THE SPECIALIST

THE MAGAZINE OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

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WOMEN IN ASMS

ANGELA BELICH | ASMS DEPUTY EXECUTIVE DIRECTOR

When I came to work for ASMS in 2001, women were 22% of the ASMS membership. Now women constitute 37% of ASMS members. Given that ASMS' membership density in the permanently employed DHB workforce is around 90%, this is likely to be consistent for all senior medical and dental officers.

Given the proportion of women in medical school and the proportion of women registrars, it seems inevitable that the senior salaried medical workforce will become a majority female workforce in the near to medium term. It will not necessarily follow in a straight line. In New Zealand, a very large proportion of our doctors are international medical graduates (IMGs) and it's possible that in New Zealand we train more women locally and then recruit more men than women from overseas.

Since 2002 the Association has been collecting data on where senior doctors and dentists are on the salary scale by gender. There are important caveats to this data. It reflects steps on the salary scale but not hours of work or any allowances. So, it doesn't reflect FTE or call or availability or any other after-hours payments or recruitment and retention payments or clinical leadership allowances.

Over the years, the survey has shown a steady gap between the salary of men and women members (see Figure 1). We hypothesised that this reflected the relative seniority of the age cohorts that were male dominant and therefore at the top of the scale. After 16 years it may be time to revisit this hypothesis.

What else do we know about women in ASMS? We know we have never had a female President and that we presently have the largest number of women we have ever had on our National Executive – 3 out of 11. We know that women form a larger proportion of members at the bigger DHBs but the smaller DHBs tend to be male-dominated.

We know anecdotally from our industrial officers that we have a steady stream of women appointed at lower steps, with lesser FTE and without the extra allowances of their male colleagues. We have even joked that a woman joining the roster seems to be a signal that recruitment and retention is no longer a problem and that any extra payments are no longer necessary. When the ASMS industrial staff know about this, we can almost always get the obvious inequities corrected. DHBs have no ideological commitment to treating women unfairly. It is just something that 'happens'. Why is explained in the book *Why so slow? the advancement of women by Virginia Valian* (Valian 1998) which was referred to extensively by Caprice Greenberg in her presidential address to the American Association Academic Surgeons (**https://academicsurgicalcongress.org/aas-2017-president-address-caprice-greenberg-md-mph/** and also see Greenberg 2017 for full text of address).

The ASMS DHB MECA (and the salary scales we have in our other collective agreements) should be very effective at mitigating against the unconscious bias we are all subject to (an online gender bias test can be found at the following: **https://implicit.harvard.edu/implicit/takeatest.html)**.

Contrary to the clichés of human resources and business management, flexibility and deregulation is most likely to allow these unconscious biases or schemas to unfold without restriction.

ASMS salary scales require movement up the scale on satisfactory performance and, since 2007, criteria for the starting salary has been carefully defined in a way that should minimise unconscious bias.

Factors such as years of relevant experience and qualifications can be taken into account but reference to recruitment and retention as a factor in setting starting salary was knowingly and consciously removed by the parties (both DHBs and the Association). The ASMS-DHB MECA is, however, a minimum rate document so there is nothing to prevent an employer paying above the MECA in a variety of ways. Given the overseas data, there is reason to suspect that this will play out in a way that favours men over women and male-dominated specialities over the female-dominated. If this is happening, it is a breach of the Equal Pay Act which has been in force since 1972.

It is a sociological truism that professions that become female-dominated lose status, power and relative wealth (Pringle 1998). The Association and our members will need to find a way to make sure that becoming a female dominated profession does not diminish our members' leadership role in the public health system but leads to an era of sustainable work patterns and patient-centred care.

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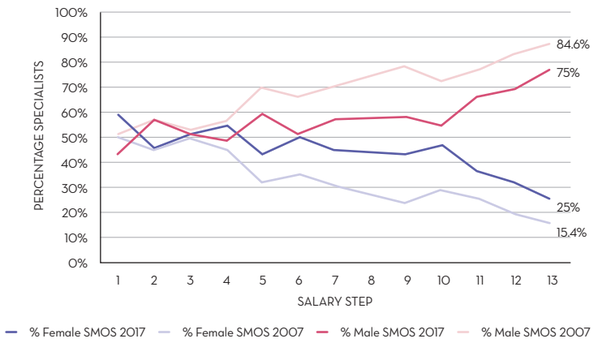


FIGURE 1: PROPORTION OF SENIOR DOCTORS AND DENTISTS ON THE ASMS SALARY SCALE BY GENDER

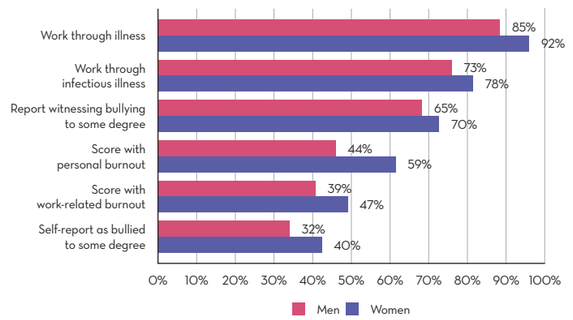


FIGURE 2: KEY DATA FROM RECENT ASMS RESEARCH AS IT PRESENTS ACCORDING TO GENDER
ALL DIFFERENCES BETWEEN MALE AND FEMALE RESPONDENTS FOR EACH VARIABLE ARE STATISTICALLY SIGNIFICANT (P<0.05)

CELEBRATING THE WORK OF OUR WOMEN MEMBERS

New Zealand led the way 125 years ago when it became the first self-governing country to grant women the vote. As part of the commemorations of that event, ASMS is celebrating the work of our women members, whose own practice of medicine builds on the foundations laid by this country's early suffragists.

ASMS is responding to the issues raised by our women members by providing opportunities to network at each ASMS Annual Conference and to connect with other women doctors at all stages of their medical careers through the Facebook group Women in Medicine, which we established at the request of our members.

We have also been conducting research into issues which affect many of our members but seem to have a particularly adverse impact on women senior doctors and dentists, such as the high rates of burnout reported (**https://www.asms.org.nz/news/asms-news/2016/08/12/burnout-rife-among-senior-doctors-dentists-working-public-hospitals/**). We have also been taking up issues such as breastfeeding policies and facilities when we meet with district health board chief executives and senior managers.

Our next steps include conducting a pilot survey of members to identify whether a gender pay gap exists for our members. In a further piece of work which will be reported on later this year, ASMS Principal Analyst (Policy & Research) Dr Charlotte Chambers is analysing qualitative research into why younger women members may be more prone to burnout than their male counterparts.

In this article, we hear from six women specialists at various stages of their own careers about their journey into and through medicine.

EARLY NEW ZEALAND WOMEN DOCTORS

Some of New Zealand's early women doctors included:

- Emily Hancock Siedeberg: **https://teara.govt.nz/en/biographies/3s16/siedeberg-emily-hancock**
- Margaret Cruickshank: **https://nzhistory.govt.nz/nzs-first-registered-woman-doctor-margaret-cruickshank**
- Sylvia Gytha de Lancey Chapman: **https://teara.govt.nz/en/biographies/4c17/chapman-sylvia-gytha-de-lancey**
- Theodora Clemens Easterfield: **https://teara.govt.nz/en/biographies/4h6/hall-theodora-clemens**
- Eleanor Southey Baker: **https://teara.govt.nz/en/biographies/3b5/baker-mclaglan-eleanor-southey**
- Jean Mary Sandel: **https://teara.govt.nz/en/biographies/5s1/sandel-jean-mary**
- Cecily Mary Wise Clarkson: **https://teara.govt.nz/en/biographies/4p12/pickerill-cecily-mary-wise**
- Doris Clifton Jolly: **https://teara.govt.nz/en/biographies/4g14/gordon-doris-clifton**
- Eily Elaine Gurr: **https://teara.govt.nz/en/biographies/5g23/gurr-eily-elaine**

I always thought that if the boys could do it, then I could too.

TANYA WILTON

Tanya Wilton has worked as an emergency physician for the past 10 years, and is employed by Hutt Valley District Health Board.

Tanya Wilton (left) with friend Kate Neas, who is also an ASMS member

I have had an interesting journey through medicine. I was a graduate student entering medical school after completing a degree in physical education. It was at the start of my medical degree that higher fees and student loans were introduced. I had managed to pay my own way through my first degree without any debt. However, the fees and loan scheme meant that I graduated from medicine with a large student debt, in spite of continuing to work part time throughout my medical degree. Incongruously one of my jobs was at a bottle store and I had the signs of chronic liver disease frequently in front of me!

In hindsight, I think that the increased fees and student loan scheme disadvantaged and continues to disadvantage those students who end up earning less - often women, who take time out of the paid workforce to have children. I have non-medical friends who still have a sizable student debt more than 20 years after graduating.

I recall a lovely GP talking to a group of us (I guess all female) when we were medical students in Dunedin, saying that you couldn't do it all. That to combine having a career and having children was hard. I thought to myself that this was slightly ridiculous - I always thought that if the boys could do it, then I could too. However, I think there is a partial truth to her caution. It doesn't seem to be my husband who notices that the kids have grown out of their clothes or need to take a present to their friend's party or even remembers the friend's party, and there are a lot of little things that end up being on my plate. Maybe other families manage this better?

The challenging thing for me has been figuring out how much of myself to devote to the different roles I need and want to play as well as having time for my own non-work pursuits.

When I started emergency medicine training, there were few specialists in New Zealand and even fewer women. Those I came across were encouraging and interested in getting trainees on the path to emergency medicine but it was a pretty tough run for them being only one of one or two consultants supporting a whole department. I completed most of my training in Australia, where emergency medicine was more developed and had greater numbers of specialists from whom to learn.

I trained with a generous and collaborative group of women who were combining career and early parenthood. We had study sessions at odd times of the day, often with babes at the breast and toddlers roaring around as we shared our study knowledge, kid knowledge, our successes and failures. It was this crazy and accepting support group that got me through the training programme.

The department I worked in was flexible. They didn't get upset when my husband turned up with a hungry baby and we had a meal break together. I was determined; it never seemed like it couldn't be done. However, there were some exhausting and difficult times. I'm not surprised that the recent ASMS survey found that it was the 30-39 age group of women that had the highest levels of burnout. As all parents know, those early years of parenthood are demanding and often severely sleep-deprived, especially when combined with work and study.

Overall, I am hugely grateful to those women who have come before me and forged a path into medicine and opened doors for women like me. Gratitude also to those women who refused to accept the historical limits that were part of the social mores of their times. There are many who have made it easier for women to have a career in medicine. I think the current challenge for medicine as well as emergency medicine in Aotearoa is to increase the diversity of our workforce so that we better represent the communities we serve and can improve the barriers to health that often trouble our communities.

I feel strongly that we need to hold on to the taonga that is our public health system. It seems there is an increasing creep of private medicine in New Zealand. It is argued that this 'takes the strain off the public system - freeing it up for those that need it'. However, in my experience this does not always alleviate the pressure on the public system but reduces the availability of clinicians committed to the public system as more move to the often less frustrating conditions in private medicine.

In my dream health system there would be equity of access to medical, nursing and allied health training, as well as equity of access to receiving health care regardless of gender, economic status or cultural background. This is the future that I wish my children to live in. In this way we can all flourish and make the best of our various talents.

Nāku te rourou, nāu te rourou, ka ora ai te iwi

With your basket and my basket, the people will live

I am hugely grateful to those women who have come before me and forged a path into medicine and opened doors for women like me.

I am encouraged by the increasing number of female surgical trainees and registrars working on the wards and theatres in New Zealand.

JESSICA BUCHANAN

Jessica Buchanan is an oral and maxillofacial surgeon at Greenlane Clinical Centre with the Auckland District Health Board.

I am the first woman to graduate as an oral and maxillofacial surgeon from the University of Otago, and therefore a majority of my mentors were men, great surgeons who care about their patients and work.

My training involved both medicine and dentistry, and I have been lucky to work alongside incredible anaesthetists, intensive care specialists, neurosurgeons, general surgeons, ORL specialists and dental specialists. I have especially been inspired by the work of Dr Heather Keall, who has dedicated her career to treating children with cleft lip and palate at Middlemore Hospital.

I have been an SMO for five years now and I am currently reading for a MSc of Surgical Science and Practice at Oxford University.

I am encouraged by the increasing number of female surgical trainees and registrars working on the wards and theatres in New Zealand. More recently, Oxford University has introduced me to a global network of women in surgery. All doctors have unique work challenges, and being able to share, network and gain solutions on similar issues is important.

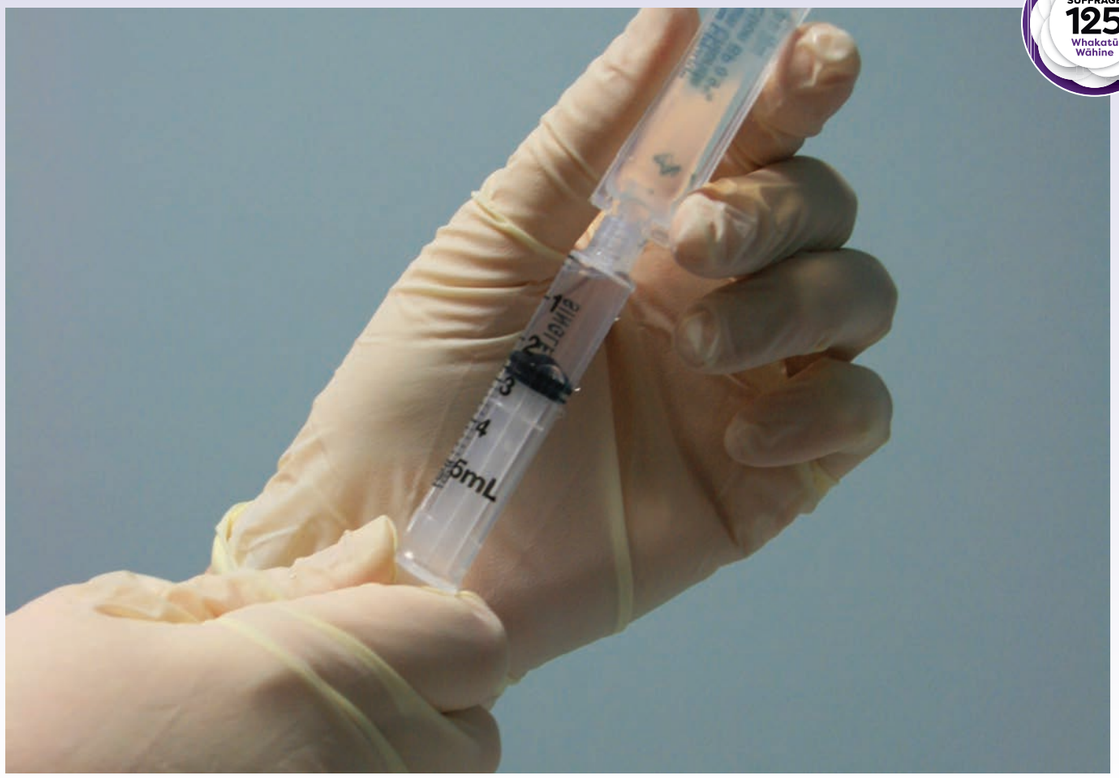
Most clinicians work in high pressure roles which can affect their performance. Creating a healthy, safe, sustainable workplace culture is important. Health care systems that are patient-centred and value-based have been shown to improve patient outcomes but also promote a good workplace culture. I am encouraged by the work ASMS undertakes to support this, and also the research undertaken at Ko Awatea, Counties Manukau.

The exhibition 'Are We There Yet?' at the Auckland War Memorial Museum Tamaki Paenga Hira celebrates the 125th anniversary of women's suffrage in Aotearoa New Zealand. Gaylene Preston has produced a short-film from the memoirs of suffragists, revealing that these were women who challenged the world view, were determined to do the job well and make a difference to society.

This is also the story of many women in medicine and surgery.

Jessica Buchanan

Oxford University has introduced me to a global network of women in surgery.



GUIN HOOPER

Guin Hooper works in the emergency department for Wairarapa DHB.

I work in the Emergency Department as an SMO, and have done so for about two to three years, although I received my MBChB around 20 years ago. It took me a while to decide on a specialty, and by that stage I had started a family, so the logistics of full time study and full-time parenting were incompatible.

In general, I find that medicine as a profession is a lot more accepting of women than it was 20 years ago, though a large proportion of my class were women back then too. I remember that a number of older professors were inclined to make incredibly sexist and patronising comments, and I'm pretty sure that sort of thing would be unacceptable nowadays.

In general, I find that very few of my colleagues treat me any differently than they do men in the profession, and I appreciate that.

I think that in general, medicine is a pretty good fit for women, if you are willing to make significant personal sacrifices.

I have felt very conflicted in the past when you have, for example, a sick child, and a shift that needs covering. It has generated a lot of stress for me, knowing that I am letting my colleagues down, but knowing that I cannot leave my child alone and unwell at home, and I suspect that situations like these are one of the reasons that burnout is highest in younger women in medicine.

Generally my colleagues have been very supportive in situations like these, but management has occasionally been less so. That makes it really tough, sometimes.

I'd like to see a future where those kinds of commitments are acknowledged and supported.

Guin Hooper

Medicine is a pretty good fit for women, if you are willing to make significant personal sacrifices.

When I spoke to the deputy medical superintendent in chief about needing to take leave, he said "If you plan to have any more children, Dr Marks, please talk to your colleagues first".

ROSEMARY MARKS

Rosemary Marks

Rosemary Marks is a paediatrician at Starship Hospital, Auckland DHB.

I came to New Zealand from the UK in 1977 for a year, having done my medical training at Bristol University and worked for a couple of years as a house surgeon in the south-west of England. I had always been interested in New Zealand.

In my first year in the old Princess Mary Hospital I was asked to take on a registrar role because someone hadn't turned up. I was a very green paediatric registrar, not having done any paediatrics since qualifying; the support I received from my seniors was quite variable. I was asked to do consultant clinics when there was no consultant to supervise me, and to be honest that was not an uncommon practice. However, I enjoyed living in New Zealand and decided to stay and train in paediatrics.

In 1980 I was able to attend some sessions at the annual scientific meeting of the Paediatrics Society, held in Auckland. Dr Bonnie Camp, who pioneered Developmental Paediatrics at the University of Colorado in Denver, was the invited international guest speaker. One evening when I was on call, I went to get my dinner and there was Bonnie Camp, sitting there eating dinner with the junior doctors. No one wined and dined guest speakers in those days or put them up in five star hotels. She talked about her work in developmental paediatrics, and I was inspired to pursue this as a career.

I returned to the UK for a couple of years to obtain subspecialty training in Developmental Paediatrics. I came back in 1984 to take up a post at the Mangere psychopaedic hospital. It was the newest of the psychopaedic hospitals at the time, and it had a mix of children and younger adults. I was relatively isolated from other medical colleagues because of its location. However, I was very well supported by John Newman, who was also a relatively new paediatrician at that time who went on to manage Starship.

I had thought it was too difficult to practise medicine and have children but my husband persuaded me otherwise. There were other women consultants on the same path as me, and in fact my son was at the tail end of a string of paediatric pregnancies. When I spoke to the deputy medical superintendent in chief about needing to take leave, he said "If you plan to have any more children, Dr Marks, please talk to your colleagues first". Any senior hospital manager who said that to a young woman doctor now would be outed.

Balancing work and family has been tricky; however, being a mother has made me a better paediatrician. I was slightly stunned when my six year old son said to one of his little mates about me: "Don't bother asking my Mum, she's always working". It made me stop and think about my 'work-life balance'.

My team now is all female. We're a very small team, five of us filling just over 2 FTE, and we all have children. I think the really important thing is to have a supportive partner. My husband's not a doctor and he's always been able to be flexible and share the childcare.

My son graduated from Otago medical school in 2016 and women then made up about 60% of the students. When I was at medical school there were 20% women in the class – it was a quota! The young people coming through the medical training now have different expectations and we need to work smarter, nurture them, and ensure a quality, safe service.

I do have a connection with the suffrage movement. Elizabeth Garrett Anderson, the first woman to qualify as a doctor in the UK (**https://en.wikipedia.org/wiki/Elizabeth_Garrett_Anderson**), was the niece of Richard Garrett. My great-great-grandmother married Richard Garrett on her return to England after her first husband died in the Australian Gold Rush. And Elizabeth had a sister, Millicent, who was a leading campaigner for women's suffrage in the UK (**https://en.wikipedia.org/wiki/Millicent_Fawcett**).

I'm now at the winding down stage. I used to say that I would retire when my son finished medical school. However, I've continued working for the time being, because I enjoy the intellectual stimulation of work. I now do clinical work a couple of days each week and plan to stop before too long. You don't want to go on working and then have people saying, oh, she's really past it. Timing is everything.

I think the really important thing is to have a supportive partner. My husband's not a doctor and he's always been able to be flexible and share the childcare.

Hardly any of the consultants were female. You could literally count them on the fingers of one hand.

LIZ ALMOND

Liz Almond

Liz Almond is a general adult psychiatrist with a special interest in perinatal mental health at Masterton Hospital and is employed by Wairarapa DHB.

I attended an all-girls school in the UK and was told that because I was good at science perhaps I should be a nurse. I went to Sheffield medical school in 1982. We were the first intake where women were the majority of medical students there, just slightly at 52%. One of the things I particularly noticed throughout my time at medical school was the lack of female role models, especially in hospital medicine. Hardly any of the consultants were female. You could literally count them on the fingers of one hand.

During my registrar training, there were a few women working in psycho-geriatrics and child psychiatry, but no women in adult psychiatry. It's interesting talking to current medical students today and finding that they still feel there is a lack of female role models.

I did my psychiatry training in Leeds and came to New Zealand for a one-year locum for my first consultant post in 1994, in Wellington. I fell in love with both New Zealand and my husband, who's a Kiwi. I've worked in New Zealand for most of my career apart from eight years in Australia.

One of the things I noticed was that there was less sexism in New Zealand than I had experienced in the UK. For example, when I was a registrar there, I remember the reaction when I wore trousers to work one day. Women always wore skirts, and there were comments about me being radical by wearing trousers. I remember one of the male consultants saying in a meeting that every time he was allocated a female registrar he wanted them to take a pregnancy test at the start of their run because he was sick of them going on maternity leave. In Australia I also encountered more sexism in the workplace and generally in society.

It felt refreshing when I came to New Zealand. I preferred the work environment here and I haven't struck major issues as a woman in medicine. I suspect psychiatry may be more supportive of women than other specialties.

Medicine generally needs to be more family-friendly and support a balanced life. That means more flexibility around careers, which will benefit men as well as women.

I remember one of the male consultants saying in a meeting that every time he was allocated a female registrar he wanted them to take a pregnancy test at the start of their run because he was sick of them going on maternity leave.

JULIET RUMBALL-SMITH

Juliet Rumball-Smith

Previously Director of Health Intelligence at Northland DHB; began new role as Clinical Chief Advisor at the Ministry of Health in September.

I am a public health physician. This was an easy choice of specialty for me as I have always been interested in population health and equity – however, my training and early SMO years were slower than most. Essentially, I became distracted by (1) research, and (2) the rocky and rapid arrival of four children in four years, including premature twins. Looking back, those early years in our family were characterised entirely by trying to cope, with the growing of these four cherubs and two careers, and the added challenge of doing so in a metre of snow and frequent ice storms (Montreal and Toronto). We returned to New Zealand a little bruised, and the warmth of Northland - both environment and people - was just what we needed.

My time as a Medical Officer of Health here in Te Tai Tokerau showed me first-hand and daily the impact of poverty on health; I saw it in rheumatic fever, extracted teeth, and large families in small mouldy houses. I also lived the importance of true collaboration across the sector and the benefits of enhanced holistic community-based care. Hence my growing interest in policy and strategy, and I was lucky to be able to focus on this during a one-year Harkness Fellowship to the US. I am sad to leave behind Northland, but I am looking forward to the challenge of the Ministry of Health and the opportunities of my new role.

Ten years ago my husband received an email on his personal account, the sender sweetly suggesting that I 'step aside' and 'focus on my husband's career'. I think this type of overt bias is less common now, and although we still have a way to go, our workplace 'gender manners' (ie, openly disrespectful behaviour, those funny-not-funny jokes, interview questions about our baby-making plans) have improved. But the bias is still there, and we see its impact in the low numbers of women in leadership and governance positions, the gender pay gap, the 'motherhood penalty', etc. I still feel uncomfortable on occasion. I am getting better at calling it out – but it is very difficult to do this in response to the subtler forms of bias.

Recently I had my very first senior female boss/mentor and was astonished at the world it opened up for me, one that I had never had access to before. We went to a conference and could share a room to keep the costs down! We had long discussions over late dinners about medicine and research and politics and family, and I didn't feel uncomfortable about the environment or the risk of accidental subtext. Most importantly, she demonstrated a completely different style of leadership, one that felt accessible and achievable. The year was a lightbulb moment for me – was this the sort of familiarity and openness that my male colleagues had been having all along? It was a big part of my decision to try and promote mentoring for women working in medicine, through the organisation Wāhine Connect (**www.wahineconnect.nz**).

You ask: 'how would I like to see medicine as a profession for women in the future?' First, I want us to realise that women are allowed to have different styles of care, and ways of approaching team-work and leadership. We should value these differences, understanding that these approaches have been shown to be highly effective, and can produce better outcomes for patients and organisations.

Second, we should insist on higher standards of behaviour in our workplaces – from meeting conduct and those poorly-worded jokes, right through to our entitlement to harassment-free workplaces. [Note: many of my medical friends and acquaintances posted '#metoo' on their Facebook pages. Others paused and gave it some thought – Did it count if you were so busy you barely noticed? What was the difference between sexual harassment and the garden-variety misogyny we get most days? Did it count if it was a patient? Food for thought...]

My mother wasn't allowed to go to medical school – my grandparents couldn't afford it – and considering she was only allowed to finish high school because 'the wool price had gone up', she felt grateful to go to university at all. At age 30 she was awarded a fellowship from the American Association of University Women to do research at Cornell University. They revoked it immediately when they discovered she was pregnant, and only allowed her to come after she provided intimate financial details, and also stated that she had paid for her plane ticket and would be coming irrespective.

The point of this story is that 25 years later I started at Otago University, and the Governor-General, Prime Minister, and Chief Justice of this country were all women. It seemed like the suffragists and society had achieved their goal. However, later that year, I sat next to a fellow medical student in a lecture who stated unashamedly that his future doctor wife would give up her career to look after the hypothetical children, because she would be 'better at it'. Twelve years after that, my medical husband requested some time off to look after the children, and the manager asked: 'why can't your wife do it?'.

Gender-based biased attitudes and behaviour let us down as a medical profession. However, they also let down the broader community: the taxpayer heavily subsidises our medical training, and none of us get through medical school/house surgeon years/specialty training without the support of whānau and community. I truly believe that New Zealand society see the benefit of a diverse medical workforce, and assume that their New Zealand medical workforce is treated respectfully, and without bias. I think they would be surprised to hear about the patient that tried to kiss us, those comments on our 'saucy boots' (footnote: they really weren't), or how often we are talked over in meetings. I am also confident that as mothers and fathers, brothers and sisters, they expect the gender parity seen in medical school to continue, and to be evident in the proportion of women who are surgeons and clinical directors and Chief Medical Officers (just a few examples). Irrespective of ethics or the benefits of diversity or natural justice – for the sake of respecting the investment made by all New Zealanders into our workforce and their trust in us; for this reason alone, we need to do better.

Gender-based biased attitudes and behaviour let us down as a medical profession.

DOES INCREASED USE OF PRIMARY CARE REDUCE PRESSURE ON HOSPITAL SERVICES?

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

Internationally, sitting behind much of the discussion about how to improve health systems is the question, sometimes explicit but more often not, of how to contain cost. Given that hospital services are the biggest cost item, the question inevitably becomes one of how to contain hospital costs. One obvious answer – to reduce the need for hospital services – usually leads to policies aimed at strengthening primary care, which is emphasised in government health policy, including the Government's recently commenced review of the health and disability system. In an environment of constrained government spending this often means shifting resources from hospitals to primary care. Calls for such a shift are common in health systems discussions.

Studies have shown that a 'strong' primary health care system has the potential to contribute to population health at the individual and population levels. It can help to prevent illness and death. Nevertheless, the evidence also shows clearly that attempts at prevention in primary care are having little impact on reducing pressure on hospital services. Whether in New Zealand, Australia, the United Kingdom, acute hospital inpatient admissions have increased well above the population growth rate, despite increased rates of primary care consultations and policies focused on prevention.

The evidence from New Zealand and overseas shows that while in theory primary care services are well placed to implement health improvement policies, in practice there are many shortcomings. A study in the Netherlands, which has seen substantial increases in the rates of hospital admissions since 2000, identified 24 specific facilitators for implementing health promotion activities in primary care, against 41 'barriers', many of which are cited in other international studies. The most cited barriers relate to:

- lack of practitioner time
- lack of practitioner confidence in the effectiveness of interventions (due in part to conflicting evidence and the non-generalisability of evidence)
- lack of confidence in providing the right advice
- lack of patient compliance and perceived lack of motivation
- practitioner attitudes, and
- financial disincentives.

Regarding the latter, while the introduction of capitation funding (via Primary Health

Mitigating these barriers requires political commitment to an inclusive, long-term strategy, with the necessary resources, aimed at systematic continuous improvement.

Some of those who may be in most need of early health care intervention are not receiving it.

Organisations) was meant to encourage a population health approach in primary care, evaluations of the Primary Health Care Strategy show it has had little effect, in part because general practices continue to derive part of their income from patient charges. The patient charge, in turn (and limited availability of primary care services in many areas), create significant access barriers for many New Zealanders. Which means some of those who may be in most need of early health care intervention are not receiving it.

IMPACT OF BARRIERS

The impact of these barriers to prevention and promotion activities in primacy care is illustrated in Australian studies: in 2016 less than 20% of people with high cholesterol who saw a general practitioner (GP) reached recommended cholesterol levels; less than 30% with high blood pressure who saw a GP had it adequately controlled; less than half of people with diabetes seeing a GP had recommended levels of blood pressure, blood sugar and cholesterol. While over 60% of Australians are overweight or obese, only 3.4% of GP encounters involve nutrition or weight counseling. There is little data on mental health in primary care in Australia, but in a study of the treatment of common mental disorders in general practice conducted over a decade ago, less than a third of those with mental illness received some form of intervention. Even among those with severe conditions, only half were provided with specific psychological or pharmacological treatment.

LONG-TERM STRATEGY REQUIRED

Mitigating these barriers is not a simple, short-term task. It requires political commitment to an inclusive, long-term strategy, with the necessary resources, aimed at systematic continuous improvement. Arguably the most urgent need is to remove the barriers to access and to address primary care workforce shortages.

Further, a well-functioning primary care service is dependent on well-functioning, accessible hospitals to succeed in the overall goal of health improvement. Given the large majority of hospitalisations are for conditions not considered avoidable, timely and effective hospital treatment is clearly contributing to health improvement. On the other hand, delays in diagnostic tests, first specialist assessments, and hospital treatment, along with increasing acute hospital readmission rates (see 'Vital Statistics' page 25) are clearly impediments to the goal of health improvement, as well as adding to the workload of primary care services.

The increasing dependence on multidisciplinary teamwork and growing complexity of illness with an aging population also requires additional clinical time for collaboration between health professionals, especially between primary care practitioners and hospital specialists. The well-documented rapidly growing pressures on mental health care, for example, requires greater collaboration between GPs and psychiatrists, as commented in a report from the Royal Australian and New Zealand College of Psychiatrists: "In some cases ... very complex patients can require weekly case conferencing with both a psychiatrist and the treating GP to appropriately manage their care, and that this is very difficult within the current funding and caseload structure."

The need for greater collaboration and integration of services is underscored by the many studies on the often-wide variation in primary care practitioner referral rates to specialist services.

There is strong, mounting evidence that integration between hospital services, primary care and social services, to provide good patient-centred continuity of care, is the best approach for keeping people out of hospital.

The experiences from successful integration consistently indicate it is possible only if it comes from the bottom up. Integration can be achieved as a consequence of specific, clinically-led 'micro interventions', which are developed over time by enabling multidisciplinary teams to use the available evidence and tailor it to fit with the context of local needs through a process of learning and adapting. A strong commitment to distributed clinical leadership is a critical component of successful integration. Effective distributed clinical leadership, in turn, is dependent on the adequacy of clinical staffing to allow the necessary time needed for leadership.

SOCIAL DETERMINANTS OF HEALTH

But policies with the potential to have the greatest impact on reducing the need for hospital care lie outside the health system. This includes addressing the well-known determinants of ill health, such as poverty and poor housing.

Poverty and its flow-on effects can have a significant influence on the likelihood of potentially preventable child hospitalisation, with New Zealand children aged 0-4 years in deciles 9 and 10 being nearly two-and-a-half times more likely to end up in hospital than those in deciles 1 and 2.

In addition, top of the list of a five-year Australian study evaluating the cost-effectiveness of 150 preventive health interventions are tax and regulation aimed at reducing smoking and consumption of alcohol and unhealthy foods, and a mandatory limit on salt in basic food items.

The evidence indicates efforts to improve the effectiveness of health services to reduce the need for acute hospital care will struggle to make headway without also addressing these broader issues.

An ASMS *Research Brief* examining the evidence on prevention activities in primary care and the effects on secondary care will be published onllne shortly. Further *Research Briefs* will include the topics of integrated care, distributed clinical leadership, workforce requirements, health funding needs and the determinants of ill health.

Evidence shows that attempts at prevention in primary care are having little impact on reducing pressure on hospital services.

MEDICAL LEADERSHIP – WHY SO HARD TO DO THE 'RIGHT' THING?

PROF MURRAY BARCLAY | ASMS NATIONAL PRESIDENT

Recently, I was invited to speak at a national meeting of the New Zealand Medical Students Association on the topic of Leadership in Medicine. I started by polling the students using software for instant audience feedback (Polleverywhere). With no previous discussion, I showed them a concept graph relating annually increasing resource allocation in health care in New Zealand to corresponding increasing patient need (figure 1), showing growing unmet patient need.

This schematic is illustrative of the past nine years or so of restricted health funding, with patient need outstripping annual increases in funding. I then gave the students two sets of options that medical leaders could apply to deal with the problem (figure 2).

Eighty-six percent of students believed the B options to be the best. However, in a subsequent question 94% believed most medical leaders in New Zealand would follow the A options. Eighty-eight percent also believed that leaders who chose the A options were much more likely to be chosen as leaders and promoted. These students had not yet entered the hospital workforce and so had not been exposed to hospital management. Their answers were therefore very illuminating.

The consequences of choosing the A options are becoming very clear to see. If increased resource is not requested it is not given, and workload becomes unmanageable. This leads to the range of problems we are now observing amongst New Zealand senior medical staff and in our public hospitals, ie, increasing rates of clinician burnout and bullying, crumbling hospital buildings with inadequate space, inequity in patient care and ultimately, inevitably, worse quality of patient care resulting from all of the above.

So why is it so hard for some medical leaders to choose what are supposedly the better options? The answer is likely complex, but some potential factors come to mind. Firstly, requests for more resource usually require detailed business plans. These take significant time and effort to prepare, time that is often difficult to find when one is already overworked. Also, if there is a history of business plans being repeatedly turned down at any point of line management (ie, the line manager

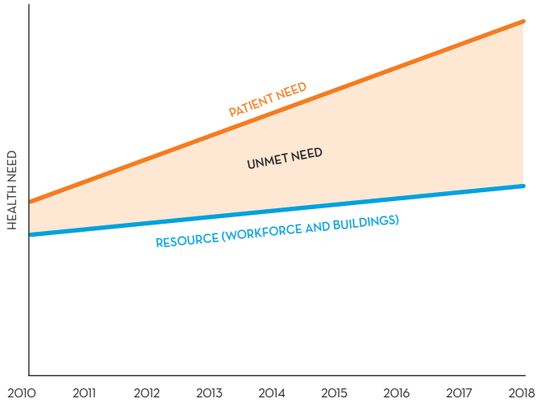


FIGURE 1

A

- Accept there will be no increase in resource
- Be guided by the budget set
- Strive for more efficiency
- Teach mindfulness, resilience techniques

B

- Calculate health care need
  - FTE
  - space
  - equipment
  - medicines
- Advocate strongly for this need
  - to management, ministry, public
- Request resource on behalf of patients and staff
- Make time to innovate using patient-centred care principles

FIGURE 2: TWO SETS OF CHOICES FOR CLINCAL LEADERS

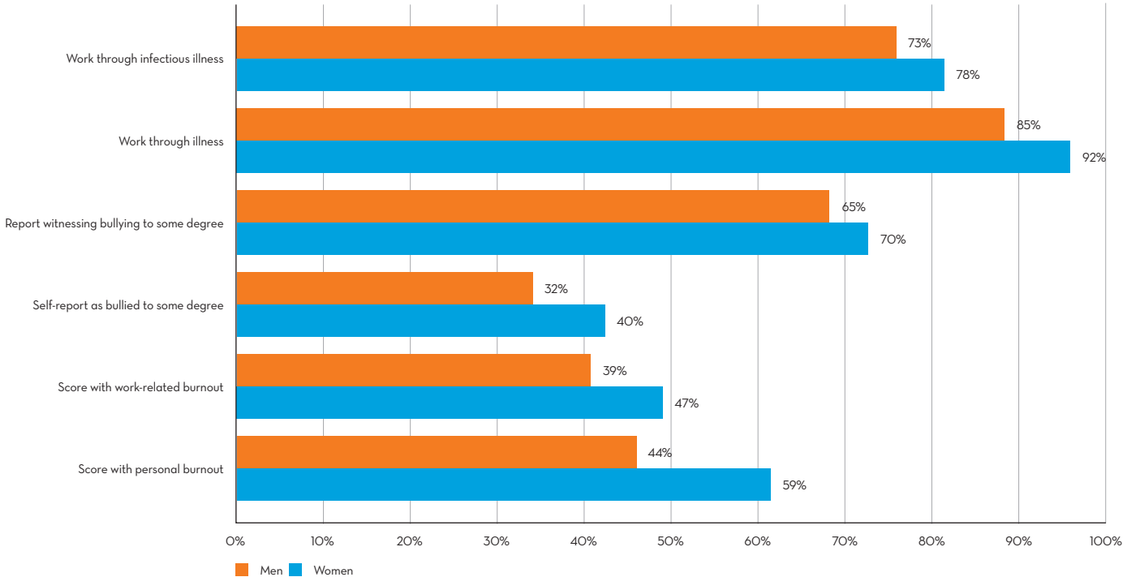


FIGURE 3: DISPARITIES BETWEEN MALE AND FEMALE SMOS BASED ON ASMS SURVEYS OF MEMBERS

is choosing the A options), this negative reinforcement further deters from doing the 'right' thing for patient need. So, the A options are likely easier, especially when these choices are likely to be appreciated by those higher up the chain.

Secondly, advocating for patients by pointing out that more resource is required to provide appropriate care for them is not always seen as a doctor's duty. Patient need is sometimes left to non-clinical administrators to determine, or to the levels of line managers up as far as the Chief Executive, or Health Minister. But who best understands the needs of patients and what is required to provide appropriate care? Surely it is the clinical staff who see patients on a daily basis and are trained to assess their medical requirements. Patient advocacy seems to be something that doctors may or may not see as a duty, and is generally not a topic that is taught at medical school, but may need to become more routine and embedded in medical practice to ensure better patient care provision. Again, advocating for patients is not always easy.

Lastly, and perhaps most importantly, hospital leadership structures and the pressures of clinical leadership may confuse the leader regarding who they are really working for. The medical students could see that the B options listed above would be chosen by someone who is clearly working primarily for their patients and their clinical team. The A options would more likely be attributed to a leader who is working primarily for their line managers and maybe the finance team. Perhaps the ideal clinical leader is working for both, but there is an argument that the clinical leader should primarily be responsible for assessing patient care requirements and then providing this information to those with the purse strings to aid resourcing decisions.

In summary, there are a range of reasons including time, work pressure, negative reinforcement and possible concern regarding career advancement that may make it difficult to do the 'right' thing. However, there are serious consequences from taking the 'easier' options.

On a related note, ASMS research in the last three years has shown that the negative consequences of an overstretched senior medical workforce are even more severe for females than for males in every area studied (figure 3). Forty percent of ASMS members are female. ASMS is therefore actively studying reasons for these inequities and looking to take positive steps to improve conditions for female members. However, benefits from this work are likely to be seen by all members, not just female. As one part of this programme, in the coming months ASMS will be conducting research on salary variance, which will include a member survey. Good participation will be important to ensure valid results. Participation in previous surveys has been fantastic and it would be great to continue this.

Patient advocacy seems to be something that doctors may or may not see as a duty, and is generally not a topic that is taught at medical school, but may need to become more routine and embedded in medical practice to ensure better patient care provision.

At the very least, the new Act should specify that those that work in the public health sector should have the right to speak publicly and engage in public debate on issues within their expertise and experience.

REVIEW OF THE STATE SECTOR ACT

ANGELA BELICH | ASMS DEPUTY EXECUTIVE DIRECTOR

The Government has announced a review of the State Sector Act, signalling a shift in the way the public service operates.

State Services Minister Chris Hipkins announced plans to review the Act at the start of September: **https://www.beehive.govt.nz/release/joined-more-convenient-services-reach-public-service-reform-plan** and the full text of his speech at the launch of the consultation process is at **https://www.beehive.govt.nz/speech/launch-consultation-process-public-service-reform.**

BACKGROUND

The 1987 State Sector Act was part of the wave of neoliberal reforms that broke the old public service. The central tenets of the movement were that private sector organisations were more effective and efficient than those that were publicly run, that the profit motive offered innovation and efficiency in contrast to an ethic of service to the public and the collective good which lead to stasis and complacency. State Sector agencies were accordingly set up to mimic as closely as possible private sector firms with a powerful fixed term Chief Executive answerable for outputs (later and less sharply focused outcomes) GAAP (generally accepted accounting principles) and accountabilities under the Public Finance Act that fostered privatisation, contracting out, outsourcing and militate against cooperation between agencies. 'Tomorrows Schools' which set up each school as a separate entity is now regarded as part of that wave.

This neoliberal wave of 'reform' finally broke on the intransigence of health professionals, many of whom were ASMS members when they rallied public support against the marketisation of the public health service. This was heavily reliant on the courage of senior doctors speaking out publicly individually and collectively (for example the *Patients are Dying Report* by senior doctors at Christchurch Hospital).

Prior to the 1987 State Sector Act, there were separate wage fixing regimes in the public sector and the private sector. The 1987 Act abolished the separate legislation covering state servants including senior doctors and dentists. The Association was formed as a result. DHBs are defined under the Crown Entities Act as crown agents and are covered by the State Sector Act. At present the main impact of the proposed changes is that DHB employees are bound by the Code of Conduct for the State Sector which was issued by the State Services Commissioner in 2007.

The scope that the SSC has outlined for this consultation document is limited and reflects the concerns the Sate Services Commissioner has had about the operation of the Act. These are essentially the same concerns that were raised when the Act was first passed in the teeth of the considerable opposition from state sector unions and were raised repeatedly since but never resolved. The concerns are essentially that the Act's structure in the public service militates against integration between state sector agencies and does not of it itself foster an ethic of public service. There were a couple of attempts in the original 1987 Act to introduce integration between public sector agencies; a Senior Executive Service and the legislative responsibility of the SSC for collective bargaining in the core public service were attempts to address it but have never worked. The proposal for a senior leadership service, as proposed by Minister Hipkins, will almost certainly meet the same fate.

These concerns have been raised repeatedly, for example in the Schick report in the 1990s, the ethics project in the 1990s and the State Sector Code of conduct promulgation and in the Crown Entities legislation.

CONSTRAINTS ON CHIEF EXECUTIVES

The limitations on the power of the Chief Executives have been delivered through unions' collective bargaining (though in many state agencies this does not reach to second, third or even fourth tier managers) the agencies with responsibility for oversight (Treasury, Department of Prime Minister and Cabinet, and the State Services Commission), the whistle-blower legislation and the legislative framework that covers all employers. This system has prevailed over a massive failure of stewardship. The examples that come to mind are decaying hospitals and schools, non- existent or unpoliced regulatory structures, huge unmet need in health, backed up wage expectations due to a public-sector wage freeze and the continued existence of a gender pay gap after 56 years of equal pay legislation. There is also a list of disasters from Cave Creek to Pike River.

The blame is laid on governments who deliberately ran down the state. Core public service Chief Executives, however, have never come out publicly to say that the money wasn't enough to

ASMS interpreted the State Sector Code of Conduct as putting an obligation on our members to speak out on matters involving their expertise.

deliver the services required. (A handful of health sector Chief Executives have made that call). Doubtless these conversations may have been had in the best traditions of 'speaking truth to power' with ministers in private but the over-powerful chief executive, the code of conduct, the way the OIA has been used essentially to protect the reputation of the Chief Executive or Board, short termism and the overwhelming group-think that over powerful chief executives engender has meant that in most state agencies, most of the time, critical comment and attention to the counterfactual has been neglected.

STATE SECTOR CODE OF CONDUCT

The 1987 Act gave the State Services Commissioner the right to issue a code of conduct to cover all of the state services. This power covers both the compulsory education sector and the public health service. In 2007 the State Services Commissioner issued such a code. It did not cover the compulsory education sector but did cover the public health service. The Association was consulted at the time (but as somewhat of an afterthought) and got some changes. The legal advice we had at the time was that the right of senior doctors at DHBs to speak out was protected both in our MECA (which is probably of equal status to the Code) and by Schedule 1B of the Employment Relations Act which probably trumps the Code.

The State Sector Code of Conduct specifies under the heading 'Impartial' that:

We must:

- maintain the political neutrality required to enable us to work with current and future governments
- carry out the functions of our organisation, unaffected by our personal beliefs
- support our organisation to provide robust and unbiased advice
- respect the authority of the government of the day.

ASMS interpreted the State Sector Code of Conduct as putting an obligation on our members to speak out on matters involving their expertise equally – it doesn't matter which party was in power.

Nevertheless, the way DHBs have operated the Code particularly around elections has had a chilling effect. There has also been reluctance to comment by members when funding or contracting issues will affect continued employment or the viability of a service.

The inclusion as part of the principles of the Act of 'political neutrality' and 'impartiality 'as a value would have the potential to override the right to speak out as set out in Schedule 1B to the Employment Relations Act. During the early consultation the CTU unions proposed to the SSC officials that they included the wording of Schedule 1B of the ERA in the new Act and have it apply to all those who work in public services. The suggestion was received with something of a sense of panic.

The proposals in the document do not address the real problems in the Act head on, though an explicit requirement for stewardship may be a welcome development.

State Sector unions criticised the purpose, principles and values as uninspiring. There was considerable comment that doctors, nurses and teachers, though probably comfortable with the proposition that they serve the public, would not think of themselves as public servants

At the very least, the new Act should specify that those that work in the public health sector should have the rights set out in Schedule 1B (the Code of Good Faith for the public health sector) of the Employment Relations Act to speak publicly and engage in public debate on issues within their expertise and experience as employees.

These rights could easily be extended to teachers and scientists in the Crown Research Institutes.

REMOVAL OF PATHOLOGY FROM THE LONG-TERM SKILL SHORTAGE LIST


IAN POWELL | ASMS EXECUTIVE DIRECTOR & LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

ASMS has written to the Minister for Economic Development, David Parker, requesting his intervention in the decision by the Ministry of Business, Innovation and Employment (MBIE) to remove pathology from the Long-Term Skill Shortage List.

The removal of pathology from this list is a mistake and will not only add further pressures to a workforce already under stress but could also impact on a wide range of other health services dependent on an effective pathology service.

It undermines Health Workforce New Zealand's efforts to respond to the long-term needs of an increasingly fragile workforce, and ASMS has asked the Minister to reverse the decision immediately.

Pathology is one of Health Workforce New Zealand's (HWNZ) top four 'hard-to-staff specialties' identified for the 2018 intake of the Voluntary Bonding Scheme, which aims to encourage graduate doctors into particularly vulnerable specialties.[1] Like most of the New Zealand specialist workforce, pathologists have been in short supply in New Zealand for many years (among the worst), so it was no surprise when pathology was recognised in HWNZ's first *Health of the Health Workforce Report* of 2013/14 as a specialty with 'critical shortages'

HWNZ has identified pathology as a highly vulnerable specialty because there are relatively few trainee pathologists per current practising pathologists over the age of 50. The data from the Medical Council of New Zealand's (MCNZ) Workforce Survey 2016 indicates 55% of practising pathologists were aged 50-plus and 26% were aged 60-plus. But the ratio of trainees per older specialist indicator, concerning though it is, understates the fragility of this workforce, which is compounded by several factors:

THE LONG-TERM WORKFORCE SHORTAGES

Workforce data from the Royal College of Pathologists of Australasia (RCPA) show there were 288 pathologists practising in New Zealand in 2016, or approximately one pathologists for every 16,295 people. This is lower than every State and Territory in Australia apart from the Northern Territory. To be on a par with Australia, New Zealand would need to increase its pathologist workforce by 28% - from 288 to 369 (as at 2016).

INCREASING DEMAND

Ministry of Health pathology workforce projections, based on workforce exit and entry trends, indicate the pathology workforce will increase by about 13% in the next five years. However, an Australian study shows that for more than a decade the number of pathology tests has grown by an average 5.4% per year. While some of this growth will be due to enhanced diagnostic technologies, it also reflects the increasing needs of the aging population and greater focus on prevention. It is estimated that 32% of the increase in pathology requests by medical practitioners is due to preventative health treatments.[2] New Zealand is experiencing similar increases in health service demand.

The functioning of most health services is dependent on a well-functioning pathology service. An estimated 70%–80% of all health care decisions affecting diagnosis or treatment are influenced by laboratory medicine results.[3]

The removal of pathology is a mistake and will add further pressure to a workforce already under stress.

HWNZ has identified pathology as a highly vulnerable specialty because there are relatively few trainee pathologists per current practicing pathologists over the age of 50.

THE SMALL SCALE OF PATHOLOGY DISCIPLINES

Pathology comprises 10 disciplines, though New Zealand has nine (there are no oral pathologists). The main discipline – anatomical pathology – accounts for just over half of the workforce, with the remainder making up the rest. The loss of one or two pathologists, especially in disciplines like forensic pathology, general pathology and immunopathology, where there are just 5-7 pathologists, can have an immediate, significant impact on the service. And currently there is just one genetic pathologist and one virology pathologist.

RCPA workforce data for 2016 show:

- The were 18 chemical pathologists, of which (in the previous year) 30% were aged over 61. There were just two trainees in this discipline.
- There were five forensic pathologists (recent media reports indicate seven in 2018; RCPA data show there were nine in 2007) and this workforce faces further pressure with a proposed fragmentation of the service. In 2015 two pathologists were aged over 60. There are only two trainees who will not qualify for another 3-4 years.
- There were only two trainee genetic pathologists. Genomics is the fastest growing specialist discipline within the pathology profession worldwide. New Zealand is being left behind.
- There were seven pathologists practising in a genuinely 'generalist' role. This small workforce is also aging and as there have been no general pathology registrars in New Zealand for over a decade, it is expected this discipline will disappear completely from New Zealand once these current pathologists retire in the next few years.
- There were seven immunology pathologists, and four trainees. As has been the case previously, access to specialist immunological services is restricted to three major cities, and characterised by significant waiting times for consultation and follow-up treatment and management services.

DEPENDENCY ON OVERSEAS RECRUITMENT

In 2015 nearly one in five pathologists practising in New Zealand had gained their specialist (vocational) registration overseas. It is a specialty in high demand internationally. MCNZ data show New Zealand's main source of overseas doctors is the UK, which is itself facing recruitment and pressures and looming retirements, with the pathology workforce contracting by 4% between 2011 and 2015, and half of all its specialists aged 50 years and over – the highest percentage of any specialty in the UK.[4]

Not only should MBIE's decision be reversed immediately, ASMS has suggested that its processes and criteria for reviewing the skills shortage lists are themselves reviewed. We understand HWNZ is moving towards a model of health workforce planning which takes into account New Zealand's health needs and unmet needs, and the workforce required to address those needs. There is a lot of merit in this approach, which MBIE might like to consider.

1 HWNZ. Voluntary Bonding Scheme Terms and Conditions for New Graduate Doctors 2018. **https://www.health.govt.nz/our-work/health-workforce/voluntary-bonding-scheme/voluntary-bonding-scheme-terms-and-conditions-and-payment-application#2018**

2 CIE. *The Economic Value of Pathology: Achieving better health, and better use of health resources*, Centre for International Economics, April 2016.

3 *Report of the review of NHS pathology services in England*. London, England: Department of Health, 2006.

4 General Medical Council (UK). The state of medical education and practice in the UK 2016,

An estimated 70%-80% of all health care decisions affecting diagnosis or treatment are influenced by laboratory medicine results.

2018 ASMS BRANCH OFFICERS' WORKSHOP

LYDIA SCHUMACHER | ASMS COMMUNICATIONS ADVISOR

ASMS President Murray Barclay welcomed ASMS branch officers from across the country to Wellington on 31 August 2018 for the annual ASMS branch officers meeting.

Senior Industrial Officer Lloyd Woods and Industrial Officer Sarah Dalton began the meeting by explaining the role of a branch officer and the ways that ASMS Industrial Officers can assist our members. The benefit of JCC meetings and having a wide representation of specialities at the meetings was discussed, and a case study was shared from Northland DHB where these benefits are coming into play. Burning issues for our members such as recovery time, safe shifts and gender pay audits were also discussed.

A presentation from Heather Simpson, Chair of the Health and Disability System Review, about the review followed morning tea. This presentation was informative, and members had a chance to ask questions. Afterward the branch officers worked in groups to share their feedback.

ASMS Principal Analyst (Policy & Research) Dr Charlotte Chambers presented preliminary findings from a qualitative study exploring why younger women members may be more prone to experiencing burnout than their male counterparts. Her research suggests that understanding this requires a much broader perspective of the gendered nature of medicine including the factors that shape speciality choices and inflect the daily experiences of women throughout their medical careers. Her research will be explored further at the ASMS Annual Conference and will be published in full in a Health Dialogue in 2019.

This was followed by a report from Industrial Officer Steve Hurring on a new mapping system being implemented at ASMS which will allow us to understand members and their specialties more efficiently.

The day wrapped up with a discussion about ways that branch officers could network between DHBs.

PHOTOS FROM THE ANNUAL ASMS BRANCH OFFICERS WORKSHOP

THE CURSE OF DEFERENCE

IAN POWELL | ASMS EXECUTIVE DIRECTOR

There is a curse in the senior medical and dental professions employed by district health boards. It is not a curse driven by a supernatural power, although perhaps this can't be ruled out. It is the curse of 'deference'.

Deference is an interesting word of French origin from the mid-17th century meaning respectful submission or yielding to the judgment or opinion of another. Its usage peaked in the first half of the 19th century followed by a gradual decline until around the 1930s, where it plateaued.

Deference might appear to be the courteous behaviour well suited to professionals. Being courteous and treating others with respect are good; deference to the extent of submission is a bridge too far in the context of what a profession is. The fundamental ethical standard of 'first do no harm' in respect of managerial or political decisions that compromise access to and quality of care trumps relationships with these decision-makers who lack the same ethical code.

CORE PROFESSIONAL EMPLOYMENT RIGHTS

The distinct duties and responsibilities of DHB-employed senior medical staff protect and promote 'first do no harm'. These are contained in the legal document that provides the core minimum terms and conditions of ASMS members employed by DHBs – the multi-employer collective agreement (the MECA).

The context, protection and promotion of these distinct duties and responsibilities begins with the second paragraph of the Preamble to the MECA which states:

> *Senior medical and dental officers are a distinct, vocationally trained, occupational employee group. District health boards (DHBs) as employers benefit from these employees having significant influence in their internal decision-making. The parties recognise that both senior medical and dental officers and DHBs have different roles, responsibilities and distinctive features.*

The MECA then proceeds, in Clause 2 (Time for Quality), to state that "managers will support" senior medical and dental officers (SMOs) "to provide leadership in service design, configuration and best practice service delivery."

SMOs have accountabilities well beyond their responsibilities to DHBs as their employers and to ordinary employment relationships established under the Employment Relations Act.

Note that that it states that SMOs will provide leadership, supported by managers, not the other way around.

Clause 39(a) states that DHBs recognise the "...primacy of the responsibility" of SMOs "to their patients and to their role as a patient advocate." This is in the context of where this responsibility clashes with the responsibility to the DHB; the former explicitly trumps the latter.

The next two sub-clauses (b and c) of Clause 39 recognise that SMOs are responsible and accountable to the Medical and Dental Councils, including their relevant policy statements and guidelines. This responsibility and accountability extends to the ethical codes and guidelines of relevant colleges and professional associations.

Separately the clause on job descriptions (48), which require mutual agreement, says there must be a statement in each SMO's job description that he or she is "...required to undertake their clinical responsibilities and to conduct themselves in all matters relating to their employment, in accordance with best practice and relevant ethical and professional standards and guidelines, as determined from time to time by..." their relevant college or professional association.

Significantly, the same clause acknowledges adherence to the DHB's policies and procedures but with the qualifier that these can't be "inconsistent" with other provisions of the MECA, including that discussed immediately above.

Clause 40 (public debate and dialogue) states that, in recognition of the rights and interests of the public in the health service, DHBs respect and recognise the right of SMOs to "...comment publicly and engage in public debate on matters relevant to their professional expertise and experience."

The clause covers the situation where such comment might be about, and be critical of, the DHB. That is, the concern behind the comment should have been discussed or raised with the DHB to avoid the circumstance where the chief executive or senior manager only learns of the concern for the first time through the media. However, the permission of the DHB for SMOs to make such comment is not required.

Elsewhere, in Clause 41, where SMOs have serious concerns over actual or patient safety risks that can't be resolved satisfactorily with the DHB, then they are entitled to an agreed dispute resolution process.

SMOS ARE NOT IN AN ORDINARY EMPLOYMENT RELATIONSHIP

As employees, SMOs are in an employment relationship with their DHBs - but it is not an ordinary employment relationship. Much of the work they do is beyond the skill level and knowledge of those that employ them. DHBs as their employers are dependent on them.

As a consequence of the level of professionalism required to perform their duties and responsibilities to the necessary standards, SMOs have accountabilities (including legislative accountabilities such as the Health Practitioners Competence Assurance Act) that go well beyond their responsibilities to DHBs as their employers and to ordinary employment relationships established under the Employment Relations Act. This is explicitly recognised by DHBs in our MECA.

Too often, regrettably, these expectations captured as legal rights in the MECA do not translate into consistent behaviour. This is largely due to an excess of deference to those who, while their positions should be respected and treated with courtesy, do not merit it because they lack the expertise and experience in what SMOs do.

When initiatives such as reviews arise relevant to the expertise and experience of SMOs, it should be them who lead the exercise rather than allowing management to dictate and marginalise them to a limited, reactive role.

Essentially, the MECA requires, enables and enhances distributed clinical leadership. But it requires the confidence of SMOs to behave consistently to achieve it. Recently, in a proposed review of the surgical journey in a public hospital where management sought to impose a rigid, clunky decision-making structure, I advised members working in the theatres to have the confidence to take it over, use their expertise to come up with recommendations that make good clinical and systems sense, and forward them to the chief executive.

This requires five 'c' words – confidence, collectiveness, collegiality, concerted action and cogency.

It is doable. Be bold and just do it.

The MECA states that SMOs will provide leadership, supported by managers, not the other way around.

VITAL STATISTICS

YEAR TO JUNE	HOSPITAL DISCHARGES	ACUTE READMISSIONS
2013	811,064	89,898
2017	912,749	107,415
% Increase	**+12.5%**	**+19.5%**

Population growth for this period: 7.2%

SOURCES:
Ministry of Health 2018
Statistics New Zealand 2018

ASMS 30TH ANNUAL CONFERENCE

THURSDAY 29 & FRIDAY 30 NOVEMBER 2018
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 28 November, and a conference dinner will be held on Thursday 29 November at Te Wharewaka o Pōneke.

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.

DELEGATES REQUIRED

The ASMS makes all travel and accommodation arrangements for ASMS delegates to attend its 30th Annual Conference. Register your interest today to **ar@asms.nz.** Registrations close on 12 October.

ASMS
TOI MATA HAUORA
www.asms.nz

Angela Belich and Lloyd Woods hand out pamphlets at ACC

COLLECTIVE BARGAINING IN THE NON-DHB SECTOR

LLOYD WOODS | SENIOR INDUSTRIAL OFFICER

ASMS has had members at ACC since the late 1990s and in the past 10 years we have grown membership from 9 to 44.

Unfortunately, it must be said that our relationship has had rocky patches starting right back in 2009 and 2010 when we had to take ACC to mediation after its refusal to negotiate a collective agreement, and most recently when we were forced into strike action in order to settle the most recent agreement and legal action to prevent mass disestablishment of members jobs, with eventual redundancy for some.

MASS DISESTABLISHMENT (SACKING) OF MEMBERS AND A STRIKE

All ASMS members at ACC work in the Clinical Services Directorate (CSD) - 44 members at the time of writing. On Monday 24 May we received an embargoed copy of a proposal to disestablish all staff in the CSD, including our members. This proposal then had them all undergo an Expression of Interest process to determine who would keep their jobs. Roughly 60 medical advisors (MA) would be disestablished in order to find perhaps 10 (6.4 FTE) to make redundant.

This started an ugly process that was wrong from the outset and that eventually we won with no members being disestablished or required to do EOIs.

Firstly, we objected to the two-week consultation period and took ACC to urgent mediation to discuss this and concerns in general about the lack of consultation. We got a two-week extension (although ACC claimed this was because of staff feedback and nothing to do with the ASMS).

Next, we took an urgent injunction to the Authority based on the proposal being unlawful and breaching health and safety. "Disestablishment" means dismissal and an employee can only be dismissed for disciplinary reasons or through redundancy. For 50 MAs out of 60 it was clear that no actual redundancy could apply, hence it was unlawful to go through a "mass disestablishment" process. Further to that, every employer has an obligation to keep employees safe and in forcing 50 of 60 through disestablishment and an onerous EOI process, the ACC was callously causing stress and distress for no reason. This obvious (to us) breach by the ACC had never been challenged when the same process was used repeatedly at ACC in other areas and has been used in many government departments over the years. Our injunction challenged the status quo and we were pleased when, having met with our ACC sister union the PSA to put our argument, the PSA got quite excited about it. They were supportive and agreed to join in on eventual legal action.

ACC ON SHAKY GROUND

ACC seemed shocked (and extremely irritated) with our action but clearly understood that they were on shaky ground. At the meeting with the Authority to discuss our injunction, ACC informed us that they were withdrawing the proposal and would table a new one for consultation "that would meet the union's needs". This was another victory.

On 23 July they released the revised proposal that stopped the disestablishments but still had all staff going through an EOI process, at the end of which redundancies would apply to those who 'missed out' based on some very inappropriate criteria. We reinstated the injunction process.

At the same time as all of this was going on we had been battling to conclude bargaining for the replacement Collective Employment Agreement (CEA) and our members had, through a secret ballot, voted strongly in favour of taking strike action. This was planned for five half days on strike over five consecutive weeks. The ASMS office and communications team swung into action and we had very good media cover and continual contact with members. The first half day was very successful and, as we understand it, every member covered by the collective agreement and due to work that day was taking action. The second half day of strike action had a similar result, including the ASMS team distributing pamphlets at the ACC head office. ACC was furious about this.

During this period, we had several conference calls with members and the feedback was that ACC was coming to realise that ASMS members were not going to lie down and be bullied into a wrongful redundancy situation or an unsuccessful outcome to the CEA bargaining. As a result, on Friday 27 July we contacted ACC and proposed that we get around the table to settle both matters and we were pleased with their agreement to do so urgently.

This was a successful initiative leading to an acceptable outcome for the CEA (albeit not getting everything we were pushing for) but as quid pro quo the complete withdrawal of any disestablishment process for Medical Advisors in the CSD proposal. It was agreed that 'the sinking lid' would deal with any supposed over-staffing. Membership had increased by seven members (19%) in the meantime and membership feedback has been very positive. The CEA and agreement to stop the CSD disestablishments etc were both ratified by members.

With ACC you can never be sure what the future holds, and it is quite possible that in future we will see new efforts to downsize the MA roles and, given our experience so far, we could even see them try to contract out all medical work. This would be against the wishes of the current Government and the public in our view but in any event, they will be in for a huge battle if they go down that line.

We have made clear to the ACC management that the Collective Agreement could have been resolved in January without such drama if they had negotiated in good faith and with a desire to come to an acceptable outcome. We have also made clear (both through the strong actions of our members and through our legal action) that we will not be pushed around and that with proper consultation and good faith the whole battle around the Clinical Services Directorate could have been avoided.

We have made very clear to the ACC that we want to work positively with them for the good of our members, the ACC and ACC claimants. We look forward to ACC working more positively in the future although the past suggests this might be a somewhat naïve hope. Time will tell.

FIVE MINUTES

WITH NEIL STEPHEN

NEIL STEPHEN IS A DENTAL SPECIALIST AT HUTT VALLEY DISTRICT HEALTH BOARD AND ASMS' HUTT VALLEY BRANCH PRESIDENT.

WHAT INSPIRED YOUR CAREER IN DENTISTRY?

It's interesting to reflect on that, but to be honest I don't have the slightest idea! I'd received an invitation to study towards honours in chemistry at university but that didn't really inspire me, so I somewhat opportunistically decided to apply for admission to dental school. That was in 1976 and I still can't really explain why, there was no great insightful reason for doing so.

The better question is probably what inspired me to continue. As an undergraduate there was a fantastic sense of camaraderie in one's class with only 60 fellow students. I have since worked predominantly in the public sector, initially in the hospital dental unit at the School of Dentistry/Dunedin Public Hospital. I'd credit my career from that point forward to my first boss, he was an extraordinary humanitarian. We were dealing with some of the most vulnerable people in society and seeing his approach to that was inspiring. He was a terrific mentor and eschewed interest in the business and commercial aspects of dentistry.

Similarly, I was involved with a number of respected senior colleagues during in my early employment. Their approach, professionalism and lack of interest in commercial spoils was inspiring, and the fact is, they always put their patients at the centre of what they did. Patient-centred care is nothing new!

After three years, because there was no defined career pathway at that time (a time when most young dentists headed to the UK) and limited post graduate opportunities existed, I moved into private practice. I ended up in Australia in 1984 and for a while I questioned whether I wanted to continue in dentistry, I was disillusioned really, I struggled hard to reconcile the provision of dental care with the necessary business considerations. However, a new opportunity came along to undertake post graduate training in hospital-based dental practice (these days called Special Needs Dentistry), so I moved back to New Zealand and the University of Otago in 1991 with three young children in tow.

That was quite a big thing to do in those days. Unlike the vocationally-based medical model, post graduate training in dentistry was entirely self-funded and not associated with employment or remuneration: it cost a lot. I completed my Master's Degree in restorative dentistry in 1993.

WHAT DO YOU LOVE ABOUT YOUR JOB?

To give some history, I've completed a post graduate degree and been in the New Zealand Defence Force as a regular force consultant dentist officer. I 'retired' from Defence in 1998 and then spent a short period in private specialist practice until returning in 2005 to the public health environment as a full time SMO at Hutt Valley DHB. Generally, I've had very good employers over the years.

I enjoy being able to operate in a system that isn't entirely driven by commercial interest, although some commercial rules still apply, for example, oral health care and rehabilitation for New Zealand adults remains not fully subsidised at the public expense. Apart from that, I get a buzz out of treating the underdog, working as part of a larger team, working with medical colleagues and dealing with vulnerable patients; these factors all help in preventing one from getting into too much of a silo and too narrowly focusing one's approach.

WHAT ARE SOME OF THE MOST CHALLENGING ASPECTS OF PRACTISING DENTISTRY IN THE CURRENT HEALTH ENVIRONMENT?

It's tough working in the public system. There aren't enough resources and, however well intentioned, there are inequalities with accessing the system and meeting people's expectations. People have to reach thresholds, and there's a limit on service funding.

Hospital dentistry is a secondary level service with at times a tertiary level of service provided. We provide care to patients that can't be safely managed in the community at a primary care level, or are more appropriately managed in a secondary level facility with all the support services available. Often we receive referrals from primary care requesting management of patients whom could be managed within the community, often the reason for referral is largely based upon a patient's ability to pay and because we have limited capacity to meet such requests they are declined. Frustratingly, in New Zealand there is no publicly funded or subsidised system for adults that enables them to receive affordable routine dental care and maintenance in the primary sector.

I do the triaging and often have to send patients back if they don't qualify for treatment. That's really disheartening because they might end up being ignored. It comes down to resource constraints; there's simply not enough of us to go around and we can only afford to provide care to the medically compromised and most vulnerable high needs patients in our community. This really is the reality of working in the public system, but to end on a positive note, we do have some terrific patients and enjoy wonderful collegiality.

WHY DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

Some time ago, around 2009, I took an interest in going along to the Joint Consultation Committee meetings between ASMS and the DHB's management. I had known Steve Purchas for a long time, from university days in fact, and he was actively involved with ASMS. When he decided to step down as branch officer at the next ASMS elections, I put my hand up and was elected as Vice President. I think this was around 2012. Sadly, during my first term, the ASMS Hutt Valley branch president passed away, and I took over that role until the following election (I think 2015) where I was returned as branch president. I've just been re-elected as branch president for the next three years.

I would like to see more of my colleagues actively engage with the union, rather than just signing up when they're in strife.

I was also part of the recent MECA negotiating team. That was a really interesting experience, seeing aspects of DHB engagement. Although this was at times unpleasant and acrimonious I wouldn't shy away from being involved again.

WHAT HAVE YOU GAINED OR LEARNED FROM YOUR ASMS INVOLVEMENT?

I've found it interesting to see the union's involvement in disputes and pay and rations, as it is referred to. ASMS is an interesting union in the respect that we are actively engaged in more than pay and rations, we do things like engagement in process and quality improvement in the health system. It has been informative and very useful to learn about aspects of employment law, particularly around rights and resolution and to apply this to supporting colleagues in an informal way when there have been issues.

Observing ASMS' work has nurtured my enthusiasm further. I've enjoyed the opportunity to learn about industrial relations and see the ways ASMS works with members to try to improve things in DHBs, as well as offering advice or direction to colleagues when the need arises.

I've always had a bit of a traditional union leaning, and after seeing the work an industrial officer does, I've certainly learned a bit. Given the opportunity to turn back the clock to 1976 I think I may have considered a career in a similar area. I value ASMS as a collegial support network which supports your day-to-day work, as well as being there if there are industrial difficulties to address. ASMS has a real impact.

DID YOU KNOW

DID YOU KNOW ABOUT... SICK LEAVE

Sick leave is on full pay regardless of if you are on ACC or not or whether the injury was in work time or not. Full pay applies for the whole period of sick leave and is your normal pay all inclusive.

DID YOU KNOW... ABOUT THE EMPLOYER SUBSIDY FOR YOUR SUPERANNUATION?

Clause 17.1 of the DHB MECA specifies that your employer will make the required employer contribution in respect of any of the superannuation schemes operated by the National Provident Fund or the Government Superannuation Fund to which you belong. If you do not belong to one of these, then Clause 17.2 of the MECA entitles you up to a 6% employer subsidy matching your contribution to an approved superannuation scheme, and ASMS encourages members to take advantage of this. **https://www.asms.org.nz/clause-17/**

DID YOU KNOW ABOUT... COVER FOR ABSENT COLLEAGUES

If your service has been correctly service sized the annual and CME cover of colleagues can be expected to be covered by colleagues but generally any other leave must be covered through locums, extra duties payments or the work is not covered at all. If you have not been service sized it is possible that even annual and CME leave does not have to be covered depending on vacancies and staffing. If in doubt talk to your industrial officer.

DID YOU KNOW... ABOUT JOINT CONSULTATION COMMITTEE MEETINGS?

ASMS organises Joint Consultation Committee (JCC) meetings three times a year with your DHB's management team. These meetings are a good chance to put issues that matter to you and your colleagues in front of the chief executive and senior managers. We always discuss things that are topical and relevant to your work as an SMO, and we greatly value your input at these meetings.

DID YOU KNOW...?

As a DHB employee, you're entitled to reasonable leave on full pay "on the bereavement of someone with whom you have a close association".

Your entitlement is found in MECA Clause 27.1 and is not limited in time (eg, to only three days) or to the death of a close or immediate family member. Each case should be considered sensitively and recognise your particular culture, family responsibilities and travel requirements. There is no obligation on you to 'make up' any clinics, after-hours call or weekend shifts missed during bereavement leave.

More information is in clause 27 of the DHB MECA: **https://www.asms.org.nz/clause-27/**

We respond quickly and in a welcoming and friendly manner, and this is often a great start to a new doctor's orientation to New Zealand.

ASMS FREE SERVICE

LLOYD WOODS | SENIOR INDUSTRIAL OFFICER

Did you know that ASMS provides a service checking job offers that advantages job applicants but also affects all SMOs/members? This service is free to all, including non-members.

Many ASMS members had their first contact with the ASMS before they ever took on their first medical job in New Zealand due to somebody advising them to send us their job offer for checking.

We see job offers from RMOs for their first SMO appointment, prospective SMOs/doctors from all over the world, and also current members moving to a new job (including within the same DHB).

We respond quickly and in a welcoming and friendly manner, and this is often a great start to a new doctor's orientation to New Zealand.

We welcome this work because ensuring that new employees (or employees taking on new roles) have the proper salary step, recruitment devices (where applicable) and protections means we can avoid (for them and the DHB) the problems that come up downstream otherwise.

Job offers are often wrong and we have seen numerous applicants get the right deal only after our advice. Many would not have realised their rights to superannuation or relocation cost reimbursement, for instance.

Clearly it is advantageous to the applicant to ensure everything is correct but it is also equally important for existing colleagues. We have picked up inequities and issues for existing members that only came to light due to seeing a new job offer.

If you are looking at changing your role (temporarily or otherwise) in your own DHB, feel free to send the paperwork through.

Otherwise – please - whenever possible, advise job applicants to send their job offer to us for checking.

We have picked up inequities and issues for existing members that only came to light due to seeing a new job offer.

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'.

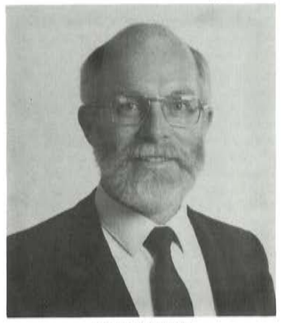
A S M S

NEWS LETTER

ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

NEWSLETTER No. 1 OCTOBER 1989

We're Under Way



George Downward

Since legislative changes forced us out of the Health Medical Officers' Advisory Committee and into independent Union status, we have achieved much. In existence since April 1989, the Association of Salaried Medical Specialists (ASMS) has already undertaken virtually all the roles required of it as a union. Specifically, we have defended individual members, negotiated redundancy deals, concluded an award round (being the first group ever to go to final offer arbitration), and have provided advice and collective support to many members.

National elections, as required by our rules, have been held, with the results reported elsewhere in this newsletter. We have a well appointed office at 26 The Terrace staffed by our Executive Director, Ian Powell, and his personal assistant Angela Kiwha, and we are currently in the process of advertising for a third full-time staff member. Shirley Homewood continues to provide legal advice on a part-time basis.

The support given the ASMS has been most gratifying with over 1300 financial members, 14 established branches and a keenly contested election with a 60% voter response. The interest of and involvement by individual members augurs well for the future of the ASMS.

The future direction of the policy of the ASMS has yet to be firmly established. The first Conference to be held on 3 November will have an important role in policy development. I believe that a priority is actively working towards professional unity, with all representative groups of our profession communicating and proceeding with common purpose. We have already established a liaison with the New Zealand Medical Association (NZMA), the Colleges' Liaison Committee and the New Zealand Medical Women's Association. We have also co-operated with the NZMA in producing a joint press release on speaking out against employer policy.

An invitation by the NZMA to seek affiliation has yet to be answered. Affiliation would achieve speaking and voting rights in the Council of the NZMA for the ASMS, and hence a positive influence on NZMA policy issues without any loss of autonomy. I envisage a decision on this important issue being made at our forthcoming Conference. I would, in any event, encourage membership of the NZMA by those members of the ASMS eligible to join. On the industrial front, we are faced with yet another award round for senior medical officers, with a date set to initiate negotiations in November 1989. A working party is being established with employer representatives to explore what *may* result in significant changes to our mode of employment. Items on the agenda include work evaluation, performance and accountability, job description, on call/call out, and limits on hours of work. Before making any commitment, consultation will be undertaken, with, time permitting, all controversial issues being debated at Conference in November.

Whilst much time is of necessity spent on the senior medical officers' and senior dental officers' awards, there are a number of smaller groups, eg, employees of the Family Planning Association, who also require active consideration. We are at this time exploring the possibility of developing one or more awards to cater for those members not employed in the public hospital service.

Much is changing in the health and industrial sectors. We can not ignore this change, and must be prepared to alter traditional patterns of employment in order to optimise our individual circumstance. At the same time we must not forget out commitment to the provision of quality health services. Industrial and professional considerations are not mutually exclusive. They cannot in fact be separated. I look forward, together with the members of the National Executive, and with the active support of individual members, to moving to meet our mutual objectives.

George Downward
PRESIDENT

THE PROBLEMS OF TREATING THOSE CLOSE TO YOU

DR TIM COOKSON | MEDICAL CONSULTANT, MEDICAL PROTECTION

In a recent Health Practitioners Disciplinary Tribunal (HPDT) decision, a hospital doctor had his registration cancelled for (among other things) prescribing inappropriately for his wife. The severity of the penalty was because he forged a colleague's signature on a number of the prescriptions. He was also found guilty of writing prescriptions for codeine phosphate for his wife signed under his own name. There was no suggestion that any of the prescriptions was for his own use, and the Tribunal recognised that his wife had a significant medical condition and barred publication of any details of that condition. But the Tribunal found he was a danger to the public which needed protecting from him.

Is this an isolated incident or something much more common? In the year to March 2017 the Medical Council of New Zealand's Complaints Triage Team reported receiving 17 complaints involving allegations of prescribing for self or family. The notification is usually when either a pharmacist or Medsafe recognise that the surname matches on a number of prescriptions and checks are done which confirms the relationship. Occasionally it is colleagues or even disgruntled family members who complain to MCNZ.

The current MCNZ statement on providing care to yourself or those close to you is strict, even if it is not strictly adhered to by the profession. It is also rather encompassing, with care defined as anything that is done for a diagnostic, preventative, palliative, cosmetic, therapeutic or other health-related purpose. Family member includes not only spouse or partner, children and siblings, but also members of your extended family and those of your partner or spouse. Other individuals included in this net are those with a personal or close

The current MCNZ statement on providing care to yourself or those close to you is strict, even if it is not strictly adhered to by the profession.

relationship with you – ie, friends and close colleagues. You **must not** (MCNZ emphasis) prescribe medication with a risk of addiction or misuse; psychotropic medication; controlled drugs and a few other situations. There are exceptions in emergency situations and in small communities where access to other providers is limited.

SO WHY DOES IT HAPPEN?

So if this is all so clear, how is it that this practice continues to be so common amongst the medical profession? We can be excused for some confusion. Less than 10 years ago it was still possible for a retired doctor to get a limited APC that would allow prescribing for oneself or family under certain circumstances. Then it changed and not only were you not able to treat self and family etc. but also colleagues, whether or not you were close to them.

Fortunately, MCNZ recognised that this meant that no doctor could get any medical care if the logic was taken to the extreme, and that restriction has been removed in the latest statement. It would be assumed that if MCNZ has taken such a firm line against this practice, that this would be universal amongst medical jurisdictions – not so. Some developed countries such as Germany and Holland have no such concerns, with German doctors only being recommended not to charge family members for the care provided. In Singapore it is not recommended, but equally it is recognised that this will occur, and if a doctor does a major operation on a family member they should take special care in doing so.

There are also very big cultural differences in expectations, with doctors in some cultures not only expected to provide care for their families, but liable to be ostracised if they refuse to do so. The rationale put forward by MCNZ for this limitation on doctors providing care for those close to you is that you may lack clinical objectivity, may not get all the relevant information, and that you may over or under-treat accordingly. Clearly this view is not universally shared, so what is the evidence that we are causing harm by treating those close to us? MCNZ, despite expecting doctors to make decisions based on good evidence, does not provide any evidence. They do quote the other jurisdictions that share the same view though.

In practice it is not hard to find examples of where care provided in this manner is not appropriate. Last week a male patient presented with urinary symptoms. He had already spoken with a very close doctor friend who decided that he had a UTI and prescribed antibiotics. No notes were written, no investigations done, his symptoms did not improve, and he took a completely unnecessary course of antibiotics. This was clearly not good management, and my patient was more at risk of harm than good as a result of his friend's intervention.

RESPONDING TO THIS ISSUE

So how does MCNZ treat the complaints it receives about this? The answer is on a case-by-case basis, with a trend towards lower tolerance where psychotropic medications or drugs with potential to cause addiction are prescribed. Although the statement says we must not prescribe psychotropic medications to family, it merely admonished a doctor who prescribed antidepressants to his wife without any other doctor involvement, despite the fact that she went on to try to commit suicide. At the other end of the spectrum a GP had charges laid in the HPDT for prescribing antibiotics to colleagues and the Tribunal found him guilty of professional misconduct for this. This decision was overturned by the High Court.

Complaints to MCNZ are almost always related to prescribing, but there are many other therapeutic interactions that occur where prescriptions are not involved. According to the statement, I am supposedly not able to advise my uncle to stop smoking (a preventative measure with evidence to support it). In reality I am confident that I would not be criticised if my uncle complained about this to MCNZ. However, I am certainly not going to tempt fate by prescribing any psychotropic medications to my wife (even though she has a different surname) as I have no desire to appear before the Tribunal and have my registration cancelled. As a profession we need to recognise that the rules have changed, our families and those close to us will be better cared for if we adhere to those rules, and we will be safer too.

As a profession we need to recognise that the rules have changed, our families and those close to us will be better cared for if we adhere to those rules, and we will be safer too.

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

Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
36 Brandon St, Wellington

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

P 04 499 1271
F 04 499 4500
E asms@asms.nz
W www.asms.nz
www.facebook.com/asms.nz

Have you changed address or phone number recently?

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

ASMS
TOI MATA HAUORA
www.asms.nz

ASMS STAFF

Executive Director
Ian Powell

Deputy Executive Director
Angela Belich

COMMUNICATIONS

Director of Communications
Cushla Managh

Communications Advisor
Lydia Schumacher

INDUSTRIAL

Senior Industrial Officer
Henry Stubbs

Senior Industrial Officer
Lloyd Woods

Industrial Officer
Steve Hurring

Industrial Officer
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Industrial Officer
Dianne Vogel

Industrial Officer
Ian Weir-Smith

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Phil Dyhrberg

POLICY & RESEARCH

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Principal Analyst (Policy & Research)
Charlotte Chambers

SUPPORT SERVICES

Manager Support Services
Sharlene Lawrence

Senior Support Officer
Maria Cordalis

Membership Officer
Saasha Everiss

Support Services Administrator
Angela Randall

PO Box 10763, The Terrace
Wellington 6143, New Zealand
+64 4 499 1271 **asms@asms.nz**

Our commitment

At MAS, we're committed to doing what we can to make a positive impact on the health and wellbeing of future generations of New Zealanders, and to a more sustainable country.

It's why we've implemented a socially responsible investing approach across $1.4 billion of superannuation funds and insurance reserves and do not invest in the manufacture and sale of armaments, tobacco, or the exploration, extraction, refining and processing fossil fuels.

Talk to us about our socially responsible Retirement Savings and KiwiSaver plans today by calling **0800 800 627** or visit **mas.co.nz**

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