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ASMS
TOI MATA HAUORA

www.asms.org.nz

Industrial law changes threatening

Understanding employment law and its application to the workplace circumstances of our members is critical to the ASMS's ability to provide effective representation collectively and individually, both inside and outside DHBs. It goes to the core of our 'bread and butter' work.

Since our formation in 1989 we have had two broad conflicting forms of industrial law. From 1991 to 2000 we had the Employment Contracts Act which, consistent with the ideology of that decade, saw employment through a narrow contractualist lens. The assumption was that employment could be reduced to words in a contract, it was little more than a commercial transaction, and that there was a level playing field between employer and employee. This approach lent itself to a more adversarial approach to employment relations.

> *In most jobs and occupations there is a significant imbalance in the employer-employee relationship favouring the employer.*

Since 2000 we have had a fundamentally different approach under the Employment Relations Act (ERA) where the focus is on the employment relationship (not the contract only). In most jobs and occupations there is a significant imbalance in the employer-employee relationship favouring the employer. The ERA endeavours to reduce this imbalance by focussing on the quality of the employment relationship between employer and employees (which is also seen as enhancing productivity) and the rights of employees to negotiate collectively through their applicable unions.

In contrast to its predecessor, the ERA has fostered the development of a single set of transparent, fair conditions of employment for senior doctors and dentists, codified ultimately in the ASMS DHB MECA. The ERA has proved a good framework for systematically working through sometimes very difficult issues for our members who form a crucial part of the New Zealand public health system.

This framework is now threatened by the Employment Relations Amendment Bill, currently before Parliament, in three main ways. Some of the principles of the first more adversarial form of industrial law are being introduced (rather like a Trojan Horse) into the shell of the second more cooperative form.

Government arguments for the Bill

The arguments for the Bill advocated by government are four-fold – the ERA needs more flexibility; the Bill will create jobs; the ERA needs to be (according to Minister of Labour Simon Bridges) "rebalanced" towards employers; and the Bill will lead to greater productivity.

There is no evidence to support three of these four arguments. By international standards the ERA is already very flexible and is one of the most deregulated industrial laws in the OECD. No evidence is produced to support the 'create jobs' argument. In fact, reducing high unemployment seems to be more likely in countries with more regulated industrial law than New Zealand. Similarly no evidence is provided that productivity will rise from this Bill.

But on one of these four arguments Simon Bridges is spot on. It will, if adopted, increase the power and authority of employers at the expense of employees, whether cleaners or doctors albeit to different degrees.

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Removing the obligation to conclude a negotiation

One of these ways is the removal of the current obligation in the ERA for employers and unions to conclude negotiations for a collective agreement. This duty is important because it provides protection against those who would otherwise only go through the motions of bargaining in order to avoid it.

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While it does not determine what the settlement should be, it does require that there be one.

Since 2004 the ERA has required that a collective agreement be concluded unless there is genuine reason based on reasonable grounds that it not be. The legislation then spells out the limitations on what constitutes a genuine reason on reasonable grounds. It is unlikely that DHBs would have invoked the opportunity had they had it available in our four MECA negotiations since 2004 because of their own preference for collective agreements and the ASMS's relative strength due to high density membership. But, with some of the more adversarial attitudes emerging under the relative revival of managerialism coupled with the high variability in capability of human resources managers (linked in part to their high turnover), a change of position is conceivable.

What can be said with confidence, however, is that some of the collective agreements that the ASMS has concluded since 2004 with employers outside the DHB sector would have been unlikely to have been concluded if the proposed amendment had been in effect.

If this provision is removed then only DHBs and other health employers would have any incentive to take advantage of this situation (employees through their unions would have no incentive at all). But in the more vulnerable non-DHB sector we could see some employers going through a sort of 'fake bargaining' where they go through the motions but have no intention of and never intended to have a collective agreement.

Opting out of a MECA

One of the strengths of the ERA is the ability to negotiate industry or sector focussed multi-employer collective agreements (MECAs). This has been particularly beneficial for the health system which functions best on a 'whole of system' basis. Integral to this are nationally consistent entitlements in DHBs such as salary scales, job sizing (including recognition of non-clinical time), CME and annual leave.

But also integral are rights. Why should the right of senior doctors to participate in public debate and dialogue (speaking out), to refer unresolved concerns over patient safety to a disputes resolution, or to require their DHB to respect senior doctors' primacy of responsibility to their patients vary between, for example, smaller DHBs such as Wairarapa and West Coast, medium sized DHBs such as Hawke's Bay and MidCentral, and larger DHBs such as Auckland, Capital & Coast or Canterbury?

The proposal in the Bill is that any employer with whom bargaining for a MECA is initiated can opt out by writing to the other parties within ten days of receiving such a notice. The MECA the ASMS negotiates with DHBs provides the base terms and conditions of employment for an increasingly 'joined up' public health service. Collaboration between DHBs would have been far more difficult in a situation where senior doctors were not covered by a single MECA.

The ability to opt out will make maintenance of national MECAs more difficult to sustain thus cutting across successive governments' commitment to national collaboration in the public health sector in the absence of a direct order from the government.

The position of the DHBs currently is that they support MECAs. This is good and responsible. But it is their current position. DHBs are notorious for their inconsistency, fluctuations and flip-flops. Their betrayal over the agreed Business Case in 2011, influenced by government pressure, is a sharp and unpleasant example of this. Things can change at the whim of a new national leadership, as a result of a shift in political direction, poor human resources advice, or the revival of managerialism.

Protection for new appointees in their first 30 days

The ERA requires employers such as DHBs to employ new appointees under the applicable collective agreement (where one exists) if they are a union member (eg, ASMS) or, if not a union member, to be offered the same terms and conditions of employment as an individual rather than collective agreement. This protection is particularly important for senior doctors in DHBs but this retrograde Bill seeks to remove it.

The ASMS was confronted by a similar threat when there was no such protection in the 1990s employment legislation. Eventually we were successful in thwarting it but it did force some new appointees to go through a bad experience.

With 42% of doctors practicing in New Zealand having gained their primary medical qualification overseas it is likely that at least this proportion, if not higher, work in public hospitals. Medical Council data suggests that the rate for new vocational registrants is around 50%. Further, according to data provided by the Minister of Health to Green MP Kevin Hague under the Official Information Act, 60% of the new hospital doctors since Mr Ryall became Minister are overseas trained. This is trending in the opposite direction of Health Workforce New Zealand Chair Des Gorman's aspiration to bring this share down to 15%.

The ASMS provides advice to these senior doctors about to take up employment with a DHB. It is hard to over-emphasise how little many of these doctors understand about the New Zealand arrangements for salaried employment. In the pre-ERA era of the 1990s much effort was expended by the ASMS on unravelling some of the confusing, unfair and often counterproductive arrangements that had been arrived at in the early days of their employment.

Short sighted; nothing to commend it

This Bill is an extremely short sighted provision for a nation that is seeking to establish a skilled and stable labour force and is particularly short-sighted in the public health sector. Any senior doctor who discovers that they have been taken advantage of in this way will inevitably have difficultly trusting in their employer's goodwill ever again.

> *These amendments in the Bill are irrelevant in the hands of wise good employers but high risk in the hands of the less wise and good.*

There is nothing to commend this unfortunate Bill. The good principles of the ERA should be strengthened and extended, not weakened. These amendments in the Bill are irrelevant in the hands of wise good employers but high risk in the hands of the less wise and good. Unfortunately in the health sector we don't just have the former; we also have the latter.

Ian Powell
Executive Director

PRESIDENT'S COLUMN

MECA debrief and imagining the future

The MECA has been ratified (old news) but some of the story remains untold. It is important that this story is told to give you a greater understanding of how we ended up where we did. To start with, I want to take you back 43 years.

Picture the scene

Three men; Jim Lovell, Jack Swigert and Fred Haise are in space and approximately 320,000 km from earth heading towards their target, the moon.

Mission Control asks Jack Swigert to give the hydrogen and oxygen tanks a stir. A minute and a half later a loud bang is heard. Then the famous words, 'Houston we've had a problem'.

The reply from Houston, after an uncomfortable silence; 'Well guys we have had a bit of a chat down here and we realise that the Union for Astronauts (UFA) is currently in salary negotiations and we reckon you are over-exaggerating this whole "our oxygen tank has exploded" to further your case. We have given you enough oxygen and resources to start with. You just need to learn to live and breathe, within your means. We also have data here indicating that we have appointed a thousand extra astronauts. Keeping all that in mind you should have no problems. We reckon you can achieve your target. Oh, and please do not try the "CO2 is building up gag". We have heard that one before. Houston Out.'

The scenario above is difficult to imagine.

Reality

About seven months ago in a white room here on planet earth, in Wellington Airport, two groups of people met. The ASMS negotiating team, and across the table from us, a negotiating team representing the 20 DHBs. After the usual exchange of pleasantries we started to set out our case and indicated that 'we've had a problem' and in fact we have had one for quite sometime. One that DHBs acknowledged in the jointly agreed *Business Case* (November 2010), one that the Minister of Health acknowledged (3 October 2010) when he said: "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."

This problem has not gone away, in fact our most recent research published *The Public Hospital Specialist Workforce; Entrenched shortages or workforce investment?* indicates it is getting worse. Now to our surprise, after an uncomfortable silence, the answer from across the table was (and I paraphrase):

> *The DHBs do not believe there is a problem, we are not interested in listening to your research, we have done some research ourselves and in fact things are looking much better, but if you continue to believe that you have a workforce problem, we suggest you speak to Health Workforce New Zealand. That is what they are there for. We are here to discuss the salary scale and terms of the MECA only. (Houston Out)*

We heard the same 'we were given strict parameters, $42m' rhetoric coming from the DHB negotiators. We started to question whether we could classify the process as a negotiation seeing that there was very little actual negotiating happening.

What changed that? As we all know we turned down the initial offer. So back to the 'negotiating' table.

Two stories

Two stories were told that in my opinion changed the course of negotiations. The first by past president, Jeff Brown, who related to the DHB negotiating team the fact that Clinical Directors are very aware of DHB budgets and financial problems and we are not here to further bankrupt health care but unfortunately 0.7% is just not acceptable.

The second a story by John MacDonald, a simple country surgeon, who told us in a very heart felt delivery, how the down scaling of services in Ashburton had a profound effect on the outcome of a particular clinical case. It suddenly added a good dose of reality to the negotiations as the outcome of the case was not good. It highlighted to all of us in the room that despite all the research and rhetoric, we are dealing with real patients, real clinical situations and decisions in a white room far removed from the coal face can have a significant impact on the delivery of health care.

We started to make progress and for the first time it felt like we were starting to actually negotiate. BUT it became clear once again that although the parameters might have shifted we could only push things to a certain point without resorting to hinting at possible industrial action.

Unfortunately the behaviour of denying that there are any problems in the public health sector started to spill into the media. During this time if Executive Director Ian Powell or the ASMS made any comments suggesting 'we've had a problem' or any reference to the 'creaking and straining' health care system, it was rebutted by: 'they are in MECA negotiations, what else would you expect. There is no problem.'

The possibility of industrial action, or threat thereof, was discussed on several occasions both at our regroup sessions during negotiations and also informally between ourselves and with members in our DHBs. Our conclusion was that the ASMS would not have public support or sympathy for industrial action and our members would not commit to it either. So in the end we played the hand we were dealt the best we could and left the industrial-action-card tucked away up our sleeve.

Back to Apollo 13 and Mission Control

In real life the response was very different from what I previously suggested; in fact they immediately acknowledged and investigated the problem. They decided that 'failure is not an option' and a problem that could have turned out to be a major disaster ended up being one of the most memorable triumphs.

As new problems arose they tackled them with the same determination. They got the best people on the job to find solutions. Carbon dioxide was building up rapidly. The solution was literally to make a square peg (cartridge) fit into a round hole.

What does this have to do with our New Zealand health system?

Imagine if DHBs and the government started to acknowledge that we do have problems and take us seriously. We do need to get the best people for the job, on the job. Imagine if there was a deeper realisation of the fact that failure is not an option and that this health care system needs to serve 4.5 million New Zealanders, come hell or high water (or earthquakes).

> *Imagine if there is a deeper realisation of the fact that failure is not an option and that this health care system needs to serve 4.5 million New Zealanders, come hell or high water (or earthquakes).*

Do not get me wrong here; there are a lot of positives happening in our health service as well. We should not lose sight of that and give praise where praise is due. As a paediatrician it is great to see what we have achieved with the immunisation rates. Further analysis of how this was achieved is interesting. It was set as a target by the Minister of Health. The benefit to patients was clear and evidence based. The target was embraced by DHBs and the front line. We had to plan and work together across primary and secondary care. We put the patient and families in the centre and planned our actions around them. It took a team effort and hard work to reach the target but we did it. More importantly everyone (from the Minister to the front line) achieved this together.

I look around me every day and I see people working very hard. However sometimes efforts are misguided. As the saying goes; 'If you are heading in the wrong direction, the last thing you need is progress.' Not only that but the energy utilised to head in the wrong direction, is not available to make progress in the right direction. Double whammy.

Next year is election year and we are already seeing some not so friendly banter in parliament. Health undoubtedly will be central to political campaigning once again and it is only going to escalate closer to election time. Who do the public believe in the end? What is fact and what is political spin. The ASMS will invariably be asked to comment on these matters.

> *The message to politicians is clear, to ignore (or spin) the facts does not change the facts.*

The public should be able to rely on the ASMS to be the voice of reason. The public deserve to be given the facts. The message to politicians is clear, to ignore (or spin) the facts does not change the facts. Health is too important an issue to have spin put on. It touches everyone's lives. The ASMS will comment and for the next three years the rebuttal of 'they are in negotiations' will not be available to those who do not accept the fact that the ASMS, at its core, is working for better health care in New Zealand.

We have a big, very square peg to fit into a very round hole and failure is not an option.

Hein Stander
National President

EXECUTIVE DIRECTORS COLUMN

Time to retarget targets?

Last month there was an interesting public debate between Labour's health spokesperson (and formerly the longest serving Minister of Health) Annette King and the close to first equal longest serving Health Minister Tony Ryall. The subject matter was emergency department triage data the former Minister obtained under the Official Information Act revealing that some DHBs were not meeting the standards for some of the triage categories in emergency departments.

Health Minister disappointing

The ASMS became embroiled in the debate that followed, responding that while the government's six hour target had achieved much good, resulting in hospital-wide gains for patients, this data revealed that there was still room for improvement within emergency departments

Mr Ryall's response was disappointing, however. In essence he dismissed outright the usefulness of triage data despite them being developed by the Australasian College of Emergency Medicine. This is significant because it was also the ACEM that developed the six hour target which Mr Ryall is rightly proud of.

Further, ironically for the Minister, in the preceding month the ACEM revised their policy on their triage scale describing it as "a clinical tool for ensuring that patients are seen in a timely manner, commensurate with their clinical urgency." The triage scale is identified as an important means of coping with overcrowding and access block pressures. It was sad to hear the Minister misuse the College developed six hour target to discredit the College developed triage scale.

In another media discussion on health targets earlier this year the ASMS's position was misrepresented by Lester Levy, Chair of both the Waitemata and Auckland DHBs. He is the Board chair most likely to be used to defend the government's position even to the extent of attributing to others (i.e. ASMS) a position that they do not hold. In fact, the ASMS has been supportive of the target because it has been clinically developed and led.

Further, the ASMS defended Dunedin emergency medicine specialist Dr John Chambers for exercising his right under the MECA to 'speak out' over lack of progress in achieving the target in Dunedin Hospital.

Targets – a strategy they do not make

A major weakness of our health leadership is that we lack a strategic direction over where our health system should be going and how it should get there. The six hour target, which is much more than being about what happens in emergency departments, has helped achieve important hospital-wide change which has been beneficial for patient care and the patient journey.

The electives target has gone a long way to meet unmet patient need and, in effect, is a cost effective form of early intervention preventing conditions from deteriorating further and becoming more complex and urgent.

But targets are no substitute for a coherent strategy. While generally laudable and benign, avoiding the rigidities and perverse incentives of those in the National Health Service in England, they are blunt instruments that only measure what can relatively easily be counted. This is considerably less than the totality of what public hospitals actually do, such as treating chronic illnesses, providing acute surgery and mental health services as well as providing secondary services in a community setting – none of which lend themselves to targets.

Targets themselves are not the problem, what is the problem is intense micro-management coupled with insufficient investment in the resources (usually workforce) needed to deliver them. Even though targets constitute only a small part of what DHBs do, their constant monitoring and reporting coupled with ministerial and central government direct communications to DHBs (including at the level of senior management), such as phone calls and texts, puts extreme pressure on DHBs and generates risk of distraction from more substantive quality and safety issues.

The electives target itself is starting to create difficulties, particularly given the lack of workforce capacity. The problem is not so much the increased volumes but the reduced maximum waiting times from six to five months, and then to four next year, along with removing the previous buffer mechanism.

Membership feedback on targets

The ASMS has regular Joint Consultation Committee (JCC) meetings in each of the 20 DHBs. These are good mechanisms for engagement with senior management including chief executives. We have started to use JCCs to discuss the experience of targets including their unintended consequences. To date, what has emerged includes:

- Some types of clinical need are being favoured over other equally pressing clinical needs that are not covered by a target.
- Referrals of emergency department patients to the wrong hospital service due to pressure to meet the six hour target.
- DHBs insufficiently resourced to meet the reduced waiting time target for cancer first specialist appointments.
- Elective follow-ups being crowded out by the pressures to do more first specialist appointments.
- Concern that specialists would be accused of cynical manipulation in the meeting of targets through, for example, relabelling.
- Deliberately incorrectly coding in computer records where the ED patient is. That is, the computer record states that the patient has been admitted to a hospital ward thereby being counted for the purpose of achieving the six hour target but, in fact, the patient is still in ED.

It is not a question of radically changing or getting rid of the targets. But it is a question of easing the pressure on their achievement including backing off the micro management. It is also a question of developing a strategic direction for our public health system that is more than keeping bad news stories out of the media.

What do we know about health targets if health targets are all we know? The Minister of Health might wish to reflect on this.

Ian Powell
Executive Director

ASMS now has a Māori identity!

Toi Mata

There are many good reasons for having a Māori name. One is purely practical. We are talked about in the Māori language, in the media and on Marae. It's good to have a name in te Reo by which we are consistently known.

Te Huirangi Waikerepuru and Te Urutahi

It also reflects our commitment as senior health professionals to Māori as patients, as well as colleagues and present and future members of the Association.

And as an influential organisation in New Zealand's public health system we should have an identity reflecting our place in Aotearoa.

The name was gifted to us by Te Huirangi Waikerepuru of Ngāti Rauru and Taranaki. Te Huirangi has a long-standing association with ASMS as a kaumatua in the wider union movement. He was also a founder of the organisation Nga Kaiwhakapumau i te Reo, which was instrumental in the revitalisation of Māori in broadcasting and education. He was recognised for his achievements with an honorary Doctorate of Literature from the University of Waikato in 1995.

The name he gifted is **'Toi Mata Hauora'.**

The name can be explained like this:

Toi = summit or peak. Toi is used, by extension, to mean 'art', 'artistry' and 'expertise', so is perhaps a better acknowledgement of the nature of ASMS members' work and achievements than our English designation of 'senior'.

Mata = eyes, referring here to our role in supervision, oversight, planning, prediction and watching out for the health system as well as our patients. "Mata" can also mean "face" and here references the 'faces' of a mountain indicating the many medical specialties.

Hauora = 'health' and is made up of two words 'hau' = 'breath' and 'ora' = life. Breath is a culturally important reference in Māori; for example part of the purpose of a hongi, or the ceremonial pressing of noses, is to allow breath to mingle – a symbol of unity. 'Ora' is of course well known in the expression 'kia ora' literally meaning, emphatically 'have life!' or 'be healthy'!

So the name expresses ideas of 'the epitome of health expertise' or 'the many facets of excellence in health' or 'the art of health' and maybe even 'the view from the top of health'.

Toi Mata Hauora does not of course translate exactly into any of these. A highly literal transcription (allowing for differences in Māori word order and multiple meanings) is "Peak Expertise and Vision for Health".

It is common for Māori words and phrases to have multiple meanings, depending on context, and it is entirely appropriate that the Association has an identity which translates into several meanings, all of which reflect our members, severally and collectively.

There have been two events associated with our new name. The first was the formal gifting of the name by Te Huirangi and his daughter Te Urutahi at the branch officers meeting on 26 March 2013 in Wellington. The Executive, Branch Presidents and Vice Presidents, and national office staff were moved by, and appreciative of, the respect shown by Te Huirangi for our work, and the obvious pride he took in being asked to decide on and to gift the name.

National President Hein Stander, National Vice President Julian Fuller, Colin Feslier and National Secretary Jeff Brown

Hauora

ASMS Representatives at Te Kōpae Tamariki Kia Ū Te Reo

The second event was a reciprocal visit I made to the Taranaki. Supported by Assistant Executive Director Angela Belich and her husband Colin Feslier, I was welcomed into Te Kōpae Tamariki Kia Ū Te Reo in New Plymouth. This is a kohanga reo (Māori language pre-school) nominated by Te Huirangi to receive a koha marking his gifting of the name to us. Appropriately enough, we learned that the kohanga was also named by Te Huirangi. We were entertained by the tamariki and their teachers, shared a meal, and left them with song and mutual respect. Along with some slightly noisy musical objects for the tamariki and a financial contribution to their kohanga.

It has been a long journey reaching this point in our Association's life when we can adopt a Māori identity. It was important to find the right person with the mana and credentials to choose and to gift the name. It was important to receive the gift in the appropriate manner and ceremony. It was important to recognise the gifting with appropriate koha. It is also important that our Māori identity is illustrated in our stationery, website, and communications so that our professionalism is enhanced and our identity reflected to all who look to us for leadership and representation.

You should all be proud of the new look and identity.

In our 25th year, I certainly am.

Jeff Brown
National Secretary

A special thanks to Colin Feslier

Colin Feslier played a central role in the ceremony gifting "Toi Mata Hauora", observing protocol and guiding our responses. He was instrumental in our visit to return koha, fluently speaking for us in te reo. He relished the chance to spend time with his former mentor and tutor, Te Huirangi Waikerepuru and considered that to be reward enough. However we would like to publically acknowledge Colin's contribution for which we are sincerely grateful.

Kia ora Colin,
tēnā rawa atu koe.

A new brand for ASMS

The gifting of the Maori name Toi Mata Hauroa to the ASMS encouraged the Association to undertake a rebranding process. We felt it was important that our new identity be reflected across all our communications and we sought a new logo that would both incorporate and represent our Maori name.

We have considered ideas for the rebrand during this year, aiming for a design which, while not radically changing from our current identity, adequately reflects the meaning of the new Maori name (described in detail in the Toi Mata Hauora article on pages six and seven).

Our final design is something we feel signifies the meaning of our gifted Maori name particularly well. The three mountains represent the many faces of healthcare and acknowledge ASMS members, as senior doctors and dentists, at the 'peak' of the health profession, and the ASMS' multi-faceted role at the summit of the health system.

We have maintained our original colour palette, so although we have revamped our designs, our publications will still be easily recognisable. The new logo has been incorporated into the designs of all of our publications, print and electronic communications and stationery.

Rebranding with the new logo and designs will build on ASMS' reputation as a professional organisation at the forefront of the New Zealand health sector, reflecting the essence of our new Maori name Toi Mata Hauora.

Recent ASMS Publications have adopted the new branding regime.

ASMS Online Membership Form

The ASMS has recently undertaken the development of an online membership form. There have been several driving factors behind the decision to implement this but most importantly it is hoped that an online form will make joining the Association as easy as possible.

The new form features comprehensive drop down lists with fast-find features allowing the majority of users to find and select both their employers and departments by typing in just the first few letters of the name. We have included the ability to add multiple workplaces and it is easy to select where you would like any mail or communications from us to be directed.

Members wishing to pay their membership subscription by salary deduction are able to join immediately by instantly validating the deductions authorisation via a link which automatically notifies the ASMS and the employer's payroll department with the deduction details. The option to pay annually by invoice is still provided, however membership is not activated until payment is received.

We have recently completed live testing with around 50 members having used the new form which will be launched on the website this month. We hope the form is successful in saving time during the application process and that our joining members will find it simple and easy to use.

The Health Practitioners Competence Assurance Act: review plans reviewed

The Health Practitioners Competence Assurance Act (HPCAA, the Act) is the piece of legislation that sets up the Medical and Dental Councils; and the other health professional regulatory authorities such as the Nursing Council. As such this Act is the basis for New Zealand's system of regulating the health professions

In 2012 the government's health workforce agency (part of the Ministry of Health) Health Workforce New Zealand issued a discussion paper posing some fairly fundamental questions about the HPCAA. This paper left little doubt that the government was prepared to entertain a substantive revision of the Act. The most fundamental change proposed was to shift the Act's primary focus from the health and safety of the public to a focus on workforce needs.

> *This paper left little doubt that the government was prepared to entertain a substantive revision of the Act.*

There were 145 submissions on the review including one from the ASMS (Health Workforce New Zealand's summary of submissions is available on **www.health workforce.govt.nz/tools-and-resources/consultations/submissions**. In our submission we focused on the need for the HPCAA to focus on maintaining standards through a focus on public safety.

HWNZ backs off

Health Workforce New Zealand, apparently as the result of submissions which were very strongly of the view that the Act was working well, have drastically cut back their plans for reviewing the Act.

Instead of the planned discussion paper that was to have been released in the middle of this year they held focus groups to discuss four proposals to change the Act. The proposals were;

- Change the Act to give guidance to the regulatory authorities as to what information they should provide relating to complaints and disciplinary outcomes
- Require the authorities to develop a shared code of practice for all health professionals
- Require the authorities to develop a shared set of standards for team work and communications between health professionals.
- Audit all authorities every three years against a set of indicators

In addition there are 22 recommendations that came out of the 2007-2009 operational review that have been awaiting action.

Originally HWNZ proposed to have two focus groups for the regulatory authorities and one for all other stakeholders with only one representative for both employers and unions from the National Bipartite Action Group. We managed to get a separate union focus group set up.

The next step is for recommendations to be made to the Minister of Health. In the meantime the regulatory authorities are looking at proposals for a shared secretariat.

Angela Belich
Assistant Executive Director

Joint Consultation Committees – a good place to be

Joint Consultation Committees are set up in each of the 20 DHBs under the MECA. They comprise the ASMS and DHB represented by senior management usually including the chief executive. They are held three times a year.

The JCC has a history now as a useful means of engaging with senior management over issues of importance to ASMS members. This includes encouraging greater SMO engagement and leadership in the DHB and raising local issues of interest and concern.

Some features of the JCC discussions include:

- Normally there is an update from the Chief Executive on issues of note.
- Regular reports on SMO staffing levels and developments along with sabbatical usage and planning.
- Local concerns such as IT and primary-secondary collaboration or integration.
- Promoting SMO engagement and clinical leadership in the DHB.
- Whether a 'Mid Staffordshire' could occur in New Zealand?
- Local application and implications of national processes and issues such as Health Benefits Ltd and (sometimes unintended consequences) in the DHB of national issues such as the government's health targets
- ASMS employment advisory publications on bullying and working away from one's home base.
- Application of the MECA (not individual member cases however).

The JCC is an important vehicle for constructive engagement with senior management over issues of importance and relevance to SMOs. Members interested in joining the ASMS team on the JCC should contact their local ASMS branch president or vice president; or ASMS Membership Support Officer, Kathy Eaden **ke@asms.org.nz.**

Misleading claims on public hospital doctor numbers

On the evening of Tuesday 30 July Parliament debated the Vote Health Estimates. Five MPs participated in the debate – Annette King, Kevin Hague and Barbara Stewart from the opposition parties and Paul Hutchinson and Jian Yang from the government.

During the debate the latter two MPs sadly repeated the deliberately misleading claim of 1,000 extra hospital doctors in DHBs since the National-led government took office in late 2008.

The context of this claim is important to understand. In opposition, the Hon Tony Ryall asserted that there was a specialist workforce crisis in DHBs.

As Health Minister he continued to articulate this in meetings with the ASMS and in public as late as October 2010. It was his number one priority. In November 2010 the DHBs and ASMS agreed with the Minister that the crisis remained in a joint publication *Securing a Sustainable Senior Medical and Dental Officer Workforce in New Zealand: the Business Case.*

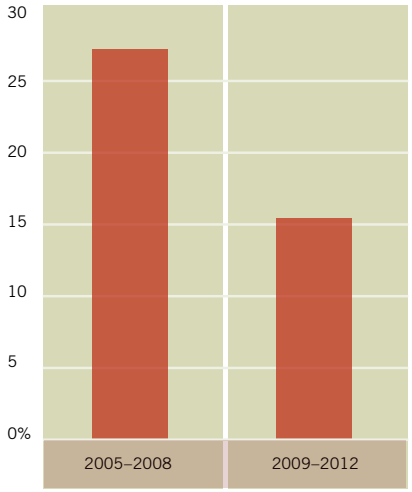
Change to political spin

Suddenly, in election year 2011, the assessment changed without any explanation as to why. Instead the political spin was that we were having record increases in the number of hospital doctors and now it is claimed that there are over 1,000 extra hospital doctors in DHBs since the National led government took office.

> *But this is a political spin cover-up achieved by both fudging the data on resident medical officers (RMOs) and then using unreliable RMO figures*

But this is a political spin cover-up achieved by both fudging the data on resident medical officers (RMOs) and then using unreliable RMO figures [at the beginning of the four year period a large number of RMOs, mainly in the wider Auckland region, were employed as contractor locums, coded as 'casuals' and, as a result, not counted as employed hospital doctors; by the middle of this four year period this form of employment had been drastically reduced and they were counted as employees].

Number of Specialists
Annual average % change



Source: DHB Salary Survey Data (2004-2012)

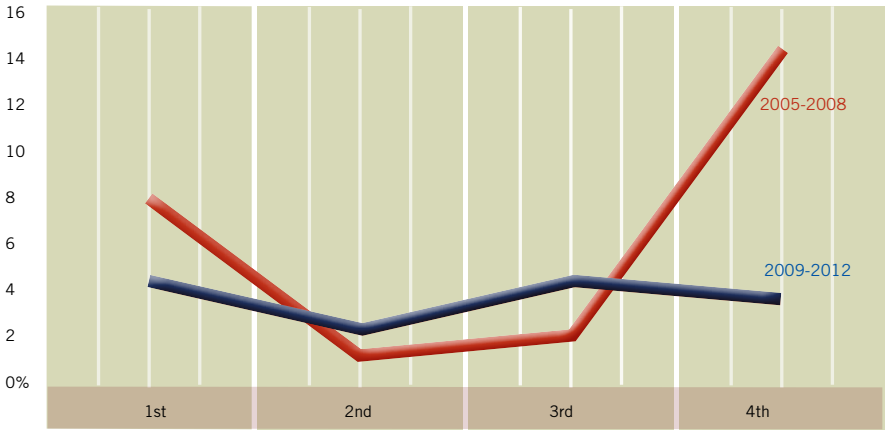
According to DHB data the number of specialists increased by 514 (129 per annum) in the four years from 2008 to 2012 (using a 1 July date). In the previous four years (2004-08) they had increased by 703 (178 per annum. This declining trend (27.5% decline in the rate of increase from the four years to 2008 to the four years after) should also be seen in light of the joint assessment in 2010 by the ASMS and DHBs that the number of specialists needed to increase by over 200 per annum.

Specialist shortages in public hospitals have become the entrenched norm. Specialists are overworked and overstretched while at the same time they are hit by the combination of demographic changes (aging population), high public expectations and increased government demands.

> *Specialists are overworked and overstretched while at the same time they are hit by the combination of demographic changes (aging population), high public expectations and increased government demands.*

Knowingly using misleading data to cover up this unacceptably risky situation is disrespectful of public hospital specialists and irresponsible towards the public. We need leadership, not spin.

Number of of Specialists
Annual % change (2005–2008 compared to 2009–2012)



Source: DHB Salary Survey Data (2004-2012)

ASMS Twenty-fifth Annual Conference

THURSDAY 28 & FRIDAY 29 NOVEMBER 2013
RENOUF FOYER, MICHAEL FOWLER CENTRE, WELLINGTON

Dinner and Pre-Conference Function

A conference dinner will be held on Thursday 28 November at Te Wharewaka on Wellington's Waterfront. A pre-conference function will be held at The Boatshed on the evening of Wednesday 27 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 **17 October 2013**.

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.

DELEGATES REQUIRED

The ASMS makes all travel and accommodation arrangements for ASMS Delegates to attend its 25th Annual Conference.

Register your interest today
ke@asms.org.nz

ASMS
TOI MATA HAUORA

DR JOHN BONNING

Shorter stays in ED – four years on

Dr John Bonning, Chair NZ Faculty Australasian College of Emergency Medicine (ACEM), was one of the core group that designed the six hour target. He comments here on the challenges and progress in meeting that target. Dr Bonning is also a former ASMS National Executive member.

Each year New Zealanders make around one million visits to emergency departments (EDs) at our public hospitals. Demand for ED services has grown inexorably over the past decade for a number of reasons: the total population has increased; a higher proportion of people live to an advanced age; there is an increasing burden of chronic conditions and there is unmet healthcare need elsewhere in the sector that ends up in our EDs. As a result, some EDs are struggling to cope and patients face delays before being admitted to hospital, transferred or sent home. These problems were particularly apparent prior to 2009, with increasingly prolonged ED stays for many of our patients.

> *These problems were particularly apparent prior to 2009, with increasingly prolonged ED stays for many of our patients.*

Prior to introduction of the shorter stays in the ED target more than 20% of patients stayed more than six hours in ED prior to their disposition. The accumulation of these patients in the ED caused increasing ED overcrowding. The cause of this overcrowding included problems throughout the whole acute care system, meaning patients at all stages of their journeys through the system were being delayed before they could move on to the next phase of care. If patients are coming into the system in increased numbers, but cannot progress through the system in a timely manner, then they accumulate in the ED causing prolonged ED length of stay and ED overcrowding.

The target – response to a failing acute care system

ED overcrowding is a manifestation of a failing acute care system and is associated with a number of adverse consequences, including patient deaths.[1] In response to concerns about ED overcrowding and pressure for more focus on acute care (including the recommendations of the Working Group for Achieving Quality in Emergency Departments), on 1 July 2009 the 'Shorter Stays in Emergency Departments Health Target' (the Target) became one of six national health targets in New Zealand.

The target is defined as '95% of patients will be admitted, discharged or transferred from an emergency department within six hours'. The NZ Faculty of ACEM was heavily involved in the planning and introduction of this target as were many clinicians involved at the front line of acute care. It was clear that given some perceived systemic failures of the four-hour target in the NHS in the UK we did not want to see another Mid-Staffordshire Health Trust debacle, in which increased mortality was attributed, in part, to over-zealous attention to such targets.

> *The NZ Faculty of ACEM was heavily involved in the planning and introduction of this target as were many clinicians involved at the front line of acute care.*

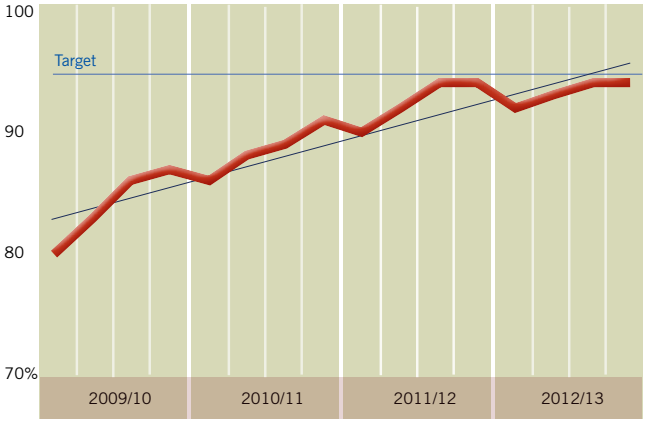
Significant progress has been made in the four years since introduction of the target, with all DHBs making marked improvements. A majority of DHBs now achieve the target and 80% overall performance has improved to just under 95% averaged across the country.

Clinician drive, whole-of-hospital approach

Some of the perceived mistakes made in the NHS were a top-down approach, financial incentives that promoted fudging of figures, other perverse incentives that encouraged shunting patients for the sake of the target, not for the sake of quality care. The target in New Zealand has been heavily clinician-driven and has required a whole of hospital approach. Patients continue to come in the front door, must flow through the (hospital) system and be discharged back onto the community effectively and efficiently. Whilst the majority of clinicians support the efficient processing of acute patients there are still pockets of clinicians and services that raise resistance and introduce delays when referred acute patients.

Capacity planning undertaken in most hospitals predicts within 10% on a day-to-day basis how many patients are expected to present to ED and what proportion will need admission. Demand is increasing, efficient flow through the system is essential and predicting demand is accurate. It behooves all of us to use what we know to eliminate unnecessary delays to patient care.

Quarterly preformance against the
Shorter Stays in Emergency Departments health target



Addressing challenges

There have been significant challenges to address when attempting to improve care for acute patients, and some of these were documented in a 2010 study[2] and include:

1 Difficulty accessing hospital beds.

2 Delays to access to diagnostic tests such as CT scans.

3 Delays to assessment of patients in ED by inpatient teams.

4 Increased demand for ED services (mentioned above).

5 Poor ED design/facilities.

6 Insufficient ED staff – SMOs, RMOs, nurses.

7 Delays to discharge of inpatients – the "back door."

8 Difficulty in engaging hospital staff in changes.

9 Difficulty in accessing aged care beds.

10 Problems at nights and weekends, including worsening contributions from all of the above.

Some of the initiatives[3] developed to address these challenges include:

- Development of 'special beds' – creation of ED short stay and inpatient assessment units has allowed further assessment in a space well suited to that purpose.
- Hospital operations planning – prediction of patient/work load to enhance the use of human and physical resources around the predictable acute workload.
- Discharge planning – for the front door to function properly so must the back door.
- Access to imaging – guidelines for access to imaging over extended hours.
- Responsive acute secondary services – separation of acute and elective roster conflicts to allow for responsive inpatient services.
- Pathways for acute patients – agreed (between EM and inpatient clinicians) pathways for patients with relatively straight forward conditions, such as #NOF, to be admitted to the ward without having to wait for an inpatient registrar assessment in ED.
- Acute demand mitigation – analysis of drivers of acute demand and interventions to mitigate this demand.
- Enhanced ED layout – streaming of patients into appropriate parts of ED or Assessment Units and good 'command and control' of busy EDs.
- Enhanced ED senior staffing – enhanced decision making at the front door.
- Engagement of all hospital staff – marketing changes with an appropriate whole of system and patient-focused emphasis.

What is most significant about these, and other initiatives, is the need for a whole of system, collaborative approach to improving the care of patients for whom we all have a mutual interest.

Emerging emergency medicine

Emergency medicine has developed enormously in the last 20 years in New Zealand, with our specialist workforce growing from 11 Fellows (FACEMs) in NZ in 1996 to over 150 now. We treat and discharge many patients from ED who previously might have been admitted. Most childhood and wrist fractures, dislocations, abscesses and wounds requiring suturing are dealt with in ED. Under 65s with paroxysmal AF are cardioverted and discharged. Cellulitis and DVT diagnosis and management are done as an outpatient through ED.

Emergency medicine is a 24/7 business and specialists are at the coalface in ED for over 18 hours of the day, ensuring excellent initial care, appropriate referral and safe discharge of patients. In addition they police the target to ensure that no action is taken purely for the sake of the target and not for patient care. The emergency medicine community has committed to working towards improved patient care and not to allow 'gaming' or inferior care in the name of the target. The target is a means to an end – improved patient care – and not an end in itself.

> *It behoves us all to work together to ensure how 2,700 or so patients presenting to EDs around the country every day can get the same service we would expect a loved one to have.*

In summary, no clinician who considers the plight of one of their family members, young or old, a friend or one of their patients would doubt that that person should be safely and appropriately assessed, symptoms treated, management initiated and either admitted or discharged within six hours. It behooves us all to work together to ensure how 2,700 or so patients presenting to EDs around the country every day can get the same service we would expect a loved one to have.

1. Richardson DB et al. Increase in patient mortality at 10 days associated with emergency department overcrowding. Med J Aust. 2006;184:213-6.

2. Ardagh M. How to achieve New Zealand's shorter stays in emergency departments health target. N Z Med J. 2010;123(1316).

3. Ardagh M et al. Improving acute patient flow and resolving emergency department overcrowding in New Zealand hospitals. NZMJ 14 October 2011, Vol 124 No 1

Parental leave Q & A

ASMS members are entitled to take periods of parental leave around the time of the birth of a new baby or adoption of a child. Most parental leave is unpaid but some of it is paid either by the state through IRD or by your employer, under your employment agreement.

Prospective parents often have questions about how much time they might want (or need) to take off work or about what their actual parental leave entitlements will be, paid or unpaid or whether as a mother or partner.

Our industrial team has put together a list of commonly asked questions to help answer some of your concerns. For more detailed answers or, if your situation is a little more complicated than the ordinary, we would encourage you to read the provision in your collective employment agreement, or the Parental Leave and Employment Protection Act itself.

You may also wish to discuss with one of our industrial officers the finer points of your particular needs and concerns.

Q Where is the entitlement to parental leave set out?

A Your collective employment agreement and the Parental Leave and Employment Protection Act 1987. Clause 28 of the ASMS national DHB MECA has the most comprehensive clause, which effectively supersedes the Parental Leave Act. Our non-DHB collective agreements, for the most part, contain less comprehensive entitlements and need to be read in conjunction with the Act.

Q Are there different kinds of parental leave?

A Yes, they include:

Maternity leave for a mother, taken around the time of the birth or adoption.

Partner's leave, sometimes referred to as paternity leave.

Extended leave that may be available to either parent in addition to their other parental leave entitlements.

Q How much parental leave am I entitled to?

A 12 months' leave if you have more than a year's service, or six months' leave if you have less than a year's service.

Q Is the parental leave paid?

A Some of it is:

The primary care giver of the child is entitled to up to six weeks' leave on full pay.

The partner of the primary care-giver is entitled to up to two weeks' leave on full pay, to be taken within three weeks either side of the birth or adoption.

In addition to any payment under their employment agreement, most mothers will also be entitled to 14 weeks' statutory paid leave through the IRD.

Q What is the rate of pay for paid parental leave?

A Your average weekly earnings for the six week period immediately preceding your leave. The statutory payment through IRD is your gross weekly pay up to a maximum of $475.16 per week.

Q Must parental leave be taken as one continuous period?

A Yes, as a general rule, but some employers are prepared to be flexible about this. You may also agree with your employer to undertake some occasional duties during your leave, without your overall entitlement being affected.

Q Is my partner also entitled to parental leave?

A Maybe:

If your partner is also a DHB employee, there is an entitlement under the MECA.

If your partner is not a DHB employee they may have an entitlement under their own employment agreement or the Parental Leave Act.

Q Who is the primary care-giver?

A The primary care giver is the person who assumes the day to day care of the child. It is possible for two people to share the primary care of a child, in which case they may agree to share the six weeks of paid leave.

Q How much notice do I have to give to go on parental leave?

A Normally three months' but this may be varied by the employer in cases of adoption or particular circumstances beyond your control.

Q Is my service with other DHBs relevant for parental leave purposes?

A No.

Q May I take CME leave or use my CME funds during my parental leave?

A You can't take leave when you are already on leave but because you remain employed during parental leave, you are entitled to access your CME funds, in the usual way.

Q Does the period of my parental leave count as service for the purpose of other entitlements?

A For most purposes, yes.

Q Do I continue to accrue annual leave during my parental leave?

A Yes.

Q I was told that if I took annual leave within 12 months of coming back from parental leave, that annual leave would be paid at less than my normal pay. Is that true?

A No. The MECA annual leave entitlement is on full pay, which means your regular fortnightly pay.

Q May I return to work following parental leave to reduced hours or job size?

A Yes, but only after discussion and agreement in the usual manner.

Q Am I guaranteed a return to my old job and hours of work at the end of my parental leave?

A As a general rule, yes, subject to the following qualifications:

Wherever possible, your employer must hold your position open or fill it on a temporary basis until your return.

If they can't hold your position open, they must offer you a similar one which generally means one with an equivalent salary, the same job size and hours of work and at the same location and level of responsibility.

However, if the employer is unable to hold the position open and it is a key position, they may fill it permanently. But the test for a key position is a tough one and not likely to be satisfied very often.

Q How much notice do I have to give to return to work early?

A One month, although your employer may agree to less.

Q How much notice do I have to give if I decide not to return to work?

A Three months, as with any resignation.

Q What are the consequences of not returning to work?

A You may have to repay any paid leave you have received from the employer.

Q May I extend my parental leave after it begins?

A Yes, but this will require agreement with your employer.

Q What happens if my child or I am sick and unable to return to work at the end of my parental leave?

A You may be entitled to sick leave on full pay under the MECA's standard sick leave provision.

Social media membership survey

The ASMS's first electronic membership survey was on social media. The survey took place over the period of a week, (3–10 July) and focussed on the extent to which ASMS members use online social networking and media sites.

In summary:

- A total of 546 members (15.6%) completed the survey.
- Facebook and LinkedIn were the two most popular social media sites with 284 respondents using Facebook (52%) and 218 (40%) using LinkedIn. Just over 200 respondents were not using any type of social networking sites (37%).
- 51% of respondents did not use social media sites in a typical week.
- Facebook is the most used social media site in a typical week.
- 137 respondents were using social media sites for less than 30 minutes each week.
- Despite its profile only 10% of respondents use Twitter.

After discussing these results the National Executive concluded that at this stage there was no basis to pursue social media such as Facebook and Twitter. The Executive had already decided, however, to explore linking the ASMS homepage to a mobile app.

DR DENYS COURT, MEDICAL PROTECTION SOCIETY

Product liability as a risk to surgeons

Recent publicity related to the PIP breast implant scandal as well as the failure of Du Puy ASR hip prostheses has focussed legislators, lawyers, patients and the public on issues of product liability. This has heightened the question of who carries the liability risk when a product fails or is recalled—the manufacturer or the surgeon? What is the risk for surgeons and how is this best managed?

Australian PIP story

The tensions are best demonstrated with the PIP story in Australia. Given the trial earlier this year involving the former founder of PIP and four of its senior staff for involuntary injury relating to use of industrial grade silicone in their breast prostheses over a period of 10 years to cut costs, no clearer case of manufacturer liability could occur. This despite testing undertaken by the Australian Therapeutic Goods Agency (TGA) which showed no evidence that the medical risks involved with the use of PIP breast implants are any greater than those for any other brand of silicone gel-filled breast implants with the exception of an increase in rupture rate1.

> *…the class action against the Australian distributor of the PIP implants collapsed in late March 2013 because the supplier had limited product liability insurance so liquidating that company would not allow reasonable compensation to flow to plaintiffs.*

It would be expected that a class action against the PIP manufacturer would be a 'slam dunk'. However, the class action against the Australian distributor of the PIP implants collapsed in late March 2013 because the supplier had limited product liability insurance so liquidating that company would not allow reasonable compensation to flow to plaintiffs. Tindall Gask Bentley partner Tim White stated; "It is disgraceful that a company was allowed to supply high-risk medical devices to thousands of women without insurance"[2]. The question now arises as to whether that or other legal firms will investigate the possibility of pursuing other defendants, including surgeons.

Vicarious risk for surgeons

In New Zealand the agency currently responsible for approval and monitoring of medical devices is Medsafe. Under agreement between the Australian and New Zealand governments in June 2011, there will be a single regulator known as the Australia New Zealand Therapeutic Products Agency (ANZTPA). These reforms become effective 1 July 2015. ANZTPA is intended to safeguard public health and safety whilst encouraging economic integration. Developments in Australia will have a direct impact on the regulatory environment in New Zealand and to the vicarious risk for surgeons.

> *Developments in Australia will have a direct impact on the regulatory environment in New Zealand and to the vicarious risk for surgeons.*

Perhaps the clearest indication that doctors cannot rely upon product regulators alone to protect them from liability is shown by the vaginal mesh (for pelvic organ prolapse (POP)) example. In 2002 the FDA cleared the first surgical mesh specifically for use in POP. Such FDA clearance followed the manufacturer being able to evidence that the mesh was free from manufacturing defect and is safe and efficacious. However, the FDA relies on evidence provided by the manufacturer which is not independently tested. Where the FDA goes, it is reasonable to say the Australasian regulators usually follow, utilising the same evidence.

Activist marketing of vaginal mesh followed, with almost exponential increase in use between 2002 and 2010. Between 2005 and 2010, 3979 mesh related injuries/malfunction/deaths were then reported to the FDA[3], with a five-fold increase in reporting of adverse events in the 2nd half of that period. In February of this year, in New York, a plaintiff was awarded over (US) $10 million in compensatory and punitive damages against the manufacturer. There are now 1,800 claims in New Jersey alone.

In counterbalance to the litigation frenzy in the US, Medsafe's current assessment, consistent with other regulators, is that surgical mesh is safe when used in accordance with the manufacturers' instructions by an appropriately trained surgeon.[4]

ACC treatment injury provisions

Obviously the treatment Injury provisions of the ACC legislation provide considerable protection for surgeons. For example, to date ACC has paid out over $4 million to claimants for vaginal mesh treatment injuries[5]. However, it is as yet untested as to whether under the Consumers Guarantees Act 1993 (CGA) litigants may have an additional action against manufacturers, suppliers, DHBs or surgeons.

Section 3 of the Act indicates that services covered by the Act include "work of a professional nature"; supplier means a person who, in trade "supplies services to an individual consumer or a group of consumers" and trade means "any trade, business, industry, profession [or] occupation." Under section 28 "…where services are supplied to a consumer there is a guarantee that the service will be carried out with reasonable care and skill". There is no doubt that this includes the duty to warn a patient as to possible issues with medical products. Under section 6, the guarantee extends to include "…where goods are supplied to a consumer there is a guarantee that the goods are of acceptable quality."

> *...it is as yet untested as to whether under the Consumers Guarantees Act 1993 (CGA) litigants may have an additional action against manufacturers, suppliers, DHBs or surgeons.*

Where the goods fail to comply with the guarantee Part 2 of the Act may give the consumer a right of redress against the supplier; and Part 3 may give the consumer a right of redress against the manufacturer. This may include the obligation to remedy a failure and the availability of damages to be awarded against suppliers of products or services.

In determining the risk of liability relative to that of manufacturers or suppliers, the "learned intermediary doctrine" has been developed in the US. This would likely be persuasive in New Zealand Courts and indicates that a manufacturer's duty is to warn doctors as to the risks of their products.[5] Once adequate warnings have been provided, the risks related to recommendations of treatment and the duty to disclose product related risks squarely fall upon the doctor.[6] It has been established in Australia that the duty to warn rests with the treating physician not the manufacturer or distributor.[7] The courts have indicated that such consent discussions should include the doctor providing to the patient the information provided by the manufacturer.

Regulators can't be relied on

In summary we can conclude that regulators cannot be relied upon by doctors to ensure safety for their patients in relation to medical devices used. Doctors have an obligation to advise their patients of all the known risks known at the time of the use of such devices and will be liable for any failure to do so. In New Zealand, whilst much of the risk related to product failure is absorbed by the ACC administered Treatment Injury provisions, there remains some risk that the CGA may be separately applied. Where a device is clearly defective and this was not known to the doctor prior to use, any claim for damages may be restricted to the manufacturer. However, where a complainant/plaintiff is less confident of a claim against manufacturer/supplier "Intermediaries" (professionals) are more likely to be joined to any litigation that may occur.

> *Doctors have an obligation to advise their patients of all the known risks known at the time of the use of such devices and will be liable for any failure to do so.*

A doctor is therefore vulnerable where (s)he is or should be on notice that the device/prosthesis is or may be defective; or fails to ensure that the patient has been made aware of the known risks related to implantation of the device/prosthesis or fails to exercise his/her best judgment in the selection/recommendation of an implant which accords with the patient's needs. Importantly, the doctor must also ensure the patient is aware of any alternative options apart from the medical device being recommended. Acting according to professional consensus and in line with any College statements related to products/procedures is essential.

It should be remembered that a doctor who acts as an importer and therefore local supplier of products, even if only for his/her own patients, assumes all the risks of the manufacturer if that manufacturer is not incorporated in New Zealand.

Finally, where product recall occurs, the doctor/DHB who performed the original procedure is responsible for ensuring timely patient recall.

1. Senate (Australia) Community Affairs Committee, 31 May 2012; http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/completed_inquiries/2010-13/implants_2012/info.htm
2. http://www.smh.com.au/national/health/compensation-hopes-for-faulty-hip-implant-victims-20130323-2gmhq.html#ixzz2S09cZEFD
3. FDA Safety Communication (2nd) July 13, 2011; http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm262435.htm
4. Medsafe Statement Jan 2013; http://www.medsafe.govt.nz/hot/alerts/UrogynaecologicaSurgicalMeshImplants.asp
5. Sterling Drug, Inc. v Cornish 370 F.2d 82 (8th Cir 1966); Phelps v Sherwood Medical Industries 836 F.2d 296 (7th Cir 1987)
6. Brooks v Medtronic, Inc. 750 F.2d 1227 (4th Cir 1984)
7. H v Royal Alexandra Hospital for Children (1990) Aust Torts Reports 81-100.

MARTIN STOKES MAS CHIEF EXECUTIVE

Big changes for Kiwi house insurance

You need only see the TV ad with the talking letterboxes during the evening news to know there are major changes afoot in the New Zealand insurance industry.

The changes taking place have been a hot topic in newspapers for several months. A Business Day feature on the Stuff website in March revealed that most insurers were moving from replacement to capped 'sum insured' policies:

> *...international reinsurers have required New Zealand insurers to stop offering traditional house replacement insurance, which guaranteed homes covered would be rebuilt regardless of the cost. Instead, cover is now for the sum insured, though capped insurance might be more accurate," it said. "Any replacement policies still in existence are being phased out this year.*

Indeed renewals of most existing replacement policies in New Zealand began switching to sum insured in May and these policy changes will continue through next year. So what does the change to sum insured mean for homeowners?

Bushfires and cyclones

The article referred to a report back in 2005 by the Australian Securities and Investment Commission (ASIC) that investigated why many people who lost their homes in the 2003 Canberra bush fires were unable to rebuild. It found that low pay outs were due in large part to 'rampant' underinsurance on capped policies, and the consumers' resulting inability to cope with the rising costs to rebuild.

> *…many people who lost their homes in the 2003 Canberra bush fires were unable to rebuild. It found that low pay outs were due in large part to 'rampant' underinsurance on capped policies…*

CHOICE, the leading consumer advocacy group in Australia, noted localised building costs had spiked 50% after the Canberra bush fires and 50% after Cyclone Larry in 2007. CHOICE also found uncapped policies are priced competitively with capped policies and are better for the consumer: "ASIC says total (uncapped) replacement policies are safer for the consumer and we recommend that as well," said a CHOICE senior content producer quoted in the article.

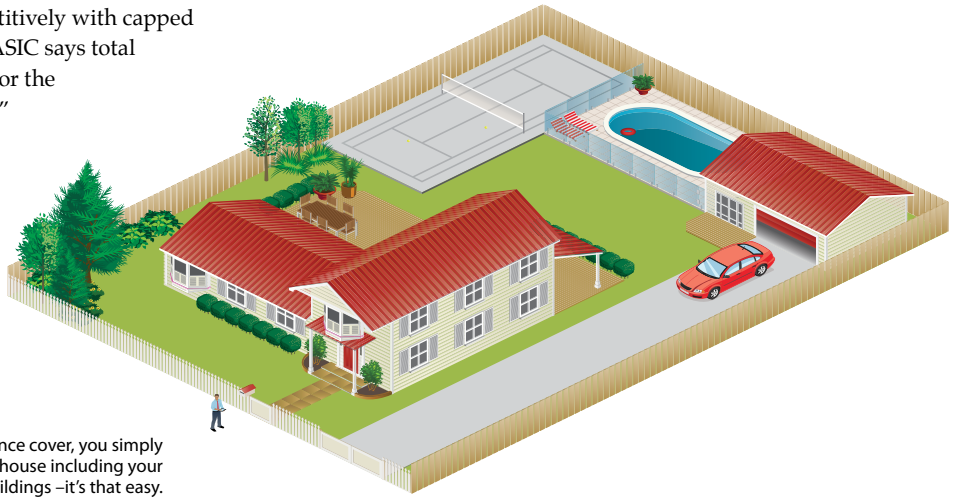
Earthquakes NZ style

More recently here at home, we know from our experience of Canterbury earthquakes that the cost of rebuilding has risen and more increases are expected for labour and material costs as the rebuild progresses. Many homes in Wellington and Blenheim had already switched to sum insured when the earthquake hit just weeks ago. Fortunately the residential damage was minimal, but how will sum insured policies work in the event of another large-scale earthquake or other disaster?

As advised by a partner from law firm Morrison Kent in a June Business Day feature on Stuff:

> *The onus is now on you to tell your insurer the cost to rebuild your house. If you under-estimate the cost and your house is destroyed, your insurer will not be prepared to rebuild your home to the same size and specification as it was before. It's also worth noting that the rateable value of your home doesn't have a direct bearing on the cost to rebuild, therefore it is not a good idea to rely on the RV for insurance purposes. Instead you should investigate the actual cost of rebuilding your home to set your sum insured.*

The article suggested using one of the online calculators that many insurers now provide for their customers to use to arrive at a suitable sum insured, but it's important to consider the complexity of the factors involved in the calculation. The Commission for Financial Literacy and Retirement Income's popular 'Sorted' website offers some advice on 'What a calculator can't do':



With MAS's full replacement house insurance cover, you simply calculate the total floor area of your house including your garage and any outbuildings –it's that easy.

While you may start out with a 'safe' sum insured…won't it be easy to just skip raising that sum each year and avoid paying increased premiums? Companies and calculators may suggest a higher amount, but it will be up to you to increase your sum insured… Although the online calculators should be able to give you a general idea and periodically adjust for inflation and market conditions, one size cannot fit all. Building costs themselves can vary because of so many circumstances. There's also the cost of removing all your stuff from a damaged house, for instance, or rental costs, design costs, building consents – things that a calculator may not include.

Another option is to engage an expert and get a property valuation, but even the most accurate valuation cannot account for the kinds of building cost spikes that can occur after a major disaster when everyone is vying for the same materials and services. And of course if your sum insured is set too high, you may end up paying significant excessive premium over time.

> *...but even the most accurate valuation cannot account for the kinds of building cost spikes that can occur after a major disaster when everyone is vying for the same materials and services...*

Seismic shift in risk

MAS was featured in a recent article from The Press that talked about the shift from replacement to sum insured policies in the context of the Canterbury earthquakes:

New Zealand households have been told the shift to a specified sum insured is inevitable, forced by reinsurers shocked at how much they had to pay out after the Christchurch earthquakes. But the case of two affinity-group insurers appears to show that replacement cover is not as inevitable as the public has been led to believe.

The article added, "The change represents a seismic shift in risk from insurers and reinsurers to homeowners." We agree, and MAS is one of the insurers mentioned that will continue to offer full replacement cover with very few exceptions.

> *The change represents a seismic shift in risk from insurers and reinsurers to homeowners.*

We're not taking the position of the wider industry on this issue because we don't think it's fair or reasonable to ask our Members to accept the risk of getting this important decision wrong.

The Specialist is printed on
Forestry Stewardship Council approved paper.

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.

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

ASMS job vacancies online *www.jobs.asms.org.nz*

We encourage you to recommend that your head of department and those responsible for advertising vacancies, seriously consider using this facility.

Substantial discounts are offered for bulk and continued advertising.

ASMS email broadcast

In addition to The Specialist the ASMS also has an email news service, ASMS Direct. This is proving to be a very convenient and efficient method of communication with members.

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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ASMS
TOI MATA HAUORA

You only need one tool to rebuild your house completely.

Unlike most house insurance providers, MAS isn't switching to capped sum insured cover. We think it's unreasonable to expect you to accurately calculate the cost of rebuilding your house in the event of a total loss. So we're doing what's right for our Members by continuing to provide full replacement cover for our house insurance policies.

This means you can rest easy knowing that we'll rebuild your house to the floor area you provide us with. You work out the area, and provide us with some basic information about your property, and we'll calculate the cost. It's that easy.*

To find out more about MAS house insurance, email us today at **info@mas.co.nz** or call **0800 627 659**.

*In limited situations we will not be able to offer full replacement cover where the property does not meet our standard underwriting criteria.

MAS