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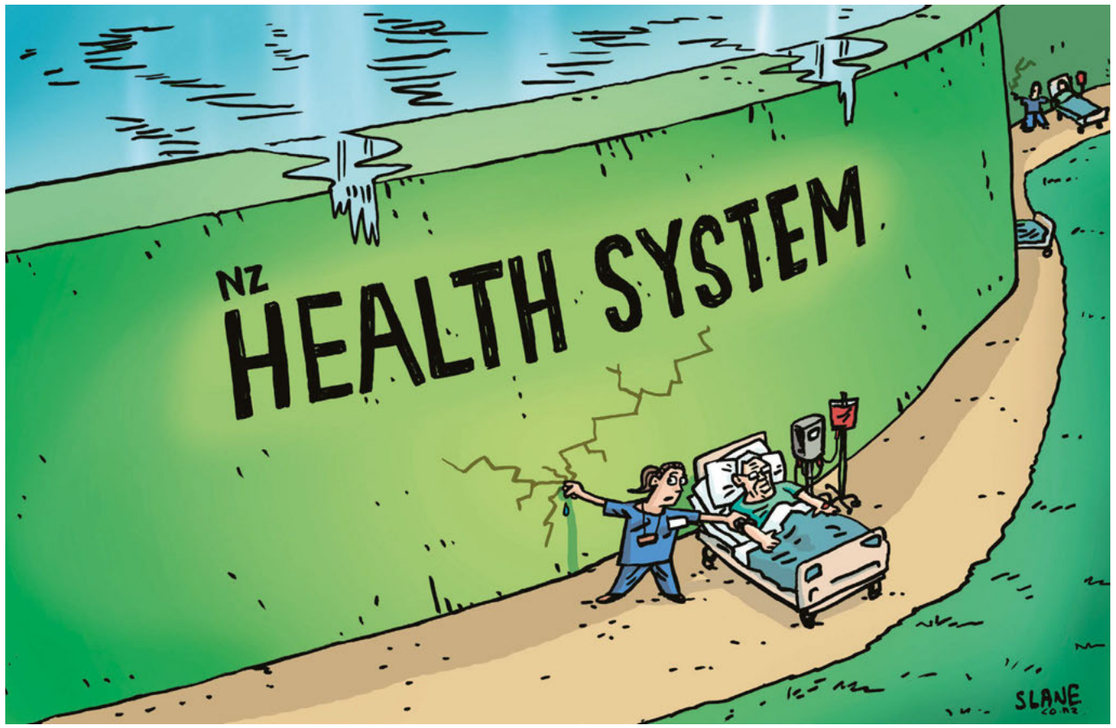

BURNOUT IN NEW ZEALAND'S SENIOR MEDICAL PROFESSION

DR CHARLOTTE CHAMBERS | ASMS PRINCIPAL ANALYST (POLICY & RESEARCH)

Half of all ASMS members who responded to a survey in November 2015 are likely to be suffering from very high levels of burnout.

This worrying statistic was one of the core findings from the recently released report into levels of burnout in the senior medical workforce. Burnout is an issue of serious concern for the senior medical workforce, with clear implications for the health and wellbeing of individual doctors, as well as their patients.

This study is the first to assess levels of burnout in the New Zealand senior medical workforce using the Copenhagen Burnout Inventory (CBI).

The results suggest that burnout is prevalent across the New Zealand senior medical workforce, with particularly high scores for individuals' physical and psychological exhaustion across all DHBs. Work-related burnout scores were also high, with 42% scoring with high work-related burnout. This increased to 47% for women who responded to the survey.

Women in general had statistically significant higher burnout scores than their male counterparts. Nearly 60% of women surveyed scored as having high personal burnout. Women aged 30–39 had the highest burnout scores, with nearly 71% in this demographic scoring with very high burnout. Both genders in the 30–39 age bracket had high burnout scores, with 62% scoring as having high levels of personal burnout.

> *There were significant differences according to medical specialty for work-related and patient-related burnout.*

Those working in emergency medicine and dentistry topped the work-related burnout prevalence, with 57% and 56% respectively. Those working in psychiatry had 49% work-related burnout and 30% patient-related burnout. Dentists also had 23% patient-related burnout. Across all respondents, patient-related burnout was only 16%.

The average hours worked across the week for respondents was 61.5 hours. This included hours on call and time spent at home doing administrative duties. There was a clear correlation between greater hours worked and higher overall and work-related burnout. Those scoring as burnt out had worked 64.3 hours on average over the week prior to the survey.

- 47% worked more than 14 consecutive hours in the survey, which was also correlated with higher overall and work-related burnout.

- Of those who worked more than 14 hours consecutively, 54% scored as burnt-out.
- 33% of respondents did not have a 24-hour break free from work, and this was also correlated with personal and work related burnout.
- For those who hadn't had 24 hours free of work, 56% were burnt out.
- 53% did not have a break of 10 hours between periods of work.

The study found differences in work-related burnout scores that were statistically significant according to the host DHB of the respondent. While the reliability of these statistics is questionable, particularly in DHBs with very low numbers of respondents (eg, Whanganui), these differences appear correlated in some way to the numbers of ASMS members at each DHB. This was most evident when the DHBs were grouped according to four categories of numbers of ASMS members.

> *The DHBs scoring particularly poorly for mean rates of burnout were those with members numbering between 101 and 200.*

These DHBs include Nelson Marlborough, Hutt Valley and Northland, which also ranked highest in the burnout prevalence scores. ASMS members at Hutt Valley DHB, for example, had 63.3% prevalence of personal burnout, and Nelson Marlborough had 61.5% prevalence of work-related burnout as well as correspondingly high mean burnout scores across these categories.

Analysis of the qualitative comments cross-cut by DHB did not reveal any particular trends as to why this may be so, other than key points relating to workload that are consistent across the board. The differences according to DHB nonetheless do suggest that there are some factors that might be increasing work-related burnout at certain DHBs that would benefit from further investigation.

The high scores for work-related burnout, as well as the positive correlations between hours of work and work-related burnout, suggest that the impact of work and working conditions is a significant contributor to feelings of exhaustion and fatigue.

The relatively low incidence of patient-related burnout suggests that the majority of respondents attributed their fatigue and feelings of exhaustion to factors other than their interactions with patients, although some specialties did find interactions with patients a source of burnout.

Compared with other studies using the CBI, the findings from this research suggest the levels of personal and work-related burnout in ASMS members are significantly higher than baseline scores found in Danish human service workers.[1] Scores for patient-related burnout, however, were similar to those found in other studies, and in some instances were lower.[2, 3] The scores for personal and patient-related burnout were very similar to those found in the German study of physicians,[4] which also had a similar sample size.

Increasing mean and burnout prevalence scores were strongly correlated with worsening self-rated health status, suggesting that burnout has a clear relationship with poor health, although directional causality cannot be inferred from the findings. A multiple regression analysis also found poor health status to be a significant independent factor associated with burnout. Given the high rates of presenteeism found in another recent ASMS study on the DHB-based membership, and the known correlations between ill health, burnout and presenteeism behaviour, this relationship warrants further examination.

It is feasible to assume that those who have a high personal burnout but not high work or patient-related burnout may have additional stressors in their lives, such as poor health or family demands (eg, the impact of old or young dependents). While the current study could not examine these factors further due to limitations with the demographic variables selected for inclusion, there was frequent reference to themes such as the impact of age and having young children, in the qualitative data.

Further, given the attributional emphasis of the structure of the CBI (the degree to which people make connections between their fatigue and either their conditions at work or their patient work), the themes illustrated by the qualitative data are particularly important in terms of providing the detail of these various attributional schemata.[5]

> *The clear emphasis on issues such as under-resourcing, workload, poor management and short staffing are noteworthy themes in this regard.*

As the qualitative data in the study reveals, how individuals attribute the symptoms of their stress, fatigue and, in some cases, explicitly attribute their burnout, highlights the manner in which people make sense of their feelings of stress and fatigue and explain these features in their day-to-day lives.

It is further reasonable to assume that the pressures cited as additional extenuating circumstances influencing burnout are highly likely to be exacerbated by pressures associated with work or patient contact, even if these causal attributions are not made explicit. The scales of burnout highlighted by the CBI in this study are therefore best understood as overlapping spheres of influence and attribution.

What the relatively high level of work-related burnout suggests, however, is that there are significant stressors associated with working conditions within New Zealand's DHBs that have a significant impact on levels of exhaustion and fatigue experienced by individuals. In other words, work-related stressors are clearly spilling over to affect the levels of exhaustion experienced by individuals.[6]

The findings from this study give an updated, nationwide perspective on the burnout study conducted by Surgenor et al.,[7] which was based at Canterbury DHB in 2006–2007. The findings from their study, which used the Maslach Burnout Inventory (MBI), found prevalence of burnout was relatively low, particularly for emotional exhaustion and depersonalisation. It is worth noting that Canterbury has subsequently experienced considerable upheaval, in part due to the earthquakes of 2010 and 2011.

Mean burnout scores for Canterbury as reported in this study were 46.5 for personal burnout and 42.9 for work-related burnout, and were around the middle range of burnout scores for DHBs. Notably, however, Surgenor et al. found that longer working hours and less medical experience were both independent factors that increased the odds of scoring as burnt out for emotional exhaustion in the MBI. This is similar to the results of the multiple regression analysis in this study, with age possibly acting as a proxy for length of medical experience.

> *Overall, the findings from this survey provide an important insight into the psychosocial health of senior doctors and dentists working in New Zealand's public health sector.*

The high proportion of this critical workforce currently feeling tired, worn out and uncertain is of great concern. Further research is needed to consider the extent to which these high levels of burnout are affecting patient care and whether burnout is influencing other workforce trends, including retirement intentions.

Meanwhile, these findings act as a clear call to government, health policymakers and DHB chief executives to urgently address burnout and help those already afflicted. The clear emphasis on staffing levels, hours of work and poor resourcing suggests major changes to better resource DHBs and improve management culture are required.

GLOSSARY

Personal burnout
The degree of physical and psychological fatigue and exhaustion experienced by the person overall, including work-related burnout, patient-related burnout and non-work-related factors.

Work-related burnout
The degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work.

Patient-related burnout
The degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work with patients.

Response rate: 1,487/3,740 (40%) 51% left comments for qualitative analysis	Overall burnout (%)	Work-related burnout (%)	Patient-related burnout (%)
All participants	50.1	42.1	15.7
All female participants	59.4	46.9	17.0
All male participants	43.9	39.0	15.6
All participants aged 30–39	62.2	47	14.3
All participants aged 40–49	55.2	45.9	16.0
All participants aged 50–59	46.8	42.3	16.4
All participants aged over 60	34.8	28.4	15
Female participants aged 30–39	70.5	51.1	10.8
Male participants aged 30–39	51.4	41.9	18.6
Anaesthesia	44.2	32.9	9.1
Dentistry	53.1	56.3	22.6
Diagnostic & Interventional Radiology	58.9	47.2	5.3
Emergency Medicine	57.8	56.9	17.6
General Practice	27.3	27.3	9.1
Internal Medicine	49.9	40.8	13.6
Obstetrics/Gynaecology	47.5	37.7	9.8
Paediatrics	45.3	29.9	14.6
Pathology	57.8	48.9	0
Psychiatry	56.3	49.2	30.1
Surgery	44	43.5	14.9

GENDER AND BURNOUT

The research identified a spike in the prevalence of burnout for women in general, but specifically among women aged 30–39 who had over 70% high personal burnout. Men in the same age group had 51% high personal burnout, which is still high but much lower than their female counterparts. Women surveyed were significantly more likely to score as burnt out across personal and work-related measures of burnout than their male counterparts. Being female also significantly increased the odds of scoring ≥50 for personal and work-related burnout by 2.1 and 2.6 times respectively.

The trend for women to have worse burnout scores held when cross-cut according to age and self-rated health status.

The literature on connections between gender and burnout is varied. Some studies find that male physicians are more likely to experience burnout than women,[8] whereas others have found the opposite.[2, 4, 9] Recent research into levels of burnout in Australian medical graduates, which also used the CBI, found females had significantly higher personal burnout scores than their male counterparts,[10] although possible contributing factors were not explored.

Other research notes work-family conflict was found to be a strong correlate with negative mental wellbeing for female physicians, whereas this was the least significant factor for men[4]. Others have found women aged between 30 and 35 often have the highest prevalence of burnout and women aged between 30 and 40 had the highest prevalence of psychological job demands as measured by Karasek's Job Strain Model.[11]

These variations in gender burnout scores appear to be at least partly related to which tool is used to measure burnout. In one study,[8] for example, the burnout scores varied according to gender depending on whether they were reporting the CBI scores or the MBI findings. In their research, females had higher scores for personal and client-related burnout than their male counterparts, whereas men had worse burnout scores according to the MBI.

Both prevalence and mean personal burnout scores peak for women aged between 30 and 39. This may reflect particular life-stage issues, such as the challenges around establishing oneself as an early career specialist and possibly being involved with the demands of young children. For example, one woman in the sub-group of 30–39-year-olds who left comments noted: "I have a small toddler at home and am currently pregnant. Not sure what is more exhausting – work or home!".

Future research would benefit from having additional questions about the number of dependents and their care arrangements as a variable against which to analyse the findings and to investigate this trend further.

The possible connections between life stage, gender and burnout, however, must also be considered in light of the culture of medicine. In previous research on the ASMS membership, women in the same 30–39 age group also scored very highly for rates of working through illness. Comments in this previous study referenced stress and tensions manifesting between the expected norms of professional behaviour and commitments to family life and self.

As some authors have noted,[12, 13] assumptions about what constitutes 'ideal' medical practice is interwoven with subtly gendered expectations such as being available for 'all hours work'.

This notion was explicitly referred to by one respondent who stated: "For me, the hardest part of being a female in the medical workforce is resisting the notion that we should work in our own time to keep up with our paperwork. Family and childcare commitments mean that I can't work from home in my own time and, quite frankly, I won't allow myself to fall into that habit. This is something that some of my more 'senior/old school' colleagues don't seem to agree with or understand."

As with the issue of presenteeism, it is conceivable that these pressures to work in personal time, as well as other expectations around how best to demonstrate commitment to the profession, are factors contributing to the propensity for burnout amongst women in this age group. Perhaps most significantly, this trend suggests there are key issues faced by female doctors and dentists in the senior medical workforce that need addressing.

To this end, the ASMS is currently investigating levels of interest for setting up a 'women in medicine' network that, at least initially, could seek to provide support, advice and mentoring for women who may be experiencing difficulties with burnout.

If members would be interested in such a network, or have other suggestions, please make contact with Charlotte Chambers either by email **cc@asms.nz** or phone **04 499 1271**.

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RESPECT, PATIENT SAFETY AND TEAM WORK

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

I have a hat. It is a very useful hat. In the summer it protects me from the sun and in the winter it keeps my head warm and dry. If I get something horribly wrong, I could end up eating my hat and, if worse comes to the worst, I can always put my hat in front of me on the sidewalk. Tipping one's hat is an old tradition of showing respect.

I want to tip my hat to the Royal Australasian College of Surgeons for launching its "Let's operate with respect" campaign. I am further encouraged by a united front of health unions and DHBs exploring the implementation of a robust yet sensible system to deal with and discourage harassment, bullying and discrimination.

> ***I have always thought that respect is a matter of common decency taught to children from a young age. However, two doctors' experiences as patients gave me second thoughts about respect in health care.***

A few years ago a colleague and friend of mine was diagnosed with cancer. During his treatment, he had countless contacts and interactions with health care professionals, and experienced long stays in hospital away from home. Health care workers would come and go all the time. What struck and frustrated him was the fact that on occasion people did not introduce themselves and, to make matters worse, often they did not even wear a name badge or any form of identification.

He told me: "As a patient, so much is going on that finding the brain space to remember names is hard, never mind with a 'chemo-brain'! Sometimes ID badges were worn below the waist: it's not easy to have a surreptitious glance in that direction when you've forgotten the name. The lack of introduction was particularly noticeable at weekends, when on-call doctors, or staff that I would only see once or twice, came in and started a discussion about my health and wellbeing and assumed that I knew who they were, or that they seemed above such normal social etiquette.

What was startling was the contrast with those staff who did introduce themselves, because it seemed such a natural thing to do, setting the tone of the human relationship, which remains the cornerstone of care and compassion. Shining exemplars of this were the core nursing team on the oncology ward, and this was a culture led by the charge nurse. That shows that it can be done. And it felt good."

After his return to work he started a campaign asking everyone to wear a name badge and urging us to introduce ourselves.

Dr Kate Granger was diagnosed with cancer in 2011. She started a blog: "A doctor & terminally ill cancer patient musing about life & death". She was a geriatrician in the United Kingdom and died on 23 July this year, aged 34.

She made the same observation as my friend did. From her blog: "I was recently a hospital in-patient with post-operative sepsis following a stent exchange

procedure. During this admission I made some observations on the quality of my care. Perhaps the starkest of these was that not every member of staff who approached me introduced themselves."

She continues: "As a healthcare professional you know so much about your patient. You know their name, their personal details, their health conditions, who they live with and much more. What do we as patients know about our healthcare professionals? The answer is often absolutely nothing, sometimes it seems not even their names. The balance of power is very one-sided in favour of the health care professional."

She started an online campaign #hellomynameis, which has since gone viral.

> ***Respect in the workplace should start with us introducing ourselves to patients. It is not difficult to do; it is a matter of common decency and the cornerstone of the therapeutic relationship.***

So what does that have to do with patient safety? Actually, quite a lot. In the United States, medical error has become the third leading cause of death behind heart disease and cancer (*BMJ* 2016;353:i2139), around 250,000 deaths per year. The US consumer organisation recently published the results of its patient survey (**http://www.consumerreports.org/cro/magazine/2015/02/the-surprising-way-to-stay-safe-in-the-hospital/index.htm**). The organisation surveyed 1,200 recently hospitalised people and found a striking link between respectful treatment and patient safety. Those who said they rarely received respect from the medical staff were two-and-a-half times as likely to have experienced a medical error.

Danielle Ofri is a doctor at Bellevue Hospital in New York City. She wrote in the *New York Times*: "When we tolerate a culture of disrespect, we aren't just being insensitive, or obtuse, or lazy, or enabling. We're in fact violating the first commandment of medicine [first do no harm]. How can we stand idly by when our casual acceptance of disrespect is causing the same harm to our patients as medication errors, surgical mistakes, handoff lapses and missed lab results?"

I did my house surgeon year at Edendale Hospital in KwaZulu-Natal, South Africa. The majority of house surgeons lived on the hospital grounds in the doctors' residence. We had our own pub called Easy Riders. We worked long hours, often doing a 1 in 2 on call. Work–life balance was very blurred. We all worked and socialised together. Everyone knew everyone. Not just by name but as a person; their dreams, fears, career aspirations and interests. Respect and trust seemed to come naturally. As a young doctor, I had a strong sense of belonging. I was part of the team. There were times we did receive robust 'feedback' on our performance, but we never felt as if we were being 'attacked' or bullied. On Friday afternoons, all of the senior doctors joined us in Easy Riders for a beer and a social chat before they headed home. In Easy Riders, we were all equals, friends and colleagues.

Since those days, work–life balance has become increasingly important. Work and life are seen as two separate parts of our lives and the emphasis has shifted towards 'having a life'. We all now tend to live our separate lives outside of work. Combine that with an increase in shift work and rostering of house surgeons and doctors in training, and SMO locums and turnover, and it is clear why it has become more difficult to get to know each other and to develop a sense of belonging to a team and develop respect and learn to trust each other.

> ***However, there is compelling evidence that the respectful leader has a major influence on the functioning of a team.***

Christine Porath, Associate Professor at Georgetown University's McDonough School of Business and co-author of the *Harvard Business Review* article "The Price of Incivility" writes: "Being respectful doesn't just benefit you, though; it benefits everyone around you. In a study of nearly 20,000 employees around the world (conducted with *Harvard Business Review*), I found that, when it comes to garnering commitment and engagement from employees, there's one thing that leaders need to demonstrate: respect. No other leadership behaviour had a bigger effect on employees across the outcomes we measured" (**https://hbr.org/2015/05/the-leadership-behavior-thats-most-important-to-employees**).

Respect is a two-way street. If you don't give respect, you don't deserve to receive it. Atul Gawande, a surgeon and respected writer, points out in an article "Cowboys and pit crews" in the *New York Times*, that effective health care can no longer be delivered by individual doctors but requires coordinated care similar to that of pit crews. He makes the point "And they include teamwork, the recognition that others can save you from failure, no matter who they are in the hierarchy."

Turning his statement around: an effective clinical team (pit crew) with mutual respect and trust can save patients from coming to harm from an individual's failing.

Health Minister Jonathan Coleman, in his address to the ASMS in November 2014, said: "One of the things I really want to focus on today is the concept of 'team health New Zealand." In his closing comments, he stated: "As we go ahead I see the whole health service as a team, and that the decisions the Government and I make are all built on delivering a better public health service for all New Zealanders, particularly for those in most need of those services."

Are we there yet? You be the judge.

Let us start by respecting our patients. Introducing ourselves to them is the first step. Get to know your fellow workers and let them get to know you. We need to build strong clinical teams where there is a feeling of belonging and mutual respect and trust. And finally our leaders in health care need to know that no other leadership behaviour has a bigger effect on employees than demonstrating respect.

DHB MECA NEGOTIATIONS

You can keep up to date with the progress of the ASMS–DHB MECA negotiations through our *Bargaining Bulletins*, which are sent electronically to you all after each round of talks and are also posted on the ASMS website at **http://www.asms.org.nz/publications/bargaining-bulletin/**.

The latest MECA update is available at http://www.asms.org.nz/wp-content/uploads/2016/09/DHB-MECA-Bargaining-Bulletin-6.pdf, and some of the matters that arose are also covered in Ian Powell's column on page 13 of *The Specialist*.

PSYCHIATRY SHORTAGE ADDS TO PRESSURE ON THE SPECIALIST WORKFORCE

CUSHLA MANAGH | ASMS DIRECTOR OF COMMUNICATIONS

DR MARTIN O'SULLIVAN

A national shortage of psychiatrists is making its presence felt in Northland.

Child and adolescent psychiatrist Martin O'Sullivan, who works at Whangarei Hospital, says it's an ongoing struggle to recruit and retain psychiatrists in the area. While the psychiatry service is usually short by one or two FTE, at the moment it's down by several people – and that puts pressure on existing staff.

"There's no question that services here are stretched," says Dr O'Sullivan. "In a community like Northland there are high levels of adversity, poverty, alcohol and drug use, and there is a sense of a widening gap between the haves and the have-nots. It's a stressful environment for psychiatrists to work in."

The Northland shortage is part of a bigger national and international picture. Overall, New Zealand is below average among OECD countries in terms of specialists (including registrars) per population, with 1.6 specialists per 10,000 population in 2014 compared with the OECD average of 1.7.

A glance at the New Zealand medical registrar shows that, as at July 2016, there were 566 vocationally registered psychiatrists with New Zealand addresses. That works out at 1.2 psychiatrists per 10,000 people, based on current population estimates.

The state of the mental health and addictions workforce has been on the mind of health decision-makers for a while, and various reports have been published.

Earlier this year ASMS made a submission to the Ministry of Health on its draft Mental Health and Addiction Workforce Action Plan 2016–2020. A full copy of the ASMS submission is available at: **http://www.asms.org.nz/wp-content/uploads/2016/03/Submission-to-MOH-Draft-Mental-Health-and-Addiciton-workforce-action-plan_165097.3.pdf**

The Ministry's action plan acknowledged shortages in the specialist workforce and anticipated a doubling of demand for mental health and addiction services by 2020. Despite this, ASMS noted in its submission that the actions outlined to address workforce issues were tentative and largely dependent on the availability of funding. Not good enough, said ASMS. Given the pressures on the workforce, improving the situation needed to be a 'must do' rather than an optional extra.

"A coherent approach to increase the attractiveness of specialist mental health roles in the workforce is critical, including a strong commitment to recruitment and retention measures based on developing attractive environments and conditions in which to practise," reads the ASMS submission.

The strains of workforce shortages and inadequate resourcing are becoming more apparent, with two significant pieces of research by the ASMS finding high rates of both presenteeism (**http://www.asms.org.nz/presenteeism/) and burnout (http://www.asms.org.nz/wp-content/uploads/2016/08/Tired-worn-out-and-uncertain-burnout-report_166328.pdf**) among New Zealand's senior doctors and dentists.

These surveys show – overwhelmingly – that many doctors are working through illness and that burnout is prevalent and a cause for great concern. Some medical specialties reported higher levels of burnout than others – in particular, emergency medicine, dentistry and psychiatry.

The fact psychiatry features prominently doesn't surprise Martin O'Sullivan, who says working in the speciality now is more stressful than ever. He attributes this to various factors. On a personal level, he estimates a local child psychiatry case-load burden that is up to four times the New Zealand norm.

"When you factor in the number of children and adolescents in this large rural district, the small FTE of child and adolescent psychiatrist clinical time (1.2), our exemplar access rates and the extent of adversity which our community experiences it is a considerable burden," he says.

"For my adult psychiatry colleagues there has been higher than usual occupancy rates in the DHB's psychiatric inpatient unit in recent years, resulting in patients who are very unwell by the time they enter the hospital system."

On-call work is more onerous, and psychiatrists in the region do a high proportion of first on call. All of this has led to some historic tensions with management over hearing and acting upon clinical concerns. Some of those factors, such as the relationship with management, are definitely improving but others continue to be a concern.

"Colleagues tell me that there's a very high threshold for admission to Whangarei Hospital's adult inpatient unit," says Dr O'Sullivan. "When patients are admitted, they are often very ill with high levels of aggression or high risk of suicide. It's very challenging to provide treatment in these circumstances and to know that people are not fully recovered by the time they leave the hospital."

Martin O'Sullivan moved to New Zealand four years ago from a role as Clinical Director at the Mater Hospital in north Dublin and a stint as a consultant with the South London and Maudsley NHS at Guy's Hospital in south London. He came here for a year but fell in love with the place. His experience gave him a realistic understanding of resourcing difficulties, but he thinks Northland's issues need to be addressed.

Recruiting and retaining psychiatrists has been an ongoing battle, he says.

"There is a small pool of potential applicants and if people know there are problems with resourcing here it can be hard to attract people to the area. The fact we don't have a clinical director is an additional problem for the service. The reality for local clinicians is that they have so much on, they can't contemplate taking on additional leadership responsibilities."

The answer, at least in Northland, requires an effective clinical and managerial partnership that provides opportunities for real collaboration and shared decision-making. The service also needs a clinical director and the inpatient unit needs to expand its bed numbers to ease some of the pressure on psychiatrists.

"It's a very resilient community here. That's one of the first things that struck me. Ultimately, though, it's our families or whanau who take on the burden of receiving people who are still quite unwell back into the community. While it's stressful for psychiatrists we shouldn't forget our families who bear the brunt of these resourcing issues."

PATH TO PATIENT CENTRED CARE

ASMS TOI MATA HAUORA

MAKING TIME FOR PATIENT CENTRED CARE

LYNDON KEENE | ASMS DIRECTOR OF POLICY & RESEARCH

While of course not all DHB senior management have strained relations with their senior medical staff, many senior doctors would probably agree that the general state of disharmony between themselves and senior management is mirrored in a commentary on 'leadership and engagement' in the National Health Service (NHS) in England, published by the King's Fund:[1]

> *It is a striking feature of the NHS that it employs some of the brightest people in the country, then disempowers and alienates many of them. Consultants are more likely to say they work 'at' rather than 'for' a trust, and doctors often underestimate both their power and responsibility when it comes to improving quality and productivity.*
>
> *But being a doctor often doesn't feel powerful. They may have no budget, no status to make demands on the administration, no power to hire and fire, and little influence over the organisation's goals. Yet the decisions they take not only have a profound impact on patients, but on the quality of care, productivity and reputation of their employer.*

The importance of 'medical engagement' and 'clinical leadership', as well as 'collaboration' and 'service integration' and now 'patient centred care' (which depends on all of the former), are well recognised as policies central to achieving higher quality and greater efficiency in the delivery of health care. For example:

> *Nowhere is leadership more crucial to improving care quality than on the front line – in wards, clinics and general practices.* – The King's Fund, 2013[2]
>
> *There is no top-down, imposed way to integrate care; it will be done through distributed, engaged leadership or it will not be done at all.* – The King's Fund, 2012[3]
>
> *Quite simply, the reforms we need are only likely to be successful if clinically led.* – Professor Des Gorman, Executive Chair, Health Workforce New Zealand[4]

But aside from the isolated pockets of successes, policies promoting engagement and distributed clinical leadership, which are prerequisites for successful patient centred care, have failed to gain much traction, either here or in other systems like the NHS. The complex adaptive nature of health services means the reasons for this are numerous and varied, but there are two that stand out in the literature that are inter-related: policies supporting top-down decision-making reflected in the comments opening this article, and lack of clinician time due to clinical workload.

That many of New Zealand's senior doctors, like their NHS counterparts, feel disempowered and under-valued, is well documented in the Senior Medical Officer Commission report of 2008, and feedback from ASMS members to now suggests little or no improvement.

> *I am the nominated clinical leader for our service. Despite this, my ability to influence any aspect of the operation of our service is severely limited. It is this constant lack of control – the knowledge that things could be much better than they actually are but the inability to make the necessary changes – that is so sapping for me.* – ASMS Burnout survey respondent 2016.
>
> *I left the UK [United Kingdom] because of frustration with the stupid health care system. I came to New Zealand as the system here was much better. The idiocy has followed me.* – ASMS Burnout survey respondent 2016.

Top-down leadership, or managerialism, is typified by laying down demanding targets, leading from the front, often being reluctant to delegate, and collaborating little – and is the consequence of the health service focusing on targets, budgets and throughputs with recognition and reward dependent on meeting them. Such policies have been described as dehumanising health care.

They are policies that produce a kind of culture where leaders become detached from those on the front line and from the consequences of their decisions – a trend discernible not just from organisational management but also from further up the chain.

As Robert Francis notes in his inquiry into the failings at Mid Staffordshire NHS Foundation Trust: "DH [Department of Health] officials are at times too remote from the reality of the impact of the service they oversee on patients." This led to the board and senior managers prioritising and explicitly rewarding the achievement of financial targets while overlooking patient safety and basic care standards – to such an extent that front-line staff began to see finance and targets as ends in themselves. The result, in Francis's words, was "a culture focused on doing the system's business – not that of the patients".[5]

The policies of top-down command and control leadership have been found incapable of accommodating the complexities of a more participative, supportive environment that is required for patient centred care.

Instead, those policies have introduced a system that enables politically oriented micro-management where, in the words of one former senior Ministry of Health official, "clinician decision space is shrinking fast".[6]

Worsening the effects of those policies is that clinician 'time space' is also shrinking. While the quality of the patient-doctor interaction is considered to be at the 'heart of patient centred care', having the time to ensure good quality arises frequently in the literature discussing barriers to the patient centred care approach.

A systematic review of health professionals' perceptions of the barriers and facilitators to implementing shared decision-making with patients found the most often reported barrier to be time constraints (18 of 28 studies). The review included the views of more than 2,784 health professionals (most of them doctors) from 15 countries.

Time barriers can be directly or indirectly related to the quality of interactions between patients and doctors. Senior doctors need time to have the (sometimes many) conversations with the patient and family, especially if the patient has difficulty understanding the information, and recognising an aging population will lead to increasingly complex needs. They need time to undertake clinical leadership and continuing professional development to maintain good quality communication and cultural competency skills in a constantly changing environment with changing expectations. They need more time for multidisciplinary teamwork and delivering better integrated care. All of which are key factors in delivering good quality patient centred care.

ASMS surveys of heads of department in two DHBs, to ascertain the adequacy of current senior doctor staffing levels to meet local health needs, indicate time pressures on doctors are creating significant barriers to them undertaking these activities.

Not least, senior doctors need time to work safely. Two recent national surveys of senior doctors showing significant prevalence of burnout and high levels of 'presenteeism' reveal for the first time the effects of long-standing and mounting work pressures on the senior medical workforce. Not only do these findings raise serious occupational health concerns, but also questions about the effects on the quality of patient care.

The literature on patient centred care is unequivocal about the impact of poor working conditions:

> *To succeed, a patient centred approach must also address the staff experience, as staff's ability and inclination to effectively care for patients is unquestionably compromised if they do not feel cared for themselves.*[7]

No matter how dedicated senior doctors are in providing the best care for their patients, they are unlikely to do so while sick or fatigued, with an extensive and growing body of evidence showing fatigue in doctors contributes to increased errors and accidents.

In order for patient centred care to become a reality, the immediate task is to address senior medical workforce shortages, not only to ensure safe staffing levels but also to enable senior doctors to find the time for all the activities associated with developing patient centred care.

In addition, policies that impede patient centred care must be replaced with policies that facilitate the best quality interaction between patient and doctor. – a 'bottom-up' approach that, from the senior medical workforce perspective, includes, critically, policies that foster clinical engagement and distributed clinical leadership in practice.

- The ASMS's first four short papers on patient centred care have focused on the topic from mostly a senior medical workforce perspective. Future work will consider other aspects of patient centred care, such as exploring strategies that have been shown to support patient and community engagement.

REFERENCES

Unless otherwise indicated, references are available in ASMS publications *The Time Barrier* and *Making Time for Patient Centred Care*, available at **http://www.asms.org.nz/path-patient-centred-care/**

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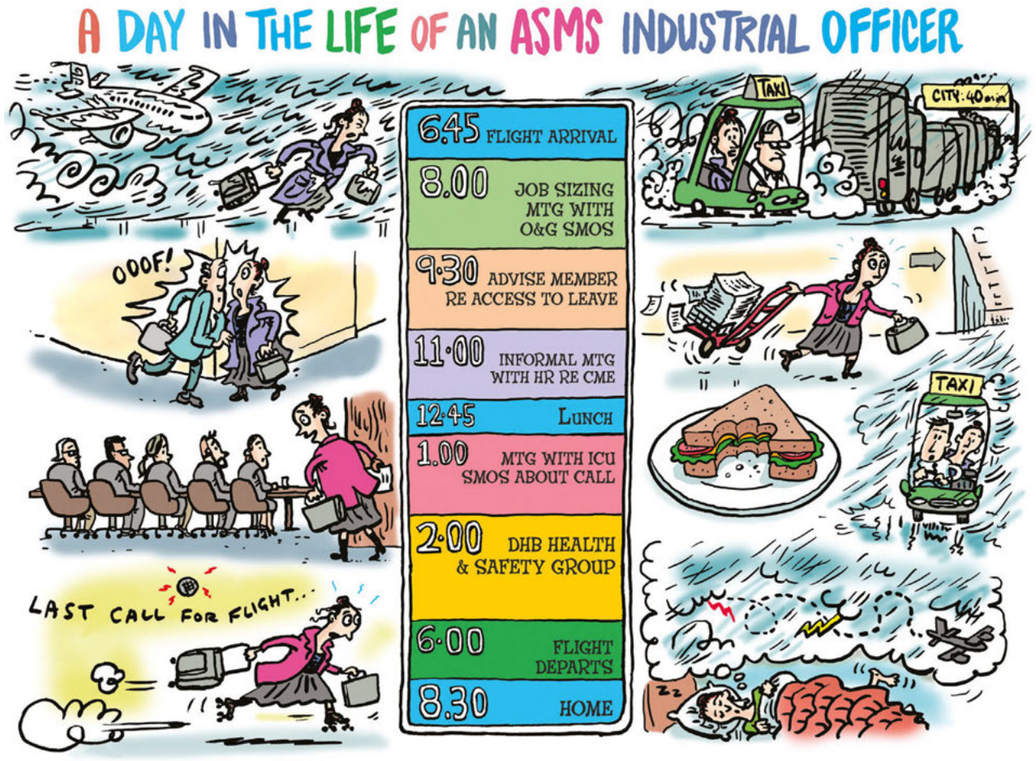

A DAY IN THE LIFE OF AN ASMS INDUSTRIAL OFFICER

SARAH DALTON | ASMS INDUSTRIAL OFFICER

Job sizing is an important aspect of our work. Its aim is to support SMOs to regulate their individual and collective workloads, and to offer an evidence-based approach to managing staffing. Increasingly, we find that clinical and support staffing is pared back, so that members often find it challenging to use their leave entitlements; but also that cuts to nursing and allied staffing mean senior doctors have to work outside of their scope – to the detriment of service efficiency, teaching and patient care.

Sometimes when doctors are struggling to access leave – either for rest and recreation or for professional development – ASMS staff intervene. Generally, our members manage these types of issues well, but where ongoing discussions have not resolved the matter, or where we identify concerns about how a DHB is responding at a systems level, it can be productive to get involved as liaison – or directly with management.

Disagreements and differing interpretations about CME entitlements, for example, are a frequent occurrence. So, from time to time, we work with our branch officers and HR staff to develop guidelines that help all parties better understand the provisions in the collective agreement. This can involve anything from meetings, to drafting and reviewing documents, to running seminars and member workshops.

> *Direct contact with our members is at the heart of our work.*

When I sit down with SMOs in a particular service to discuss call or availability requirements, we often touch on a raft of clinical and workplace issues that are constantly being juggled and balanced. Members feel a real sense of frustration that the goodwill they put into their work on a daily basis does not always appear to be reciprocated as management quickly claw back allowances when staffing changes occur. Senior doctors value genuine engagement and discussion – particularly when it relates directly to provision of clinical services within their own department or service. We spend quite a bit of time working with members on how best to tackle changes to call and related staffing issues.

Committees and meetings are the bane of everyone's life. Although much of our work is at the pointy end and focused on MECA education, engagement and enforcement, we also like to be proactive and want to be part of positive developments in workplace culture and conditions. That's the thinking behind meetings like workplace health, safety and wellbeing committees, and our regular JCC meetings between ASMS and each DHB.

HEALTH SYSTEM LEADERSHIP DEFICIT HIGH RISK FOR PATIENTS

IAN POWELL | ASMS EXECUTIVE DIRECTOR

In respect of hierarchy, much of our health system leadership is located with the Minister of Health, Ministry of Health and at the top echelons of DHBs (boards, chief executives and senior management). This does not ignore the role of agencies such as the Health & Disability Commissioner and Health Quality & Safety Commission, but while they influence, they don't lead on policy and operational matters.

I have been reflecting for some time on the quality and capacity of this leadership, which has come into sharper focus as the impact of ongoing health funding shortages become apparent. While funding has increased in absolute terms, it has not kept up with the increased costs of providing health care driven by increased demands on the health system, which, in turn, are driven by factors such as the aging of the population, population growth and increasing poverty. Since 2010, an estimated $1.5 billion (at least) has been sucked out of the DHBs.

> *There is a narrative that financial adversity brings out the best of leadership. This is a myth.*

The far greater likelihood is that it brings out the worst and exposes serious leadership deficits.

DHB CHIEF EXECUTIVE LEADERSHIP

I have been known from time to time to be critical of DHB chief executive performance, either individually or as a group. But earlier this year I was outflanked by someone who publicly:

- expressed doubts about whether the talent is there to take up the high salaried positions running our 20 DHBs
- asserted that we lacked a good system for developing talent for and training executive management, including chief executives
- commented that when we needed a new chief executive we "just advertise in the *Otago Daily Times* or the *Dominion Post* or whatever".

If I had criticised chief executives like this, there probably would have been a formal letter of complaint about me in the name of some or all of them to the ASMS National President. But there is a slight difficulty for the chief executives. The criticisms came from Health Minister Jonathan Coleman in an interview with the *Listener*. This transforms strong criticisms to a slap down.

At one level who I am to disagree, although I have got doubts about the Minister's third point. More importantly it shows a serious lack of confidence in the leadership of DHBs from the top. This may be valid but those above them at the 'top' of the hierarchy have also contributed to this sorry assessment.

The impact of financial constraints on a system caught between a high level of fixed costs and increasing demand has been the most severe in ASMS's more than 26-year history.

> *While responsibility for this shoots home to the Government, it has also exposed serious weaknesses in the calibre of DHB leadership with an increasing focus on the short term without sufficient regard to the medium-to long-term consequences.*

Inevitably, the pressure to further marginalise distributed clinical leadership increases. There are too many senior health managers ironing their underpants. This is a recipe for increased financial risk over time.

HEALTH MINISTER WALKS AWAY FROM CLINICAL LEADERSHIP

But then we have to consider the signals the Government gives DHBs. ASMS was disappointed to learn that, for the first time for many years, the Health Minister's annual letter of expectations to DHBs contained no reference to clinical leadership as one of their priorities. We formally wrote to the Minister expressing our serious concern over this policy shift. Jonathan Coleman, in reply, maintains that he is still committed to clinical leadership, but this is unconvincing.

Further, the message that this gives to chief executives and senior management teams is unambiguous – clinical leadership embedded at all levels and in the culture of DHBs is not a priority; other things are more important. These other more important things included 'living within our means', deficits and achieving heavily monitored targets that only apply to that small part of what public health services do that can be counted.

'Living within our means' and deficits in particular are best achieved through medium to longer term decision-making based on distributive clinical leadership rooted in an engagement culture and sufficient workforce capacity to deliver. But all the incentives reinforced short-term decision-making, creating a high risk of poorer longer term financial performance occurring on someone else's watch.

It is reasonable for Dr Coleman to chastise chief executive leadership. But it would also be reasonable for him and his government to take responsibility for creating the environment that has exposed the sector's leadership deficits and risks to quality of care.

WHAT ABOUT THE HEALTH MINISTRY?

In this context, the direction of the Ministry of Health needs to be considered.

> ***Director-General Chai Chuah has a focus on leadership in general terms but not clinical leadership in particular. In doing so, he misses the boat.***

He refers in general terms to three types of leadership in a manner that seems more structurally rigid rather than organically dynamic: strategic thinkers, high performing implementers and networkers.

Linking to the revised new health strategy he identifies five themes:

1. people-powered
2. closer to home
3. value and high performance
4. one team
5. smart system.

But, in the absence of specific contexts and application, these are merely slogans that can mean all things to all people. Because they are so high level, they are unlikely to resonate with the sector.

Substantive innovations in the health sector require three things:

1. workforce
2. technology
3. distributive clinical leadership.

The Ministry's direction appears to accelerate the importance of technology, making the two drivers 'also runs'. But, if we neglect workforce and clinical leadership, then the benefits of technology are minimised at best and lost at worst.

BACK TO DHBS; BURNOUT RESPONSE

Coming back to DHBs, the reaction to the scary results of ASMS's recently published burnout survey is instructive.

Before the official release of the burnout survey, ASMS had written to chief executives in all the 20 DHBs giving them a heads-up of this pending event and expressing interest in discussing the results with each of them as soon as possible. The letters did not call for a substantive response other than perhaps acknowledging the need to discuss the survey results with us.

The DHBs have a national shared services agency called DHBs Shared Services (DHBSS). Its main role is to provide advocates for the DHB's collective bargaining teams, employment relations advice to DHBs and secretarial support for national DHB meetings (eg, chief executives and chief medical officers).

Upon becoming aware of ASMS' heads-up, DHBSS drafted a recommended letter of response for chief executives that was dismissive of the survey results, downplayed the significance of SMO burnout, falsely asserted that ASMS had reached an agreement with the HR general managers at a national meeting over how the results of the survey would be handled and misused barely relevant data.

The reference to the HR general managers was a regular national meeting in May where ASMS gave a presentation on the preliminary results of the survey. The minutes of the meeting recorded some agreements reached between the HR managers after ASMS representatives departed. But these were then cut-and-pasted into the recommended letter. When read in the context of preceding and subsequent paragraphs, it suggested ASMS had breached a national approach to the survey results agreed between ASMS and the HR general managers.

A small number of chief executives, in effect, copied the DHBS letter on to their own letterheads and posted them off to ASMS. On the other hand, most chief executives appear to have binned it. While the main response is good, it remains disturbing that the DHBs' shared services agency can provide such poor quality and disingenuous advice over such a serious and threatening issue as SMO burnout.

Let's leave the final word to the Ministry of Health. In a recent circular promoting attendance at a national health symposium being organised for November, the Ministry trumpeted that over "...the two days we will explore the techniques of Exponential Organisational Strategy and Disruptive Innovation. We will look at how they can transform the health system...".

At a time of under-funding, under-investment in the health professional workforce, overworked and overstretched specialists, and alarmingly high burnout among senior doctors, the best we get from our central government leadership is *exponential organisational strategy and disruptive innovation*. If this doesn't mean Mid Staffordshire culture and outcomes, here we come, then what does?

ASMS 28TH ANNUAL CONFERENCE

THURSDAY 17 & FRIDAY 18 NOVEMBER 2016
THE OCEANIA ROOM, TE PAPA, WELLINGTON

DINNER AND PRE-CONFERENCE FUNCTION

A pre-conference function will be held at The Boatshed on the evening of Wednesday 16 November, and a conference dinner will be held on Thursday 17 November at Te Marae, Te Papa.

These are a great opportunity to mingle with conference delegates and others in a relaxed social setting and, of course, to enjoy some of Wellington's fine hospitality!

LEAVE

Clause 29.1 of the MECA includes provision for members to attend Association meetings and conferences on full pay.

The ASMS makes all travel and accommodation arrangements for ASMS delegates to attend its 28th Annual Conference. Please contact our Membership Support Officer, Kathy Eaden, at **ke@asms.nz** if you have any questions about your arrangements.

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ASMS BRANCH OFFICERS' WORKSHOP

Burnout, the burden of being on call, progress on the DHB MECA negotiations, and staff safety – these were top of the agenda when ASMS branch officers gathered in Wellington in August for their annual national workshop.

Branch officers (or their representatives) from around the country attended the day-long workshop, along with National Executive members and staff from the ASMS national office.

As always, the workshop featured lively presentations and discussion on topics relevant to ASMS members.

"The annual workshop is an opportunity for branch officers to discuss pressing issues for their members at a local level and to also influence and contribute to the work being undertaken by the ASMS," says ASMS Executive Director Ian Powell.

Questions tackled during the day included ways to challenge 'the new normal' involving shortages and shortcuts becoming business as usual, ideas to improve SMO cover arrangements and health and safety priorities.

Following opening remarks by ASMS National President Dr Hein Stander, the workshop discussed the following topics:

- Giving up call – Tauranga Branch President Dr Matthias Seidel and Senior Industrial Officer Lloyd Woods
- Staff safety – Counties Manukau Vice President Dr Sylvia Boys and Industrial Officer Sarah Dalton
- MECA report back – Ian Powell
- Burnout research findings – ASMS Principal Analyst Dr Charlotte Chambers presented on this as part of the ASMS's publication of the results on the same day
- JCCs and building branch engagement; introduction to mapping – Ian Powell and Lloyd Woods.


5

RESULTS OF THE ASMS ANNUAL SALARY SURVEY

DR CHARLOTTE CHAMBERS | ASMS PRINCIPAL ANALYST (POLICY & RESEARCH)

The ASMS has been recording the salaries of specialists and medical and dental officers working at DHBs throughout the country since 1993. Information is requested from DHB human resources about the number of senior medical and dental staff on each step of the salary scale as at 1 July 2016, whether they are ASMS members or not. The salary steps are those derived from the ASMS DHB multi-employer collective agreement (MECA), which came into effect on 1 July 2015. The current findings reflect the number of people on each step rather than full-time equivalents.

In addition to recording numbers of senior medical and dental staff per salary step, the survey requests a breakdown of these numbers by gender.

> ***This provides an insight into the gender composition of senior medical and dental staff according to DHB, as well as allowing us to track changes in this regard since the data became available over 10 years ago.***

The figures report an increase in the average specialist salary of 5.7% from $192,861 to $203,910. This increase is likely due to progression through the salary scale but may also be influenced by wider margins between the higher steps as negotiated by ASMS in the previous MECA negotiations. The highest average salary for specialists this year is at Whanganui DHB ($203,164) and the lowest is again at Counties Manukau DHB ($190,462).

There was a decrease in the average medical and dental officer salary of 2.8%, compared with the previous year. Contributing factors may be medical officers at the top of the scale retiring without necessarily being replaced or there may be instances where individuals are transferring to the specialist scale as a result of obtaining vocational registration (including, for example, in rural hospital medicine). The highest average salary for medical and dental officers is this year shared between Tairawhiti, South Canterbury and Southern DHBs ($166,000) with the lowest average salary again to be found at Auckland DHB ($137,350). This year, there were no medical or dental officers recorded at Wairarapa DHB, representing a decrease of six individuals from 2015.

> ***As at 1 July 2016, there was a total of 4,560 specialists and 484 medical and dental officers employed across New Zealand's DHBs, giving a total senior medical workforce of 5,044 individuals.***

These figures represent a 5.1% increase in specialist numbers and a 2.9% decrease in medical and dental officer numbers, compared with the previous year. A possible explanation for some of these two differing trends is the transference from the medical officer to the specialist scale discussed above.

In respect of gender, 2,946 (64.6%) of specialists were male and 1,614 (35.4%) were female. This represents an increase in the number of male specialists of 5.2% and an increase in the number of female specialists of 5%. Proportionately, this 64:35 gender balance has not changed from the previous year. For medical and dental officers, 256 (52.9%) were male and 228 (47.1%) were female. This represents a decrease in the number of male medical and dental officers of 1.5% (four fewer) and a decrease in the number of females of 4.4% (11 fewer) from 2015.

In 2016, 1,802 (40%) of all specialists were on the top step of the salary scale, compared with 1,629 (38%) in 2015. In terms of the gender distribution on this top step, 432 (24%) were female and 1,370 (76%) male. For medical and dental officers, 232 (48%) were on the top step, comprising 102 (44%) females and 130 (56%) males. For both specialists and medical and dental officers, the overwhelming majority were on the top step with the next largest grouping of specialists being on step 5 (499 individuals). The next largest grouping of medical and dental officers was on step 1 (64 individuals).

VITAL STATISTICS

In 2009/10, Core Crown Health Expenses were 6.67% of gross domestic product (GDP).

For 2016/17, Core Crown Health Expenses are forecast to be 6.26% of GDP.

If Core Crown Health Expenses had maintained the proportion of GDP they had in 2009/10, they would be $1.08 billion higher in 2016/17.

SOURCES:

Fiscal Times Series 1972–2015, New Zealand Treasury, May 2016.

Budget Economic and Fiscal Update, New Zealand Treasury, May 2016.

NOTE: CORE CROWN EXPENSES

These are the day-to-day spending that does not build or purchase physical assets by the core Crown. This is an accrual measure of expenses and includes non-cash items such as depreciation on physical assets. Core Crown Health Expenses include some expenditure outside of Vote Health, such as spending for the Health Research Council.

SOURCE:

Budget Economic and Fiscal Update 2016.

SUPPORTING SENIOR DOCTORS OUTSIDE DHBS

LLOYD WOODS | ASMS SENIOR INDUSTRIAL OFFICER

The ASMS has had members employed outside of DHBs for many years and our membership has steadily grown.

Our aim is to recruit employees who are working outside of DHBs wherever it is possible and, given a majority of doctors join, to negotiate collective agreements for them. There is tremendous scope, particularly with GP practices, although it is difficult to determine where GPs are employees rather than owners or contractors.

Currently, we already have 226 members employed across almost every part of the New Zealand non-DHB sector by 48 different employers.

We have two MECAs outside of DHBs, the larger covering 12 hospices (with a thirteenth currently being included) and 37 members. The smaller is our MECA covering union health centres in the wider Wellington region, with four employers covering 20 members.

We have 13 single employer collectives covering 117 members as shown in the table below:

Employer	Type of employment	Number of members
ACC	Branch and Senior Medical Advisors	31
Ashburn House	Mental health	3
NZ Blood Service	SMOs	4
Central Otago Health Services (Dunstan Hospital)	SMOs	7
Family Planning	SMOs	21
Hokianga Health	General practice	6
Te Runanga Toa Rangatira	Iwi-based general practice	17
Ngati Porou Hauora	Iwi-based general practice	3
Golden Bay's Community Health	General practice	6
Otara Union Health Centre	Union health general practice	3
Christchurch Union and Community Health	Union health general practice	6
Compass Health	Sexual health services	6
Waitaki District Health (Oamaru Hospital)	SMOs	4

The remaining 52 members are spread across 18 employers that are just as diverse as the list above.

This diversity brings new information and ways of working into the ASMS and is valued.

We encourage you, as ASMS members, to mention to colleagues outside of DHBs that the ASMS is very interested in providing membership coverage outside of the DHBs and that they are most welcome to contact one of the ASMS industrial officers.

SPEAKING OUT

Panel discussions in Auckland and Wellington on the rights and responsibilities of professionals 'speaking out' were stimulating and well-attended, report the organisers.

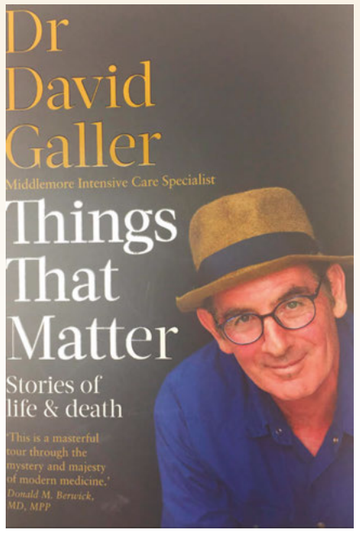
One of the speaking-out events was held in Auckland on 11 August and the other in Wellington the next day, immediately after the ASMS branch officers' workshop.

Both events were organised by the education union New Zealand Educational Institute Te Riu Roa in conjunction with several other unions, including ASMS, the New Zealand Nurses Organisation, Public Service Association, Tertiary Education Union and the New Zealand Post Primary Teachers' Association.

The idea was to spark a conversation about the importance of speaking out for democracy, good outcomes and for good policy-making.

ASMS members Dr Joshua Freeman and Dr Erik Monasterio spoke at the events – both have spoken out publicly previously on issues such as the Trans Pacific Partnership Agreement. Other speakers included Jessica Walker, a high school teacher from Brisbane who has been active in speaking out for refugees, physicist and author Professor Shaun Hendy, and principals from schools in Auckland and Wellington who have spoken out about the introduction of national standards.

More than 100 people attended the Wellington event alone; a mix of doctors (including ASMS members), nurses, teachers, public servants and scientists.



STORIES FROM THE CLINICAL FRONT LINE

Intensive care specialist David Galler has been telling tales.

His book, *Things that matter: Stories of life & death*, is a collection of his personal experiences and reflections on practising medicine for quarter of a century – and he says he loved writing it.

"Really, really enjoyed it. I still can't quite believe I've produced this book."

> *"For doctors, writing is an opportunity to express our feelings about some of the profound things we come across. So much of what we do is not black and white, it's grey, and we want to help people to understand that."*

Dr Galler has been an intensive care specialist at Middlemore Hospital in Auckland for 25 years. He is also the clinical director at Ko Awatea and a former ASMS National President, and is one of the leaders of the innovative doctors' writing website, the Medicine Stories Project (**http://themedicinestoriesproject.co.nz/).**

He wrote the book when he took a year's leave of absence from Middlemore to live in Samoa and work voluntarily for the National Health Service of Samoa during 2015.

"Life in Samoa was less complicated than it is at home in Auckland so although I was really busy working and on call everyday, when I did have time I wrote. I had a spot on our verandah that overlooked a lovely garden. I mapped out the things I wanted to discuss, and then worked on the book.

"What surprised me was how difficult it was to sit still! I couldn't believe the level of distraction that I was used to. Being still was quite an achievement, rewarded with the pleasure to think and remember, and to let the connections between things come to me."

The book is available for sale online and in bookstores.

Dr Galler was interviewed by Kim Hill on Radio New Zealand's *Saturday Morning* programme (**http://www.radionz.co.nz/national/programmes/saturday/audio/201810250/david-galler-stories-of-life-and-death).** He has also been interviewed on *Stuff* (**http://www.stuff.co.nz/national/health/82434000/Dr-David-Galler-on-life-death-and-things-that-matter**) and in the *New Zealand Herald* (**http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11689610**).

REVAMPING PASSION – LAUNCHING THE MEDICINE STORIES PROJECT

DR JEFF BROWN | ASMS NATIONAL EXECUTIVE, ON BEHALF OF THE MSP TEAM

Last October we went fishing. A gentle cast onto the ocean of emotion. A website for doctors to send stories, to expose their jottings to inspection, to open their notes for others to read. We offered editorial and literary advice to gently polish the pearls. We caught the eye of doctors from the breadth and depth of medical practice, netting poems and prose submissions that took our breath away.

Over the first six months, the Medicine Stories Project was clicked on and viewed, stories searched, blogs read, and the web team collected data on what pages and portions grabbed most interest. We have used this data to revamp the website to bring your stories to the front, refreshed the design to enhance accessibility, added a list of stories by doctors in Aotearoa New Zealand over the centuries, and highlighted the authors of the stories we publish.

In the months since last October, passion has shone through. Windows have been opened into your minds. Your submissions have generated admiration, respect and wonder. Now we are ready for more.

Our website has been relaunched. Our fishing is fleet. Whatever your hook, whatever your catch, whatever your passion, we have revamped our repository for your writing.

Be brave and leap into our harbour of hope.

http://themedicinestoriesproject.co.nz/

THE MEDICINE STORIES PROJECT

DR COURTENAY KENNY IS A SPECIALIST OCCUPATIONAL PHYSICIAN AT WAITEMATA DHB IN AUCKLAND.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

I was in a top academic stream at Auckland Grammar School and I had a strong interest in science. Medicine seemed to be the option that built on that interest the best. A lot of people from my class went into medicine, law or engineering. My mother may have been a big influence also, as she had been a registered nurse for a long time.

After graduating from Auckland medical school and completing my years as a house surgeon, and because I was in the Medical Corps as a territorial medical officer, I had an opportunity to go on a deployment with the Navy. This was part of the Southern Cross telephone cable survey, and the trip to Fiji, Australia, Hawaii and eventually Vancouver. I chose to join the Navy on a short commission, But ended up remaining with the RNZN for 17 years, eventually as Director of Medical Services.

After working at sea and with the navy dockyard in Devonport, it became clear that this was occupational medicine (rather than simply primary care for Naval men and women), which was a relatively new specialty at that time.

Occupational medicine probably had its more recent origins in military medicine. There were always doctors and nurses in the armed forces going back many years. In more modern times, occupational ('industrial') medicine was practised in the large factories and large hospitals. It was particularly important in remote areas. There was always the 'works doctor' providing primary health care for employees in places where there was no town nearby. These days a lot of such occupational health practice that has been contracted out to occupational nurses, or interested GPs, especially in smaller centres.

> *During my time with the Navy I was based in Auckland, with several big overseas deployments to the United States, Persian Gulf, and the UK.*

During this period, I did my British exams in occupational medicine, and then the Australasian exams.

I was deployed in Iraq for six months with the United Nations Special Commission, following the Gulf War, where I was the New Zealand national officer, in charge of the New Zealand team of military people in Iraq and the Senior Medical Officer for the UNSCOM. My predecessors were directly involved with overseeing the medical aspects of locating and dealing with chemical weapons of mass destruction. By the time I was there, most of those chemical stockpiles had been destroyed but we were still searching for residual supplies and monitoring the sites where they had been developed or stored.

The medical team looked after the military personnel and the scientists who came into Iraq to do all these inspections. That was interesting because there were some very unfit and unwell scientists who came to Iraq for two weeks at a time, into 50 degrees Celsius heat which played havoc with their heart disease, diabetes and other chronic medical conditions. Some of the people coming into Iraq were US or other military experts on munitions, chemical weapons, etc and they were usually extremely fit and well-acclimatised, but other people were arriving from a civilian background from countries such as Germany, Britain, etc and they weren't necessarily in good health.

HOW DID YOU END UP WORKING FOR WAITEMATA DHB?

I left the Navy in 1997 as the Director of the naval medical service. That was about as far as you could go in a clinical position. I would have had to go to Wellington into a non-clinical role if I wanted to progress that career further. I decided to join a group of occupational medicine colleagues in private practice.

Within a few months, I was also asked by a colleague at North Shore Hospital to provide short-term cover as he was going to be off work for a number of months due to a skiing injury. In the end he didn't come back to the job so I ended up accepting a permanent position almost by default. At that time I was doing 50-50 public and private work. Now I work three days at the hospital and two days in private practice. I'm 0.7 FTE for Waitemata.

WHAT DO YOU LOVE ABOUT YOUR JOB?

I love seeing working people getting on with their daily lives, and helping them to do that.

> *I enjoy the clinical components, seeing people and hearing their narratives, assisting them through some difficult times in their lives. There's a lot of variety in this role.*

We see all DHB staff members, not just doctors, and we see them them when they have health issues that are being caused by or are affecting their work. Waitemata DHB has a team of 15 FTE occupational health staff, most of them nurses, and I am the only SMO. We deal with everything – skin conditions, musculo-skeletal problems, anticipated periods off work due to surgery, helping people remain at work.

The second way people come to us is when someone has an injury. Waitemata is part of the ACC partnership programme whereby the DHB is responsible for assessing and managing all of its own injury claims. So we have to make sure the staff member receives the right treatment, we negotiate with their managers to find suitable work for them if they can't go back to work straight away, including restricted or alternative work.

The third pathway to occupational health is for staff who have been referred by their manager. This could include staff struggling with conditions such as major depression, cancer, heart disease, or following debilitating conditions or major surgery. We try to facilitate their treatment through the health system, whether through public or private services.

Sometimes we'll see people who are drug or alcohol dependent. There's probably the same level of dependency in the hospital workforce as there is in the community. Some of them will be well managed and looked after by community agencies and never come to our attention, but in other cases their colleagues might report that the person is working impaired.

Some people will be referred to us through their professional registration body. I work with those registration bodies and the person's treating clinician to keep the staff member at work as much as possible. We're focused on the health and well-being of the staff member, as well as the safety of patients.

We're privy to their private lives but it's no different to other specialists who are treating colleagues and other staff for mental health problems or operating on them.

> *The occupational health records for staff are confidential, and we believe very strongly in that as essential in securing the trust of fellow employees.*

It's a careful balance, though. We have to safeguard the private clinical information of staff members but at the same time provide useful advice to managers about what the health of a staff member means in terms of being able to do their job.

WHAT IS THE MOST CHALLENGING ASPECT OF PRACTISING MEDICINE?

It's difficult when a person's health may be precluding them from continuing to work – they're just not up to doing the job any more, and we're trying to assist them with coming to terms with that.

It's also difficult sometimes to determine when a condition a person has developed is an injury. For example, if someone has a sore back which they think is due to their work but it becomes clear subsequently that it's not, that actually they've had back pain for a long time and it's likely to be from age-related changes etc, then that requires some working through. We might have to help them understand the situation is not as simple as they might have thought.

Unlike some colleagues who are restoring vision or doing hip operations, staff tend to be rather sceptical or worried that when they deal with occupational health , perhaps feeling that they may be denied some health entitlement.

The other factor is that we're dealing with a lot of well-qualified medical, nursing, and other clinicians, so they are more likely to question or challenge the advice they're given, as well as to often seek 'corridor consultations' with clinical colleagues. Since occupational health staff often also work in the hospital environment as well as in this department, I think that gives staff a degree of reassurance that we understand what they do.

WHAT HAVE YOU GAINED FROM YOUR ASMS INVOLVEMENT?

My main motivation for joining the ASMS was to better understand the support systems for SMOs within the DHB.

> *It's wonderful to have a service that can provide good advice and support to SMOs as they move through a range of issues, not just MECA and conditions of service issues, but also issues to do with their careers, sabbaticals, sick leave, and health issues.*

ASMS has always been there with SMOs as a sounding board. In my role, I might be providing advice as to whether someone can continue to work or whether we should be offering medical retirement to some of these people. It's good to know that there is that union support.

Fortunately I haven't had to avail myself of advice from ASMS in a crisis, but I'm always grateful that ASMS is there. If my job was being disestablished or there was an employment situation, I know where I would turn to for support.

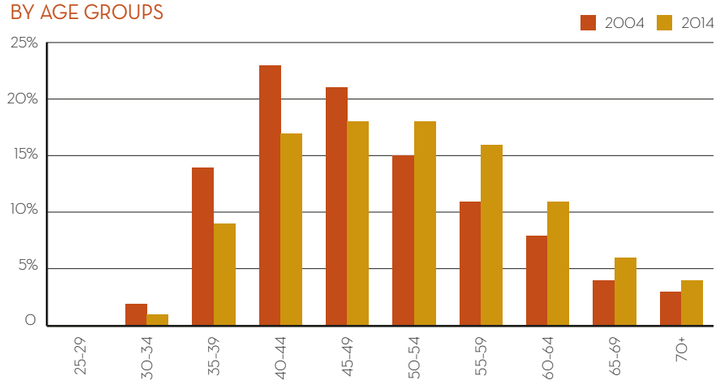
DEMOGRAPHIC TRENDS

LYNDON KEENE | ASMS DIRECTOR OF POLICY & RESEARCH

As the 'baby boomer' generation of specialists approaches the standard retirement age in New Zealand, questions have been raised as to how the health sector will respond to the expected increasing specialist workforce attrition rates over the next 10 years.

Medical Council of New Zealand data show that in 2004 the largest group of specialists practising in New Zealand fell in the 40–44 age group. By 2014 (the latest figures available), the largest group had shifted to the 50–54 age group. In 2004, 40% of the workforce was aged 50 or over; by 2014 it was 55%. More than 10% of the specialist workforce is now working over the traditional retirement age (Figure 1).

FIGURE 1: PERCENTAGE OF TOTAL NEW ZEALAND SPECIALIST WORKFORCE BY AGE GROUPS



SOURCE: Medical Council of New Zealand Medical Workforce Survey Data, 2014, MCNZ 2016.

Medical colleges are among those who have raised concerns about looming retirements and how they could exacerbate current workforce shortages.

A report prepared for Health Workforce New Zealand (HWNZ) in 2011 acknowledges that "older doctors are working fewer hours and many are retiring earlier" and suggests strategies to retain doctors in their older years. They include ways to improve job satisfaction, satisfaction (including interventions to reduce stress), changing work roles, introducing more part-time and job-share positions and more flexibility in work hours, retraining in other specialties, and career and succession planning.[1]

However, it notes there is limited discussion in New Zealand on how to influence and if possible delay the retirement age of doctors and urges that: "Increasing focus on strategies to retain doctors in medicine is needed now."

Four years later, HWNZ acknowledges medical workforce aging trends in its report *Health of the Health Workforce 2015*, but has little to say about it other than: "However, an ageing medical workforce is an international trend... and New Zealand is better placed than many other OECD countries in terms of the number of doctors in the workforce aged 55 years and over."

The apparent unconcern, however, fails to recognise that New Zealand is worse off than many other OECD countries in terms of practising specialists per head of population. This is reflected in long-term shortages across a broad range of specialities, which HWNZ acknowledges.

Further, New Zealand's specialist workforce depends more heavily on international medical graduates (IMGs) than most other OECD countries (only Israel is more dependent).

> ***The aging specialist workforce in many countries is leading to increasing use of IMGs to fill the gaps opened up by retirements, and is therefore creating an increasingly competitive market for doctors to which New Zealand is especially vulnerable.***

OECD data show the number of overseas-trained doctors working in the United States alone increased by 14.5% in the four years 2010–2014.

As a recent European report notes, the aging health workforce is leading to an "upcoming massive replacement need, even with gradually growing workforce sizes". It also points to a growing trend in Western countries for the younger generation of doctors to place greater importance on work-life balance. "Not accommodating these and other trends by means of strategic thinking and planning may well lead to increasing global competition for scarce medical resources...[2]"

The report to HWNZ in 2011 notes the lack of such strategic thinking and planning in New Zealand and calls for more research about doctors' intentions with respect to retirement, and what would keep them in practice to enable longer term workforce planning.

To help fill the research void, the Association is undertaking a study of senior doctor retirement intentions, with preliminary findings to be released later this year.

REFERENCES

1. Ineson S. Retention of doctors in their 'third age'. A report for HWNZ, May 2011.
2. European Commission. *Mobility of health professionals: Final Report Summary*, 2016.

LLOYD'S PROJECT.

LLOYD WOODS WITH HIS GRANDSON LACHLAN.

NATIONAL OFFICE STAFF

In this issue of *The Specialist*, we introduce ASMS Senior Industrial Officer Lloyd Woods, who (with fellow Industrial Officer Dianne Vogel) looks after members in Nelson Marlborough, West Coast, Canterbury, South Canterbury and Southern DHBs.

I have three 'children' (the youngest of whom is 30) and three grandchildren. I am both a proud father and grandad, and I believe family to be very important. I lived in Christchurch all of my life until moving to Wellington in 2002.

I like cycling (currently only as a commuter and not often enough) and very much like tramping and generally getting into the great outdoors. However, due to studying part time for a Master's in Public Policy during the past three years, the great outdoors has had to wait. Having successfully graduated last December, I am hoping that later this year I will be out there, preferably in the Southern Alps and West Coast, which are my favourite parts of New Zealand. I also enjoy using my old skills as a motor mechanic and fixing a variety of people's cars, often when everybody else has given up. I prefer European cars but have purchased a project for my spare time (a 1960 Humber 80).

I started working for the ASMS in January 2009 after a number of years involved in tertiary education and tertiary unions, including four years as National President of the Association of Staff in Tertiary Education (ASTE).

I thoroughly enjoy working for the ASMS. I am a Senior Industrial Officer within the industrial team and we have excellent leadership directly by Angela Belich. This has created a tight team that, while working hard, is also carefully looked after. Overall, I am proud to work for the ASMS as the entire ASMS team is hard working and professional, and it is a pleasure to work with great colleagues across the whole team.

In terms of my duties, I have always taken an interest in the non-DHB sector and currently negotiate most of the non-DHB collective agreements. I am also very interested in issues around the health and wellbeing of senior doctors. In particular, I have been looking for better ways to deal with alleged misconduct, especially bullying.

As a result of my studies, I am very interested in the concept of integrity management. While it goes without saying that we already work with integrity within ASMS, Executive Officer Yvonne Desmond and I are leading a project to look at how we might incorporate these practices more formally within the organisation.

The best thing about working at the ASMS (alongside being in a great team of colleagues) is the variation in work across our membership and our members in general. I am constantly reminded of the passion that ASMS members have for the public health system and for delivering excellent care (often despite resource constraints) for their patients.

It's great to have a job where you can feel proud to be involved.

ASMS SUBMISSION ON THE HEALTH OF OLDER PEOPLE

LYNDON KEENE | ASMS DIRECTOR OF POLICY & RESEARCH

An update of the Health of Older People Strategy is currently under way, with the call for submissions recently closed.

The Association has raised a number of concerns in its feedback to the Ministry of Health (**http://www.asms.org.nz/wp-content/uploads/2016/09/Submission-to-MOH-Draft-HOOPs_166591.2.pdf**) though most of the goals aspired to in the draft strategy appear reasonable as far as they go. An underlying question is whether there will be funding available to implement the programmes to achieve those goals.

An earlier, more candid, Ministry of Health draft strategy on the mental health and addiction workforce plan acknowledged "All actions in the draft are tentative" depending on the availability of funding (see ASMS submission: **http://www.asms.org.nz/wp-content/uploads/2016/03/Submission-to-MOH-Draft-Mental-Health-and-Addiciton-workforce-action-plan_165097.3.pdf**). It is reasonable to assume that the same proviso applies to this latest draft strategy. There were no signs in this year's health budget, at least, that specific services for older people were being earmarked for a future funding boost.

Much has been said about the effects of the aging population on the nation's health services. To put this in perspective, relative to recent funding trends, around 40% of government health spending is for those aged 65 and over.[1, 2] Since 2009/10, the population in that age group has increased by an estimated 24%. Over the same period, the shortfall in government health expenditure has been conservatively estimated to have accumulated to more than $1 billion.[3]

To look at the issue from an international perspective, New Zealand has until now had some advantage in health funding over many comparable countries in that our population is relatively young. Currently, around 14% of the population is aged 65 or over and it is estimated this will increase to around 17% by 2021. OECD data shows that, in 2013 (the latest data available), 14 western European countries already recorded 17% or more of their populations as in that age group.[a]

Their average spending on health totalled $4,203 (US$ PPP[b]) per person in that year, compared with New Zealand's $3,486, suggesting New Zealand has some catching up do over the next five years.

First, current funding trends will need to be reversed.

ASMS submission to the Ministry of Health:

NOTE:

a. The 14 countries are Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Netherlands, Portugal, Spain, Sweden, Switzerland, United Kingdom.

b. Purchasing Power Parity (PPP) equalises the purchasing power of different currencies, taking into account the relative cost of living and inflation rates in different countries.

REFERENCES

1. Bryant J, Teasedale A et al. *Population Ageing and Government Health Expenditures in New Zealand*, 1951–2051, NZ Treasury, Working Paper 04/14, September 2004.
2. Ministry of Health. *Health of Older People Strategy: Consultation Draft*, July 2016.
3. Rosenberg B, Keene L. *Did the 2016 Budget provide enough for health?* Working Paper on Health, No. 15. NZCTU, ASMS, May 2016.

DID YOU KNOW

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

DID YOU KNOW...

That when you are appointed to a job in another city you are generally entitled to relocation costs. This provision is described in the MECA as "by negotiation" between you and the employing DHB, although we see the general principle as being that relocation should be cost neutral, so it's important to engage with them before you move. Also, if the employer offers an amount that seems insufficient, you are entitled to negotiate – providing estimates and quotes is usually helpful. Overall we would expect that your new employer would cover travel costs for you and your family, plus the cost of moving your household, along with reasonable settling in costs (eg, rental car and accommodation for a few weeks). Reimbursement of relocation costs requires receipts as well as agreement, so it is important to keep these.

http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-22/

FIXED-TERM CONTRACTS

Generally, we do not encourage fixed-term employment and under the Employment Relations Act 2000 a job may only be for a fixed term where there is a "genuine reason based on reasonable grounds" that it is not permanent. Covering for an SMO or SDO who is on leave (eg, parental, sabbatical, long-term sick, etc) is the most common reason for this. However, there are some other situations where a fixed-term appointment may be appropriate, such as for a fixed period to complete further sub-specialty training. We do recommend that where a fixed-term position is being offered the affected SMO or SDO and department seek ASMS advice.

LEAVE FOR MEETINGS

SMOs "elected, seconded or otherwise appointed" are entitled to leave on full pay in order to attend professional meetings, including those of the MOH, HPDT, medical and dental colleges, NZMA, NZDA and, of course, ASMS. This clause also applies if you are invited to teach and/or assess trainees for your college or professional association. SMOS may be granted leave for other bodies but these must be agreed with the employer.

You can read the full clause here. **http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-29/**

DID YOU KNOW...

That the clinical director of your department (or a nominated SMO or SDO from the department) must sit on any SMO or SDO appointments committee. The local senior staff committee (or agreed body) also has the right to nominate a further member of the interview panel, from an appropriate specialty, for SMO and senior clinical positions. You can read clause 52 here.

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

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'.

Wed., Nov. 25, 1964, Page 3.

Pay For Doctors On New System?

WELLINGTON (PA).—The Government hoped to be able to devise a new salary system to give full-time medical staff a proper opportunity to negotiate on salaries, the Minister of Labour, the Hon T. P. Shand, said in the House of Representatives last night.

Speaking in the adjournment debate, Mr Shand said he had met a British Medical Association deputation on the matter yesterday.

The deputation was not satisfied with present procedure for fixing salaries.

The present satary advisory committee system did not give much opportunity for representations to be made and no opportunity for rapid negotiation.

Negotiations for new scales had been continuing since April and under the present system they took some time.

Both he and the Minister of Health, the Hon D. N. McKay, hoped a new procedure could be devised, Mr Shand said.

Calling for the Government to relax its "belt-tightening attitude" and take "remedial action" to raise the salaries of full-time hospital doctors, Dr A. M. Finlay (Oppn., Waitakere) said that despite repeated calls since 1961, the Government had taken no action.

Speaking during the half-hour adjournment debate, he asked when the report of the advisory committee on salaries for hospital doctors and specialists would be available.

Dr Finlay warned that if conditions of work and pay were not improved, the whole of New Zealand's medical service would be "thrown into chaos."

He pointed out that the superintendent-in-chief of the Auckland Hospital Board had recently claimed hospital doctors were working "under an unremitting strain."

"I wonder if the Government appreciates the reputation some New Zealand medical specialists have overseas," Dr Finlay said.

The reputation of the cardio-thoracic unit at Auckland's Green Lane Hospital had won world renown.

Replying, Mr J. B. Gordon (Govt., Clutha) said negotiations for higher salaries for hospital doctors had been going on since 1948, but he pointed out that as the Director - general of Health received £4,700 a year and senior hospital doctors received £3,800 a year, hospital doctors could not expect pay increases unless the director-general's salary was raised as well.

"If we did this, where would we stop?" he asked. "It would mean raising salaries right up the scale."

Mr Gordon said the National Government had managed to get more senior hospital doctors and specialists than ever before.

He said four years ago there were approximately 135 hospital specialists in the country. Now there were 250.

Mr J. J. King (Oppn., Waitemata) said the first approach to the Government had been made in 1961. The Government did not seem to appreciate the strain on the medical staff or the shortage of staff.

Staff in hospitals had to work much longer hours than they should. The increase in staff had not kept pace with demand.

Mr King said the Labour Party had recognised there was a shortage of house surgeons and medical superintendents and would have done something about it.

It also considered the general practitioners 7s 6d fee was not sufficient reimbursement, he said.

Mr W. W. Freer (Oppn., Mount Albert): We are exactly where we were in 1961.

He asked why specialists should be the last to receive salary adjustments.

The Minister of Health said it was a pleasant surprise to see that the Opposition had changed its tune.

"For the past two or three years they have been critical of the medical profession," he said. "Given the opportunity they would socialise the profession."

Mr McKay said earlier recommendations had been made on salaries but they had not been accepted by the Salaries Advisory Committee. He accepted this responsibility.

"The system we have at the present time is not wholly satisfactory, but it is the system that has been in operation since 1947," he said.

Australian Cricket Team

Sydney. — The Australian test cricket team to play Pakistan at Melbourne from December 4 to 8 was announced last night.

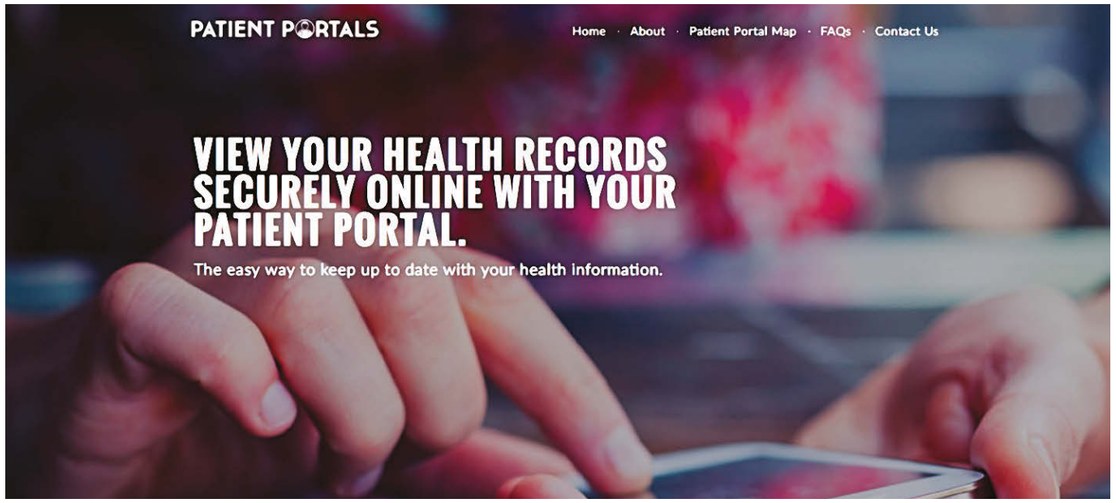
The team is: R. Simpson (New South Wales, captain), B. Booth (N.S.W.), I. Chappell (South Australia), R. Cowper (Victoria), N. Hawke (S.A.), B. Jarman (S.A.), W. Lawry (Vic.), G. McKenzie (West Australia), I. Redpath (Victoria), B. Shepherd (W.A.), D. Sincock (S.A.), T. Veivers (Queensland).

The twelfth man is to be named later.

FREE BUS TRIPS FOR ELDERLY

Otago Road Services, Ltd., is to assist old people to take bus trips at weekends.

In response to a letter, "Help for Aged," published in the Otago Daily Times, the company will issue 12 free passes for each Sunday



PATIENT PORTALS AND THE IMPLICATIONS FOR SECONDARY CARE

DR TIM COOKSON | MEDICAL CONSULTANT, MPS

Over the last couple of years, general practices around New Zealand have been steadily rolling out a programme known generically as a patient portal, and specifically branded as ManageMyHealth by the most widespread GP practice management system (PMS).

In essence, the programme allows individual patients to access some of the information about them contained in a GP's records and to have a more direct electronic link to the practice, enabling them, for example, to make appointments online.

> *How much information is available to patients varies from practice to practice, but virtually all enable access to the PMS inbox, which contains lab results, radiology reports and any letters that have been sent electronically.*

For security reasons, patients do not directly access the GP's computer. Instead, the relevant information is uploaded to a site in the 'cloud' and both the GP's computer and the patient interact with this site.

More details of the programme will be explained later in the article, but firstly – how does this affect you as a specialist working in a DHB or in private practice?

The most important change is that your patients will be able to view any information that is sent electronically to their GP as soon as this has been filed by

the GP. This can significantly change how quickly your patient will know about the results of tests you have ordered if you have arranged for a copy to go to the GP. Many will see the results before you do.

Before the introduction of the patient portal, any results copied to a GP would have been filed in the patient inbox, the GP would be aware of the result, and the patient would only find out if they contacted the practice and specifically asked for those results. Now, as soon as a result has been filed, the patient is automatically notified that there has been 'activity' on their site, and they are invited to view that new activity.

A GP is able to choose to not upload any particular result by ticking a box, but the default position is for the information to be uploaded. As you will be aware, primary responsibility for informing patients of results lies with the person who ordered the test and patients are entitled to be informed of any results in a timely fashion. If a particular result is ticked to not be uploaded, the GP will have to remember to go back to that result at a later date and 'un-tick' it so that it is available. At a practical level this becomes very cumbersome, and the majority of results will be uploaded directly.

Clearly most results will not be problematic, and there is unlikely to be any negative impact on the patient from learning the result.

More difficult are the results that are mildly abnormal, and will require interpretation that takes into consideration the full clinical picture. The patient is likely to contact the GP to ask for an explanation of this result and the GP may be in a position where the only safe answer is to say that they are unable to give a full explanation and direct the patient back to you, the person who ordered the test. GPs may not feel able to provide an interpretation of the result because it is a test that is not ordered frequently in general practice, or a more common one but the GP is not aware of the full significance of the result.

Depending on how quickly you review your results, you may be in the situation of being asked to contact a patient about a result before you have seen that result.

> *The most problematic issue will be the truly serious result; the unexpected melanoma or malignant polyp.*

Although the person who receives a copy of a result is not primarily responsible for managing that result, there is a responsibility to ensure that appropriate action is being taken. The GP is now in the challenging position of needing to decide whether or not to upload such a result. They are also faced with the dilemma of whether they should inform the patient in a more empathetic way, such as by arranging a consultation, or whether the decision is that this is the responsibility of the doctor who took the sample. None of us looks forward to delivering bad news.

Some multidisciplinary hospital teams have started heading their letters with 'Information embargoed – do not upload to ManageMyHealth'. Many GPs have concerns about this approach as it means that the GP will be in possession of significant information relating to their patient, but is in effect muzzled from sharing this with their patient.

MPS is not aware of any complaints relating to this that have gone to the Health and Disability Commissioner, but anticipates that this approach would be carefully examined if a complaint was lodged.

GPs who are offering patient portals have also had to review how they manage aspects of patient care. There are options available for patients to view their notes, as well as their long-term medications, diagnoses, allergies etc. While patients have always had the right to ask for copies of notes, this is relatively uncommon. The knowledge that patients can immediately view what has been recorded tends to focus the mind of the doctor writing the notes. This can only be a good thing.

Patient portals can also enable patients to request repeat prescriptions online, to make appointments online and, if agreed with the GP, set up a secure email link. This has the potential for 'virtual consulting' by email, and is another relatively new challenge for GPs.

At this stage, only around 5% of the population is enrolled on a patient portal, but with active encouragement from the Ministry of Health, this number will steadily increase. Some of your patients currently have access to the benefits of this system, and we all need to consider whether we should to change our practice accordingly.

The potential immediacy that the system allows creates challenges for both primary and secondary care providers, but the overall benefits for patients are clear and the feedback from patients is overwhelmingly positive.

Medical Protection website: **http://www.medicalprotection.org/newzealand**

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

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