discussion about these significant problems. We have a new government with a different philosophy and this could represent a pivot for change. Surely New Zealanders should demand and expect better public dermatology services.

So I ask my colleague public dermatologists, who I know to be hardworking and completely committed to the public and to public service, to pause a moment before trudging towards the 'mountain pass' while a dialogue starts. However, unless the dialogue is meaningful and with tangible outcomes, I fear that the future for dermatology in New Zealand is spartan.

REFERENCE

1. *Dermatology Workforce Service Forecast – November 2014.* Available at **http://www.health.govt.nz/our-work/health-workforce/workforce-service-forecasts/dermatology-workforce-service-forecast**

PROTECTING EMPLOYMENT RIGHTS FOR A FAIRER LIFE

ANGELA BELICH | ASMS DEPUTY EXECUTIVE DIRECTOR

Every now and then we see the words 'master and servant' in discussion about employment law. It reminds us that the one real right that employees have that is intrinsic to the employment relationship is the right to leave. It is what distinguishes us from the serf or the slave.

But every other right we have has had to be won from employers who at one time held the true power of a 'master'. Things such as the rights to time off, to bargain, to organise with other 'servants', the right to safe conditions, and the right to fair treatment and protection from discrimination on the basis of race or sex have accumulated gradually. Some were won first from employers and then taken into law. Some were won through the law requiring employers to improve conditions.

But many rights can go in a flash, as we see in the euphemistically titled 'right to work' states in the United States, or in New Zealand under the Employment Contracts Act. ASMS members did better than some other employees under the Employment Contracts Act, but many will remember the struggles that they went through to gain collective employment contracts, transparent salary scales and decent conditions. All New Zealanders were left with the Employment Contracts Act's legacies of increasing inequality, falling life expectancies for sections of our community, and wages that kept large sections of the community in poverty.

THE FINAL BLOW TO THE ARBITRATIONIST SYSTEM

The Employment Contracts Act, which came into force in 1991, is often talked about as a sudden cataclysm, which in many senses it was. However, it can be viewed as the final blow to an arbitrationist system which had served New Zealand for nearly a century. In return for the reinstitution of compulsory unionism, private sector unions in 1986 gave up the compulsory arbitration that had ultimately allowed a court to adjudicate on terms of employment, even when the employer was unwilling to take part. The state sector was forced to follow with the State Sector Act in 1987. The basic concept behind that system was the concept of fair relativity where the complexity of tasks and training were weighed and adjudicated on. Occasionally ASMS members will refer to the days when their salaries were set by the Higher Salaries Commission. Now called the Remuneration Authority, this last relic of the arbitration system now sets the salaries of MPs and judges. It continues to work well for them.

"Whether we are high-income or low-income employees, we have an interest in ensuring good policy development in support of fairer, wealthier, and healthier lives."

"ASMS members did better than some other employees under the Employment Contracts Act, but many will remember the struggles that they went through to gain collective employment contracts, transparent salary scales and decent conditions."

It has become clear that the result of the sweeping away of the arbitrationist system was unexpected, both to at least some members of the governments that passed them and to the unionists that viewed the system as the 'leg irons of labour'. Both thought that unions were strong enough to defend working people without the elaborate arbitrationist structure. This proved to be the case for most state sector unions, particularly those that represented a workforce of professionals. In the private sector though, many unions were wiped out and much of the workforce was left with no union and no power to negotiate. Union membership as a percentage of the workforce has declined since the early 1980s from 60% to 18.7% today. The Employment Relations Act (passed by Helen Clark's government), which came into force in 2001, hoped to rectify that through its primary aim of promoting collective bargaining. Disappointingly, but unsurprisingly, it did not.

ATTEMPT TO EXCLUDE HIGH EARNERS FROM PERSONAL GRIEVANCE PROVISIONS

Helen Clark's government strengthened the Act in 2004. The Key government largely rolled back the 2004 changes and weakened the Act further by introducing the 90-day trial period where new workers (initially in small businesses but later spread to all employees) can be dismissed for no reason during the first 90 days of their employment. The notorious 'hobbit law' was also passed by the Key government, which redefined film workers as contractors irrespective of the law that applied to all other employees. The parliamentary members' Employment Relations (Allowing Higher Earners to Contract Out of Personal Grievance Provisions) Amendment Bill, which exempted high earners from the personal grievance provisions, was also making its way through Parliament. The Association made submissions opposing both the 90 days 'fire at whim' law and the more recent attempt to exclude high earners.

Excluding high earners and new employees from the personal grievance provisions of the Employment Relations Act takes aim at the personal grievance provisions which protect employees from arbitrary dismissal. This protection was extended to all employees by the Employment Contracts Act and, given the collapse of collective bargaining in the private sector, is one of the major protections left to all New Zealand employees. Without these procedures, including free fast and fair mediation, higher-income employees would have to fall back on litigation through the High Court. Costs would be very high.

Using the Employment Relations Act to lift private sector employees out of static or low wages has been pretty much a failure, though for the minority of private sector workers who are covered by collective agreements, there is still a union premium. This is not just a moral problem. Low or static wages may be affecting overall national productivity as well as increasing inequality and failing to address poverty.

State sector unions with a long history of voluntary membership were in a better position than private sector compulsory unions when the Employment Contracts Act was introduced. Compulsory unions were not able to transfer resources readily to recruitment. They were also largely underfunded because their secure membership base had been built into fees and into the failure to build up reserves. The organising techniques that were such a revelation to private sector unions in the 1990s were built into the voluntary state sector unions' DNA. State sector organisations were also usually large employers. Unions faced with negotiating with thousands of small employers in the absence of compulsory unions and awards covering large employment groups faced an impossible task.

In practice, employers have proved generally unwilling to share productivity gains and improve wages unless compelled and, in the private sector, except in the small percentage of private sector workers who are union members, there is in any case no mechanism to do this. Unions have instead campaigned on the minimum wage, the living wage and parental leave, influencing public opinion, influencing governments and taking cases to court which have improved working conditions for entire classes of people.

IMPROVEMENTS TO WORKING LIVES

Improvements have been made by the Clark, Key, English and now Ardern governments through 'Working for Families', increasing the minimum wage, strengthening health and safety legislation and extending parental leave. Cases have been taken by unions which resulted in changing conditions for employees who sleep over at their place of employment and employees who must spend a lot of time travelling between places of work.

The conceptual breakthrough which may result in real change has come through using legislation long thought to be well past its use-by date (in fact, Margaret Wilson, Minister of Labour in the Clark government had been seriously

considering its repeal) – the Equal Pay Act. This law was used by unions to make the case for equal pay for caregivers. The judiciary agreed. The politicians followed.

The suite of changes to employment law announced by the new Employment Relations Minister Iain Lees-Galloway (see box) signal the restoration of some of the changes weakening collective bargaining made by the Key government and make the ASMS position somewhat stronger in the DHB sector. They will have even more of an impact for our 241 members employed by other employers. None of our members are likely to be offered the 90-day fire-at-will provision still retained as a result of coalition agreements watering down Labour opposition to them. However, for those of our members concerned about inequality and poverty in the community and their health consequences, the signalled 'fair pay' agreements may offer a way to address the large proportion of the workforce untouched so far by the union movement.

The genesis of these was the industry agreements that were promoted by the late Helen Kelly. The idea was to provide a base set of terms and conditions for each industry. (This is still the practice in much of Australia.) It is unclear precisely how these agreements will work, the legal mechanisms that will allow them to take place or when the government will introduce them. ASMS has been strong enough and lucky enough to have avoided the effects of weak employment law on our members' terms and conditions, but there is a case for employment law to be regarded as of concern to our members as one of the social determinants of health.

Many rights won by unions over long years of campaigning remain. All have been threatened at some point. Whether we are high-income or low-income employees, we have an interest in ensuring good policy development in support of fairer, wealthier, and healthier lives.

SUMMARY OF CHANGES IN THE EMPLOYMENT RELATIONS AMENDMENT BILL

RECTIFYING THE PREVIOUS GOVERNMENT'S CHANGES

- Restoration of statutory rest and meal breaks.
- Restriction of 90-day trial periods to SME employers (less than 20 employees).
- Reinstatement will be restored as the primary remedy to unfair dismissal.
- Further protections for employees in the 'vulnerable industries' (Part 6A) on transfer to a new employer.

COLLECTIVE BARGAINING AND UNION RIGHTS

- Restoration of the duty to conclude bargaining unless there is a good reason not to and repeal of the process to have bargaining declared over.
- Restoration of the earlier initiation timeframes for unions in collective bargaining.
- Removal of the MECA opt out where employers can refuse to bargain for a multi-employer collective agreement.
- Restoration of the 30-day rule where for the first 30 days new employees must be employed under terms consistent with the collective agreement.
- Repeal of partial strike pay deductions where employers can garnish wages for low level industrial action.
- Restoration of union access without prior employer consent provided access is at a reasonable time and place and has regard to business continuity, health and safety.

NEW PROPOSALS

- A requirement to include pay rates in collective agreements.
- A requirement for employers to provide reasonable paid time for union delegates to represent other workers (for example, in collective bargaining).
- A requirement for employers to pass on information about unions in the workplace to prospective employees along with a form for the employee to indicate whether they want to be a member.
- Greater protections against discrimination for union members.

REFERENCES

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WHAT'S BEHIND THE MINISTRY'S POOR PERFORMANCE?

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

'Efficiency' is a word often taken to imply 'doing it for less'. Budget cuts are expressed in terms of 'efficiencies'. By this standard, the Ministry of Health has achieved remarkable efficiencies. Its operating budget for the 2017/18 financial year is an estimated 17% less than it was in 2009/10 in real terms. It now operates with 370 (26%) fewer staff – and fewer still if temporary staff are excluded.

Nor is there any suggestion that the Ministry's workload has decreased. If anything, it has most likely become increasingly more challenging as health service budgets have lagged behind the country's growing health needs. The cuts to the Ministry's resources do not appear to have been guided by any evidence that it had expendable capacity or responsibilities; rather, it was a part of government policy to reduce the size of government, primarily by systematically 'capping' – or cutting – staffing levels. The implicit assumption was that the public sector could achieve more for less.

As the State Services Commission (SSC) puts it: "The key to doing more with less lies in productivity, innovation, and increased agility to provide services. Agencies need to change, develop new business models, work more closely with others and harness new technologies in order to meet emerging challenges."

However, the SSC's review of the Ministry's performance, released after the general election and in the customary 'bury it' period just before Christmas, demonstrates the facileness of those words. And the stressful conditions for staff is palpable.

YEARS OF CHANGE TAKES A TOLL

While the SSC calls for change, new business models, innovation and 'increased agility', its review points out: "The Ministry has had a high degree of internal change and uncertainty in recent years at a leadership, organisational and policy level," which has "impacted on the organisation's agility and cohesion".

Further, the Ministry is currently "undertaking an ambitious restructure of its organisation" – ironically named 'Ministry on the Move'. But this is "a

"The review in general paints a picture of a Ministry that has lost touch with the sector."

"As a consequence of the Ministry's struggles to cope with cuts to resources over the past nine years, its performance ranking is 'weak' in a number of key indicators."

significant additional programme of work on top of its normal operational requirements and delivery of government priorities". The review adds that "the current resources and capability allocated to do this are insufficient for the scale, scope and timing of the changes required".

Noting the Ministry has cut its 'Capability Investment' budget, the review comments: "This combined with the reduction in funding for the Ministry on the Move transformation is concerning and has significant risk associated with it given the extent of change resulting from the restructures."

The review also reported that staff and external stakeholders were anxious that there are no new resources to support implementation of the Health Strategy ("to date there does not appear to be momentum in progressing it") while also maintaining essential services.

There is ample evidence internationally showing the destructive links between inadequate staffing, high levels of stress, disengagement and reduced productivity. It is also well established, including in the ASMS' own research, that stressed workplaces take a toll on employees' health and morale, which in turn can lead to negative behaviours and impact on retention.

With regard to the Ministry: "Turnover has been high and at times the Ministry has struggled to recruit required capability, often using external advisors and consultants to fill the gaps." The day-to-day "work culture, values and behaviours" need attention, as does "an apparent tolerance for what is at best described as a lack of respect for colleagues in pockets of the Ministry..."

On the matter of external relationships, "the Ministry has indicated that its strategy is to move from a focus on predominately transactional activity into relational activity". But at present: "We heard universally that the Ministry's relationships are at an all-time low." Tensions with Canterbury District Health Board (CDHB) were given special mention. "Until both the Ministry and CDHB can work more constructively together, it is hard to see how performance is likely to improve."

A key issue was that the Executive Leadership Team (ELT) faced a challenging environment in which it needed to "form and storm", but because "the ELT has spent considerable time working on itself", leadership is "invisible in the Ministry and across the system".

POOR PERFORMANCE RANKING IN KEY INDICATORS

As a consequence of the Ministry's struggles to cope with cuts to resources over the past nine years, its performance ranking is 'weak' in key indicators such as implementation of the New Zealand Health Strategy, leadership and governance, 'values, behavior and culture', collaboration and partnerships, its operating model, management of people performance, and engagement with staff.

While the cost of these failings to the health sector overall is indeterminable, it is likely to be significant. Responsibility, however, is a moot point. The SSC review highlights shortcomings in the Ministry's leadership, but does not question the Government's fiscal policy that underpinned the conditions in which the Ministry worked.

Finally, the review in general paints a picture of a Ministry that has lost touch with the sector. In the reviewers' words: "The Ministry needs to ... fully understand its customer base." 'Customer' is used throughout the report, "the core customer being the people of New Zealand receiving health services". On issues of 'collaboration and partnerships', in what the reviewers describe as a 'fragmented' health system, they note that while the Ministry has made progress in collaborating with cross-sector agencies, it needs to bring a holistic view of the customer to the table rather than a clinical view. All of which raises questions as to the extent to which the reviewers themselves are in touch with the sector.

Following the release of the SSC report, Health Minister David Clark said the Government would consider the review's findings and would refer the report to his new Ministerial Advisory Group. The level of funding allocated to the Ministry will be one of many points of interest in this year's Council of Trade Unions/ASMS analysis of the Health Budget.

"While the cost of these failings to the health sector overall is indeterminable, it is likely to be significant."

"We plan to extend non-DHB coverage and welcome enquiries from members or prospective members working outside of the DHBs."

COLLECTIVE BARGAINING IN THE NON-DHB SECTOR

LLYOD WOODS | SENIOR INDUSTRIAL OFFICER

There are now approximately 240 ASMS members employed outside of DHBs, and this number is steadily increasing. The various collective agreements in place are key to this. Although often small to start with, these collectives often grow over time.

Collective agreements are in place for members employed at: -

- Otara Whanau Medical Centre
- New Zealand Family Planning Association (see separate article in this issue of The Specialist)
- Wellington Southern Community Labs
- New Zealand Blood Service
- Ashburn House
- Compass Health
- ACC
- Christchurch Union Health
- Ngati Porou Hauora (Gisborne)
- ACC
- Hospice Whanganui
- Oamaru Hospital (Waitaki Health Services)
- Dunstan Hospital (Central Otago Health Services)
- Union and Community Health Christchurch
- Te Runanga O Toa Rangatira (Porirua)
- Hokianga Health Enterprise Trust
- Golden Bay Health.

We also have two collective agreements covering multiple employers:

- The 14 hospices Hospice MECA
- The 4 Wellington Union Health Services

Aside from those covered by collective agreements, we have a further 26 members working in smaller organisations or where there are too few (often only one) members for negotiation of a collective agreement.

The industrial team is busily negotiating one or more of these various collective agreements on a fairly constant basis. While this can be challenging, we see it as part of the Association's role in providing professional and industrial advice and support across the wider health sector.

We plan to extend non-DHB coverage and welcome enquiries from members or prospective members working outside of the DHBs part or full time in the dental or medical areas.

IN YOUR OWN WORDS

Here is a sample of comments by individual doctors provided as part of the ASMS survey on bullying in the senior medical workforce. The results of the survey are available on the ASMS website (**www.asms.nz**) under 'publications'.

"I AM ANXIOUS AND SLEEP POORLY. I AM STRUGGLING IN MY PERSONAL RELATIONSHIPS BECAUSE I FEEL LIKE I SHOULD BE ABLE TO COPE BUT DON'T SEEM TO BE ABLE TO. WHEN I WAS INJURED AT WORK, I WAS GIVEN THE IMPRESSION THAT I WAS SOMEHOW RESPONSIBLE OR THAT I HAD MISINTERPRETED WHAT HAD HAPPENED."

"Bullying by patients and their relatives is very difficult to deal with and results in feelings of resentment and ultimately, lack of empathy towards that patient with disinterest in their outcome. I think that the same behaviour by colleagues is even worse and does lead to anxiety outside of work hours."

"I have disengaged from the workplace. I do not socialise with many of my colleagues when I once did so. It has affected my mood and mental health."

"Destroyed me personally and professionally. At times it is very difficult to cope. I have gone through many nights of no sleep and severe stress related physical symptoms."

"I have little enjoyment for my job. I feel disenfranchised, disappointed and depressed about the public health system and what its future is."

"Feeling demoralised at times and powerless to change it, considered changing professions, impact on ability to be as fully present for my children."

"Withdrawn from leading role. No longer voice opinion - just come in, do clinical work and leave as soon as possible. No longer believe in transparency or sincerity of management."

"IT IS DEMORALISING, UNPLEASANT, UNDERMINING AND IMPACTS ON BOTH PROFESSIONAL AND PERSONAL LIFE."

"I have stopped working in a particular area and reduced my interactions with that group as much as possible. This affects my area of practice and skill base and also the care available to patients, which is harder to access now that I do not do the procedures myself."

"MY UNDERSTANDING OF BULLYING IS THAT IT INCLUDES PLACING UNFAIR DEMANDS ON PEOPLE AND CAN BE CONSTITUTED BY AN EXCESSIVE WORKLOAD AS OPPOSED TO SIMPLY BEING 'TRADITIONAL' BULLYING BEHAVIOUR OF PHYSICAL/VERBAL/SEXUAL INTIMIDATION ETC. IF THIS IS THE CASE THEN I WOULD CONSIDER MY CURRENT WORKING CONDITIONS TO CONSTITUTE BULLYING EVEN THOUGH I HAVE NOT EXPERIENCED 'TRADITIONAL' BULLYING. THE INHERENT IMPLICATION THAT ONE IS NOT MANAGING ONE'S WORKLOAD DUE TO INEFFICIENCIES, INABILITY TO CHANGE OR ADAPT SYSTEMS IS WEARING. FOR ME THIS (PLUS SOME PERSONAL FACTORS THAT WERE POORLY ACCOUNTED FOR AT WORK...) LEAD TO BURNOUT AND THE NEED TO TAKE A MONTH OFF WORK."

"A valued colleague has left the department, in part due to bullying behaviour, this upset me quite a lot. Mainly the behaviour is directed to the younger, female members of the department. I have been actively avoiding interacting with the 'colleagues' who behaved badly to my valued colleague that left, other than what is absolutely necessary for patient care. Personally, I have decided to take more annual leave, I have stopped volunteering for extra shifts (so I can utilise my time off) and I try to worry less about things out of my control. The department is aware of the recent problems and actively finding ways to resolve them and prevent future issues, which has been encouraging."

BRIGID CONNOR (CENTRE), WITH FRIENDS KIRSTY DAVIES (LEFT) AND TERESA KERR (RIGHT).

DR BRIGID CONNOR IS AN INTERVENTIONAL RADIOLOGIST WITH AUCKLAND DISTRICT HEALTH BOARD AND ASMS' AUCKLAND BRANCH PRESIDENT.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

I was really unsure what I wanted to do but knew I was sick of school, so actually spent a couple of years after school working before finally deciding on medicine. I spent a year working in sales and a year as a chairside dental assistant. I'd been wondering about something 'sciencey' or in a lab, but, after a visit with a haematologist friend of my mother's, decided medicine would be a good leaping off point. To be honest, one of the main selling points was that he was not my mother! Having someone other than her suggest that medical school was the right option for me made a big difference.

I went to see him to check out the lab and he said, "Do medicine first. If you still want to work in a lab after that, you can run it." It made good sense. Now I work in a different kind of 'lab'.

So I went off to Otago and did the full six years in Dunedin. Loved it! Such a great university city, and we were a very tight-knit clinical group.

I had designs on surgery initially, like most of my class, and flirted with the idea of vascular surgery. The turning point was a radiologist who took us for teaching while I was a house surgeon in Tauranga. She was so knowledgeable about everything, and seemed to have this great role of sorting out what was going on in the mystery patient. I wasn't sure about moving off the ward, so would spend any spare moment I got as a second year hanging out in the department with her, seeing if I thought I could become a denizen of the dark. Once I hit radiology and got a taste of interventional radiology, I felt I'd finally found my niche. Best of both worlds.

I did my house officer years in Tauranga and then moved to Auckland when I got on the radiology training scheme. At the end of my training I planned to head off overseas but I decided to stay on in NZ when my mother was diagnosed with cancer. Thankfully, she came through surgery and chemo like a star, and I then headed off to explore. I locumed my way around the UK, starting in the Channel Islands and then basing myself in London, working from as far south as Gibraltar and north to the Western Hebrides. In between jobs I travelled in Europe and Africa.

"I know it sounds cliched but I really do like helping people."

The call of an interventional fellowship in Auckland, along with family, brought me home and I've stayed here since, with regular trips to other parts of the globe. Those who know me know I need little excuse to travel, it's a passion, but I have two gorgeous nephews who live in Berlin, so that's another reason for regular trips to the other hemisphere.

WHAT DO YOU LOVE ABOUT YOUR JOB?

I know it sounds cliched but I really do like helping people. The need to get informed consent for IR procedures means I get a chance to chat to people about their condition one on one, and sometimes that's the first chance they feel they've had to ask lots of questions. I need to give them some complex information while still making them feel at ease - I'm told my bedside manner's not bad - and being able to do that in language anyone can understand is something I work hard at. Helping to ease someone's symptoms or treat their cancer is great - and who doesn't love a good pus drainage!

My job is constantly changing with new technology and equipment. I would love to feel like more of an expert but the goal-posts keep shifting. There are relatively few women in IR, and I'd like to be part of the story in terms of promoting the specialty amongst women.

For all of the challenges of working in a cash-strapped system, we are at the front line. It's great to know that you are part of a team that I think does really well when the chips are down.

WHAT ARE SOME OF THE MOST CHALLENGING ASPECTS OF PRACTISING MEDICINE?

We just seem to keep getting busier and busier and are expected to do more with less. I think the drive to save money has resulted in some great improvements and efficiencies, but I'm not sure there's any fat left in the system. Also, while the public are generally very grateful for the health system, I think expectations have changed as we've moved on from our historic paternalistic practise and that brings a new set of challenges. Patients (rightly) are now much more involved in their health and they no longer just accept that the doctor is always right. Sometimes that can be difficult when they are unwilling to accept the advice they are being given, and want something else despite evidence of no benefit, or perhaps harm. To be fair though, in secondary and tertiary medicine we are much more shielded from this than our colleagues in general practice and the emergency department.

WHY DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

I think unions are important, and strongly believe that if you are not prepared to get involved and try to help enable or institute change, then you probably shouldn't complain about your lot. I was involved in the RDA as an RMO, so there was a sense of continuation to be in ASMS as an SMO.

I've met some incredibly committed people, made friends, and learnt a whole lot more about different specialties and DHBs around the country. Still think I've just scratched the surface of how the health system works in this nation of ours!

"I've met some incredibly committed people, made friends, and learnt a whole lot more about different specialties and DHBs around the country."

"The policy objective of a 'smart system' depends largely on capital investment."

"Successful use of technology depends to a large extent on distributive clinical leadership."

'DISRUPTIVE INNOVATION' OR 'ENGAGED' INNOVATION?

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

Internationally, implementing distributive clinical leadership and making better use of new technology are two key topics that arise frequently in discussion about how to address mounting pressures on national health systems.

The first has been shown to improve quality and cost-effectiveness, *when implemented properly;* the second can also improve quality and access to services, *when implemented properly* – which generally requires engagement with the end-users (ie, clinicians, and often service users) in the appropriateness, design, development and use of the technology. In other words, successful use of technology depends to a large extent on distributive clinical leadership.

This does not appear to be recognised by the Ministry of Health, which has promoted the idea of 'smart systems' (better use of technology) over recent years as a solution to the challenges faced by our health services. Nor is there any sign that the State Services Commission (SSC) reviewers of the Ministry's performance are any wiser. Their idea of engagement, outlined in the SSC's recently released performance report, is heavily focused on the 'customer'.

Increasing emphasis in promoting greater use of telemedicine (TM), for example, is intended to improve access to clinical services that would otherwise be unavailable, especially in rural areas, while at the same time reducing specialists' time spent travelling to provide outreach clinics.

PROS AND CONS OF TELEMEDICINE

As discussed in the *Health Dialogue* on patient centred care included with this issue of The Specialist, in certain specific conditions this can work successfully, but TM also has it downsides and risks, and its value as a broad-based tool is contested, which in turn has led to a slow uptake.

TM services, when they are properly planned and resourced, and when they are thoroughly assessed as being appropriate to the circumstances, can complement effective health care delivery, but the available evidence shows they are not a panacea, and they will fail if they are done on the cheap. In other words, engagement with clinicians on the ground – ie, distributed clinical leadership – is critical to introducing TM successfully.

Waikato District Health Board's recent controversial 'smart health' initiative, driven by disgraced chief executive Nigel Murray, is an example of how things can go badly wrong when clinicians are bypassed in the initiation, planning and development of IT projects. In this case the initiative, called 'Health Tap', is reported to have cost up to $17 million and is now under investigation for its reliability and usefulness, as well as its procurement process.

Dr Murray's approach may also be seen as an example of 'disruptive innovation' whereby change is imposed upon workplace practices as a *fait accompli.* It is the antithesis of clinical engagement because engagement is seen by some policymakers and managers as providing opportunity for clinicians to resist change if they don't like the look of it.

DISRUPTIVE INNOVATION

'Disruptive innovation' is becoming the fashionable policy approach – at least within the Ministry – to breaking those perceived barriers. The recently departed Director-General of Health, Chai Chuah, like Dr Murray, spent large sums of money engaging private enterprise in Silicon Valley to advise on using 'disruptive innovation' for 'technology solutions' to New Zealand's growing health needs.

But as a way of bringing about improvement in health care services, the 'disruptive innovation' approach must be seriously questioned. While for some time the claimed effectiveness of 'disruptive innovation' in the business world, from where it originates, was subject to little serious criticism, recent scrutiny has found it is based on shaky retrospective evidence.

The outcome of intentionally disrupting a system or practice is, by definition, wholly unpredictable. When such an approach is used in complex adaptive systems such as health care, the unforeseen consequences can be far reaching. As such, it is difficult to envisage a hope-for-the best 'disruptive innovation' approach gaining traction with those responsible for the care and safety of patients, whose professional codes and practices are rooted in evidence and ethics. And it runs directly counter to the call from the Prime Minister's Chief Science Advisor, Sir Peter Gluckman, for government policy to be evidence-based.

ASMS Executive Director Ian Powell describes the idea of introducing new technology through disruptive innovation approach as "a distraction thought up by people who live in bubbles … Technology is an enabler, not a driver of change."

And if the critical link between clinical engagement and technology is unrecognised by policymakers and administrators, so too, it appears, is the link with funding.

THE NEED FOR CAPITAL INVESTMENT

The policy objective of a 'smart system', which is heavily emphasised in the New Zealand Health Strategy, depends largely on capital investment. But there is mounting evidence, including concerns raised by the Auditor-General, that years of financial constraint in the health system have led to deferred maintenance and under-investment in buildings and equipment, including technology.

The disjuncture between promoting greater use of technology and reducing capital investment is illustrated in the SSC's review, which supports the Ministry's aims to make greater use of technology but at the same time notes: "Most of its corporate systems are at the end of their useful life. Over time there has been significant under-investment in technology solutions needed to support its own work and that of the health system."

Lack of funding is not acknowledged.

While the SSC review finds a need for greater coordination and integration of services both within the Ministry and throughout the health system generally, a similar argument could be put for more coordinated and integrated use of evidence-based health policies and how they are complemented by broader fiscal policies.

Rather than depending on private entrepreneurs from Silicon Valley to advise on solutions to our health system's challenges, New Zealanders are likely to be far better served if policymakers and administrators engaged with those who hold the greatest wealth of knowledge about how to improve our health services – the country's clinicians.

FAMILY PLANNING SETTLEMENT

SARAH DALTON | ASMS INDUSTRIAL OFFICER

After a tough bargaining round, which included after much frustration a membership ballot in favour of industrial action, the Family Planning Association collective agreement has been settled for a two-year term from November 2017.

Our members in this service have, until now, been some of the lowest paid salaried doctors in NZ. Thanks to an 8% pay increase, some will now find themselves earning salaries on a par with salaried GPs employed outside DHBs and negotiated by ASMS. Even so, we have a long way to go to find achieve parity with colleagues working in DHBs.

It was disappointing that Family Planning refused to move on annual leave. Family Planning doctors are entitled to the statutory minimum of four weeks' leave each year. Given our findings on fatigue and burnout – along with a growing focus on wellbeing in the workplace – it is puzzling to find an organisation with healthy financial reserves so reluctant to make fundmental improvements to conditions of work.

There is a strong commitment from our members to lay the foundations for movement on this and allied working conditions before the next bargaining round in 2019.

VITAL STATISTICS

The total amount of capital charges paid by district health boards to government for the year to June 2017: $174.2 million (1.9% of total DHB revenue).

The total amount of interest paid by DHBs on Crown loans for the year to June 2017: $57.9 million (0.6% of total DHB revenue).

Total DHB depreciation expense for the year to June 2017: $393.7 million (4.4% of total DHB revenue).

NOTE:

DHBs pays a capital charge on the Crown's capital (equity) investment twice a year on 30 June and 31 December. It was 8% p.a. up to 30 June 2016. It was reduced to 7% for the six months to 31 December 2016, and to 6% for the six months to 30 June 2017.

SOURCE:

Ministry of Health 2017

DID YOU KNOW

... ABOUT SALARY INCREASES

With effect from 5 March 2018, all ASMS members will be getting salary increases for both the specialist and medical/dental officers' scales. We are reminding all DHBs about these increases in the current round of JCCs and thus far all DHBs have indicated that the processes are in place to ensure that the increases are paid. You should check your payslip though!

For those of you who have been on the top step of the current scales for at least 12 months on 5 March 2018, you will be eligible to advance to the first additional step on this date (step 14 for Medical and Dental Specialists and step 13 for Medical and Dental Officers). Again, we have been assured by the DHBs that the processes are in place to ensure this occurs, but you should still check your payslip.

Those who have been on the top step for less than 12 months on 5 March 2018, will be eligible to advance to the new step on their usual anniversary date. For example, if you advanced to the current top step on 1 May 2017, you will advance to the new additional step on 1 May 2018.

... THAT YOUR YEARS OF SERVICE MIGHT NOT MATCH YOUR SALARY STEP?

Members frequently ask why if they have been working for a certain number of years as an SMO they might not be on the same salary step (for example – working 12 years but on step 9).

This is, in fact, quite normal and there is a simple (sort of!) explanation. The MECA for December 2011 until 28 February 2013 changed the steps such that the numbering of steps 4 and upwards went down by three. The value of the steps rose (salary increase) but the number of the step reduced.

This means that for an SMO who started, for example, in October 2006 they would currently be in their 12th year of service and be on step 9. This is as expected, but if you have any concerns as to whether you are on the correct step you should contact your Industrial Officer.

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'.

NEW ZEALAND MEDICAL ASSOCIATION

PATRON: HER MAJESTY THE QUEEN 26 THE TERRACE, P.O. BOX 156, WELLINGTON. TELEPHONE (04) 724-741

Ref: AK PRO 105/1

10 January 1989

Dr HRR Glennie
Suite 1
243 Remuera Road
Remuera
AUCKLAND 5

Dear Dr Glennie

Thank you for your letter of 30 November 1988 requesting details of the union.

It is going to be registered in the name of the Association of Salaried Medical Specialists and will be an organisation that is legally separate from the New Zealand Medical Association. This is the easiest way in which to preserve the professional role of the New Zealand Medical Association without losing negotiation rights available to the Union. A recent survey of members and potential members has indicated that the union will be affiliated with the New Zealand Medical Association in some way; however this will not be decided until the National Executive of the Union has been democratically elected.

The Union structure is as follows:

(a) An Annual Conference which has the highest decision making authority of the union;

(b) The National Executive consisting of 10 members (president, vice-president, secretary/treasurer elected nationally, and 7 representatives elected regionally);

(c) Branches based on area health and hospital board boundaries; and

(d) Hospital or work place delegates whom we presume will be elected by senior medical staff associations.

If the Annual Conference feels that a decision it has to make is of such importance that the views of all members are required then a secret postal ballot of the membership will be held. It is intended that the union will be using the secret postal ballot more than most unions in order to maintain democratic representation of views.

The term of office for the National Executive members will be 2 years and for the Branch Members 1 year. There is no limit on the number of terms of office.

AFFILIATED WITH THE BRITISH MEDICAL ASSOCIATION AND THE AUSTRALIAN MEDICAL ASSOCIATION

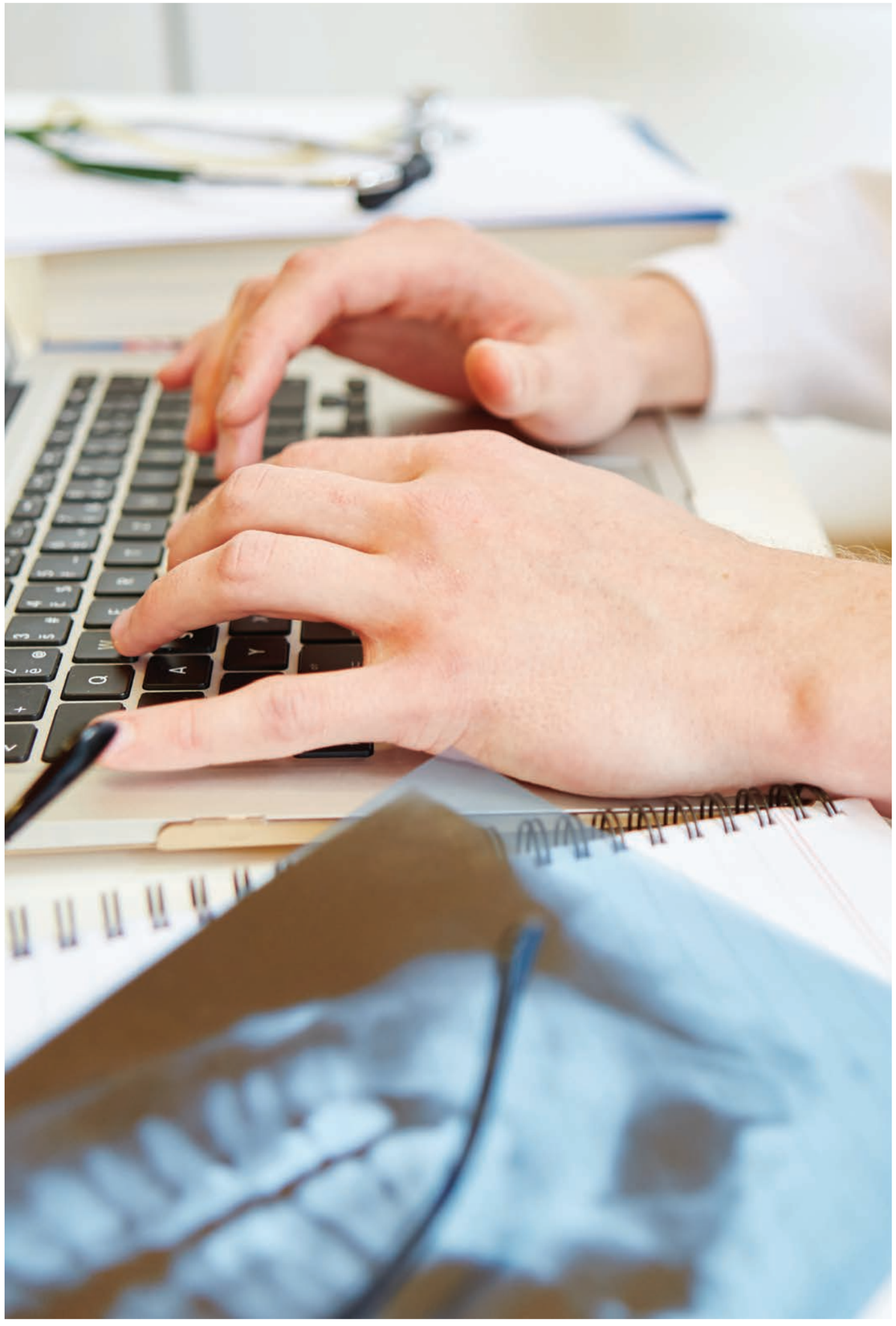
The Union will be based in Wellington, and at this stage it appears that it will be taking up the offer of accommodation within the NZMA Building. It will have a small secretariat. The position of Executive Director or administrative head of the union is presently being advertised with the final interviews to take place on 2 February 1989. It is expected that there will be an industrial and education officer, membership and accounts person and a secretary reporting to that person . The role of the secretariat will be to prepare all material for National Executive and conference meetings, to maintain membership records and complete all returns the union is obligated to file by law, to run education programmes for the members on what it is to be a union and how to get involved with the union, and to handle any personal problems members may have relating to their terms and conditions of employment.

In the interim the Central Specialists' Committee has taken on the role of union. To speed up decision making, as we approach the deadline of 1 April, a small subcommittee consisting of three members of the CSC will meet on a regular basis. The next meeting of this committee will consider the draft budget and therefore subscription rates for the union, the facilities needed by the central secretariat, educational programmes to be carried out before 1 April and other such issues.

If you have any further questions, please write.

Yours sincerely

Jill Thomson
Executive Officer
(Salaried Medical Officers' Services)



WRITING A REPORT TO THE CORONER

DR MARK BURNS | MEDICAL ADVISER, WITH GARETH COCKMAN, BUSINESS DEVELOPMENT EXECUTIVE (MPS)

Receiving a request from the coroner to write a statement can often be a daunting and worrying time. This need not be the case. Medical Protection regularly receives requests from our members to assist them with a response and have put together a template that can easily be used in the majority of cases.

If you receive a request from the Coroner for a report, it is important to contact your indemnifier for assistance. Medical Protection can give guidance over the phone in writing the report, and then review the draft report.

YOUR DETAILS AND BACKGROUND INFORMATION

So, what should be included in the report? Firstly, clarify what the Coroner has requested. There are often specific questions that the Coroner asks in the request letter.

Begin with information that lays out the basic details of the case in question. You should include the following at the top of the report:

- Statement prepared by (insert your name, post-nominals and MCNZ registration number)
- Re: (insert name of patient)
- Date of birth of the patient (insert)
- Date of death of the patient (insert)
- At the request of (insert name of Coroner).

The opening paragraph underneath this should include an overview as to your current role, role at the material time (if different), relevant experience and qualifications (including dates).

The second paragraph should include an expression of empathy or condolences that you are comfortable with. Often if the enquiry proceeds to inquest, you will be reading your report aloud with family in attendance.

In the final part of the first section, a statement describing the basis of your

"Medical Protection can give guidance over the phone in writing the report, and then review the draft report."

"Your role is to provide the Coroner with a comprehensible narrative outlining the care provided."

report should be included along the lines of: "This statement has been prepared on the basis of the contemporaneous medical records, and my recollection of the consultation(s) in question."

CHRONOLOGY

The second section of the report should then include a chronology outlining your involvement in the patient's care. Begin this section with an overview of the background medical conditions that the patient had. Often the Coroner asks for a list of medications and their purpose. These could be listed in bullet points if necessary.

Then move to a narrative chronological account. If there is a very long but relevant history going back many years, the more distant history is best summarised. It is usually relevant to include the last six months to one year in more detail however. Furthermore, the most recent consults often should be described in detail. It is not acceptable to simply cut and paste from the clinical notes. This is often disjointed and difficult to read, and the Coroner usually requests the clinical notes anyway. Your role is to provide the Coroner with a comprehensible narrative outlining the care provided.

One approach is to have date headings along the following format, starting with the most distant in time working towards the present:

Date (e.g. 1 January 2018)

- Set out the history for each consultation/encounter in chronological order with accurate dates.
- Refer to the patient by their name, either given name or better by formal title and surname, but not both.
- If the information was not recorded in the records, then it could be introduced along the following lines: "I recall that…" Avoid adding anything that is not in the notes unless you have a clear memory of it and annotate that it is from your memory.
- If an examination was undertaken, then you should set out the examination findings.
- Explain your working diagnosis together with the rationale for making the diagnosis.
- Explain the management plan including any investigations that were instigated and include the results (including laboratory reference ranges). You can refer here to any other relevant information (e.g. issues relating to consent or any discussions with colleagues).
- You should explain any medical jargon that you use in lay terms. Give an expanded description of an abbreviation when it is used for the first time, and avoid uncommon abbreviations.
- You should make reference to any relevant negative findings.
- Make sure your report is consistent with what is recorded in the notes. Remember that you might be reading your report to the Coroner's court and may be cross-examined – for example, by lawyers acting for the family, or the Coroner – on anything in your report.
- Your indemnifier is likely to want to see the clinical file when reviewing your report.

RESPONDING TO SPECIFIC ISSUES

If you have been asked to respond to specific issues, then you should do so in the final section, if it has not been addressed explicitly in your chronological narrative.

After the above has been completed, a statement should be made as to when treatment ceased by you as their doctor; for example, "I had no further involvement in Mr Smith's care after 1 January 2018." Unless you are responding, for example, on behalf of a district health board, you would not usually go into detail of the care provided after your last involvement.

Finally, use your signature to sign off the document, along with the date. Depending on the length of the report, you may want to include page and/or paragraph numbers for ease of reference.

Remember:

- When writing your report, it might be tempting to put across personal views and feelings regarding the case, especially if you are concerned your practice might be criticised, but it is important to give a factual account and report what has been asked of you.
- As mentioned before, it is important for you to seek assistance from your indemnifier. Medical Protection assists many of its members with responses each year, without subsequent incident. Problems can arise when a doctor responds to a request without obtaining assistance. Be aware that the Coroner may make an adverse comment regarding the care provided or alternatively refer a case to the Health and Disability Commissioner (HDC). In this case, the Coronial enquiry would be deferred until the HDC process has been completed.
- The Coroner has the ability to obtain expert opinions if considered necessary. If the expert opinion is critical, this may be noted in the Coroner's own report. Although you would have the opportunity to comment on any expert opinion or intended adverse comment by the Coroner, the Coroner may not necessarily accept your views. This means that it is very important to identify if there are any aspects of the care that might create vulnerability for you and to discuss these with your indemnifier.

(With contribution by Dr Tim Cookson.)

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 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.

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 because 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*.

How to contact the ASMS

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36 Brandon St, Wellington

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

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

Have you changed address or phone number recently?

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

ASMS
TOI MATA HAUORA
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Join the 85% of NZ Medical Professionals* who protect what matters most with MAS.
Moving countries can be a little overwhelming, which is why we're committed to helping you out. Our advisers are all commission-free and can meet at a time and place that suits. So if you want help with superannuation (pension), insurance or lending, get in touch.
Call 0800 800 627 or visit mas.co.nz/join-mas
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