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The Specialist

The newsletter of the Association of Salaried Medical Specialists

ASMS vindicated in hospital doctor numbers controversy

The ASMS has been cast through factors beyond our control into an oppositional position with Minister of Health Tony Ryall over claims of increased public hospital doctor numbers in DHBs. This has been infuriating; we have been put in a space we did not want or seek and have not enjoyed. Making it worse has been the frustrations we have been faced with in trying to resolve it. But at long last we can confirm that data from the Ministry of Health's National Health Board (NHB) affirms the veracity and accuracy of the ASMS's position.

As we suspected, this should have come as no surprise given that the NHB and ASMS got their data from the same source – DHBs. The differences are the use of full-time equivalents compared with headcounts (bodies) and timing. But the outcome is almost identical.

At long last we can confirm that data from the Ministry of Health's National Health Board affirms the veracity and accuracy of the ASMS's position.

The backstory

In opposition, Tony Ryall declared that there was a specialist workforce crisis in public hospitals. He reaffirmed this when, as Minister of Health, he met the ASMS National Executive in 2009. Then, on 3 October 2010, he reiterated this declaring that:

"We have a workforce crisis in New Zealand because we need to maintain more of our hospital specialists, I say yes we do, it's our number one priority." (TVNZ Q&A)

Consistent with the Minister's assessment (linked to our multi-employer collective agreement negotiations at that time) in November 2010 the blueprint document, '*Securing a sustainable senior medical and dental officer workforce in New Zealand: The business case*', jointly developed by the DHBs and ASMS, reaffirmed that there was a specialist workforce crisis, that it was causing serious risks for the public health system (including standards of patient care and financial wastage), and set out actions to address the crisis.

When it came to the actions, however, political and bureaucratic knees wobbled. The DHBs national leadership made a deliberate choice to undermine the *Business Case* and sabotage the MECA negotiations (and the goodwill that had developed with the ASMS). In concert, the government's language changed. 'Crisis' disappeared from the language in 2011 to be replaced by 'increased hospital doctors'. The starting point was 30 November 2008, immediately after Mr Ryall became Minister. During 2011 the claimed increase began with 500 but towards the end of the year, and significantly just before the general election, jumped up to 800. Now, as of April 2012, the figure is over 1,000.

The issue erupted when Mr Ryall addressed the ASMS Annual Conference last November.

Ministerial skirmishing

The issue erupted when Mr Ryall addressed the ASMS Annual Conference last November. When he repeated his 800 extra hospital doctors claim, he was challenged by delegates because it did not correspond to the reality back at their workplaces. Rather than pause and think about the reliability of this response, he reiterated his line and was heckled as a consequence. Unsurprisingly this was immediately followed by some tetchy media coverage.

Subsequently the Minister made claims on increased doctor numbers at Capital & Coast and then Counties Manukau that made no sense when the facts were ascertained.

ASMS

Executive Director
Ian Powell

Assistant Executive Director
Angela Belich

Senior Industrial Officer
Henry Stubbs

Industrial Officer
Lyn Hughes

Industrial Officer
Lloyd Woods

Executive Officer
Yvonne Desmond

Membership Support Officer
Kathy Eaden

Admin Officer
Terry Creighton

Admin Assistant
Ebony Lamb

Level 11
Bayleys Building
Cnr Brandon St &
Lambton Quay
PO Box 10763
Wellington
New Zealand

Ph 04 499 1271

www.asms.org.nz

They significantly overstated the reality and led to more necessary public criticism from the ASMS. For example, Mr Ryall claimed an increase of over 100 hospital doctors at Capital & Coast in his first three years as minister, but when the data was closely examined the actual figure was around 33 (18 SMOs and 15 RMOs).

If the Minister's claim was correct there would have to have been about 400 more resident medical officers during 2008-11: implausible...

A similar claim about Counties Manukau was also widely off-mark. His claim of over 100 extra hospital doctors conflicted with DHB data supplied to the ASMS that specialist numbers were around 20% of this assertion. It would be incredulous to suggest that resident doctors made up anywhere near the other 80%, especially at a time when the number of positions was being held down.

On this and other occasions the ASMS drew upon data provided to us by DHBs on specialists employed on the MECA

This particularly unsatisfactory meeting reflected poorly on the NHB.

salary scales. In summary, in the three years from 1 July 2008 (five months before Mr Ryall became health minister), they increased by 373 (11%; 124 per annum). If the Minister's claim was correct there would have to have been about 400 more resident medical officers during 2008-11 (implausible especially as the three Auckland DHBs covering around one-third of the numbers had imposed strong restrictions on the number of positions).

Dancing with the foxy NHB

Meanwhile since last November the ASMS was seeking a meeting with the National Health Board. While some of the difficulty in setting dates involved ASMS representatives' availability, overwhelmingly the problem was the NHB with long periods of non-responsiveness. The ASMS had to go above to get some progress. Eventually the NHB agreed to provide the breakdown of their data provided to the Minister, at a meeting on 26 June.

But that meeting was not without its own drama. The evening before the meeting we received an email from the NHB advising that the Health Minister would not allow the NHB to release the information to the ASMS. At the meeting itself the explanation was a little different; the Minister's office had been too busy to consider the matter.

What was really astonishing was that NHB officials said that their data was not broken down for RMOs and SMOs. This was extraordinary. We knew from our information that it did and yet these officials familiar with it continued to deny it despite us continuing to challenge them.

Further, we repeated that the advice they were providing the Minister was unreliable and damaging his credibility with senior doctors (because their RMO data was so seriously dodgy) they continued to claim it was robust. This particularly unsatisfactory meeting, which reflected poorly on the NHB, concluded with the officials committing to providing their data in a few days. True to form, we received advice from the NHB a few weeks (not days) later that the NHB's report on hospital doctor numbers in DHBs was now on the Ministry's website.

The truth is out there

The cult conspiracy theory television programme X Files was right - the truth is out there. The most recent NHB data (30 April 2012) confirmed the legitimacy of the ASMS data on specialist increases which is hardly surprising because they came from the same source - DHBs.

The only differences were that the NHB data was full-time equivalents up to 1.0; was senior medical/dental officers (SMOs - including non-vocational medical officers); and over a different period of time (41 months from 30 November 2008 to 30 April 2012. In contrast, the ASMS data is a headcount from 1 July 2008 to 1 July 2011 (36 months) and was those on the specialist scale, not the medical officer scale as well (however, medical officer numbers have barely increased).

The NHB data shows an increase of 473.2 specialist ftes from 30 November 2008 to

NHB data shows an annualised increase of 138.8 fte specialists compares with the annualised 124 headcount specialists from the ASMS data. The difference is paper thin.

30 April 2012. Annualised it is 138.5 per year. This compares with the annualised 124 from the ASMS data. The difference between the data on specialist increases of the NHB and ASMS is paper thin (see Figure 1).

Because it is fte and because of the impact of job sizing (in the three Auckland DHBs alone there have been large scale job sizing reviews over this period leading to a mix of fte and headcount increases) it will be the case that the increase in NHB's data will exceed that of the increase in the specialist headcount numbers. For example, in a large department (anaesthesia at Counties Manukau) during this period of time, job sizing led to an increase of 22 ftes which included a headcount increase of 14.

Annual specialist increases from 2009 are averaging 25% less than they were over the previous three years.

So why the high hospital doctor numbers

Despite the Minister's claims of increased hospital doctor numbers, based on the headcount data provided by the DHBs, essentially the annual specialist increases from 2009 are averaging 25% less than they were over the previous three years –23% less than the average since 2000 (see Figure 2).

The total hospital doctor numbers from the Minister, based on the advice of the NHB, would only make sense if there has been an explosion of resident medical officer numbers (the flawed NHB advice to Tony Ryall claims 570.5 registrars and house surgeons (20% increase). But there is no evidence of this. The high figures given by the NHB to the Minister are due to suspect and dodgy resident medical

Figure 1: NHB data / ASMS comparison

NHB Data	30 /11/ 08	30 /4 / 12	Increase	Annualised
FTE Positions	2,758.5	3,231.7	473.2	138.5

ASMS Salary Survey	1 / 7 / 08	1 / 07 / 11	Increase	Annualised
Headcount	3,312	3,685	373	124

Figure 2: Data derived from ASMS Salary Surveys

ASMS Salary Survey	2000–11	2005–08	2008–11
Headcount Increase	1,773	501	373
Percentage Increase	93%	18%	11%
Annualised Increase	161	167	124

officer numbers in no small part because of changes in the RMO locum market, particularly in the wider Auckland region, and the reclassification of several of them from casuals (coded no fte) to employees (actual ftes, usually coded 1.0).

The veracity of the ASMS's conclusion that Tony Ryall's wildly inaccurate numbers is due to embellished RMO numbers is confirmed by the latest medical workforce survey undertaken by the Medical Council. From 2008 to 2011 the number of house officers increased by 143 (16%) while registrars increased by 134 (8%) - in fact the registrar increase from 2010 to 2011 was 13 (0.7%).

As part of the spin the NHB has reported to the Minister in a misleading manner. It advises him that senior doctors have had the greatest increase among the categories of hospital doctors. However, this is only achieved by dividing resident doctors into two – house surgeons and registrars. This is a minor sin but it compounds the bigger one

In order to explain away the previously identified specialist workforce crisis in the DHBs the NHB has allowed itself to become a political spin machine. It has provided the Minister of Health with very dodgy data that serve to embellish the real situation. The question is, was it the NHB who did this on its own initiative or, (to borrow the American White House concept of 'plausible deniability'), did the Minister deliberately frame his questions to the NHB to avoid the answers he did not want to hear (and the NHB failed to tell him what he did not want to hear). The truth is still out there on this one too But, as of now, we don't know the answer.

While it is nice to be vindicated, this unpleasant distracting debacle was unnecessary in order to get to this point.

Ian Powell
Executive Director

PRESIDENT'S COLUMN

Something old, something new, something borrowed, something...

Health warning. This is an unashamed call to alms. An effort to convince and inspire radical change. To shame and embarrass dopey opinions. To encourage a marriage of polarised politics for the future of our nation.

I am a paediatrician and a father. I am privileged to walk in corridors and sit in boardrooms with some movers and shakers. Yet I despair almost daily over the children I encounter who are deprived and suffering through no fault of their own. I agonise about the transient help I can provide against the effects of insidious forces. So, without trepidation, I implore you to consider, challenge and change your traditional vows.

Something old

There is a silver tsunami bearing down on our health services. Much evidence and polemic indicates that the sandy shores of comfort in our system are already being washed away by the waves of elderly and the multisystem problems age brings. The challenges we will increasingly face are articulated in this very issue by Tim Frendin. There is no escaping the need for society and health services to re-examine their priorities and responsibilities. To ask if families, extended whanau, the village we live and love in, or the state we pay taxes to, should shoulder responsibility when we can no longer completely care for ourselves.

The solutions to these challenges consume ministers, policy makers, funders and providers, all trying to bend the curve of future spending without alienating their voters, advisors, contractors and employees. To solve the problems of extended life spans. Living longer which can be attributed at least as much to improved infant mortality as to care of adult afflictions. The successes of public health and hygiene are now revisiting us in escalating demands of the aged and aging, with uncomfortable conversations required to devise innovative and affordable solutions.

But it is not just the elderly who loom ever more hungry for health dollars.

Something new

The unfortunate truth for New Zealand, distinct from other industrialised nations, is that we are faced with a terrible double jeopardy. Along with the silvered tide, we have child morbidity, and infant mortality, that is shameful. That is linked strongly with child poverty. We are challenged simultaneously by the tsunami of caring for the elderly and the awful necessity of fixing the damaged young.

One shameful example of this damage, in which the current government has recently invested, is rheumatic fever. Acute rheumatic fever rates for Maori and Pacific children have increased substantially since 1993 while non-Maori/Pacific rates have declined. Rates are highly correlated with deprivation with 70% of cases occurring in the most deprived quintile. Mortality rates are 5 to 10 times higher for Maori and Pacific peoples with most of the hospital costs occurring in those aged over 30 years and three quarters due to valve surgery. No argument with rheumatic fever as a government target. But is that single target enough? And is the investment all in the right sector? Will the dollars fix the deprivation, or just the sore throats?

We have numerous other markers of poor child health akin to third world rates, such as skin infections, pneumonia and injury (both accidental and non-accidental). All of which I see in my daily work. All belying the fond myth of being a great country to grow up in. And all strongly linked to child poverty.

Something borrowed

Ignoring child poverty is borrowing from our kids' future to fund our present. The costs of the 250,000 or more children growing up in poverty are between six and ten billion dollars, per year, depending on which economist you follow. The costs occur in four areas – health, crime, social welfare, and poor education and its effect on productivity, all adding up to 3 per cent of GDP annually. Three-quarters of that cost is avoidable, which makes the usual "can't-afford-it" response to child poverty policies all the more irrational.

Brian Easton says "If families under-invest in their children - and when they are seriously income constrained that is inevitable - the children will suffer. But so will society as a whole. Not only will the retired suffer when it becomes the younger generation's turn to fund them, but the under-invested children will cause more government spending - such as on law and order and health care - and other government spending - on education - will be inefficient." Poverty exacts enormous human and economic costs that we all end up paying one way or another.

The Commissioner for Children's Expert Advisory Group asks whether thousands of parents suddenly forgot how to parent properly, or were they the victims of policies that saw household incomes fall for all but the top 10 per cent between 1988 and 2004. "Solutions to Child Poverty" makes it patently clear is that child poverty isn't inevitable. International evidence shows that it can be reduced, with the right mix of policies: "Countries can choose how much child poverty they are prepared to tolerate." And evidently New Zealanders, or their elected leaders on their behalf, can tolerate quite a lot. Between 2007 and 2011, hardship rates for children increased from 15 to 21 per cent.

The expert group has solutions, some ambitious, all "realistic, evidence-based, cost effective and fiscally responsible". It also recommends the Minister of Social Development be required to report to Parliament annually on progress in poverty reduction. Reducing child poverty, says the EAG, will require "vision, courage and determination".

But unless our society has such vision, courage and determination, we are extremely dopey. Dame Anne Salmond has observed "an ageing society that doesn't care for its young has a death wish". We put the blame on blameless children. Who do not choose where they are born or to

whom, or what conditions their brains are formed in. And then we ask them to pay the price for our society's failings. Which threatens not only the health, wellbeing and life prospects of each child, but also our integrity and cohesion as a society. We are borrowing from their future to pay for our presents.

Something...

The time for party politicking is surely over when considering child poverty. If it is good enough for cross party agreements on factors dear to the elderly, or conscience votes on marriage and alcohol, then why do our future generation deserve less? Achieving immunisation targets is laudable, but tackling child poverty is multi-dimensional and multi-sectoral, and will require more than single targets. It will need the bravura of leaders confident in their mandate, from us.

We need to want tamariki to be treated as taonga. We need to consider children as more important than anything, bar none. We need to rebalance the profound vulnerability of a child, to overcome their lack of voice within society and invisibility within legislation.

Our Minister of Finance had a different portfolio 14 years ago, a generation of youngsters ago. As Minister of Health in his foreword to "Through the Eyes of a Child", he said these prescient words:

"The health of most New Zealand children is good, but for a significant number it is not and we have to do better. We need to give children the best start possible in life. Change will not happen immediately, but it is vital that everyone looking after children works together. We need to focus on the common objective to improve, promote and protect the health of children/tamariki and their families and whanau, not territorial differences. If we can't overcome that our interest in children is not as great as we say it is. New Zealand's children make up nearly a quarter of our population. They are the future of our country so it is in all of our interests to ensure they get the best possible start in life."

I trust he truly believed his own words in 1998. I trust he truly believes in 2012 that nothing has changed except the increasing need for effective action, for all parties to join in the crusade.

Without healthy young growing into healthy workers earning healthy incomes and paying healthy taxes, there will be no way on earth we can afford to look after the wise elders we all need to guide us through the messy mazes of modern life. To look after each of us, now and in the not so distant future.

We need to change our attitudes to those who have no choice of who they grow up with. No choice of who will provide the profoundest influences on their brain development in their first few years. No choice of who will shape their future personalities and attitudes to you and me. We need to change our attitudes to those struggling to be influencers and shapers. We need to change, us.

Change will not be easy. Change will not be quick. Change will challenge. Change will hurt.

Change will require a marriage of old, of new, of borrowed, and of the multihued rainbow of proven and yet to be proved coalitions of the willing. For the sake of our children. For the sake of ourselves. For the sake of our nation. Kia Kaha.

Jeff Brown
National President

Proposed Government changes to the Employment Relations Act

The Government is seeking to amend the Employment Relations Act 2000. Some of these proposed changes are of serious concern to the ASMS. These include:

Concluding a Collective Agreement

The Government will return to the pre-2004 provision where the 'duty of good faith' in the Act does not require a concluded collective agreement. At the moment the parties must conclude negotiations unless there is "a genuine reason, based on reasonable grounds, not to". The removal of a duty to conclude a collective agreement will weaken the framework for collective bargaining because it allows employers to adopt a position where they refuse to negotiate meaningfully because they don't want a collective agreement. It is doubtful that ASMS would have achieved a collective in ACC if this change had been made at the time.

The 30-day rule for new employees

Currently if the work of a new employee is covered by a collective agreement and a new employee is not a member of the relevant union the employee must be employed on the terms and conditions in the collective for their first 30 days of employment. Under the proposed provision employers could offer new employees less (or more). This would give the employer power to have alternative sets of conditions in the workplace to those set through collective bargaining and use this power to undermine the collective bargaining process.

Allowing employers to opt out of MECA bargaining

At present it is difficult for an employer to refuse to bargain in whatever configuration bargaining is initiated (MECA or single employer collective agreement). The effect of this change will be to make it more difficult for unions to achieve a combined agreement across a sector or to rationalise bargaining.

EXECUTIVE DIRECTOR'S COLUMN

There's nothing normal about Christchurch

I was struck by the following paragraph in an article by respected journalist Jane Bowron in the Dominion Post (20 August):

February 2011 turned the corner of Fitzgerald Ave and Kilmore St into your classic image of what a quake-hit road looks like with its ripple of ruptures, and it continues to astonish how long the road has been worked on, and will be worked on. I'm not saying there is any incompetence at play but the cost of this one stretch must be staggering.

As a former Christchurch taxi driver I found her description resonated. If a stretch of road takes so long to put back to together (task still incomplete), how long does it take to put back together Canterbury's labour intensive and health professional dependent health system?

It took me back to last month at our Canterbury Joint Consultation Committee with senior management where there was an unscripted, unanticipated but from the heart revealing discussion over post-quake Christchurch. The JCC is a joint ASMS-DHB management body that exists in all 20 DHBs and is a creation of our national collective agreement with them. They are usually attended by the DHB chief executive

At this meeting Chief Executive David Meates outlined the massive extent of the damage and rebuilding programme caused by earthquake devastation. More buildings are being identified as being potentially unsafe given another big earthquake and these have to be vacated. As of March this year, 30 of the 200 CDHB buildings had been identified with major issues with 17 having been evacuated. The most recent count was 20 buildings needing to be demolished with a further five to be vacated shortly. Overall 12,000 of 14,000 hospital rooms DHB-wide need some repairs.

"The biggest threat was the view from the rest of New Zealand now thinking things were back to normal in Christchurch …."

The bigger repair jobs have started with the internal staircase replacement underway but as another example the Christchurch Women's building requires all floor coverings in every room on every floor to be pulled up in order to inject resin into the various cracks. This relatively simple job will require complex planning to minimise disruption.

But he really hit the nail on the head when he asserted (correctly) that, despite the severity of the quakes at the time and the immediate heroic rescue and recovery work that followed, the worst was yet to come. The biggest threat was the view from the rest of New Zealand now thinking things were back to normal in Christchurch and not making allowances for the reality of the situation. As an aside one might add that this risk also exists within Christchurch itself from those parts of the city either not directly affected or relatively lightly affected by the damage.

This has been exacerbated by Canterbury DHB delivering so well post-quake. He noted for instance that the recent flu epidemic should have closed the hospital but "we coped" making people elsewhere think everything must be fine. In no small part this coping was due to the impressive clinical strength and cohesiveness of the Canterbury health system pre-quakes, including but not confined to the well regarded 'Canterbury Initiative' and health/clinical pathways between community and hospital healthcare.

This level of coping and 'getting on with it' is not sustainable. Christchurch has yet to see the worst effects of the earthquakes; these are only starting to arrive. Tiredness and alcohol and drug issues are on the rise and the level of reporting/complaint of nurses to the Nursing Council has increased significantly. It would be unwise to see this as simply a nursing issue. It is more likely to be observable among nursing because the far greater size of this profession makes it more noticeable. It should be seen as a message and warning to the other professions.

"This level of coping and 'getting on with it' is not sustainable."

There are reported noticeable "frayed edges" to various staff, including some senior medical staff. There are also concerns about staff not taking their leave. This was identified as being either because they did not want to or had nowhere to go (or nothing to do so why waste it).

These post-quake consequences contribute to tensions between Canterbury DHB and central government agencies, including the Ministry of Health's operationally focused National Health Board. It was not helped by the unwanted and unwise distraction of the government forcing CDHB to explore a controversial and inherently high risk Public Private Partnership for its facilities rebuilding and operation – they needed that as much as they needed a hole in the head – but at least that particular threat has dissipated. In the view of CDHB the NHB is asking why things in Christchurch were more expensive, which is seen as an example of 'outsiders' thinking it is time to 'get over it'.

To quote one participant at the JCC, Canterbury is "right on the edge" and "it is not normal here". Further, "if people think that the earthquakes were disruptive we are about to move in to the real disruption. In a few years people will look back and see the first 18 months as the easy bit".

This is a message that policy makers and the wider health sector needs to hear.

Ian Powell
Executive Director

National Office Staffing

The National Executive has reviewed the level of national office staffing in the ASMS's industrial and administration teams. There were a number of factors considered by the Executive including:

- ASMS membership has grown from 2,833 in 2007 when the last increase in national office staffing took place to 3,920 an increase of 38%.
- The effect of our Joint Consultation Committees in each of the DHBs is increasing awareness of the profile of the ASMS and the wider range of issues we are expected to become involved in.
- The wish to have a greater prominence in the enforcement of existing collective agreement entitlements, particularly the MECA (eg, job sizing).
- The wish of some staff to reduce their hours of work.
- The capacity of national office staff to cope without additional staffing has reached its limit which places pressures on national office staff to maintain an effective balance between work and the rest of life.
- The industrial team is facing increased work pressures (including travel and job sizing) and an inability to sufficiently advance development work (eg, production of more ASMS Standpoints on employment related issues).
- The administration team provides so much of the glue that holds the ASMS together. If we only focused on improving the industrial officer capacity it would become self-defeating. The administration team has been feeling the immediate effects of the increase in membership and bargaining fee payments with additional processing and the concomitant enquiries as well as additional tasks associated with the MECA settlement. It has had of necessity to rely on increased levels of temporary staff and reached the stage where the workload is such that efficiency is compromised.
- The higher priority given to updating the website has also eroded the time available to administrative staff.

Consequently the Executive approved the creation of two new positions – a third industrial officer (currently we have one Senior Industrial Officer and two Industrial Officers as part of a team led by Assistant Executive Director Angela Belich) and a new senior administration officer position (in the team led by Executive Officer Yvonne Desmond). However, our present accommodation is insufficient to house two extra positions. Consequently, before advertising, the national office is exploring the possibility of either expanding our existing premises or moving to new larger offices. This may take some time.

Food for thought!
ASMS trio take on poverty challenge

In the last week of September three national office personnel will take part in poverty awareness campaign *Live Below The Line* to raise to raise funds for anti-poverty initiatives and help raise awareness of poverty. The campaign invites individuals, groups and communities across New Zealand to feed themselves with just $2.25 a day; the New Zealand equivalent of the Extreme Poverty Line.

Executive Officer Yvonne Desmond, Industrial Officer Lyn Hughes, and Administration Assistant Angeline Tuscher have teamed together to take on the challenge of feeding themselves for five days, from September 24th - 28th, with just $2.25 a day per person to raise awareness of the challenges faced by those in extreme poverty, and to support the work of Oxfam.

To add to the trial, the team has agreed to take on an additional fund-raising challenge – to cater the National Executive lunch on 27 September i.e. provide a well-balanced menu for no more than $2.25 per head! The Association has agreed to donate the difference between the cost of the ingredients used on the 27th and what it would normally spend on lunch. In addition, National Executive members will support the initiative by agreeing to make a koha of what they feel the food deserves to the campaign.

The trio has chosen Oxfam NZ as its aid-partner. In addition to the fund raising aspect the trio will take a short glimpse into how hard it must be for those who have to feed their families on $2.25 or less per person per day.

You can follow the team's progress on **www.livebelowtheline.com/team/food-for-thought**

Constitutional Amendments

The National Executive is recommending to the ASMS Annual Conference on 28-29 November in Wellington two main amendments and some consequential amendments.

The first arises from a recent law change requiring all unions to include a provision for secret ballots for strikes in their rules, which the Association does not have. The second is to fill a void in the ASMS Constitution, which arguably might prevent the National Executive from initiating amendments to the Constitution.

Secret ballots for strikes

The Employment Relations (Secret Ballot for Strikes) Amendment Act 2012 was recently passed and given royal assent on 14 May 2012.

Under this Act, unions are required by 15 May 2014 to include in their rules a provision that requires a secret ballot of affected members before they may take strike action. Unions that do not currently have such a provision in their constitutions are required to amend their rules as soon as is reasonably practicable after the commencement to section 5 of the Act, which was 15 May 2012.

The ASMS does not currently have a strike ballot provision in its Constitution and the National Executive has begun the amendment process to give effect to this new legal requirement.

The proposed amendment satisfies the statutory requirements. The first four procedures, including the wording that must appear on the ballot paper, are expressly required by the legislation while the fifth point, about the National Executive determining such other procedures as may be practical and necessary to conduct the ballot, will allow a degree of flexibility to meet the particular circumstances at the time.

National Executive initiated Constitutional Amendments

Under the current Constitution, there is provision for branches and members to initiate and submit constitutional amendments, but no express provision for the National Executive to do so. This has not caused us any difficulty in the past and is unlikely to do so in the future; nevertheless we believe it would be sensible to clarify the position by giving the National Executive express authority to initiate constitutional amendments.

To avoid any legal doubt about possible procedural irregularity in the process, both the amendments have been formally submitted by members of the Executive, as members of the Association in their personal capacities.

PROPOSED AMENDMENTS TO THE ASMS CONSTITUTION

1 Secret Strike Ballots (the addition of a new Clause 20)

Where the law requires a secret ballot to be held in relation to a proposed strike, the following procedures shall be used to conduct the ballot:

- The ballot will be of all members who would become a party to the strike;
- The result of the ballot will be determined by a simple majority of the members who are entitled to vote and who do vote;
- The Association must notify the result of the ballot to the members who were entitled to vote in the ballot;
- The question to be voted on in the ballot will be: Are you in favour of the strike? Yes or No.
- The National Executive will appoint a Returning Officer for the ballot and determine such other procedures as may be practical and necessary to conduct the ballot.

2 Subsequent renumbering

Existing Clause 20 and all the clauses that come after it will need to be renumbered, accordingly.

3 Conference Remits

Replace the first sentence of Clause 10.4(a) with the following:

Remits for consideration by an annual or special conference may be submitted by the National Executive or any branch or member of the Association.

4 Constitutional Amendments

Replace the first sentence of Clause 26.1 with the following:

Amendments to the constitution may be considered at an Annual Conference or at a Special Conference called for that purpose, in strict accordance with the notice and other requirements of Clause 10 and elsewhere in this Constitution.

ASMS Twenty-fourth Annual Conference

Delegates Required

The ASMS makes all travel and accommodation arrangements for ASMS members to attend its 24th Annual Conference as delegates.

THURSDAY 29 TO FRIDAY 30 NOVEMBER 2012
OCEANIA, TE PAPA, WELLINGTON

Dinner and Pre-Conference Function

A Conference dinner will be held on Thursday 29th 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 28th 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 closer to the date 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

ASMS CONFERENCE 2012

DR TIM FRENDIN – ASMS NATIONAL EXECUTIVE

Are we ready for old age?

The following article is a personal perspective from National Executive member and Hawkes Bay based specialist physician (healthcare of the elderly), Dr Tim Frendin. It was first published in the July/August addition of the lively local Hawkes Bay publication, 'Bay Buzz'.

Aging of our population is one of the success stories of modern social policy and medicine. The gain in average life expectancy over the last century is perhaps the best measure of the effectiveness of modern medicine.

"The gain in average life expectancy over the last century is perhaps the best measure of the effectiveness of modern medicine."

Since the early 1900s, Western societies, including NZ, have seen the life expectancies of their populations increase on average 2.5 years per decade, from approximately 50 years (male and female) in 1900 to the current 78 for males, 82 for females. This increase has yet to show signs of slowing, though there still is no reason to suspect that the ultimate human lifespan is anything but finite!

In the future, only an exceptional person will still survive beyond 110 years, whilst there are good theoretical grounds to believe each of us could expect to live on average for 85 years or so.

Effective medical treatment on a scale sufficient to impact human longevity began in the 20th century. Public health services, improved nutrition, eradication and treatment of infectious diseases in the earlier part of the century improved life expectancy mainly by reducing deaths in the younger population.

However, since about 1970 improved longevity has arisen more from effective management of chronic disease in our older population, achieved mainly by improving risk factors for cardiovascular disease within our population (such as reduced smoking and cholesterol, and increased physical activity), together with effective medical treatments for individuals.

Apart from antibiotics introduced in the late 1930s, drug treatments were not known to be effective in terms of improving survival until a number of important medical studies were published in the 1980s. Until then, treatments were limited to control of symptoms of disease without necessarily changing long-term outlook.

Amongst the most important of current 'effective' medications are ACE inhibitors (used for high blood pressure and heart disease), beta-blockers (blood pressure, heart disease), statins (high cholesterol, vascular disease) and warfarin (anticoagulant, stroke prevention), all of which have been introduced into widespread clinical practice. Such medications have unquestionably improved both population and individual health outlook by reducing the rate of premature deaths from vascular disease (heart attack and stroke) as well as adding to life expectancy.

"Although we have reduced the risk of early and sudden death, our aging population is now subject to an accumulation of chronic diseases"

Despite improvement in our population's average lifespan, the importance of social determinants of health cannot be overlooked. Major disparities persist within our society. Life expectancy for Māori is less than for Pakeha (8 years less on average). Lower educational attainment and social deprivation also impact negatively on an individual's prospects for longevity.

Chronic diseases now the issue

Although we have reduced the risk of early and sudden death, our aging population is now subject to an accumulation of chronic diseases (such as diabetes, heart disease, stroke, chronic lung disease, osteoporosis, dementia). Towards the end of life, these diseases are associated not only with a greater need for acute medical care, but also the potential for loss of independence and a need 'to be cared for' either at home or in residential care - a major driver of cost to society for effective ageing of its people.

"currently about 15% of our population is over the age of 65; by 2041 this will rise to 25% of our population (as baby boomers mature). However the greatest percentage growth of population will be seen in the over 85 year age group..."

In Hawke's Bay (and the rest of NZ), currently about 15% of our population is over the age of 65; by 2041 this will rise to 25% of our population (as baby boomers mature). However the greatest percentage growth of population will be seen in the over 85 year age group, whose numbers will more than double from current 2% to 5% of total population over this same period.

For the first time in history we are faced with the 'creation' of such large numbers of population surviving close to the limits of human lifespan. Consequently, a number of unprecedented challenges will need to be addressed in the not too distant future by medicine, society and all of us as individuals.

For medicine these challenges will include:

- trying to minimise disability and dependency towards the end of life;
- attempting to ensure that investigation and intervention for people is appropriate at a time where quality of life is most important near the end of life; and,
- developing acceptable alternatives to acute hospital care in the community or home appropriate to personal need and our community's wishes.

Perhaps counter-intuitively, anticipation

of imminent death remains a difficult challenge for clinicians and their patients, though there are often indicators that a person may well be approaching the last months or so of their life.

Many chronic diseases are characterised by recurrent hospitalisations towards the end of life (during which time a large proportion of total lifetime health costs are incurred), any one of which may not be survived, despite survival being expected by all involved, including the person and their family. Treatment of a worsening of a chronic disease may be straightforward and relatively quick. However, such hospitalisations can be beset by a number of complications arising from treatment and hospital environment (including acute confusion, falls, infections, pressure areas) and may incur significant personal cost in terms of loss of independence by the time of leaving hospital, requiring additional support at home or quite possibly a move to residential care.

It also seems likely that the older we become the greater our need for such acute hospital care and the longer each stay will be. And the cost of supportive care relates directly to absolute numbers of people needing this care - numbers expected to grow for at least the next 40 years.

"Decisions may need to be made about possible limitations of treatment (explicit rationing) as hospitals adjust to cope with increasing numbers and complexity of acute hospital admissions"

As early as 2021 it is also expected that there may well be a shortage of caregivers needed to provide support for a frail population, unless demands can be significantly decreased.

Society must therefore grapple with demands from an aging population that might not be readily met, given both the actual dollar cost and the human resource required to provide basic as well as more specialised care. Decisions may need to be made about possible limitations of treatment (explicit rationing) as hospitals adjust to cope with increasing numbers and complexity of acute hospital admissions, potentially at the expense of beds otherwise needed for activities such as joint replacement surgery.

Ending of life

Perhaps most contentious, however, may be the wish to revisit decisions regarding explicit premature ending of life – euthanasia and physician-assisted suicide. As all will know, these two 'activities' are currently illegal in NZ and will remain so for the foreseeable future.

However, the most difficult challenges may remain those at a personal level – either for ourselves or as spokespeople for our ageing relatives or friends. The end of life for many of us is unknowable. Our actions and wishes when the time comes may be unpredictable and possibly contrary to our previously stated position. Our broad concepts of limitations of care we would wish to receive at the end of our life can be stated in a legally binding 'Advance Directive' but circumstances can and do sometimes change. Increasingly, specific requests within an advance directive risk being difficult to interpret and apply in precise circumstances that might not be foreseen.

On the other hand, some of us may wish to have as much done as possible to prolong our life or that of our aged friend or relative, despite such intervention having little, if anything, to offer in the circumstances. It is understandable that demand for this type of treatment is not necessarily rational; it is a reflection of our most basic need for survival. Still, such requests can heavily tax the act of dying.

Trying to match expectations with clinical 'reality' can be a delicate process. Negotiating an understanding of treatment (or limitation of treatment) appropriate to a particular situation is perhaps the art rather than the science of medicine.

Anticipating the future for many of our older, sicker people is impossible without good understanding of their overall health and wishes, and being aware of likely effects of treatment on dependency and outlook beyond the immediate future. If this perspective is lacking at times, such as admission to hospital, there is a risk of inappropriate investigation or treatment, a risk that might be compounded by the raising of false hopes and denying of an opportunity to understand real implications of the illness.

Minimising the risk of unwarranted intervention can be more difficult than you might imagine. Accepting limits to care can only occur after considered discussion between individuals, their family and their health professionals, preferably before an acute complication arises. These conversations can be confronting, but are important in preparing us all for our end, particularly when this is foreseeable. As the end of life approaches many of us would opt for limited intervention and a focus on quality of time remaining. The next challenge is that of ensuring these wishes are known and respected when we present for care in an unfamiliar setting such as the acute hospital.

Continuity of care is at the heart of 'good medicine' for an aging population, but is increasingly difficult to achieve in our current health system and acute hospitals. If we are able to accept that minimisation of intervention for many older people is not only appropriate but desirable, we as a society can look to developing community resources as viable alternatives to acute hospitalisation. This has the real potential to focus on care and rehabilitation rather than 'treatment', allow the care to be provided by health professionals including the GP most familiar with an individual's needs, and deliver the care in a more suitable environment, whether this is within a specifically staffed local care facility or possibly one's own home. This challenge is perhaps the real frontier of medicine for an aged population.

Despite these worrisome ruminations there is much to celebrate. For the first time in history we live in a world where the majority of us can expect to live to near our biologic potential. And enjoy retained independence for the majority, but not necessarily all, of our allocated time. But death is still assured and disparities are yet to be addressed.

We can improve the likelihood of getting to and maintaining healthy old age with relatively simple lifestyle measures – a healthy diet, no smoking, regular exercise, a little alcohol, something to occupy our time and our mind and a good social network. On achieving such an age, however, there is much progress yet to be made in accommodating our health needs and demands. We're not quite ready for old age.

Dr Tim Frendin
ASMS National Executive

MCNZ Workforce Survey 2011: what does it tell us?

On the face of it, MCNZ's latest workforce survey suggests New Zealand's medical workforce is in good shape. The survey report's front-page "Facts at a glance" table indicates the number of doctors per population is growing, the average age is holding at around 45 years, doctors are working fewer hours, and the average proportion of new International Medical Graduates (IMGs) retained after one year is improving. On closer examination a less rosy picture emerges.

Workforce growth in context

The largest proportional growth in the latest year is for house officers (7.6%), which may reflect earlier increases in medical school intakes. Registrars saw only a slight increase (0.7%), while medical officers saw a slight reduction (0.6%). Specialists increased by 4.9%. The combined growth for these groups amounts to 277 doctors.

To put the numbers into context, recently released OECD figures show New Zealand is well down the ranks in terms of the total number of practising doctors per population (25th out of 34 countries)[1]. New Zealand's 2.6 doctors per 1000 population in 2010 compares with the OECD average of 3.1/1000, which also happens to be Australia's figure in 2009 (the latest available). While New Zealand's workforce trends are obviously heading in the right direction, the growth rate has not been sufficient enough to close the gap on other OECD countries for at least the last decade.

An ageing workforce

The flat-line trend on the average age of New Zealand doctors over the past five years hides the fact that the workforce is ageing, as indicated on page two of the report. In the years 2000-2003, the largest group of doctors (almost 20%) was in the 40-44 year age group. By 2009, the largest group of doctors was aged 45-49 and in 2011 the largest group was aged 50–54.

Unpublished MCNZ data show almost half the specialist workforce (49%) was age 50+ in 2010. The effect of the ageing specialist workforce is two-fold. First, as the SMO Commission noted, there is a sharp drop-off in specialist numbers from age 50 onwards. Unpublished MCNZ data show that within the next five years approximately 19% of the specialist workforce will turn 50, and a further 19% will turn 55. Secondly, MCNZ statistics show the estimated average number of hours worked per week begins to fall as specialists get older. Within the next five years 12% of the specialist workforce will turn 60.

The working week

The survey figures for the average number of hours worked by doctors at their main work sites will have a significant margin of error, given the data is based on doctors' estimates of hours worked in a "typical" week (including worked on-call hours), which can vary greatly, or the hours worked in the most recent week at the time of the survey. Notwithstanding questions of robustness, the trends indicate the number of specialists working part-time is increasing. This may be due in part to the workforce getting older, as indicated above, and also because of the increasing numbers of women in the workforce, who, statistics show, are more likely than men to work part-time. In 2010 25.5% of doctors were recorded as working under 40 hours in their main place of employment compared with 22.9% in 2006. The effect of this will be to drive the average number of working hours downwards.

On the other hand many doctors continue to work long hours. In 2010, 45% of the DHB Specialist workforce are recorded as working 50 hours or more per week on average and 14% worked 60 hours or more.

Retention

Perhaps the most pressing issue for New Zealand's medical workforce is retention. The MCNZ's choice of highlighting improvements in IMGs' first-year retention rates is a curious one. It cannot be regarded as a litmus test on general retention trends because a large number of this group are doctors that evidently have no intention of staying long in New Zealand, as the MCNZ acknowledges (page 37). By the second year post-registration, the proportion remaining has averaged around just 37% over recent years, dropping further to around 33% in the third year. Improvements in retention in the first year post-registration may simply be an indicator of lengthening locum contracts or increasing availability of multiple short-term contracts.

IMGs from the Americas (mostly Canada and the United States), the United Kingdom and Oceania (including Australia) have low retention rates, suggesting these countries may not be a reliable source of anything but short-term IMGs in the future (Figure 16).

The survey report's other retention figures concern graduates of New Zealand medical schools, IMG retention after general and vocational registration, and New Zealand graduates after vocational registration. They make for sobering reading.

Retention of New Zealand graduates

At first glance, the medical school graduate retention rate one year after registration looks impressive at around 100% over recent years. However, the proportion of graduates that are not registering when they graduate has been increasing over the last five years (Table 16). In 2008 only 86.5% of the final-year class

registered after graduating, in 2009 it was 86.6% and in 2010 fell to 83%. This is not taken into account in the retention figures.

By 13-14 years post-graduation about a third of the original, registered graduates are no longer practising in New Zealand, considerably limiting the supply of the next generation of specialists (the average length of time from general registration to vocational registration is approximately 11 years[2]). Until this is addressed, New Zealand's capacity to develop its specialist workforce will continue to depend heavily on IMGs.

Retention of IMGs after general registration

New Zealand's increasing dependence on IMGs is shown in the number of IMGs gaining general registration each year, which has more than doubled since 2000, with the biggest increases occurring over the last few years (Table 20). Further, retention has been getting worse since 2000. For example, over the years 2000/01/02, the average retention rate one year after registration was 82.2%; over the years 2008/09/10, the rate averaged 74.4% (the rate for 2010 was just 69.0% - the lowest recorded over the last decade). A similar pattern emerges in the retention trends in subsequent post-registration years.

By 10-11 years post-general registration, more than half of the original IMGs are no longer practising in New Zealand, which again means the potential for replenishing the specialist workforce is diminished.

Retention of IMGs after vocational registration

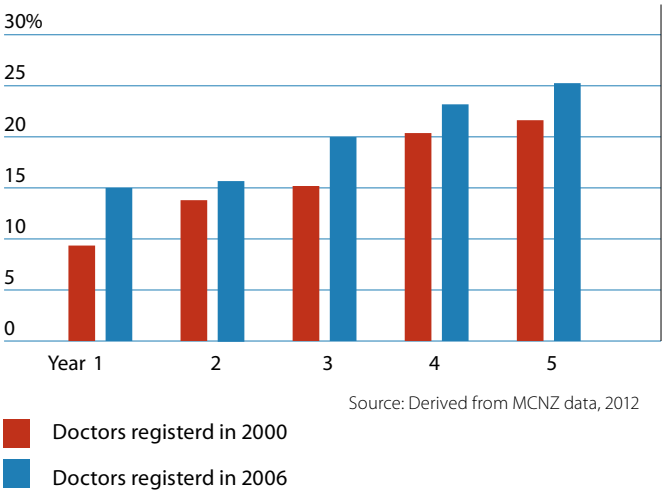
In 1980, 28% of specialists practising in New Zealand were IMGs; by 2011 that had increased to 42% (Table 14). Over the last decade, the number of IMGs gaining vocational registering in a single year has increased by 50% and, as with the retention trends for IMG with general registration, the rate has deteriorated (Table 21). For example, over the years 2000/01/02, the average retention rate one year after registration was 90.2%; over the years 2008/09/10, the rate averaged 83.3%. A similar pattern emerges in the retention trends in subsequent post-registration years.

Figure 1 compares the attrition rates of doctors who registered in 2000 with those who registered in 2006. Of the doctors who registered in 2006, 25% of them were lost within five years.

Retention of New Zealand graduates after vocational registration

Unlike IMGs, the number of New Zealand graduates gaining vocational registration in a single year has not increased over the past decade; if anything it has decreased, averaging 286 doctors in the three years 2000/01/02, and 219 doctors in the three years 2007/08/09 (figures for 2010 are not included). Further, while the retention rates fluctuate, the average rate one year after registration was 85.8% for the three years to 2009 compared with 93.8% for the three years 2000/01/03 (Table 22). A similar pattern emerges in the retention trends in subsequent post-registration years.

Figure1: Percentage of vocationally registered IMGs lost (cumulatively) over five years from cohorts of 2000 and 2006



Source: Derived from MCNZ data, 2012

Conclusion

In its submission to the SMO Commission in January 2009, the ASMS described SMO workforce movements as a "leaking bucket". The findings of the 2009 RMO Commission report suggest a similar description could be applied to the state of the RMO workforce. This latest workforce survey report shows that over the past decade the supply tap has opened up, particularly from the IMG source, but the holes in the bucket have got bigger.

REFERENCES

1 OECD Health Data 2012. Frequently requested data. **www.oecd.org**

2 Clinical Training Agency 2001. The Health Workforce: A training programme analysis. Ministry of Health, Wellington.

Responsibilities for following up results of medical tests

Dr Garry Clearwater, MPS Medical Adviser gives an overview of issues relating to medical tests, where the responsibilities lie, and highlights the need to follow up on results.

A significant number of errors and complaints relate to follow-up of medical tests such as radiology, blood, urine and other tissue tests. In MPS's experience, common themes include failing to ensure that an abnormal result is recognised and acted on, failing to bring a significant result to the attention of the appropriate clinician, and failing to notify a patient of the result and the need for follow-up.

A classic scenario is a mildly abnormal result that is overlooked or dismissed as trivial and not warranting follow-up. This becomes highly significant in retrospect, when a patient presents months or years later with advanced disease and realises that an opportunity had been lost for surveillance and earlier intervention. An example is mild microscopic haematuria that later presents with renal tract malignancy.

Another risk arises when several clinicians are involved in the care of a patient (such as a referral or handover of care) leading to confusion about where to send a test result and who is responsible for following up results ordered by another clinician.

Clinicians need to be aware of their responsibilities and risks, particularly senior medical officers who oversee ordering of tests by nurses and junior doctors, assess referrals from other clinicians (which include previously arranged tests) and review patients on ward rounds. Clinician managers and their organisations have accountability for setting up and overseeing follow-up systems.

Right 6 of the Code of Health and Disability Services Consumers' Rights specifically refers to a clinician's legislative responsibility to follow up the results of laboratory or radiology tests:

> *Right 6 (1): Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*
>
> *(f) The results of tests.*

This responsibility is reinforced by the Medical Council's statement on "The maintenance and retention of patient records":

> *02(b): Doctors should have systems in place to ensure that test results are acted upon in a timely manner, including notification of patients as appropriate.*

The doctor who orders a test needs to consider whether adequate systems are in place to ensure that crucial tests are actually performed and that results are received and acted on. These may include reminder systems to chase results.

Patients should be clearly informed as to how and when they will be notified of their test results.

It would be burdensome to routinely notify all patients of all results. The requirements of Right 6 can be managed with a policy that normal results will not be notified unless requested – if the patient agrees. The health provider must then ensure that all significant results are identified and followed up, as the patient will be acting under the assumption that "no news is good news."

Follow-up of test results has been well established as a component of a "reasonable standard of care" as determined by agencies such as the HDC and Medical Council. Doctors and organisations have been criticised and have been subject to penalties and remedies for breach of these professional standards.

The Code of Health and Disability Services Consumers' Rights that are typically quoted in HDC breach findings include Right 4(1) to have services provided with reasonable care and skill; Right 4(4) to have services provided in a manner that minimises harm and optimises the quality of life; Right 5 for co-operation among providers to ensure quality and continuity of services; and Right 6 (1)(f) to be informed of test results.

These HDC findings incorporate advice of expert advisors and commentary. They indicate that the responsibilities regarding follow-up of test results include (with relevant HDC case references):

- A clinician who orders a test has responsibility to ensure that tests are recorded in the patient's records and that a system is in place to follow up the results in a timely manner. (02HDC04719, 04HDC08084, 04HDC00841, 07HDC10316, 10HDC01419.)
- The doctor's primary responsibility to follow up abnormal test results cannot simply be devolved to the patient. The HDC recently commented (10HDC01419), *"it is the referring practitioner's responsibility to follow up test results, not the patient's."*
- If a doctor assumes care for a patient who had tests undertaken by someone else in the organisation (including by a nurse) then the doctor should identify which tests have been ordered and ensure that all of these tests are reviewed in a timely manner. (09HDC00865, 01HDC03196.)
- Organisations have responsibility to ensure that adequate systems are in place to record that tests have been taken, that results are drawn to the attention of appropriate clinicians and actioned in a timely manner. (09HDC00865, 07HDC10316, 03HDC02380, 10HDC01419.)
- When care of a patient is handed over from one doctor to another, both doctors have responsibilities regarding following up test results.
  - The doctor who hands a patient over should review all test results to hand, should document tests ordered and should notify the accepting doctor of any pending test results as well as the results already to hand. (05HDC11908, 04HDC00841.)

- A doctor who accepts care of a patient is expected to actively review results of tests already performed. (05HDC11908.)

- Supervising specialists are expected to review all test results when they review a patient. (05HDC11908.)
- Patients have a right to expect that they will be informed of all significant abnormal results. (08HDC06165, 03HDC02380, 00HDC07636, 10HDC01419.)

In summary, the process of ordering any test should include a clear, agreed plan about how the result will be reviewed and who will follow it up. Patients need to be informed as to how results will be notified to them. The default position is that patients must be informed of all significant test results – and it is the doctor's responsibility to ensure that this happens.

Furthermore, minor test abnormalities may be early markers of a developing condition and should be carefully addressed.

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

www.asms.org.nz

Have you visited our regularly updated website? It's an excellent source of collective agreement information and it also publishes the ASMS media statements.

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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***

How to contact the ASMS

Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
Cnr Brandon St & Lambton Quay, Wellington

Telephone	04 499-1271
Facsimile	04 499-4500
Email	asms@asms.org.nz
Website	www.asms.org.nz
Post	PO Box 10763, Wellington 6143

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