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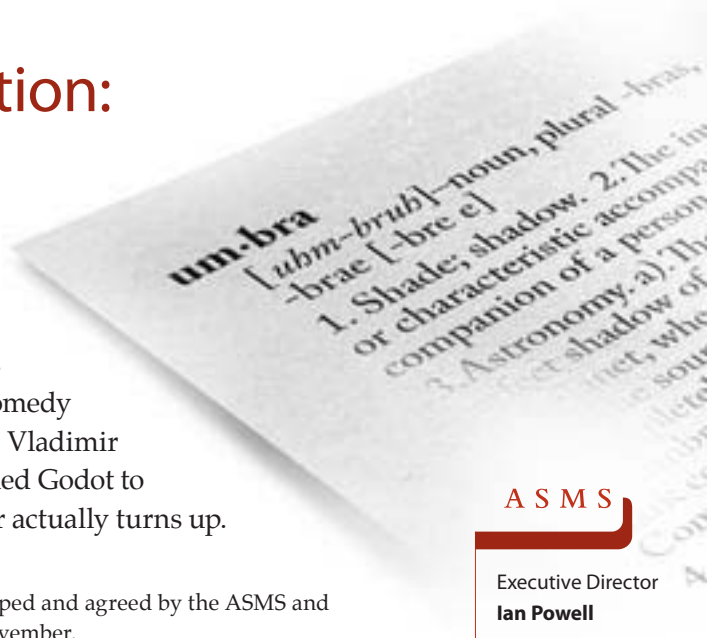
The Specialist

The newsletter of the Association of Salaried Medical Specialists

Negotiating with an apparition: cross-over from Godot to Casper or 'Ghostly Trio'



One of my sometimes over-used throwaway lines when frustrated by procrastination and delays is to retort that it is like 'waiting for Godot', borrowed from the French tragic-comedy play (1953) by Samuel Beckett. It centres on two individuals, Vladimir and Estragon, who wait endlessly for a mysterious chap called Godot to arrive although they seem to barely know him and he never actually turns up.

Godot does have some metaphoric appropriateness to the decision-making processes of DHBs in terms of delivery but also often, despite thinking we know their processes, discovering we know so little about them.

Godot and umbra

'Waiting for Godot' does resonate somewhat with the experience of our continuing MECA negotiations. But perhaps *umbra*, which the DHBs have exhibited signs of in our negotiations, resonates more. This noun involves a shadowy apparition or ghost-like image of someone or something not physically present.

The repeated experience of the ASMS negotiating team in this protracted process is to find that the people we think we are negotiating with are not actually the people we are negotiating with. We think we have reached understandings and agreements with DHB representatives only to discover subsequently that behind this layer is another with a different view. This peeling onion does not always conform to formal structures. In short, we find ourselves negotiating with an apparition. Further, each apparition dumps on the previous one; there's very little ghostly solidarity.

Not getting 'distributive clinical leadership'

Underpinning this state of affairs is that the DHBs really struggle to coordinate nationally in an effective manner and within their hierarchy there are several differing elements. Further, the ethos of 'distributive clinical leadership' is something that some DHB elements simply don't get (or don't like) even though it is the basis of *Securing a Sustainable Medical and Dental Workforce in New Zealand: the Business Case* that was jointly developed and agreed by the ASMS and DHBs last November.

With the Minister of Health frequently hammering DHBs over 'no more money' those that don't comprehend or agree with 'distributive clinical leadership' are hardly going to be enamoured by the *Business Case,* which is not about 'more money' but instead premised on the potential to improve cost effectiveness and make savings, exactly what the government claims it wants.

> *The repeated experience of the ASMS negotiating team in this protracted process is to find that the people we think we are negotiating with are not actually the people we are negotiating with.*

Perspective is required, however. Things have not yet deteriorated to the acrimonious level of our last MECA negotiations in 2006-08 when we were dealing with inexplicable macho mania, attempts to claw-back on existing conditions and rights (and to impose a managerialism agenda on senior doctors). Unless things continue to deteriorate since the unexpected behaviour of the DHBs in mid-April (which increased in intensity and vitriol in early September), hopefully we won't reach this state of affairs in which stopwork meetings and ballots on industrial action are being considered, as they were in the last negotiations.

Apparitions can be local too

Dealing with apparitions is not restricted to national DHB processes. A few years ago staff employed by the

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three Auckland DHBs had thrust upon them a document called the 'alignment protocol'. It was a genuine attempt to provide consistency and transparency in the terms of employment of the staff in Waitemata, Auckland and Counties Manukau. While laudable and much of it reasonable, its contents did include some errors. It caused some confusion over its relationship with the MECA and was also inappropriately used to delay job sizing reviews. Nevertheless it seemed to have an official status (except where it was inconsistent with collective agreements).

Now it appears we have a state of umbra with this protocol and those that developed it having become an apparition. It was blown apart by Waitemata Board Chair Lester Levy promoting highly controversial inequitable non-transparent private sector-like payments to a small number of specialists doing lists at Waitakere Hospital. This has proven to be very divisive in Waitemata and would become highly corrosive if it were to continue and was to spread further (as is now proposed for the new 'elective services centre' intended for North Shore Hospital). It completely contradicts and undermines the objectives and principles of the alignment protocol.

…those that don't comprehend or agree with 'distributive clinical leadership' are hardly going to be enamoured by the Business Case

Aside from the inequity and divisiveness, the issue here is who speaks for the three DHBs. Is it the representatives of the three DHBs who announced and endeavoured to implement the protocol in good faith? Were they an apparition? Is it Lester Levy who now chairs two of the three DHBs (also Auckland) whose decision disregards the policy? Will he be an apparition as well once his two terms end? Or will it be another short-term decision based on a fad that leaves behind it longer-term negative consequences and legacies?

This is the murkiness and muckiness that senior medical staff in the Auckland region and ASMS has to deal with. Can we take what they say at face value? Are the people representing DHBs at any given moment real or ghost-like images not physically present?

Does Casper or the 'Ghostly Trio' run our DHBs

Perhaps we should call our senior DHB leaders Casper? Or, rather than this 'friendly ghost', are his unpleasant rivals, the 'Ghostly Trio' of Fatso, Fusso and Lazo more appropriate (let's not be too precise on the number three). In our previous MECA negotiations (2006-08) it seemed like we were negotiating with the 'Ghostly Trio'; this time it seemed like it was with Casper; but recent increasingly toxic behaviour and the odd 'dirty trick' suggests the 'Ghostly Trio' are back and Casper sidelined.

If my recollection of the 'graphic novel' is correct our DHBs have Casper-like elements. The apparition that the ASMS has to deal with usually appears in the form of well meaning people. This highlights the challenge of negotiating with a cross-over drama of Godot and Casper. The DHBs want to settle the MECA with us and want to see the *Business Case* implemented.

The DHBs must try to cross-over from umbra to substance and Health Minister Tony Ryall needs to help them.

But they are struggling because of their lack of acumen regarding how to make this happen. They lack sufficient confidence in distributive clinical leadership (or are threatened by it). The ASMS's challenge is to encourage them to achieve the necessary confidence to believe in it and their own rhetoric. We can't do it on our own, however. The DHBs must try to cross-over from umbra to substance and Health Minister Tony Ryall needs to help them. We seek to put Vladimir and Estragon in a better space and to ensure the Casper and the dastardly 'Ghostly Trio' are removed from DHB leadership and returned to comic strips.

Ian Powell
Executive Director

Why DHBs and the Government can't afford to dither

The *Business Case* records a series of facts which reinforce Mr Ryall's assessment last year that New Zealand has a hospital specialist workforce crisis and that addressing it is his top priority. In summary:

- New Zealand was short of well over 600 specialists in 2008.
- According to international benchmarks, out of 26 specialties (and sub-specialties) where data is collected, 19 require workforce increases of more than 20% to meet the recommended specialist-to-population ratios (eight of which require increases of more than 50% and four require increases of at least 100%).
- New Zealand has the second highest emigration of doctors in the OECD.
- As a result of attempting to fill this gap, New Zealand also has the highest dependency on overseas trained specialists in the OECD (41% of the medical workforce; same percentage for all doctors).
- New Zealand has, in effect, become a medical training ground for other countries, especially Australia which each year attracts an estimated 280 New Zealand doctors (including international medical graduates).
- Retention rates of international medical graduates (IMGs) are poorer than New Zealand trained specialists.
- According to the OECD a sudden change in international migration flows, which could result from policy changes in OECD countries beyond the control of New Zealand authorities, could have a dramatic impact on New Zealand.
- The OECD conservatively estimates 29% of New Zealand trained doctors are working overseas.
- Remuneration is becoming an increasingly important "push" and "pull" factor.
- Specialists lack adequate time to enable quality supervision of resident medical officers. The requirements of service delivery too frequently take precedence over RMO training.
- Specialist staffing levels are an important factor contributing to potentially preventable adverse events (estimated to have cost $590 million in 2002).

PRESIDENT'S COLUMN

From Rhetoric to the Road

As the pressure goes on to medics and ministers to demonstrate outcomes that are more than outputs, the hype and hoopla begin to beg tangible turnarounds. The reformation is now being asked if it is truly touching those most in need. Whether it has gone far enough. Whether it has bypassed an underclass. Whether it has side-lined some professionals for the benefit of others.

As the rhetoric translates into rubber hitting the road, are we more together or more apart? Have we forsaken tribal behaviour in our flotilla of fiefdoms that make up the New Zealand health system?

Tribes are strongly protective inventions of humanity. They serve to look after their members in the face of threat and against the dangers of otherness. They have evolutionary imperative and advantage to our existence. They develop their own whakapapa to explain and strengthen their importance. Especially when under real or perceived stress.

Professions, specialties, generalists, partialists, Colleges, craft groups, consortia, patient support groups, age-specific lobbyists, collaborations of chiefs and CEOs, councils, associations, societies, networks, reference groups, alliances, boards, departments, divisions, directorates, ministries, MSOs, PSOs, PHOs, RTHs, TLAs, FLAs.

All tribes. All well meaning. All believing. All eager. All imploring.

Walk their way.

Sometimes their path appears to be religious fervour. An attempt to convert outsiders to their doctrine. Hospital specialists telling general practitioners which protocol to use. Telling them which referral form to fill in. Or else the patient will not be seen until the right information is in the right box. General practitioners telling hospital specialists that if only there was direct access to radiology, all would be well. That if there were no niggling special authorities, fewer would need to clutter the clinics. In these crusades one is portrayed as either for, or against. And agnostics will have no place in the nirvana of the new way.

Sometimes their path appears to curry political favour. The flavour of the month, year, or election cycle. To tap into the dollars slushing around and divert them to the just cause. With much gaming of contracts, alliances, inclusions and exclusions. NGOs forming and reforming, DHBs sharing and caring, Colleges training and restraining. Ribbons cut while budgets slashed. And crabs will still refuse to walk forwards.

Sometimes their path appears to seek social status. Find a position to show off to the new found friends. A title within a committee, organisation, board, network that might confer a semblance of power. A chance to share a drink with another acronym, to be seen on the arm of another mover and shaker. To know the goss before the next reshuffle. And avoid the lonely landmines of the solo climber.

Which tribe will we join? Which path will we walk? How will we measure our success? What will become our whakapapa?

Will our walking together be a religious pilgrimage?

A political march?

A social promenade?

Or can we become one tribe, sharing one walk, down one path? Unite the patchy togetherness, the occasional bursts of shared tribalism. The profusions of good intent, stymied by exigencies of pilgrimage, march and promenade.

The path does not even have to be known, to be there. If we believe our rhetoric, together, we can walk enough times, enough of us, to bring the road into existence.

One tribe. One vision.

Jeff Brown
National President

EXECUTIVE DIRECTOR'S COLUMN

Never let a good crisis go to waste

It was the former chief of President Obama's White House staff (currently Mayor of Chicago) who, in response to the global economic crisis in 2008, said "never let a good crisis go to waste". In other words, use it to justify other decisions that in other circumstances you might not have been confident to make.

In his numerous speeches the Minister of Health makes the following international comparisons to justify the government's economic and spending policies. These are:

- In Britain, many public servants, including doctors and nurses, are facing a two-year wage-freeze. There are large-scale savings planned within the National Health Service totalling GBP 20 billion. It is estimated 50,000 NHS staff will be made redundant over the next few years.
- In Ireland, the former Health Minister was pelted with red paint by protesters as tempers grew over her Government slashing 5% off the health budget. The Irish had already cut public service salaries by up to 15%, including doctors, nurses and teachers.
- In Canada, the provincial health authorities are now taking tough measures to curb health costs. Some of these include introducing means testing, halving generic drug prices, and controls on the salaries of top hospital executives and doctors.

But perspective is required

However, some facts and context are required for perspective. Recently I had the opportunity to visit Rand Europe which has an attachment with Cambridge University. Although the US-based Rand Corporation (parent of its European child) is more known for the largest part of its work, defensive security, it has since the 1960s also been interested in health policy.

Rand Europe was commissioned by the United Kingdom's Department of Health to investigate how European governments had approached their health systems in response to the global economic crisis. I was fortunate to access a draft of the report and had the opportunity to discuss it with its author.

The two main factors used to assess the state of a country's economy immediately prior to being hit by the full impact of the global recession in late 2008 were unemployment and government debt. At that time, just before the last election, New Zealand was placed among the best performing European economies (such as Germany and Holland) at the time – the lowest unemployment rate in the OECD and running government surpluses rather than debt. Talking to Rand Europe and other health experts it is clear that most developed western European countries would have been envious of New Zealand's position in 2008.

Talking to Rand Europe and other health experts it is clear that most developed western European countries would have been envious of New Zealand's position in 2008.

In contrast Britain's deficit was 6.9% at the same time. Further, much of the government's health policy has been driven by ideology rather than response to the recession as it ineptly struggles to implement a poorly constructed endeavour to privatise the NHS.

Ireland is not part of the study but it is hardly a secret that, along with Greece and arguably also Spain, Portugal and Italy, is among the worst of the western European economic basket cases with its 'Celtic tiger' economy based on rampant property speculation collapsing.

Canada obviously was not part of the study but its economic performance at the time of the recession hitting was poor compared with New Zealand's. Unemployment was as high as 6.1% (a little below what New Zealand has subsequently increased to) and net government debt as a percentage of GDP was 22%.

Investing in health is investing in economic performance

Consequently the Minister's constant references to these three examples veer on the disingenuous side of the continuum. Britain (aided by an ideological binge), Ireland and Canada are doing what they are doing in health because their economies were performing poorly compared with New Zealand when the recession arrived. New Zealand was much better placed to handle it although we seem to have handled it weakly compared with Germany for example.

For a range of reasons investing in health is investing in economic performance. This should be the objective, not using countries in a much more parlous state to justify positions.

Now, investing in the senior doctor workforce in DHBs in order to improve quality and accessibility of services for patients, improve cost effectiveness, reduce wastage and make longer-term sustainable financial savings by ensuring the implementation of the *Business Case* jointly developed by the ASMS and DHBs; that would really be doing something to avoid wasting the opportunity and challenges we face with the current specialist workforce crisis.

Ian Powell
Executive Director

Strategic direction for MECA negotiations

At its meeting on 23 June the National Executive reconsidered its strategic direction in our national DHB MECA negotiations which, after a promising period of several months, had turned badly to custard since late April, although there were cautious indications of improvement in an informal meeting with DHB representatives in mid-June.

In June the National Executive considered three broad options for the ASMS's future direction in negotiations.

1. Accept the DHBs' then offer to us or some minor variation to it. In summary this was a 1.7% salary increase plus further new working groups. In effect, this would mean the abandonment of the *Business Case* and, even more seriously, the high likelihood that joint collaboration between the ASMS and DHBs at least at a national level would be inconceivable for several years because of the circumstances that led to this abandonment. Having further working groups would have been untenable given that we had already done this through the joint workshops held mid-last year and the joint work undertaken to develop the *Business Case*.
2. Escalating to industrial action reasonably soon (August-September) commencing with national stopwork meetings. This was considered to be premature partly because of the tentative moves by the DHBs to engage again, partly because of the general anxiety and trauma associated with the Christchurch earthquakes, partly because of the need to continue to promote the importance and benefits of the *Business Case* to the health system, and partly because of the need to address the effects of misleading and erroneous statements by the DHBs over the cost of the *Business Case*.
3. Engaging with members over the importance of the *Business Case* being the blueprint for the future and why DHBs need to invest in their senior medical and dental workforce, through the MECA, as the necessary prerequisite to make it happen. If a settlement is not achieved by the time of the ASMS Annual Conference in November, this event would be an opportunity to reassess our direction including consideration of forms of industrial action.

The National Executive resolved unanimously to adopt the third option discussed above. This decision took into account external public relations advice we had and continue to receive. It has commenced with the start of a series of electronic 'Specialist Workforce Alerts' focussing on the risks and costs to the health system and patients of not using the *Business Case* as the blueprint and the benefits to the health system and patients (including financial) of investing in the senior medical workforce in order to deliver on this blueprint.

On 31 August the ASMS held a national meeting of our branch Presidents and Vice Presidents in Wellington unanimously adopted the following resolution:

The ASMS Branch Presidents and Vice Presidents call on the DHBs to negotiate the MECA settlement based on the Business Case already agreed between the two parties.

This resolution was reaffirmed by the National Executive the following day. The most recent developments have been an informal meeting with DHBs on 30 August and a subsequent agreement to resume negotiations on 30 September.

Ian Powell
Executive Director

HOHP Health of the Health Professional Conference 2011

Surviving and Thriving in the Health Workforce

This major international event, being held in Auckland on 3–5 November, focuses on bringing together employers, staff and unions across the health and caring professions to raise awareness and advance the state of knowledge about issues that affect the health of health workers.

The conference is being coordinated by a team of senior health sector experts led by Dr Peter Huggard, Director of The Goodfellow Unit and Dr Patrick Alley Director of Clinical Training at Waitemata DHB. The conference is being jointly hosted by the Goodfellow Unit at The University of Auckland, and the Australasian Doctors' Health Network.

Who should participate

We invite participation from doctors, specialists, nurses, medical students, allied health professionals, researchers, health sector employers, unions and government officials.

The three day programme will include professional streams with plenty of opportunities for networking and shared insights. More information is available at www.hohp.org.nz.

Keynote speakers include:

Prof Neill Piland – The Economic Impact of Ill Health in the Healthcare Workforce;

Dr Lester Levy – Dysfunctional workplaces;

Prof Erica Franks – Why should we be healthy?

Dr Jane Lemaire & Prof Jean Wallace – Physician Wellness: A missing quality indicator

Conference themes include:

Building resilience, coping strategies, re-energising using holistic approaches; caring for your colleagues; practical advice on career transitions and flexible ways of working.

Summary information

Dates: Thurs 3 Nov – Sat 5 Nov 2011

Venue: The Langham Hotel, Auckland

Website: www.hohp.org.nzw

The smokescreen of the unaffordability of the *Business Case*

Some inaccurate assertions by DHB representatives, clearly unfamiliar with its contents or choosing to disregard them, have said that the blueprint document *Securing a Sustainable Medical and Dental Workforce in New Zealand: the Business Case* jointly developed by the ASMS and the DHBs is unaffordable.

The *Business Case* states that in order to be able to recruit and retain a senior medical/dental workforce in DHBs to deliver the quality improvement, enhanced cost effectiveness, savings, and reduction of duplication and wastage, an annual investment of $200 million needs to be made in the MECA settlement. However, getting to this level would be phased in over the first three years (this phasing is where the sometimes referred to figure of $360 million comes from; if there was no phasing the total cost over the first three years would be $600 million).

The critical point is that by the end of this three year period the cost would be only 2% of current DHB funding levels (2010-11) for addressing what the Minister of Health has recognised as his top priority.

Further and more important, this relatively small investment in the senior medical workforce capacity can over time generate savings which exceed this investment through improved cost effectiveness and reduction of wastage. Both the DHBs and ASMS reached this conclusion last November when we agreed on the *Business Case*. It is false to argue that investing in the *Business Case* is unaffordable because it is such a small proportion of total DHB funding which would be offset by the financial gains.

With the right investment in more effective specialist recruitment and retention 'big ticket' financial returns can be made such as a reduction in adverse events (the Government's Ministerial Review Group in 2009 assessed potential annual savings of $800 million). This investment should mean that a high level of savings will be possible over time, predicated on preventing harm currently occurring in public hospitals.

Another 'big ticket' area is properly resourced specialist-led services. Taking the lead from the 'Canterbury initiative' prior to the earthquakes, when Canterbury's specialist workforce was stronger relative to other DHBs, the *Business Case* specialist-led initiatives could result in savings of $300 million per annum.

Further, in respect of hospital beds, it notes that if all public hospitals were able to meet the current average length of stay, this would save 382 beds, effectively the costs of building an entire new hospital along with the associated ongoing capital charges and depreciation.

The *Business Case* also provides examples of smaller scale but cumulatively significant financial savings. As an example of wastage, DHBs spent in excess of $6 million on specialist recruitment and relocation during the 2009-10 financial year. By improving retention this level of annual expenditure can be significantly reduced. Further, DHBs spent in excess of $50 million on senior medical/dental officer locum costs, mainly to cover vacancies. With a fully staffed specialist workforce, locum expenditure could be significantly reduced by up to 50%.

The benefits for patients and for the financial sustainability of DHBs provided in the blueprint that is *Securing a Sustainable Senior Medical and Dental Workforce in New Zealand: the Business Case* are immense and far outweigh the cost of the investment in the senior medical and dental workforce necessary to achieve it. The challenge is whether our DHB and political leadership have the insight and awareness to make it happen.

Health Benefits Limited: don't be fooled by the name

Health Benefits Limited (HBL) is an organisation whose activities are causing the ASMS (and several DHBs) concern.

The new shared services agency: Pharmac for services

In 2010 the new National government started to put in place the changes to the public health system that had been mooted in the Ministerial Reference Group (MRG or Horn) report. Essentially the MRG report proposed greater centralisation, co-ordination and collaboration through which the hope was the public health system could both improve the quality of health care and make savings.

The MRG group proposed to achieve this through clinical leadership and a number of new national entities: a national health board (now part of and roughly half of the Ministry of Health), a quality and safety organisation (now a separate crown entity, the Health Quality & Safety Commission), and a national shared services agency which was to be like a Pharmac for services.

Under the radar

The shell of Health Benefits Limited (see the box opposite for the structure and personnel) was adapted to become the new national shared services agency and do this work in the same way that had been initially suggested for the National Health Board. They took the name of the crown entity that was responsible for primary care funding that had become a shell with the advance of capitation and its devolution to DHBs.

Like the new Health Quality & Safety Commission, HBL is separate from the Ministry of Health. It is a crown company (listed in schedule 4 of the Public Finance Act). It has its own board which reports directly to the Minister of Health (HBL also sits on the National Health Board).

The new shared services agency was set up with little fanfare to handle the rationalisation of so-called 'back office' functions of DHBs including procurement. Such 'rationalisation' might include regional consolidation, national consolidation and outsourcing (privatisation).

HBL's 'Statement of Intent' (SOI – a statutory annual document) makes it clear that though it regards individual DHBs as its customers '"where commercial considerations in support of the national interest outweigh individual DHB preference… HBL will request the Minister of Health to utilise his powers to direct."

These are new powers given to the Minister of Health under the amendments to the New Zealand Public Health and Disabilities Act amendments passed in July 2010 and allow him to direct DHBs under certain circumstances.

What does HBL do?

HBL has been required by the Minister of Health to make savings in DHBs of $700m (cumulative) over five years (over one year of which has already passed). In order to make these savings it will "make a quantum shift in the way management, administration and procurement support services are provided".

A few weeks ago it submitted a business case to government, the contents of which are unknown. This is causing DHBs to fear that HBL may impose simplistic decisions that may be impractical or risky for financial, functional or clinical reasons.

HBL's plans for the just completed 2010/2011 financial year were to:

- build its organisation including promulgating best practice
- create a clear road map leading to the development of business cases
- help DHBs to achieve the savings of $30 million that they had already committed to for the financial year

Perhaps the most interesting portion of the 2010/11 SOI, from ASMS members' point of view, is that in the last financial year

THE HBL ORGANISATIONAL STRUCTURE

Health Benefits Limited is a crown owned company created by statute and is covered by the Official Information Act. Shareholders are the Minister of Health (Tony Ryall) and the Minister of Finance (Bill English).

The Chair is Ted Van Arkel from Restaurant Brands (who run the Kentucky Fried Chicken chain) and Abano Healthcare. He is also a director on other boards.

The Vice-Chair is Lester Levy who is the Chair of both Waitemata DHB and Auckland DHB.

Directors are Tracey Adamson (Chief Executive Wairarapa DHB), Chris Fleming (Chief Executive South Canterbury DHB), Brent Esler, Paul Harper, Edie Moke and Paula Rebstock.

Chief Executive: Nigel Wilkinson (formerly of Waitemata DHB and the 'Health Alliance'; the shared service agency set up by the three Auckland DHBs). He is spoken of with approval by members who have worked with him at Waitemata DHB.

HBL is also now a 20% shareholder of 'Health Alliance' and is described by Nigel Wilkinson as also involved in the other three regional shared service agencies.

HBL and Pharmac were to consult with the Ministry of Health and report back to the Social Policy Cabinet Committee "a carefully sequenced path for Pharmac assuming the prioritisation of assessment, standardisation and procurement of medical devices by July 2012". This process will have already started and will gain traction in the current financial year. This process will impact on the work of many, if not all, ASMS members and will require a massive degree of clinical engagement if it is not to prove disastrous.

HBL's plan for 2011 to 2012 focuses on six support service areas across DHBs –

- **collective procurement:** we assume this means collective purchase of things like cars. It is possible to envisage that this process will have an impact on ASMS members or on the provision of clinical services but it is probably not the area of greatest concern;
- **the supply/chain/procurement process:** where this impacts on clinical services this will be of concern to ASMS members;
- **finance:** this appears to be about the accounting systems at DHBs and unless it impacts in some unforeseen way on the reimbursement of SMO expenses it doesn't on the face of it have a huge impact on ASMS members;
- **human resources, payroll and rostering:** it is hard to imagine an area in which ill thought out proposals could cause more damage. HBL has assured us that they were not contemplating a national payroll system but looking at where things are working well. Rumours may have started because suppliers had been actively touting for business;
- **services and facilities maintenance management:** enormous potential for damage exists in this area as well. HBL has come to the end of its stock take and will be putting out proposals shortly. It is hard to see evidence of real clinical engagement on this issue; and
- **information services:** HBL was now also working with the national IT Board. HBL was concerned with the non-clinical aspects of IT.

HBL, consultation and clinical engagement

HBL had issued a 'change management process' that is based only on the national process applying to some of the other health unions, does not mention ASMS and does not include processes which would allow for SMO engagement where changes might impact on clinical services but might not impact on staff (as required, by Clause 43.3 of our MECA). There was also no reference to the clinical engagement and leadership obligations under the Time for Quality agreement.

It was with these issues in mind that ASMS raised HBL as an issue at our National Consultation Committee (NCC), a national joint consultative committee with ASMS and DHBs set up under the ASMS DHB MECA). The DHB chief executives told us the omission of ASMS and SMOs was not a deliberate oversight but a misunderstanding on HBL's part and

Interview with Dr Dave Bowie

(Intensive Care and Anaesthesia, Christchurch Hospital)

How did you find out about HBL?

The Head of Biomedical Engineering at Canterbury DHB gave me a heads up that there was an HBL/CDHB meeting coming up. He gave me a brief rundown and asked if I would be willing to attend to represent clinicians' views of the essential and complex nature of biomedical engineering in a tertiary referral hospital.

What has HBL been doing at Canterbury DHB?

I understand that a consultant from HBL came to Christchurch to "inspect" the DHB systems looking for opportunities for outsourcing across a range of DHB services from food to "hotel" to engineering.

What was your experience with HBL?

I attended the HBL/CDHB meeting but the meeting was so scripted that I was unable to speak usefully for the clinicians other than by the fact that I thought that this was important enough to turn up. The consultant appeared to have some fairly well developed preconceived ideas of what happened in a hospital.

What do you think might happen with HBL?

The driving motivation appears to be cost saving using techniques which have been tried with varying degrees of success in other countries. The amount quoted is $600m which brings back to me memories of the 'Gibbs report' from the 1980s which arrived at a similar figure (not inflation adjusted). Our management had discovered a number of examples, especially from Australia, where outsourcing of what the HBL uninformedly calls "backroom " (ie non-essential) had been tried and failed, and lead to costly restorations.

I was particularly worried because my two departments Intensive Care and Anaesthesia depend very heavily on Biomedical Engineering to certify and maintain our hi tech equipment. Even in a so called light engineering hub like Christchurch there is not the depth of private providers who could offer such a service. The recent earthquake illustrated to us very graphically that without in house Engineers neither our buildings nor infrastructure would have remained functional during that crisis.

Do they seem to be seeking out clinical/SMO input?

I don't really know but they seemed surprised at my presence at the meeting which made me think not. I have canvassed a few colleagues and no one had heard of HBL and, like some others apparently, when asked thought it must be something to do with welfare benefit payments.

Do you think the process being used by HBL will lead to privatisation?

Given the little I know of the proposals at least moderate scale privatisation can be the only possible outcome. Better co-ordination regarding purchasing of non-pharmaceuticals also seems likely which is generally laudable but, as shown in some of our DHB submissions, this is already happening in the South Island.

that the DHB Chief Executives have given HBL a strong message about the DHBs' responsibilities and desire to consult.

HBL's Chief Executive, Nigel Wilkinson, who briefly attended the meeting by teleconference, told us that HBL has not as yet developed an overarching clinical engagement model and has attempted to engage project by project. He said that HBL was hoping not to add to the engagement burden of clinicians and to tap into existing groups. HBL had asked for a lot of information and believed that they could see a lot of opportunities for savings but they would send out proposals and there would be an opportunity to say that proposals themselves were undesirable rather than to simply comment on the implementation of decisions in essence already made.

Privatisation

Worryingly the HBL 's communications manager has drawn a spurious distinction between 'privatising' and 'out sourcing' and said that while HBL would not 'privatise' it may 'out source'. SMOs who have been involved in discussion with HBL staffers have been worried because they were very naïve about the availability of some skills in the private sector. There are fears that their intent is massive privatisations of back room functions with the loss of scarce skills and a series of failed and costly experiments. Hopefully these fears are unfounded and SMOs will have the opportunity to scotch any silly proposals.

Where now with HBL?

ASMS will be meeting again with HBL. On the plus side members who know him at Waitemata DHB believe that Chief Executive, Nigel Wilkinson, has a good track record of consultation with SMOs. On the negative side even in the work streams that are far advanced (such as facilities management) it is hard to see any evidence of a clear process to engage clinicians especially on the issue of the purpose and scope of the exercise and the all important issue of the set of skills and experience necessary to conceptualise the issues accurately from a clinical point of view.

Angela Belich
Assistant Executive Director

Interview with an anonymous SMO

(The SMO interviewed requested to remain anonymous)

How did you find out about HBL?

I heard through my Chief Information Officer and Chief Executive and through one of the Health Ministry groups that they had been formed, and that they had plans to be involved with some work that we had underway.

What has HBL been doing at your DHB?

They came to visit our DHB for a day, and had meetings with payroll and a few other groups to discuss their plans. I see that some of these plans have now been scaled back, and in particular some of the plans for national hosting of some systems have been abandoned.

At least I hear this is the case, because it hasn't been communicated formally. This likely indicates that they have come to the realisation that there is not a bag of hidden gold out there at the end of the rainbow.

There are also regional approaches underway for IS and they had announced intentions to take over many of these regional approaches to make them national. They apparently did not realise that regional approaches were being acted on because these represented achievable 'bite sized chunks' that would then work together nationally, and that the big bang national approach had already been considered and thought to be too expensive and not really achievable.

On the surface this may sound attractive, but internationally this has not worked out, they had no idea of the scope of the work they had planned or how to fund it (other than by eventually realised savings).

The net result could have been paralysis of current activity, and would have been had we not decided to just carry on as usual in the understanding that they would not be able to deliver the next steps. Which they haven't yet.

What was your experience with HBL?

It was apparent that the plans they announced were very ambitious, the cost savings they thought they could achieve were totally unrealistic (in one case the reduction they wanted was equal to or greater than the whole budget), and the methods that they wanted to use to achieve them were themselves going to be costly to the point that the net result would be a massive cost increase.

I think that a line by one of their members summarised it best: "This is best left to those that know what they are doing don't you think?" My response was to totally agree, but to ask if they knew who that was.

There are regions that already have achieved some major savings in, for example, regional procurement, and it is very doubtful that there will be much if any additional savings by moving to a national procurement process (which inherently removes competition and promotes monopolies).

In another example they broke down the component parts of a process and then announced that savings could be achieved by reforming it thus, but neglected to add all the parts together. The omitted items could shift to the DHB directly - net effect the same but looked cheaper on paper.

What do you think might happen with HBL?

I expect that their role will be formally scaled back to a small number of items that may benefit from a national perspective, but at this time I am not sure that they have identified what they are. I think that they will also need a name change to reflect their role, which has nothing to do with health benefits. 'Health for Less?'

Do they seem to be seeking out clinical/SMO input?

Initially I thought so, but I believe that their purpose may be scaled back to items that are less clinically focussed, and I have not seen any SMO or clinical requests to support their decision making. Not sure they would know what to ask a clinician, especially if their minds are made up already.

Do you think the process being used by HBL will lead to privatisation?

Yes, but to a limited extent this is not a bad thing. For example, if there is a data centre that is required for payroll data or HR data on a national scale it would be best that this was managed by a company that is built around data storage and security, and I believe that the private sector could do this more cheaply and better than the public sector. In reality the DHBs may need to contract it out anyway. But this does not imply that the ownership of the overall system (e.g. payroll) should or could be privatised.

A public hospital for Queenstown 2026: *the answer is yes*

The expert panel set up by the National Health Board (Ministry of Health) to provide advice to the Southern DHB (formerly Otago and Southland) on planning for future health care services for the people of the Wakitipu Basin has reported with a series of recommendations that have vindicated the concerns of specialists at both Dunedin and Southland Hospitals, the doctors at Dunstan Hospital, the concerns of the Medical Officer of Health for the region, one of the GP practices in Queenstown and the doctors and nurses at Queenstown's Lakes District Hospital (LDH) itself.

The expert panel set up by the National Health Board (Ministry of Health) .... reported with a series of recommendations that have vindicated the concerns of specialists

The panel had been set up by the NHB officially at the request of the Southern DHB but, in reality because of chaotic consultation and planning by senior management of the Southern DHB and consequent loss of confidence in the DHB management by the local population. Disenchantment with Southern DHB management by the doctors and nurses at LDH and health professionals elsewhere in the DHB was a factor.

The background to the issue is set out fully in the *Health Dialogue* the ASMS published just before the NHB review started up (A Public Hospital for 2026: Queenstown available at www.asms.org.nz). The *Health Dialogue* is referred to on several occasions in the panel's report. The panel's report and recommendations are consistent with but more extensive than the *Health Dialogue*.

When the NHB review started the ASMS suspended the process we had agreed with Southern DHB to address one of our serious clinical and professional concerns, namely the plan they had to cut the "swing shift" of doctors at the hospital from 1 July. This arose out of the DHB management's determination to set up a poorly thought out 'Integrated Family Health Centre' at Remarkables Park in conjunction with the largest primary care practice in Queenstown, the Queenstown Medical Centre where access to free emergency care would be through a primary care triage.

The panel had been set up by the NHB .... because of chaotic consultation and planning by senior management of the Southern DHB

Panel members were Peter Foley (former Chair of the NZMA and Chief Medical Officer Primary at Hawke's Bay DHB), Angela Pitchford (Clinical Director of Emergency Medicine at Canterbury DHB), and David Russell a long time consumer representative. Mike Ardagh (Professor of Emergency Medicine, Christchurch Hospital) deputised for Dr Pitchford on occasions.

Their major recommendations are that the Southern DHB should establish:

- A clinical services plan across the region to ensure as far as possible equity of access and comparable outcome.
- Retain responsibility for governance and funding of LDH with Southern DHB but introduce a tier two manager with responsibility for Central Otago and LDH with responsibility for providing services independent of historic boundaries. A community reference group is to be established with which the DHB is to consult early in the planning of any clinical service.
- The DHB to "retain and enhance services at Lakes District Hospital" which is to retain an emergency department and be further developed on its existing site. Other recommendations seek enhanced services at the site including a CT scanner, an invitation to other providers of health services to relocate to the site and more out-patient clinics.
- The roster of medical staff is to remain at eight ftes at a minimum of which two may be registrars. The review team has a time line with discussions with the Association and the hospital clinicians occurring in Oct 2011.
- Several sensible recommendations for a clinical services forum for the Wakitipu and increased co-operation between Lakes District and Dunstan Hospitals (one hour drive away).

The panel decodes the funding conundrum that puzzled us when we were working on the *Health Dialogue* as to how overseas visitors were dealt with in the population-based funding formula. These are apparently funded through the population-based funding formula based on historic DHB data. The panel's report concludes that the Southern DHB needs to take more care in coding for foreign visitors.

The expert panel's full report is available from the ASMS website homepage (asms.org.nz) at the top of the "In Depth" column (immediately below the "Perspective" pieces).

Angela Belich
Assistant Executive Director

Misuse of medical staffing data

Recent statements asserting increased doctor numbers in our health system, including from the Prime Minister and Minister of Health, raise interesting issues over the use and misuse (and understanding) of medical workforce data.

The first thing to be said is that the collection of this data is a disgrace – unreliability, confusion and inaccuracy prevail. The main sources are the DHBs (currently using DHBNZ) and the Medical Council. Partly because they are collected for different reasons and ask different questions they are not consistent. Nevertheless, in amongst this mess, trends can be detected.

Subsequently, at different times, the Prime Minister and Minister of Health have jumped in stating that we now have 500 more doctors generally (either since the last election or over the last year and either in the whole health system or in DHBs only depending on when and where). As recently as 18 August, for example, Tony Ryall told the Royal Australasian College of Surgeons that "since November 2008, public hospitals now employ well over 500 extra doctors". Not surprisingly the government wants this assertion to be attributed to its performance and to take the credit.

What are the facts? Murky to say the least. What we do know is the following:

- The DHBs-ASMS jointly developed *Business Case* concluded that in order to secure a specialist workforce in DHBs we need an average annual growth of 232 specialists for the next decade so that we can match Australia's estimated number of specialists per population by 2021. In fact, this is a very conservative objective because this would still have us noticeably below the OECD average. The annual growth would have to be higher if New Zealand was to aspire to the lofty heights of average.
- Medical Council registration data for the three years to March 2011 show the average annual growth of specialists was 178 – a shortfall of over 50 specialists each year despite the modest target. Indications so far this year suggest a below average growth rate.
- DHBNZ has published on its website its most recent health workforce report. It reports 4,157 senior doctors (presumably this includes medical and dental officers and dental specialists as well as medical specialists; it may also include Medical School specialists who also work in DHBs) for the quarter to 31 March 2011. This is nearly 70 fewer than reported as at December 2009.
- According to DHBNZ data there is a growing imbalance between specialists and resident medical officers. Its data shows a growth of 212 specialists during the year to March 2011 (this may be a slightly 'overcooked' figure). Over the same time the resident doctor workforce increased by 480. This increases the inability of specialists to provide the necessary training and support for RMOs.
- There is evidence to support the government's claim of 500 more doctors depending on the period of time looked at and on the basis of including all doctors including GPs and RMOs. However, most of this growth has been RMOs, many of whom are vulnerable to attractive offers in Australia and elsewhere. It is not clear how many of these RMOs are international medical graduates. But, based on historical patterns, the greater the number the greater this vulnerability.

One thing is certain. We continue to have a specialist workforce crisis in DHBs. As Health Minister Tony Ryall said last October: "We have a workforce crisis in New Zealand because we need to retain more of our hospital specialists." Nothing has changed to what he identified as his number one priority in health.

ASMS Branch Presidents and Vice Presidents call on DHBs to negotiate based on the *Business Case*

The newly elected ASMS Branch Presidents and Vice Presidents who took office from 1 July this year (see box) met on 31 August to discuss the negotiations on the national DHB MECA, the *Business Case*, and other issues, including their role, how they will work with the ASMS industrial team, job sizing and issues such as CME policies.

National President Dr Jeff Brown led a session on the ***Business Case*** (*Securing a Sustainable Senior Medical and Dental Workforce in New Zealand: the Business Case* available on www.asms.org.nz) and Executive Director Ian Powell gave a presentation on the MECA negotiations.

The Branch Officers asked for a summary of the *Business Case* based on Dr Brown's presentation to be made more widely available to members and passed a resolution calling on DHBs to negotiate a MECA settlement based on the *Business Case*.

The branch officials found the meeting useful and committed to briefing members on the *Business Case*.

RESOLUTION

The ASMS Branch Presidents and Vice Presidents call on the DHBs to negotiate a MECA settlement based on the *Business Case* already agreed between the two parties.

Passed unanimously

I-r, Branch Presidents Ywain Lawrey, Waitemata; Seton Henderson, Canterbury; Graeme Lear and Trevor Cook, Canterbury Branch Vice-President

Kai Haidekker, Hawke's Bay President; Andrew Spiers, Manawatu North Vice-President; Robert Leikis, Hawke's Bay Vice-President

John Chambers, Otago Vice-President holding Kamryn Irvine, Marlborough

Tim MacKay, Southland President; Roger Wandless, Southland Vice-President

Derek Snelling, Wellington Branch President; Andrew Morgan, Marlborough President

Rebecca Branch, Counties Manukau Vice-President; Brigid Connor, Auckland Vice-President

Ian Page, Northland President

Jonathan Casement, Waitemata President, Julian Fuller, ASMS Vice President

BRANCH	PRESIDENT	VICE PRESIDENT
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Waitemata	Jonathan Casement	Ywain Lawrey
Auckland	Jeannette McFarlane	Brigid Connor
Counties Manukau	Simon Bainbridge	Rebecca Branch
Waikato	Thodur Vasudevan	Alan Crowther
Rotorua	David Griffith	Andy Klava
Tauranga	Matthias Seidel	Rod Gouldson
Whakatane	Guy Rosset	Christian Hirling
Taranaki	Campbell White	Alan Binnie
Tairawhiti	Graeme Lear	Deon Stolz
Hawke's Bay	Kai Haidekker	Rob Leikis
Whanganui	Athol Steward	Mark Van de Vyver

BRANCH	PRESIDENT	VICE PRESIDENT
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Wairarapa	Konrad Schwanecke	Rob Sahakian
Hutt Valley	Stephen Purchas	Sheila Gordon
Wellington	Justin Barry-Walsh	Derek Snelling
Nelson	Clive Garlick	Geoff Lingard
Marlborough	Andrew Morgan	Jacqui Irvine
West Coast	Paul Holt	Stuart Mologne
Canterbury	Seton Henderson	Trevor Cook
South Canterbury	Matthew Hills	Peter Doran
Otago	Chris Wisely	John Chambers
Southland	Tim Mackay	Roger Wandless

Seton Henderson and Trevor Cook, Canterbury President and Vice-President and respectively

Andrew Klava, David Griffith Rotorua Branch Vice-President and President respectively

Alan Binnie, Taranaki Vice-President and Brian Craig ASMS National Secretary

Jeff Brown, ASMS National President

Derek Snelling, Wellington President

Himadri Seth, Waitemata with South Canterbury Branch President Matthew Hills and Vice-President Peter Doran in foreground

DELEGATES REQUIRED

The ASMS makes all travel and accommodation arrangements for ASMS members to attend its 23rd Annual Conference as delegates

ASMS 23rd ANNUAL CONFERENCE

Thursday 17–Friday 18 November 2011,
Oceania, Te Papa, Wellington

Dinner and Pre-Conference Function

A Conference dinner will be held on Thursday 17 November at Te Papa. A pre-conference function will be held at The Boatshed on Wellington's Taranaki Street Wharf on the evening of Wednesday 16th November. This is a great opportunity to mingle, in a relaxed social atmosphere, with key decision-makers and players in the health sector

Leave

Clause 29.1 of the MECA includes provision for members to attend Association meetings and conferences on full pay. Members are advised to start planning now and encouraged to make leave arrangements and register by 7th October 2011.

Registration of Interest

Please help us plan for another great Conference and assist us in organising travel and accommodation reservations by emailing our Membership Support Officer, Kathy Eaden, at **ke@asms.org.nz**

Your interest in registration will be noted and confirmed with your local branch officers as each branch is allocated a set number of delegates. Extra members are welcome to attend the conference as observers.

Register your interest today ke@asms.org.nz

MEDICAL PROTECTION SOCIETY

Advance directives: hope on the horizon?

Dr Denys Court of the Medical Protection Society looks at whether Advance Directives may have become a blunt instrument in today's complex healthcare environment.

The Code of Health and Disability Services Consumers' Rights (the Code) includes the right to create (orally or in writing) and use an advance directive (AD) "in accordance with common law"; whereby a consumer makes a choice about a possible future health care procedure, intended to be effective only when he or she is incompetent[1], whether such incompetence is temporary (such as anaesthesia) or potentially permanent (such as dementia). The Code defines choice as a decision to receive or refuse or withdraw consent to services[2]. Without clear legislative requirements, the validity of an AD at "common law" is unclear in New Zealand. Involvement of family members, a GP, or lawyer in preparing an AD would likely see it given greater effect if challenged, as would an AD created closer in time to the procedure when it is used.

The circumstance which typically springs to mind in relation to ADs is the written advance refusal of an unconscious patient who has suffered significant blood loss, to accept blood or blood products because of their religious beliefs, in circumstances where it is known the AD is the current wish of the patient. Whilst such ADs strike fear into the hearts of clinicians where major blood loss has occurred or is anticipated, we are all well enough acquainted with such directives that we understand the legal obligations. However, where we are less acquainted with the context in which an AD was formulated, we become less certain as to our responses.

The simplest and most common form of AD is a *refusal* of a specific healthcare measure (a 'negative' AD). Where an AD is an advance *consent* (and thereby an implied request) for specified treatment, such a 'positive' AD cannot be seen to compel treatment where best interest considerations, acceptable practice or resource realities would otherwise preclude it. An example would be an unconscious patient with multi-organ failure following H1N1 influenza who has a 'positive' AD demanding to be treated with high-dose vitamin C

Nonetheless, ADs are now more frequently being used to compel the healthcare system to hear and honour the autonomy of patient choice in many differing circumstances. These ADs are often template driven (drafted by lawyers) with sweeping generalisations that are difficult to apply to complex healthcare situations and may be made in circumstances where it is impossible for a clinician to assess the context of the individual's decision making.

It is therefore not surprising that at times hospital doctors discuss with us their concerns as to the validity of such directives, and therefore whether they should feel obliged to follow them. This is particularly so in life-threatening acute circumstances where the hospital clinician has no prior knowledge of the patient in question and no family member is available to readily or easily resolve the matter. The awareness on the part of our members that where the law would consider an AD valid, provision of the refused treatment would be unlawful, raises anxieties for the clinician where establishing the validity of an AD is found to be challenging. ADs are in general valid where the individual was competent at the time the particular decision was made, where the individual understood the consequences of the decision (an informed refusal) and was not subject to undue influence, and the AD was intended to apply to the clinical circumstances in question. Notwithstanding the understandable difficulty for a clinician establishing the validity of an AD where they may have had no previous contact with that patient; that clinician may only *not* honour an advance refusal if there are reasonable grounds to do so on the considerations outlined above.

Where there is any doubt about the validity or applicability of an AD, the patient should be provided with care to secure her/his best interests while the issue is resolved; if necessary (but rarely) by reference to the courts. As held by a UK Court, the continuing validity of the AD must be proved and if there are circumstances that cast real doubt then it must give way to preservation of life.[3] Such doubt most commonly arises from a reasonable belief (perhaps indicated by family members) that there is reason to believe the patient might have had a change of mind since drawing up the directive; or where the current circumstances do not correspond to those specified in the directive; or significant advances in treatment options mean that the directive could no longer be considered an informed decision. Medical technology advances have enabled artificial or mechanical prolongation of life which has created its own dilemmas, with treatments that may be of arguable benefit to the patient. Determining whether an AD remains informed in light of such advances is at times a challenge too far.

As if the above issues are not bothersome enough, ADs can reach their problematic zenith for patients under a compulsory treatment order pursuant to the Mental Health Act (Compulsory Assessment and Treatment) Act 1992. Such patients are required to accept treatment for their mental disorder as directed by their responsible clinician, regardless of their competence. If a patient subject to a compulsory treatment order presented an advance directive refusing treatment for their disorder, that AD may have no effect. An AD purporting to refuse compulsory tube feeding in anorexia nervosa would be an example.[4]

For the reasons outlined, it could be considered that ADs are becoming too simplistic a tool for the complex health environments in which they are being applied. However, as implied in the title, there may be some hope on the horizon to this increasingly complex conundrum. In many jurisdictions, there is discussion and development of "Advanced Care Planning"[5] (ACP): providing individuals and their healthcare providers with methods to assist with thinking and talking about the end of life, about the values individuals wish to be applied, and about what

treatments and care they might want. As such, ACP could provide the context of an individual's decision making that clinicians fear is otherwise absent when they consider the validity of an AD. Based on the ethical principle of patient autonomy and the legal doctrine of informed consent, ACP advance care planning raises the hope that the contextual vacuum that may surround an AD may be filled by helping to ensure that the concept of consent is respected if the patient becomes incapable of participating in treatment decisions.[6]

It is neither possible to do the discussion around ACP justice in this article, nor appropriate to assume that role. Proponents of ACP indicate that it is a structured process with the aim of helping people understand what the future might hold related to their circumstances so that they can be better prepared, and their healthcare professionals can be better informed, to help make decisions in their best interests around the end of life. Proponents of ACP internationally and in New Zealand state that it is about having and encouraging conversations and providing information. It can also help people translate what they want when they are facing end of life decisions into "medical speak" so that healthcare providers can use this information to inform their care when they themselves cannot. For ACP to meet this goal, the key will be the opportunity for the professions to extend the relationships we have with people we care for; enhancing the information that comes out of that process. As part of such planning, understanding what is important to the individual, expressions of their wishes and/or an advance directive are some of the possible outcomes of this process.

An advance directive that is the outcome of a good advance care planning process, and is then clearly and specifically recorded, could contain the context required to indicate a truly informed consent or refusal of specific future treatment/s, the validity of which could more readily be relied on by treating clinicians when that person is no longer competent.

1. *Code of Health and Disability Services Consumers' Rights; Right 7(5).*
2. *Code of Health and Disability Services Consumers' Rights; Clause 4; definitions*
3. *HE v A Hospital HNS Trust [2003] EWHC 1017 (Fam)*
4. *Re H (Mental Health) [1996] NZFLR 998; Re FAH [1999] NZFLR 615*
5. *What is Advance Care Planning? - Ministry of Health: www.moh.govt.nz/moh.nsf/pagesmh/10170/.../acp-future-care-6-07.doc*
6. *Singer PA, Robertson G, Roy DJ. Bioethics for clinicians: 6. Advance care planning, CMAJ 1996;15(12):1689-1692*

ASMS services to members

As a professional association we promote:

- 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 district health boards which ensures minimum terms and conditions for around 3,000 doctors and dentists, over 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

Other services

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We welcome your feedback as it is vital in maintaining the site's professional standard.

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If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at ***ke@asms.org.nz***

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