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The Specialist

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New Zealand's specialist workforce crisis threatens key government objectives

The National led government has a number of laudable objectives that the ASMS either specifically or, in principle, endorses. The ability to achieve them depends in no small part on DHBs having the senior doctor and dentist workforce capacity to deliver.

This has been recognised both implicitly and explicitly with Minister of Health Tony Ryall's call for increased clinical leadership and engagement in district health boards, including through his policy statement *In Good Hands*. However, their achievement is threatened by the continuing specialist workforce capacity crisis in DHBs.

Unstated government objective

An unstated government objective, at least publicly, is that National is conscious of its record and reputation when last in office in the 1990s. Its then ideologically driven health policy became a major political Achilles Heel and tarnished its reputation for several years as being unsupportive of the public health system.

Today this government, particularly this health minister, want to be able to demonstrate that as a conservative government it can be trusted by the public to run the public health system. It wants to be seen as a guardian of rather than threat to the public health system.

The cause of the specialist workforce crisis is not the making of this government (nor is it the making of the previous Labour led government). It's cause rests on the impact of Queensland's Bundaberg tragedy on top of the vulnerability and brittleness of New Zealand as a geographically isolated small country with a small critical mass. The patient deaths at Bundaberg highlighted the risks of a desperate medical workforce crisis (shortages) on the robustness of appointment processes (although this was not the only lesson). This has led, since late 2005, to a significant improvement in Queensland specialist salaries in response which then spread to other Australian states. This development across the Tasman is not the fault of government, but the government has a responsibility to find the solution.

Pending changes to RMO training

The Resident Medical Officers Commission, reporting to the government in 2009, noted that service provision had got out of hand and become too dependent on RMOs with the effect of compromising the quality of training. In essence it recommended that specialists take greater responsibility for resident doctor training and, in effect, that they take a greater role in service delivery. These recommendations were endorsed by government. In order to achieve this there will need to be a shift to one degree or another from specialist-led to specialist-provided services.

But there is simply not the specialist workforce capacity in DHBs to achieve this. Instead we have an overworked, over-stretched workforce suffering from clinical overload, seeing their important non-clinical time to support professional activities eroded by 'clinical creep', and struggling simply to keep the health ship afloat while the government expects it to dramatically increase its cargo load. The specialist workforce is badly under-resourced to assume greater RMO training and service provision roles. Until we resolve our workforce crisis it simply can't be done.

No time for clinical leadership

The government has correctly identified that comprehensive clinical leadership is the way forward in terms of ensuring high quality and cost effective health services. This is not simply formal positions of clinical leadership but drilling down below to the unit of work so that all senior medical and dental staff are able to participate in leadership beyond their immediate clinical practice.

As Professor Des Gorman, Chair of the Ministry of Health's Health Workforce New Zealand, has said on a number of occasions, leadership is not discretionary for a health professional. But comprehensive coal-face level clinical leadership requires time and time requires the specialist numbers that DHBs simply do not have. Even formal clinical leaders are struggling for time, let alone the level of 'shop floor' engagement expected by the *Time for Quality* national agreement between the DHBs and ASMS and *In Good Hands*. But formal

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clinical leaders are only a small subset of what substantive clinical leadership involves.

Professor Gorman's statement is consistent with the *Time for Quality* agreement which requires that the design, organisation and configuration of services should be clinician led and the *In Good Hands* policy statement which includes the expectation that decisions should be clinician led and devolved as close to the workplace unit (eg, department) as possible.

Without the ability to recruit and retain more specialists how can our current specialist workforce engage in leadership beyond their clinical practice when their clinical practice is all they have time for.

Regional collaboration between DHBs

Quite correctly the government is promoting greater regional collaboration between DHBs. This is sensible recognising that DHBs can't function in splendid isolation and that it is essential for clinical and financial sustainability. DHBs are currently developing regional services plans which largely focus on building clinician-led clinical networks and strengthening public hospitals. This is expected to hit the road next year. It is not centralisation and if it were to become centralisation it would fall over.

While enhanced regional collaboration, if it develops according to its underlying aspiration, has the potential to strengthen ongoing specialist workforce capacity it will not take off (and risks becoming centralisation) unless the initial recruitment and retention investment is addressed. Genuine substantive regional clinical collaboration based on clinical leadership will not happen unless the right investment is made to achieve the necessary capacity to get it up and running in the first place. But right now DHBs are well short of this capacity.

Primary-secondary collaboration

The case for strengthening collaboration in service delivery between primary and secondary care, another government objective, is compelling. This is endorsed by the memorandum of agreement between the ASMS and General Practice New Zealand (representing primary care networks). The potential for better patient outcomes, improved patient access, and a better return for the health dollar is immense and largely untapped. But this depends on active engagement with secondary care specialists who simply do not have the time.

The government needs to learn from its 'expressions of interest' business case experience which, in several instances, suffered from lack of engagement with specialists. The potential benefits of these business cases are unlikely to be achieved because of this failure. Unless we have an effective recruitment and retention strategy designed to sustain the number of specialists necessary to generate sufficient time, the clinical and cost effectiveness of primary-secondary collaboration will be lost.

"New Zealand's specialist workforce capacity is trapped in a vicious tightening vice..."

Electives and emergency departments

An important National Party commitment in the last general election was to provide 20 additional elective operating theatres in public hospitals in order to increase elective throughput. Building elective capacity is important. Electives are often a form of early intervention. The more electives that are done in a timely manner the less likely they are to come back as more costly complex or acute cases. Unfortunately New Zealand does not have the workforce capacity to deliver on increasing electives to the expected level, especially as it is now clear that some of the recent increased elective volumes are due to the re-designation of ACC patients. This capacity need includes the specialist workforce, including surgeons, anaesthetists and diagnosticians.

The government has an objective of ensuring that 95% of patients being treated in emergency departments are either discharged or admitted into the main hospital within six hours. This is a 'whole of hospital' challenge, not just an emergency department one. While discharging patients in a timely manner is normally not too difficult, admitting them into the wards is, with specialist workforce capacity being a critical factor. In many hospitals there is not the specialist workforce, especially physicians, available to provide the model of inpatient care needed for these patients.

Trapped in a vicious tightening vice

New Zealand's specialist workforce capacity is trapped in a vicious tightening vice. It is struggling to keep up with increasing clinical demands (often described by our members as 'clinical creep') with one of the casualties being the ability to use non-clinical time to support professional activities and development.

We are increasingly dependent on overseas recruitment and are by far the most dependent OECD country, much higher than second highest Australia. This is despite the recommendation of the former Medical Training Board that we gradually reduce our dependence - a recommendation incorporated by the RMO Commission and adopted by government. We have the lowest ratio of specialists per capita in an OECD survey, even pipped at the post by Turkey.

Australia is our greatest threat, particularly in specialties where there is not a strong private sector in New Zealand. The threat is compounded by proximity, closer economic relations, and similar reciprocal training schemes. New Zealand can't compete on employment conditions against Australia in international recruitment; we are losing senior registrars to Australia seeking opportunities for specialist appointments where there are shortages; and there is the continuing corrosive trickle of specialists from New Zealand to Australia.

"Australia is our greatest threat, particularly in specialties where there is not a strong private sector in New Zealand."

This is an unsustainable recipe. It is a crisis staring us in the eye and prevents ongoing sustainability. Its severity undermines the government's ability to achieve its objectives. Solutions to this crisis are multi-factorial. But addressing Australia's superiority in employment conditions is at the top of the list.

Solutions – salaries

This superiority includes salaries, superannuation, professional development support (including continuing medical education expenses), a unique system of salary sacrifice (which more than compensates for the forthcoming tax cuts in October), more specialists on the roster, and more senior registrars to provide support. Some of these we can't fix because they are the result of the difference in critical mass. Others we can but not necessarily all at once.

The single most important measure we could take in this area is to address our salary scales. The differences between the two countries are stark and striking. Whereas New Zealand has a 15-step specialist scale ranging from the high $120,000s (NZ) to the mid-$190,000s, the average Australian scale is about nine steps from the mid-$190,000s (A) to around $260,000. It is a no-brainer that until we find some way of addressing it, this crisis will continue and the government will not achieve its objectives above a threshold of superficiality and tokenism.

The government needs to put its investment priority where its political mouth is. To quote that delightful American 'intellectual', former Vice President Dan Quayle: "if we don't succeed we will have failed."

Ian Powell
Executive Director

Quantifying the minimum specialist pay gap with Australia

There have often been references to the specialist pay gap with Australia but lack of specific data. We know that DHBs (a) are losing specialists they employ to Australia, (b) are losing to Australia senior (and even not so senior) registrars with a view to their first specialist appointment, and (c) that DHBs in NZ are seriously disadvantaged when trying to compete against Australia in recruiting specialists from the rest of the world.

Understanding of the size of the pay gap is open to confusion (over and above an appreciation that it is immense and it is hurting New Zealand's health system). This confusion includes factors such as:

1. Australia has the equivalent of collective agreements for specialists at a state and territory, but not national, level.
2. Australian states and territories have supplementary universal allowances additional to their base salaries.
3. Australia has a unique financially lucrative system of 'salary sacrifice' in its tax legislation that also well outweighs the financial gains of the New Zealand government's tax cuts this October.
4. Different remuneration systems between staff specialists and visiting medical officers (more surgical and to some extent diagnostic).

The closest estimate was up to around 35% from the SMO Commission report in 2009. However, the ASMS has made the best quantification of the gap to date based on averaging the collective agreement salaries from the states of Western Australia, South Australia, Victoria, New South Wales and Queensland which also includes the various universal supplementary allowances. Arising from this we have been able to construct a notional average Australian staff specialist salary based on a notional 40-hour week of nine steps from $(A)196,200 to $(A)255,500 with around $7,000 margins between steps. It is conservative and minimum as it excludes factors such as visiting medical officer rates, 'salary sacrifice', and other embedded supplementary provisions.

When contrasted with current key steps on New Zealand's specialist scale (1, 9 and 15) we can make the following on average conclusions that as a bare minimum:

- A specialist in New Zealand starting on the bottom step will be earning over $(A)67,000 less than their equivalent in Australia.
- A specialist in New Zealand with eight years experience (Step 9) will be earning over $90,000 less than their equivalent in Australia.
- A specialist in New Zealand will take 14 years service as a specialist to get to the top step compared with eight years for their equivalent in Australia but still earn over $60,000 less.
- A specialist in New Zealand after 14 years service as a specialist will still earn over $700 less than a specialist in Australia with no previous specialist experience.
- To put it another way it will take a specialist 14 years to narrow the gap with a first year specialist in Australia, to narrow the gap from around $67,000 to $700 (assuming the hypothetical that the specialist in Australia remained on Step 1 for 14 years).

With minimum gaps of this magnitude who can not argue that Australia threatens both the New Zealand public health system's ability to provide accessible comprehensive quality services to patients and the government's ability to achieve its objectives for the health system!

Notional Average Australian Staff Specialist Salary (40 hour week), 2010

Salary Steps	Notional Australian ($A)	New Zealand ($NZ)
9	255,500	
8	248,200	
7	240,700	
6	233,300	
5	225,900	
4	218,500	
3	211,000	
2	203,600	
1	196,200	(15) 195,441
		(9) 164,852
		(1) 128,596

PRESIDENT'S COLUMN

Fair and loathing

What joy to be a doctor. Fantastic to be a specialist at the peak of scientific endeavour. So rational and reasoning in the choices I make. In the diagnoses I divine, in the tests I determine, in the nostrums I advise. How sweet to only let emotions aid my empathy for those who suffer, not rule my intellect or wise intuition. Don't you feel the same?

As autonomous patient advocates we argue passionately when we perceive inequities of access to care. We navigate public and private options for the betterment of the person beside us. We demand fair play, and exhibit anger responses when thwarted.

As denizens of the health care jungle we rail against perceived imbalances in remuneration. We steer down rocky paths to the betterment of the specialists beside us. We demand fair pay, and exhibit anger responses when thwarted.

Where does such a sense of fair play come from? Is it special to our profession, or a fundamental human sense? Where does the anger swell from? Is the loathing special to our circumstances, or an evolutionary response conferring advantage?

Gopnik and Bloom have shown that (philosophical) babies, as young as six months, judge individuals on the way that they treat others and even one-year-olds engage in spontaneous altruism. We have an innate, possibly evolutionarily driven, sense of fairness. Of when someone is getting more than their "rightful" slice of the pie. Whether it be a patient or a colleague. We pride ourselves on fighting for the right to spend 4.5 million on "our" patient, and the right to champion the wondrous and special. And we fret over whether someone else is on a higher rung than their seniority deserves.

In playgrounds and book clubs, "it's not fair" may rank among the most readily evoked complaints. The din of inequity is not limited to children. It frames our response to finance company bailouts and to primary school pecking orders. Our innate loathing when others seem to profit beyond their efforts may be rooted in our very basis for tribal success, in our keenly honed senses of disgust and of fair play.

Lixing Sun believes that despite the fact of our specieswide social and economic disparities - perhaps in part because of them - human beings are endowed (or burdened) with an acute sensitivity to "who is getting how much," in particular a deft attunement to whether anyone else is getting more or less than one's self.

Monkeys reject unequal pay, performing tasks for cucumber slices, until they see others rewarded with grapes. Behavioural economists call it "inequity aversion" - the tendency to turn down a perfectly good offer if others are getting a better deal. Inequity aversion makes sense for a social species like capuchin monkeys, with food rewards to be distributed after a tribal hunt, but humans exposed to the "ultimatum game" also insist upon fairness, even at the apparent cost of their immediate best interest. When both are equally deserving. But perceived merit complicates things.

Merit bears a complex relationship to fairness. Differences in merit can legitimise differences in payoffs, both material and social. Yet the outcome may appear - and to some extent, actually be - unfair. Differences in merit are often exaggerated by those seeking to justify departures from fairness. After all, many mammals have evolved systems of social hierarchy, within which it may be adaptive for participants to accept their positions and thereby avoid wasteful struggles, but also to be alert for any departures from fairness, aware of circumstances that offer them at least some prospect of self-advancement. And respond with anger or disgust when fairness is felt to have left the room.

Many things elicit anger, which, as Barash shows, is simply a biological mechanism that induces people to respond vigorously - sometimes violently - to circumstances in which such a response is generally adaptive. Or at least, has been adaptive in the past. We get angry when frustrated, when we experience pain, when defending ourselves or others, and not merely because our genetic sense of fairness has been violated.

Although not all anger derives from unfairness, a fairness instinct could help us understand why certain policies and protocols are embraced and others resisted, why self-righteous anger is sometimes so easily elicited, and whether that anger is itself fair.

And then there is loathing. Disgust is different from anger. The latter is associated with rises in heart rate, the former with nausea, throat constriction and slowed pulse. And a particular facial expression (possibly arising from defence against rancid foods in millennia past). Chapman has looked at disgust and unfairness. Test subjects who played a game and considered the results unfair, reacted with the exact same instinctive facial expression as those exposed to more straightforwardly disgusting stimuli. Unfairness, it seems, can disgust us. That facial expression is not made in anger, it's really limited to disgust.

Some behavioural scientists have begun to claim that a significant slice of our morality is driven, not by religious or rational conviction, but by more visceral human considerations. Whether we feel like throwing up. A growing number of provocative and clever studies appear to show that disgust has the power to shape our moral judgments. Putting people in a foul-smelling room makes them stricter judges of a controversial film or of a person who doesn't return a lost wallet. Washing their hands makes people feel less guilty about their own moral transgressions, and hypnotically priming them to feel disgust reliably induces them to see wrongdoing in utterly innocuous stories.

That is how individuals respond. What about the "unwisdom" of crowds? Do group dynamics enhance or undermine moral thought - or instinct? As distinct from deliberate persuasion, Rieff argues that crowds can be joyful or they can be murderous; they can celebrate or they can protest; but what is beyond their reach is sobriety. His lesson, whether you are thinking about geopolitics or daily life, is that if your thinking could just as easily be expressed in a slogan, and shouted out or held aloft on a banner by a crowd, then you are probably not thinking at all. He warns, in troubled times such as our own, times he posits of the most enormous moral, social, cultural, and technological dislocation, that is immensely dangerous.

So is it all a matter of using our frontal cortex to dampen down our amygdala? And persuading others of our reason and fair ration? Our reasonableness and fair rationalising. Of how special are we, compared with our fellow health professionals. Of how special are we, compared with the toilers in the non-health determinants of health. Of how special are we, alongside the strugglers and sinkers of society.

Persuading others that we are not evangelical interventionists in esoteria, esteemed champions of cure-all at all-cost. That we are eminently fair public health proponents with ideas to burn even if no fire extinguisher in our psyche.

Evincing in others no loathing or disgust when we argue how special are the sub-sub-specialists, compared with the remote rural generalists expected to be best in everything that ails. When we debate how fair are we, confabulated with the navigators of the labyrinths of contracts and perverse price-volume schedules.

How special to be a specialist.

What joy to be a doctor.

Jeff Brown
President

Revitalising ASMS branches

The National Executive is proposing to delegates coming to the ASMS's Annual Conference on 18-19 November an important constitutional amendment relating to the management of the Association's branches.

The reason for the changes is that the provisions in the current constitution dealing with the management of branches have proven to be impractical and are largely (if not entirely) ignored by all branches. This has not yet created a problem for the Association, but one day it may and the National Executive considers it prudent to pre-empt such a problem and to develop a new model of branch governance that allows each branch to manage its own affairs in a democratic yet flexible manner.

Key Features of Proposed Branch Governance Structure

The key features of the Executive's proposed new governance structures are:

- it will create two branch positions, a Branch President and a Branch Vice President who will be the "branch officers";
- the branch officers will be elected for two-year terms, in ballots organised and conducted by the national office;
- the branch officers would be responsible for the management of branch business. They may (but are not required to) appoint a branch committee to assist them;
- members of a branch committee, where it is decided there should be one, may *either* be appointed (or co-opted) by the branch officers *or* elected at a branch meeting. Members of a branch committee may also include members from the region who are employed by non-DHB employers;
- the branch officers may work closely with the local senior medical and dental staff group by taking branch business to meetings of the senior staff group for discussion and a formal decision, if that is appropriate;
- the branch officers would keep control of branch business by determining to what extent the Association's business would be referred to the senior medical and dental staff group and whether it is simply for wider debate or a formal decision;
- local members will have the power to call for meetings of the branch and if five or more members are dissatisfied with a decision of the branch or of its branch officers may refer the matter to the Executive Director and the National Executive for resolution; and
- the current provision for secret ballots on branch matters is retained.

PROPOSED CONSTITUTIONAL AMENDMENT

1 Branch Officers and Committees

1.1 Each branch shall elect a President and a Vice President who shall be the Branch Officers. The Branch Officers shall be responsible for managing the business of the branch and shall be elected for two-year terms that will begin on 1 July in alternate years.

1.2 The Association's national office shall conduct biennial elections for Branch Officers in the three months immediately preceding 1 July in an election year. The national office shall also conduct elections to fill any casual vacancies that may arise. A Branch Officer who is elected to fill a casual vacancy in a mid-term election shall hold that position for the remainder of the two-year term.

1.3 To assist them to conduct the business of the branch, the Branch Officers may establish a Branch Committee. Members of a Branch Committee may be appointed by the Branch Officers or elected at a meeting of the branch.

2 Branch Meetings and Business

2.1 In managing the business of the branch, Branch Officers may work closely with any local senior medical and dental staff group that exists and, whenever it is appropriate to do so, to refer Association or branch business to meetings of the senior medical and dental staff group to encourage wider discussion and participation in branch decisions.

2.2 If it is practical to do so, branches shall hold at least one formal meeting a year for the purposes of facilitating formal discussion within the branch and consideration of remits for the Annual Conference. Otherwise, branch meetings shall be held as frequently as the Branch Officers or local membership interest may require and at such other times as the National Executive may request.

2.3 The Branch Officers shall convene a branch meeting if four members or 10% of the branch membership (whichever is the higher number of members) requests it.

2.4 If five or more members of a branch are dissatisfied with any decision of their Branch Officers or of a branch meeting they may send a formal written statement of their concerns to the Association's Executive Director. The Executive Director shall promptly refer the matter to the National Executive for its consideration and a decision as to how the matter should be resolved.

2.5 Decisions at branch level will normally be made by a majority of branch members present and voting at a branch meeting. However, if 20% of the branch members attending the meeting request a secret ballot a secret ballot shall be conducted of all branch members.

EXECUTIVE DIRECTOR'S COLUMN

Mid Staffordshire and New Zealand: is there a link?

Tony Delamothe, deputy editor of the British Medical Journal, wrote a challenging opinion piece earlier this year (BMJ, 16 January 2010). He began by asking of the following scandals in England, what was the odd one out and why?

- Alder Hey (retention of children's organs)
- Bristol (children's heart surgery)
- Shipman (serial services)
- Mid Staffordshire (emergency services)

His right answer was Mid Staffordshire, not simply because it was the only one that was a 21st century scandal. It was, in particular, because the details are harder to recall despite the death toll – 400 to 1,200 – compared with Alder Hey (0), Bristol (30-35) and Shipman (probably 250). But, whereas the other scandals led to various extensive and lengthy inquiries, Mid Staffordshire only generated one report of a mere 172 pages.

But there is economy in words. Mr Delamothe quotes in full the key paragraph of the Mid Staffordshire report by the Healthcare Commission, a statutory body:

> *In the [Mid Staffordshire NHS] trust's drive to become a foundation trust, it appears to have lost sight of its real priorities. The trust was galvanised into radical action by the imperative to save money and did not consider the effect of reductions in staff on the quality of care. It took a decision to significantly reduce staff without adequately assessing the consequences. Its strategic focus was on financial and business matters at a time when the quality of care of its patients admitted as emergencies was well below acceptable standards.*

Despite the difference in the specific driver (achievement of foundation status at all costs, quite literally) the lesson for New Zealand (government and DHBs) is apt. Whatever the driver, when public hospitals are placed under intense financial pressure (whether it something they want to achieve or something imposed on them) the risks for the quality of patient care and patient safety increase. Sometimes patient harm and deaths are the tragic outcome.

The New Zealand government needs to be aware that when it decreases the level of increased health funding to DHBs by around 50%, no matter how well signalled, this risks becoming a form of shock therapy. This forces DHBs, despite best endeavours, to make short-term financial and business decisions that risk placing the quality of care below acceptable standards. As a subset when the government imposes an administrative cap on so-called back office positions with a definition of 'back office' that is so broad as to include clinical support activities, quality of care standards are put under undue pressure.

We don't actually need to look as far as Mid Staffordshire for lessons on what not to do. We should also recall Queensland's Bundaberg disaster and the disgraced Dr Patel appointed during a specialist workforce crisis in the sunshine state.

This tragedy (patient deaths) was a direct result of Australia's specialist workforce crisis (incentivised deficient appointment processes to begin with) and led to the Queensland government's decision to significantly increase specialist salaries in 2005-6 which, in turn, extended to other Australian states. This development, in no small part, led to the vulnerability and brittleness of the specialist workforce in a small geographically isolated New Zealand to quickly become a crisis riddled with threats to access to care, standards of care, and achievement of laudable objectives.

Is there a link between Mid Staffordshire (and Bundaberg) and New Zealand? Only if our political policy settings allow it!

Ian Powell
Executive Director

Revamp of ASMS website

The ASMS homepage www.asms.org.nz has recently been revamped with the intention of adding appeal as well as placing greater importance on presenting latest news articles and publications in a readily accessible format. In addition to a commitment to regularly updating the *News and Reports* column (at least weekly), improvements include the introduction of:

- A slide banner to promote relevant matters and news updates.
- Imagery to accompany and add interest to news articles.
- A new *Perspective* column; consisting of opinion pieces by individuals.
- Links to in depth reports.

Members are encouraged to access our homepage regularly, perhaps weekly, as a quick means of keeping up-to-date and for downloading relevant and interesting material.

ASSISTANT EXECUTIVE DIRECTOR

Amending the New Zealand Public Health and Disability Act

The New Zealand Public Health and Disability Act, when it was first passed, restored a degree of local influence over the public health system. The health reforms of the 1990's had led both the public and clinicians to lose faith in centralised bodies of appointees. The mixed appointment and election process of the District Health Boards (DHBs) restored a degree of democratic control and autonomy around the provision of many services reassuring those who feared central control. Some central control was generally achieved through funding, monitoring of performance and some elements of direct contracting by the Ministry.

The relative autonomy of DHBs has had its downside with unnecessary duplication of resources for a small country and difficulties obtaining collaboration between DHBs.

The changes to the New Zealand Public Health and Disability Act (introduced by the Government through the New Zealand Public Health and Disability Amendment Bill that is now being considered by the Health Select Committee) are an attempt to redress that balance by giving the Minister of Health power to compel collaboration and force economies of scale.

The ASMS Submission

Like many other organisations the Association was broadly supportive of the proposed changes to the Act. As well as making a written submission, Vice President Dr David Jones and Assistant Executive Director, Angela Belich, gave an oral submission to the Health Select Committee broadly supporting the direction but suggesting that an opportunity was being missed for specifying the role of clinicians and clinical engagement in the legislation.

"ASMS submitted that clinician consultation needs to be a statutory requirement for annual plans"

One of our concerns was that the proposed legislation took away some rights of public consultation and weakened MECA consultation provisions by taking decisions away from the employer.

The Association has negotiated (in our MECA) requirements for the following:

- consultation on the parameters of reviews that affect the delivery or quality of clinical services
- participation in reviews that would affect senior doctors
- a fail safe mechanism so that serious clinical or professional concerns that may arise out of changes are resolved using an agreed process.

This means that, when DHBs propose changes, they are legally required to have input from their most senior clinicians.

Where the legislation proposes that the power to make these changes moves from the DHB to the Minister of Health, we said that there should be a parallel legal requirement for consultation with the appropriate clinical network (if it exists) or the appropriate clinicians if it does not

Objectives and functions

We welcomed the addition of the new statutory objective requiring DHBs to 'seek the optimum arrangement for the most effective and efficient delivery of services in order to meet local, regional and national needs' and the new statutory function requiring DHBs 'to collaborate with relevant organisations to plan and coordinate at local, regional and national levels for the most effective and efficient delivery of health services'.

The best health services for all New Zealanders should be the concern of the public health service without the distortion of parochialism. How this is to be obtained may, nevertheless be an issue of debate and this debate must include clinicians (nurses, doctors and other health professionals) because they have the knowledge and expertise and enjoy the trust of New Zealanders.

Plans and Ministerial Direction

Instead of requiring a DHB to produce a district strategic plan and a district annual plan the Bill would require the Minister

WHAT ARE THE CHANGES?

The amendments cover

- changes to the objectives and functions of DHBs to require consideration of what is optimal not just for their district but regionally and nationally
- changes to DHB plans and planning processes,
- provision for ministerial direction of procurement
- provision for ministerial direction to all DHBs
- provision for the Minister to deal with disputes between DHBs or between the Minister and DHBs on a plan
- establishment of the new Health Quality and Safety Commission
- regulation on disputes between publicly owned health and disability organisations to be issued without requiring the consent of the parties
- allowance for elected members of DHBs to be appointed to other Boards and a requirement for Ministerial consent to Board committees

to direct DHBs to prepare a plan each financial year and allows the Minister to direct DHBs to produce other plans. DHBs must have annual plans but they need not be simply for a single district. The Minister, by regulation may specify the form of the plan and the procedures to be followed. This may (or may not) include a requirement for consultation.

ASMS submitted that clinician consultation needs to be a statutory requirement for annual plans and that advisory committees set up to adjudicate disputes over a plan between DHBs should be either clinically led or be required to demonstrate engagement with the appropriate clinicians..

Procurement

The Bill will allow a proposal from the Director–General, or any other person or body approved by the Minister, on how administrative support and procurement services should be obtained to be submitted to the Minister. If the Minister then has reason to believe such a proposal would enhance the effective and efficient operation of the system then the Minister can direct DHBs as to how the services will be obtained and who by. He/she must first decide that direction is necessary and must also consult with DHBs affected by the proposal and anyone else that he/she considers it appropriate to consult.

The amendment defines administrative, support and procurement services as services that do not relate directly to but are necessary for the provision of care to patients. Specific services are listed including human resources and payroll, financial services information systems, clerical services and the procurement of both clinical and non-clinical supplies but care has been taken to specify that the clause is not restricted by the fact that specific functions are mentioned. Essentially DHBs with the passage of this Bill appear to have lost autonomy for support services.

The intent may not have been to include diagnostic services such as laboratories or radiology in the ambit of 'administrative, support and procurement services'. However the wording could certainly be read to imply that these services are covered by this provision.

Diagnostic services are integral to a high quality public health system. If the intent is not to include diagnostic services they should be explicitly excluded from the definition. Even setting aside diagnostic services, administrative, support and procurement services often have clinical implications. At present should such implications exist, a DHB which is abiding by its industrial agreements, would be obliged to seek the advice of its senior clinicians.

We said that the Bill should require that any proposal made under this clause will need to be either clinically led or have demonstrated engagement with clinicians.

Health Quality and Safety Commission

The Association strongly supported the establishment of the Health Quality and Safety Commission (HQSC). We also welcome the appointment of the members of its interim board including Professor Alan Merry as chair. Our concern expressed in our submission on the Ministerial Reference Group report was the suggestion that the Commission be 'self funding'. Though this is not ruled out by its establishment as a crown entity, this does not presently appear to be the intent. Charging DHBs to improve quality will function either to cut funding available for services or allow DHBs to opt out of national systems for quality improvement. It could also risk the future viability of the Commission.

The Health Select Committee is due to make its report on the Bill to Parliament on 19th November this year. We will then see if the opportunity has been taken to make clinical engagement a legislative requirement or if it is to remain an optional extra.

Angela Belich
Assistant Executive Director

Jobs.asms.org.nz promoted in BMJ Careers

The ASMS endeavours to help fill senior doctor and dentist vacancies in New Zealand, especially DHBs, through the job vacancy page on our website. **jobs.asms.org.nz** is a one-stop-shop for those seeking positions in New Zealand as it has a comprehensive list of NZ vacancies and provides direct links to key employment information and agreements.

This month the ASMS commenced another year-long advertising campaign with BMJ Careers, the United Kingdom's principal publication for medical recruitment and careers advice. We will be advertising in both their print edition (delivered to 110,000 doctors) and their online careers site (www.bmjcareers.com). The latter alone will see ASMS job advertising reach 100,000 unique online users every month.

So that DHBs and other employers can take full advantage of this advertising campaign we are offering one month's free advertising with any three-month listing on **jobs.asms.org.nz**.

The ASMS encourages members to recommend to their DHB or employer that they seriously consider using **jobs.asms.org.nz** when advertising SMO vancies. Employers can get information about our advertising rates and volume discounts from our website or by contacting **admin@asms.org.nz.**

Driven to distraction

New drug-driving laws mean that doctors have to be extra careful when prescribing. MPS medico-legal consultant Dr Brendon Gray explains the new rules and what they mean for medics

The Land Transport Amendment Act 2009 came into effect on 1 November 2009, creating a new offence of "driving while impaired with evidence in the bloodstream of a qualifying drug". This new law has significance for doctors and pharmacists because a qualifying drug includes "prescription medicines". While the new law doesn't change obligations that doctors have when they prescribe drugs to patients that may impair their ability to drive, it will likely bring existing obligations firmly under the spotlight.

The offence

There are two elements to the new offence: driving while impaired, and evidence in the bloodstream of a qualifying drug. Where a police officer has "good cause to suspect" that a driver has consumed a drug, the officer may require the driver to undergo a compulsory impairment test. If the driver fails the impairment test, the officer may forbid the person to drive and require the driver to supply a blood sample.

The compulsory test includes:

- An eye assessment – pupil size, reaction to light, lack of convergence, nystagmus
- A walk and turn assessment
- A one-leg-stand assessment.

Police can require a person who is in a hospital or a doctor's surgery because of injuries in a motor vehicle accident to provide a blood sample for testing. This is consistent with the law for drink-driving.

A qualifying drug includes a controlled drug that is classified under the Misuse of Drugs Act 1975, benzodiazepines, or a prescription medicine covered by the Medicines Regulations 1984. It is not yet clear which drugs police will test for, but opiates and benzodiazepines are a possibility, in addition to cannabis and other drugs of abuse commonly used "on the street".

Penalties

The penalties for drug-impaired driving are aligned with the penalties for drink-driving. For example, drug-impaired driving that causes no injuries can lead to three months in prison or a fine of up to $4,500, and disqualification from driving for at least six months.

Defences

It is a defence to a charge of drug-impaired driving to show that the relevant qualifying drug was consumed in accordance with a current and valid prescription written for that person by a health practitioner, and any instructions from a health practitioner or from the manufacturer of the qualifying drug. Alternatively, it is a defence if the drug was administered by a health practitioner, provided that the person complied with the instructions (if any) that the health practitioner has given.

What does it mean for doctors?

The Ministry of Transport advises that the new law does not impose any additional obligation on doctors or pharmacists.

Current obligations arise from a number of sources. Chapter 11 of *Medical Aspects of Fitness to Drive; a Guide for Medical Practitioners* states that medical practitioners should check the *British National Formulary* and/or the *New Ethicals Catalogue* to determine if any prescribed medication may impair the ability to drive safely. MPS considers MIMs would also be a suitable source of information. Where safe driving may be impaired, patients should be warned. Common medications and substances of abuse that may impair driving are listed at Chapter 11.1.

Doctors also have an obligation under s18 of the Land Transport Act 1998. That section requires doctors to inform the New Zealand Transport Agency of any individual who poses a danger to public safety by continuing to drive when advised not to.

Doctors' obligations to patients who drive while impaired have come under scrutiny previously. For example, the Health & Disability Commissioner (HDC) investigated a case where a patient on a methadone programme continued to drive while abusing other drugs and subsequently killed another road user in a motor vehicle crash.[1] The Commissioner expressed concern about the drug service's failure to appreciate and respond to the risk that the patient would drive while intoxicated.

While there may be no new obligation on doctors, existing obligations may very well come under increased scrutiny, particularly if a defence of taking the drug in accordance with a doctor's instructions is raised. Furthermore, aggrieved drug-impaired drivers may very well complain that they were not adequately warned of the possibility of impairment by their doctor after a charge is brought.

Conclusion

In order to avoid problems, doctors must ensure that they advise their patients if a prescribed medication may impair the ability to drive safely and record that this advice has been given in the clinical notes. As the HDC has noted, it is through the medical record that doctors have the power to produce definitive proof that a patient has been specifically informed of a particular risk.[2] This is particularly important when one considers that there is evidence to suggest that patient adherence to driving recommendations is low.[3] You just never know when you might need to rely on your clinical notes.

References

1. A District Health Board (29 March 2006), Health & Disability Commissioner 05HDC09043 2. bid, p.18. 3. Maas R, Ventura R, Kretschmar, Aydin A, et al Syncope, Driving Recommendations, and Clinical Reality: Survey of Patients, BMJ 2003; 326:21

This article was originally published in the Medical Protection Society's May issue of Casebook http://www.medicalprotection.org/newzealand/casebook-may-2010/driven-to-distraction

Punitive unfair changes proposed to the Employment Relations Act

The ASMS has taken two important decisions on the changes proposed by the Government to the Employment Relations Act.

First, at its September meeting, the National Executive decided to make a donation of $3,500 (roughly $1 per member) to support the Council of Trade Unions campaign against the Bill. This campaign is largely educational but includes a 'national day of action' on 20 October.

Second, the ASMS has made a submission to the Transport and Industrial Relations Select Committee outlining our main concerns about the Bill. We did not comment on all the changes in the Bill but focused on those issues which are likely to have a particular impact on our membership and consequently on New Zealand's health system which is acknowledged by all political parties to be facing a medical workforce crisis. As an affiliate of the CTU we also supported in principle its far more detailed submission.

Introduction of right of unfair dismissal (90 day trial period) to all employers

When they were first elected the government introduced a 90-day trial period for small employers. This Bill proposes the extension of this trial period to all employers. The provision first has to be agreed between the employer and employee and then, for the first 90 days of employment, an employer is able to dismiss an employee without giving a reason. This should not be confused with probation periods which in some situations might be justified. Even employees employed on probation should be entitled to basic protection against unfair dismissal and the right of an employer to dismiss without good cause.

New Zealand has the highest proportion of international medical graduates (IMGs) in the OECD. At least 40% of doctors who are registered in New Zealand gained their initial medical qualification overseas. This means that a doctor looking at job offers is very like to be entirely unfamiliar with New Zealand law and employment practice.

A very high proportion of doctors looking to take up an appointment at a New Zealand hospital will be looking at moving themselves and their family to the other side of the world. The ASMS advises many of the senior doctors looking at job offers from New Zealand DHBs. Any suggestion that, without cause, doctors can be dismissed will be extremely detrimental to recruitment.

Given the current workforce crisis DHBs may not attempt initially to incorporate these clauses in their offers to new doctors. However it may be tempting for some to give the doctor a 'trial period' or extend a policy originally intended for other staff to medical staff. The more likely scenario is for this provision, if passed, to apply initially in our smaller employers (those with more than 20 employees but only a few doctors).

The ASMS has been involved in several situations where a doctor employed by a community organisation has faced dismissal because they were attempting to adhere to appropriate medical standards in situations where employers were reluctant to do so.

The public is entitled to rely on medical professionals to speak out on issues of professional concern and patient safety. This right is protected in many of the collective agreements the ASMS negotiates and some employers have resisted these provisions in both individual and collective agreements.

At present employers would be most reluctant to dismiss a doctor while citing as a reason that the doctor had spoken out on issues of patient safety. If the employer is not required to give a reason, they need have no such qualms. A newly appointed doctor who raises such issues of unsafe practice could, if this legislation passes, face instant dismissal with no reason given.

Unfortunately even our largest health employers, DHBs, which are almost invariably the largest employer in the city or town where their main public hospital is based, have mixed performance records as good and bad employers. This 90 day trial period has the effect of rewarding bad and inadequate employment practices right at the time the doctor or dentist is most vulnerable.

Removal of reinstatement as a primary remedy in a dismissal

The ASMS handles very few dismissals and has taken few personal grievances relating to dismissals. However, senior doctors have been dismissed and some of those dismissals have been found to be unjustified.

Reinstatement for senior doctors is often the only useful remedy. Our members often have such specialised skills that there is only one possible employer in the town or city. A successful dismissal will frequently end the doctor's career.

If "reinstatement" loses its primacy as a remedy, it becomes even less likely that reinstatement would ever be achieved in a successful senior medical officer dismissal case.

The ASMS believes the current regime for personal grievances works well for both parties. The principle barrier for our members has been the extremely low level of remedies which (if reinstatement is not a realistic option) makes the process hardly worthwhile. Levels of remedies (in contrast to penalties) are not addressed in the Bill.

Justification test

The Bill amends the test of "justification" for any action of an employer, for example a dismissal, from the current objective test

(was the action one that a fair employer, acting reasonably, *would* have taken?) to a subjective one (was the action *within the range of* actions open to a fair employer, acting reasonably?).

This change will make it virtually impossible for the ASMS to ever win a personal grievance where the member's clinical practice has been brought into question even if that practice is able to be improved or even if there are differing clinical views about that practice.

Even if the view is taken that this is a desirable outcome (doctors can neither make mistakes nor improve) then doctors who are disciplined by an employer on issues other than their clinical practice face a much more difficult path to remaining at work in this country.

Fair and reasonable process

This amendment purports to raise the bar to ensure that a personal grievance over an employer's unjustified actions will focus on the substance of the employee's behaviour and the reasonableness of the employer's decision as opposed to the employer's processes in arriving at the decision to dismiss or warn. Any defects in process that were "minor or technical and did not result in the probability that the employee was treated unfairly" will not solely determine whether a dismissal or an action was unjustifiable.

"Even employees employed on probation should be entitled to basic protection against unfair dismissal and the right of an employer to dismiss without good cause."

Employers sometimes talk as if the whole process of disciplining or dismissing an employee is impossibly difficult. It is not. Procedural issues simply reflect the principles of natural justice for example; that facts should be ascertained; that you should be told what you did wrong; have the opportunity to explain; the opportunity to take advice; a reasonable chance to rectify performance and that the employer has genuinely listened to explanations.

There are also dangers in the focus on the overall outcome of the process. If someone doesn't know what they have done wrong and/or has no opportunity to take advice and/or is given no chance to explain then it is impossible to tell if the outcome was reasonable or not.

We are also concerned to the extent that an employer's resources are to be taken into account when investigating a clinical concern. An employer, it doesn't matter how small, who employs a doctor must, if investigating clinical concerns, use appropriate clinical expertise.

Access to the Workplace

This provision requires a union representative to seek the employer's consent before entering the workplace and provides that such consent may not be unreasonably withheld.

Almost invariably the ASMS has no issues with entry to workplaces. However during our stopwork meetings in 2007 some DHB human resource managers did covertly raise the issues about affecting our access. This serves to illustrate that, during times when the relationships between unions and employers is fraught, employers can be tempted to use any powers that they have to obstruct the union.

It is worthwhile thinking about what would have happened if the DHBs had had the ability (for instance) to refuse access to officials for two days. Considerable damage would have occurred to relationships between senior doctors and DHBs.

Part of the function of industrial law is to protect employers from themselves. To protect them from the temptation of damaging the long term benefits of preserving good relations with their employees (and their unions) in the interests of short term advantage.

The Select Committee is expected to report back to Parliament shortly. It is hoped that their report will suggest to the government that they rethink the thrust of this unnecessary and unfair legislation.

Angela Belich
Assistant Executive Director

ASMS Members at ACC go collective

The ACC employs approximately 58 Medical Advisors across the country and many have been ASMS members through their work at ACC and/or DHBs. Little wonder then that they are keen to move off their Individual Employment Agreements and onto a Collective. After a successful (and ongoing) recruitment campaign and good member interest a claim has been developed and bargaining started in late July.

The ACC reneged last year on a previous agreement to peg salaries to DHB MECA levels and along with regaining this the main claims are those to bring conditions closer to those of DHB colleagues.

Unfortunately, as foretold by some, negotiations have immediately become difficult and mediation has been arranged in order to move the ACC from a strongly held view that current conditions are sufficient.

It is possible we have members at ACC who we do not know are members. If you are an ASMS member working at ACC you should have received communications relating to the bargaining. If you have not please contact Lloyd Woods (lw@asms.org.nz to make contact.

Lloyd Woods
Industrial Officer

We make sure you're well covered.

Our priority is to ensure our Members have the right insurance cover.

Because MAS is made up of Members who are professionals like you, we understand your insurance needs. It's our priority to help Members get the right cover – from car and boat insurance to house and contents.

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