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NEW MECA FOR DHB-EMPLOYED MEMBERS

It took a while but we got there in the end.

After lengthy negotiations, ASMS managed to negotiate a new multi-employer collective agreement (MECA) for members employed by district health boards. The new MECA is effective from 1 July this year until 31 March 2020.

At the start of negotiations mid-last year, the DHBs tried to claw back some existing entitlements and rights, such as job sizing agreed hours of work, annual leave, and sick leave. Late last year they had a go at above-MECA remuneration in certain circumstances and, at the penultimate phase in the process, they attempted to undermine your consultation rights.

Your ASMS bargaining team successfully resisted every effort to dismantle or undermine entitlements, and achieved what the National Executive considered to be a good outcome. As always, it was not possible to achieve everything we wished, much to our disappointment, but overall some significant gains have been made – especially in the areas of salary increases, recovery time, and paid parental leave.

A good summary of the negotiations and gains achieved is on the ASMS website at **https://www.asms.org.nz/wp-content/uploads/2017/08/Special-MECA-Bulletin.pdf.** This was written before members voted to ratify the MECA but provides an overview of the issues involved.

A copy of the new MECA itself is at **https://www.asms.org.nz/wp-content/uploads/2017/08/2017-2020-DHB-MECA-unsigned.pdf.**

It's also worth reading our Q&A about the new parental leave provisions at **https://www.asms.org.nz/wp-content/uploads/2017/08/paid-parental-leave-FAQs-July-2017_168331.3.pdf.**

THE BARGAINING FEE BALLOT

The ante penultimate episode of the ASMS DHB MECA negotiations saga is the bargaining fee ballot, which was held at all DHBs in mid to late August.

The process requires DHBs and ASMS to agree that a bargaining fee will be levied on SMOs who are not members of ASMS and then for a ballot to be held at each DHB of both ASMS members and SMOs who are not members to decide whether a ballot will apply at that DHB.

That ballot has now been held and has resulted in the majority of SMOs at every DHB agreeing that a bargaining fee will be levied (see below for the results by DHB).

The next step is for non-members of ASMS to have the opportunity to opt out of the MECA (and the bargaining fee). By the time you read this, that step will have been concluded.

Following that, the bargaining fee will be taken out of bargaining fee payers salary in four equal instalments over four successive pays beginning in the pay period following 15 September.

DHB	In favour	Against	Invalid
Northland	81	9	3
Waitemata	169	3	1
Auckland	247	24	4
Counties	113	1	0
Waikato	198	16	0
Lakes	37	2	0
Bay of Plenty	69	6	0
Tairawhiti	31	3	0
Taranaki	51	4	0
Hawkes Bay	81	5	2

DHB	In favour	Against	Invalid
Whanganui	31	3	0
MidCentral	82	3	2
Wairarapa	18	1	0
Hutt Valley	66	1	0
Capital & Coast	133	3	0
Nelson Marlborough	77	6	0
West Coast	16	0	0
Canterbury	230	10	0
South Canterbury	27	2	1
Southern	103	7	0

TIME TO MODERNISE THE RULES

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

On 16 March 1989, George Downward, the then Chair of the NZMA Central Specialist Committee, wrote to all salaried medical and dental practitioners signalling the birth of the ASMS **(**https://www.asms.org.nz/wp-content/uploads/2014/12/ASMS_Important-details-of-your-new-union-to-potential-members_from-G-Downward_Chairman-of-NZ-Medical-Association_16-March-1989.pdf**).**

The ASMS has a constitution – a set of rules or fundamental principles according to which our organisation is governed. Our Constitution has been approved by the Registrar of Incorporated Societies. It can be found on our website at **https://www.asms.org.nz/wp-content/uploads/2015/04/ASMS-Constitution-2014-amendments_162343.2.pdf.**

In May 1989, the ASMS had 729 members distributed across the four regions (as determined by the constitution):

- Region I: 237
- Region II: 101
- Region III: 216
- Region IV: 175.

The first National Executive consisted of 10 representatives, as it still does today **(https://www.asms.org.nz/wp-content/uploads/2015/03/Executive-1989-1991.pdf).**

A lot has happened since 1989. The current National Executive considered the following: "Is our constitution still fit for purpose and our rules still current?" We decided to start a process of reviewing the constitution, comparing it with today's fundamental principles as well as precedents that have developed in the interim.

Myself and Executive members Tim Frendin, Jeff Hoskins and Murray Barclay, along with ASMS Senior Industrial Officer Henry Stubbs, formed a sub-committee to start this piece of work. The Executive tasked the sub-committee to specifically consider member representation on the Executive (Rule 11.5 and 11.6), governance (Rule 11.7) and succession planning.

Rule 11 refers to the rules pertaining to the National Executive - the election process, the regions, and as such the representation on the National Executive, the powers of and governance by the Executive.

REPRESENTATION AND REGIONS (RULE 11.4 AND 11.5)

The National Executive and subsequently the sub-committee considered various permutations related to representation of members on the executive, the size of the Executive and the election of the Executive, including the currently used regions.

The sub-committee concluded rather than submitting a remit for the 2017 ASMS Annual Conference, the Conference and membership should be given the opportunity to consider this important aspect of the Constitution. The 2017 Conference programme will provide an opportunity for discussion, including small group discussions. The feedback from Conference will help inform the sub-committee moving forward.

Rule 11.5 (a) and (b) can be deleted seeing that it is superfluous because it is effectively dealt with in Rules 23.1 and 23.2.

LEADERSHIP STRUCTURE AND SUCCESSION PLANNING

Many organisations have a formal and prescriptive leadership structure that determines that the Vice President will become President and, following his or her term as President, become the immediate past President.

Looking back, we have had excellent Vice Presidents serve on the Executive who did not go on to become the President (by their own choosing). The Constitution is silent on succession. Currently there is not a position on the Executive for an immediate past President. This makes succession planning more difficult. It also makes the role of the new President more challenging if there is not an immediate past President to consult with.

This has led the current President to request that the previous President remain on the Executive. The outgoing President had to be nominated and elected as a regional representative to remain on the Executive. This arrangement has been positive but it also meant that it reduced the potential for the Executive to have a new member elected.

The Executive discussed this in depth and decided that the rules should be changed to formalise a position for an immediate past president. The immediate past President can only serve for a maximum of one term but can also step down before the term is completed.

This arrangement has been captured in amendments to Clauses 11.1, 11.2 and 11.3. This would increase the Executive from 10 members to 11 members.

GOVERNANCE: RULE 11.7

Wording has been tidied up to more precisely describe and differentiate between the governance role of the National Executive and the operational or management role of the Executive Director.

Clause 11.7 (b) has been 'modernised' and adjusted to reflect the realities of electronic banking; eg, replacing co-signatories on cheques and to emphasise the responsibility that the Executive has towards our financial affairs.

The potential changes to Rule 11 were discussed at the Branch Officers' annual workshop on Monday 14 August, and subsequently the National Executive has unanimously supported a proposal to amend Clause 11 of the Constitution. The proposal will be circulated first to the branches and then to all members. It will be further discussed and put to vote at the 2017 Annual Conference. Once again, please note that no changes have been made to rules that determine representation and regions captured in Rule 11. That aspect of Clause 11 will be discussed and workshopped at the 2017 Annual Conference.

FIGHTING BACK FOR EQUITY IN HEALTH

JOHN RYALL | ASSISTANT NATIONAL SECRETARY E TŪ AND HUTT UNION AND COMMUNITY HEALTH SERVICE BOARD MEMBER

ASMS has invited John Ryall to comment on this issue. We note that ASMS does represent salaried GPs, including in VLCA practices.

A battle over health access and equity is currently occurring in primary health care, and it may not be resolved without a major review of primary health care funding.

The sharp point in this battle is the Very Low Cost Access (VLCA) funding, which is a higher level of capitation funding introduced in 2006 for primary health providers whose registers include more than 50% of the highest needs patients (Māori, Pacific and in Quintile 5 of the New Zealand Deprivation Index (Dep5)) and where providers agree to maintain their fees at an agreed low level.

The VLCA was developed because the capitation funding formula, introduced by the Labour-Alliance Government in 2001, was inadequate to meet the needs of those primary health services which had very high levels of high needs patients but were also unable to recover much or any of a co-payment due to patient economic deprivation.

Unfortunately, in the implementation of the VLCA scheme some primary health providers were let into the scheme who did not have a sufficient high needs population. They took the extra funding for their whole population and constrained their fees below the agreed level (although some have since introduced significant co-payments for nurse visits, prescriptions, smears, driver licence medicals and ECGs), and this has created some anomalies with other non-high needs providers.

ON THE OFFENSIVE

General Practice New Zealand (GPNZ) and some of the corporate primary health providers have seen these anomalies as a good opportunity to drive up a solution that will address their two bug bears about the funding system, which was created out of the Government's 2001 Primary Health Care Strategy.

The Primary Health Care Strategy was a major break with the previous small GP-owned fee-for-service practice system with its focus on population health, on identifying and removing health inequalities, working with and encouraging community involvement and through a capitation funding system (with increasing restrictions on co-payments) allowing providers to develop multi-disciplinary health care teams.

The Primary Health Care Strategy stated that there were significant inequalities in the health of different groups of New Zealanders related to wealth, income, ethnicity, housing, educational levels and the nature of their work, or lack of work. These inequalities led to higher mortality rates, higher disease and injury burdens, and higher rates of avoidable hospitalisation.

The Moodie Report argued that a large proportion of the high needs population was missing out on the benefit of VLCA because they chose to visit a GP in a well-off area.

We want some form of the VLCA scheme to stay in place as it takes account of many of the environmental factors that influence poor health outcomes.

The Primary Health Care Strategy was welcomed by community providers, such as union health services and Māori providers, and viewed suspiciously by the small GP practices, who had fought for nearly 70 years since the first Labour Government in the 1930s and 1940s to stop any restrictions on their right to charge patients whatever fee they determined above the Government payment.

Initially in 2001 the Government had introduced two levels of capitation, with a higher level going to those providers who had higher-needs populations and were willing to agree to much lower patient fees, but after pressure from the GPs all providers were able to pick up the higher level of capitation and only put minor restrictions on the patient fees.

However, the fees issue did not go away, and after furious lobbying from GPNZ the Ministry of Health agreed to commission a report from the GPNZ-dominated Primary Care Working Group on General Practice Sustainability, chaired by Dr Peter Moodie.

This report, which was delivered last year to the Ministry of Health and Health Minister Jonathan Coleman, made a number of recommendations to abolish the VLCA capitation formula in its current form and to re-introduce a community services card as the basis for getting lower fees from your primary health provider.

MOODIE REPORT A GIANT STEP BACKWARDS

The community service card had been introduced by Ruth Richardson's the 'Mother of All Budgets', along with the National Government's 'health reforms' in the early 1990s, as a way of individualising social welfare and health entitlements. Community service card holders, if they could manage to get through the excessive bureaucratic barriers to get a card, did not have to pay public hospital out-patient fees, the $500 a night public hospital bed charges, the lower than $15 an item prescription charges and lower patient fees.

The Moodie Report argued that a large proportion of the high needs population was missing out on the benefit of VLCA because they chose to visit a GP in a well-off area.

The report recommended that instead of providers being paid the VLCA capitation funding across their population, the extra payment should be individualised so that providers in rich areas could offer cheaper fees to poor patients who wanted to access a GP in one of these areas.

The report recommended that any fees restrictions that currently applied to the whole registered population in a VLCA provider should be lifted so that non-community service card holders paid whatever charge the provider set.

In one fell swoop, the previous population approach could be dismantled and the freedom to charge patient fees could be restored.

ROAD BLOCK TO CHANGE

All was going very well in the GPNZ lobbying around the acceptance of the Moodie Report until the organisations grouped around the community-based primary health group Health Care Aotearoa (HCA) started analysing the impact on community providers of implementing the Moodie recommendations.

HCA noticed that the Moodie recommendations would mean that its five Wellington providers, all of which were receiving VLCA funding and had high Māori, Pacific and Dep5 registers, would all experience an overall decline in their income and, because of the difficulties of patients paying high fees to compensate, would incur major sustainability issues.

Their previous VLCA funding would be transferred up to, for example, the retirement villages on the Kapiti Coast and their community service card eligible residents, who were mainly Pākehā. It is important to note that community service cards only ever measure income and not wealth, so there will be people who have carefully placed their assets into family trusts who will be eligible for a card.

HCA presented its findings to the Ministry of Health, and both the Ministry and the Minister of Health agreed that they could not be party to a change in funding that made those providers who were representing the neediest parts of the New Zealand population worse off financially.

THE WAY FORWARD

HCA is not content with the status quo and wants a major review of the primary health care capitation formula to re-focus primary health care on addressing the health inequalities that were a feature of the 2001 New Zealand Primary Health Care Strategy.

We want to be a part of the strategic discussions and future conversations relating to primary health care and funding reviews, which we have currently been locked out of by the GP organisations.

We want a capitation formula developed that takes into account the neediest populations and those primary health providers who have been successful in working with them for better health outcomes.

We want some form of the VLCA scheme to stay in place as it takes account of many of the environmental factors that influence poor health outcomes. It is a good mechanism for practices which are established in areas of high socio-economic need to be sustainable while also ensuring that patients are able to access affordable care.

While we acknowledge that there may need to be some other way to ensure patients who cannot afford care in other practices can access assistance, dismantling the VLCA scheme is not the way to do it.

POSTSCRIPT

Since this article was written the National Party has promised, if elected, to put more money into primary health care through offering a maximum $18 charge per GP consultation for those with community service cards whose GPs sign up to a new funding scheme for these patients.

The Labour Party has doubled up on this promise through offering, if elected, a primary health care funding package that would place a maximum fee cap of $8 for those on community service cards or enrolled in VLCA practices, a maximum fee of $2 for children between 13 and 18 years old and a reduction of every other fee by $10 a consultation.

It feels like after years of drought the heavens have opened and are raining money. However, while this new focus on primary health care is good, it may not solve the underlying problems for practices servicing concentrated low-income populations in the base capitation formula.

RELATIONAL TRUMPS CONTRACTUALISM ANY DAY OF THE WEEK

IAN POWELL | ASMS EXECUTIVE DIRECTOR

In broad terms, there are two ways in which DHBs can function. One is relational as evidenced by Canterbury, most obvious in its community-hospital health pathways for which it has been applauded by the King's Fund. This is sometimes known as the 'Canterbury Initiative'. It is also evident in the network approach to shared services in the South Island that emerged as a successful alternative to the high transaction cost approach of the now inoperative Health Benefits Ltd.

The other is contractualism, a residual legacy of the 1990s' market-driven health system ideology. The most immediate example of contractualism is the leadership of the three Auckland DHBs, who find themselves under their joint Chair Lester Levy in a virtual state of war with primary care due to the high transaction cost and contractual nature of their relationship and the DHBs' leadership culture that shapes it.

This has got to the ridiculous point of the three DHBs using the height of contractualism – a 'Request for Proposals' mechanism for seeking commercial tenders to address the provision of after-hours primary care.

It should be acknowledged that Canterbury has noticeable advantages over Auckland beyond the latter's control. It is one rather than three DHBs. More significant is that in contrast with Auckland, Canterbury only has one GP collective voice to engage with – the innovative Pegasus. But despite this the sharp difference between them is their respective leadership cultures.

THE PRACTICE OF BEING RELATIONAL

Canterbury's relational experience focuses at many levels on the collaborative working relationship between relevant stakeholders (while recognising the distinct role of the DHB as a statutory Crown entity). It has attracted the interest of the London-based King's Fund, which led to a 2013 report by Nick Timmins and Chris Ham, *The quest for integrated health and social care: a case study in Canterbury, New Zealand* (**www.kingsfund.org.uk/publications**).

This relational approach was further assessed by Anna Charles of the King's Fund in a report published in August titled *Developing accountable care systems: Lessons from Canterbury, New Zealand* (**www.kingsfund.org.uk/publications**). 'Accountable care systems' is the latest structural jargon in England's National Health Service.

Despite the obvious qualification that CDHB is a taxpayer funded statutory authority, this approach is based on a 'one system, one budget' process. Rather than magic bullets, Charles describes it as an aggregation of many simultaneous changes to the way care is organised and delivered. Central to it are:

1. integrating care across organisational and service boundaries
2. increasing investment in community-based services
3. strengthening primary care.

Critical to achieving this is networking rather than contractualism, particularly in engaging with and within general practice.

Arguably the biggest transformations have been supporting more people in their homes and communities and moderating demand for hospital care (especially among the elderly). Compared with other DHBs, Canterbury has:

- lower acute medical admission rates
- lower acute readmission rates
- shorter average length of stays
- lower emergency department attendance (at least prior to the recent winter)
- higher spending on community-based services
- lower spending on emergency hospital care.

This relational approach has not reduced the acute care rate, but it has moderated it. It is "bending the curve"; ie, slowing rather than reversing this growth.

CLINICALLY LED HEALTH PATHWAYS

Charles points out that behind this turnaround has been the development of around 900 health pathways through a clinically led collaborative iterative process in which hospital specialists, GPs and other health professionals discuss problems and identify solutions. The process of reaching this consensus both determines and is as important as the outcome.

Some pathways have changed the way services are provided; for example, some diagnostics and procedures are undertaken in primary care. The development of the electronic request management system has significantly enhanced patient-related interactions between hospital doctors and GPs.

ACUTE DEMAND MANAGEMENT SYSTEM

The King's Fund research fellow also highlights the acute demand management system now in place for several years. It enables patients with acute health needs to receive urgent care in their homes or communities, thereby avoiding hospital admission or enabling early discharge from the emergency department or medical or surgical assessment unit. Patients are managed by GPs supported by rapid response community nursing, community observation beds, hospital-based specialist advice, and rapid diagnostic tests.

Charles further reports that among GP practices that refer more people to the acute demand management system, fewer people from the practice present at the emergency department. The average cost of managing a patient within this system is $140 per episode of care compared with an average cost of $340 for each person presenting at the emergency department and $1,180 per bed day for each person admitted to an acute medical bed.

UNEXPECTED TWIST

In my opinion, the success of this approach meant that CDHB's previously identified needs to build a new larger hospital in Christchurch and significantly increase the city's rest home capacity were, until February 2011, avoided.

In what is described as an "unexpected twist in the road", Charles refers to the devastation of 22 February 2011. In my view, the consequences of this increasingly embedded relational approach made Canterbury better placed than any other DHB to cope with this level of devastation. Charles goes further, describing it as a catalyst that both enhanced existing initiatives and led to new ones such as the acute demand management system, introduction of a community rehabilitation enablement and support team and a falls management programme designed to keep people out of hospital, and rapid introduction of the electronic shared care record.

At a fledgling level the 'Cantabrian' health pathways are being picked up by the other South Island DHBs. There are two key aspects to this – the 'tool' document and the process of implementation. Of the two, the second is far more important. As discussed above, it involves health professionals in both hospital and community care developing the pathway in a way that makes good clinical sense in the local circumstances. A health pathway for geriatric care in South Canterbury, for example, will have both similarities in principle at least and differences at an operational level to Canterbury's. Rapid response teams will also function differently in the two DHBs.

If this relational approach had existed in metro Auckland, then the three DHBs' relationship with the GP bodies would not have been so corrosive and legalistic as they have become.

MACRO AND MICRO

The above is a macro analysis. At a micro level, there are many good innovative things happening in the three Auckland DHBs as one gets closer to the clinical frontline and further away from the higher-level leadership culture.

Similarly, in Canterbury there are sharp differences between SMOs and senior management in, for example, some smaller services that feel marginalised, and over issues such as SMO non-clinical work space.

But the point remains; just as a macro relational leadership culture facilitates clinical innovation and systems improvement, a micro relational culture hinders this.

FUNDER-PROVIDER SPLIT

Sitting behind this relational versus contractual approach is what is known as the funder–provider split. This was the mechanism used to try to create a competitive market in our public health system in the 1990s. The 'funder' would make allocative funding decisions to competing 'providers'.

The system failed because it was highly transactional – those in the 'funder' who made allocative decisions had less expertise and were distant from practical reality than those in the 'providers'. Consequently, poor allocative decisions were often made, it undermined necessary collaboration between 'providers', and it was very disruptive.

The structures that provided this split disappeared with our new non-competitive legislation passed in 2000, but in many DHBs it continued internally with what were unhelpfully called 'funder arms' and 'provider arms'. This did not lend itself to sensible integrated decision-making.

Fortunately, over time, in many DHBs (including Canterbury) the practical functions of funding were merged into the rest of the DHB rather than as a virtual separate entity within it.

Again, metro Auckland is different – highly contractual and consequently more bureaucratic and transactional. Lester Levy was appointed Chair of Waitemata DHB in early 2009. As it happened, that DHB was one of those still rooted in the old 'funder arm' system that many DHBs including Auckland and Counties Manukau had shifted away from.

When he subsequently became Chair of Auckland DHB, its funding roles were merged with Waitemata's and ran along the same line as Waitemata's. Now Counties Manukau is also tucked under his armpit, all the indications are that this third DHB will be forced back into the outmoded funder–provider split under a new 'virtual structure'. The obvious risk of this is the likelihood of poorer allocative decisions and higher transaction costs.

It is interesting that in 2012 the funder–provider split was enshrined in legislation for England through the mechanism of 'clinical commissioning groups'. In the short space of time since then it is generally recognised that this has failed. Instead, NHS England is endeavouring to get around it through new non-statutory formations such as 'Sustainable Transformation Plans' and 'Accountable Care Services'. In that most unusual election in which the Conservative Party both won and lost concurrently, the governing party indicated it was moving away from this split.

Those who cling on to contractualism and its structural anachronism, the funder-provider split, are clinging on to a bygone ideology but in a way which unnecessarily complicates and obstructs effectiveness and good decision-making.

If we had effective leadership from Government in the health sector, this could have required not just the three Auckland DHBs but other DHBs as well to look at Canterbury's much more effective relational approach to the community–hospital relationship, especially the clinically led collaborative process for developing health pathways, and adapt this to their own populations. If not, the new verb in the metro Auckland vocabulary may extend southwards; that is, more DHBs will be 'lestered'.

2017 ASMS BRANCH OFFICERS' WORKSHOP

The new DHB MECA, wellbeing and safety, constitutional amendments and bullying were on the agenda for the annual ASMS branch officers' workshop in Wellington in August.

National President Hein Stander welcomed branch officers from around the country to the annual gathering, and reported on the MECA ratification process then underway.

ASMS Deputy Executive Angela Belich provided an overview of the new MECA, with industrial officers then discussing specific aspects of the agreement, including salary increases, parental leave, new locum provision and long service leave.

This was followed by a discussion about the wellbeing clauses, recovery time and safety of shift rostering provisions.

After lunch, Hein Stander talked about the review of ASMS' Constitution being led by the National Executive, supported by Senior Industrial Officer Henry Stubbs. There will be more about this raised at the ASMS Annual Conference in November.

The final agenda item on bullying and what to do about it was presented by Principal Analyst (Policy & Research) Charlotte Chambers and Senior Industrial Officer Lloyd Woods.

IN YOUR OWN WORDS: WHAT IT'S LIKE TO WORK FOR A DHB

Here is a sample of comments made by individual doctors during a previous survey of DHB-employed members on workforce intentions.

"ROSTERS ARE RUN VERY LEAN. THERE IS A LACK OF GIVE IN THE SYSTEM. SMOS ARE BURNT OUT AS A RESULT. SUB-SPECIALTY AREAS ARE HARD TO RECRUIT AND THERE IS A HUGE LACK OF FUTURE PLANNING. IT SEEMS TO BE UP TO ME, RATHER THAN MANAGEMENT, TO PROJECT INTO THE FUTURE TO PROTECT MY SUBSPECIALTY AND MAKE SURE THERE ARE POTENTIAL FUTURE COLLEAGUES. THERE IS A MASSIVE LACK OF SUPPORT AND FORESIGHT INTO WORK-FORCE PLANNING."

"Although I enjoy the work I do, I feel like I am drowning in the amount. Much of my day is spent on registrar level activities. I am working with management to look at generating a registrar position or securing more SMO FTE but with the current financial situation, I am not going to hold my breath waiting for a change. An ongoing feeling of being unable to rise to the level of practice that I aspire to would be the one thing that would make me reconsider my employment options with this DHB."

"I believe flexibility of hours and part-time work is vital for the future of our workforce and especially those with children. Valuing our staff and appreciating the high rate of burnout and taking steps to address this is essential."

"New Zealand should be a world class medical workforce. We have a skilled and dedicated team of doctors across all specialties...but the Govt is creating a disenchanted and cynical workforce."

"Currently, many SMOs are working in excess of 40 hours per week to maintain safe clinical parameters, at the expense of CPD and professional development. SMOs require work flexibility and reasonable hours to deliver a safe, competent service and satisfactory work-life balance. This is difficult to achieve currently in full-time practice, leading to a desire for reduce."

"Am not enjoying the constant pettiness being imposed on us by management with respect to things such as CME claims. Getting leave is a constant headache. Little recognition of the work we do makes us feel undervalued and does not promote loyalty to the organisation, though we still feel obligations to our patients and colleagues."

"I have about 20 years till my retirement, but don't see myself staying in the DHB for more than another 6-10 years, unlike my older colleagues. While I find my chosen specialty really rewarding, the demands from the DHB for more clinical care, with more targets to be met, but with little regard for the impact on clinicians and their wellbeing - means I will not be able to continue full time in the DHB till I retire - not without cost to my wellbeing."

"Many SMOs doing 'gen med' are getting frustrated with the heavy workload and limited resources we are expected to work with. It does not help that all our concerns have gone unheeded by management. Even as a junior SMO, if I was given the opportunity, I would be seeking to reduce my after hours on call duties and maybe overall FTE. Life is too short to be spending most of it working like a dog for very little recognition and job satisfaction."

"I would like to see more flexibility in hours, eg school hours, in order to optimise time with family."

"MY MAIN ISSUE IS THAT HAVING STARTED AS A CONSULTANT 7 MONTHS AGO, I STILL HAVE NONE OF THE EQUIPMENT THEY AGREED TO SUPPLY IN THEATRE TO DO MY JOB SAFELY."

"I find my DHB role rewarding, satisfying and challenging, both clinically and from an operations perspective. I am committed to ongoing work in the public sector but also have a growing and exciting private practice and busy family life. As such I do not expect to take on more public clinical work."

"DECIDING WHEN TO RETIRE HAS BEEN A VERY DIFFICULT PROCESS. MY AGED PHYSICIAN FATHER HAS BEEN RETIRED FOR LONGER THAN MY ENTIRE CONSULTANT CAREER! I WONDER WHAT I WILL DO IF I RETIRE SOON AND THEN HAVE A SIMILARLY LONG RETIREMENT; ON THE OTHER HAND, I DON'T WANT TO LEAVE RETIREMENT UNTIL I LOSE MY CURRENT PHYSICAL FITNESS (BEING MUCH ABOVE AVERAGE FITNESS FOR AGE). AFTER A GOOD CAREER, I ALSO FEAR MAKING A MISTAKE AND ENDING ON A LOW NOTE - IT'S A REAL CONCERN, NOT ENTIRELY ASSUAGED BY REASSURING COMMENTS FROM COLLEAGUES. THERE WAS SOME ADVANTAGE IN THE 'OLD DAYS' WHEN RETIREMENT WAS AUTOMATIC AT 65, ON THE OTHER HAND MY LAST FEW YEARS (BEYOND 65) HAVE BEEN GOOD ONES. A FINAL COMMENT - ONE OF THE THINGS I WILL MISS MOST OF ALL IS THE CLOSE CONTACT WITH MY JUNIOR COLLEAGUES, WONDERFUL YOUNG PEOPLE WITH WHOM WORKING IS SUCH A JOY."

"An even reasonable standard of management within the health sector would make a massive difference to doctors' job satisfaction and happiness."

THE REALITIES OF WORKING IN MEDICINE FOR FEMALE SENIOR DOCTORS

ASMS Principal Analyst (Policy & Research) Dr Charlotte Chambers is carrying out qualitative research into the working lives of female specialists. She talks here about what she's doing, and why.

I've been travelling around the country to interview women specialists in their thirties, who are employed by DHBs and who have volunteered to participate into my research. We've been talking about what a day in the life of a specialist looks like, how they ended up working in their specialty and what some of the issues are for women working in medicine.

To date I've interviewed seven women and I have another five interviews lined up. These women work around the country in many different specialties so I'm getting a really detailed picture of life as a specialist.

I've heard some heart rending stories about the difficulties they face juggling parenthood, gruelling workloads, and the pressures faced by young specialists working in the public health system in New Zealand.

WHAT HAS PROMPTED THE RESEARCH?

This is a follow-up to the findings of our burnout study, which found women in their thirties had the highest rates of burnout across the country. I'm trying to find out why this is, and whether there are commonalities between these women's experiences and the factors that we know predispose people to experiencing burnout.

The research has actually broadened out into an in-depth window on the working lives of young female specialists. All the women I've spoken to thus far are also mothers of young children, and many have a hard time balancing their commitments to their families, their selves and their colleagues and patients. They are working in incredibly demanding and important fields of medicine and they are all passionate about what they do.

What the research is telling me is that while medicine has certainly come a long way in terms of being more inclusive of women, it's still got a long way to go.

WHEN WE WILL SEE THE RESULTS?

By the time members read this I will have presented preliminary findings to the Australasian Doctors Health Conference in Sydney **(www.adhc2017.org.au)**. I'm hoping to have completed all interviews by the end of the year and have something published in 2018.

FEEDBACK: CHOOSING WISELY AND EXPERTISE IN OPINION

We have received feedback regarding the article 'Choosing Wisely in the Emergency Room' (*The Specialist*, Issue 110, March 2017). The article expressed the viewpoint of an emergency medicine specialist, Dr John Bonning, on application of the international 'Choosing Wisely' programme across the spectrum of health care. This programme is indeed important with a focus on excellence in decision-making and appropriate use of resources.

One of Dr Bonning's comments came as a surprise to three orthopaedic spine surgeons. Although an otherwise timely and appropriate article, they took exception to his reference to spinal fusion surgery under the 'Choose Wisely' banner, when he made the following statement: "In the United States, for example, there is no evidence for the benefit of surgical spinal fusion for degenerative back conditions including sciatica."

In response, the surgeons have pointed out that spinal fusion has a huge body of literature, including indications, effectiveness, limitations and benefits in terms of disability reduction. They questioned Dr Bonning's expertise on the topic, and pointed out the lack of relevance of spinal surgery to his article, and to published 'Choosing Wisely' lists.

Dr Bonning has apologised that his statement caused offence: "it was certainly not my intention to do so. The last thing I wanted to do was distract people from the key 'choosing wisely' messages of how carefully we need to rationalise the use of our health resources." He also retracted his comment "including sciatica". Dr Bonning acknowledges that he is not an orthopaedic surgeon but clarified that he quoted from a book written by Sydney orthopaedic surgeon, Professor Ian Harris: *Surgery, the Ultimate Placebo [2016].*

Mr Peter Robertson, a spine surgeon and past-president of the NZ Orthopaedic Spine Society, has expertly discussed this very same topic when commenting on Professor Harris's book for an article in *The Listener*: **http://www.noted.co.nz/health/health/many-operations-are-no-better-than-placebo-says-top-surgeon/**. Mr Robertson further points out that Professor Harris' book was not peer reviewed, and expresses a view that is at one extreme of opinion on this topic.

All parties agree that 'Choosing Wisely' is an important addition to striving towards evidence-based, cost-effective practice, and has the added benefit of taking the patient on the journey with us.

AUCKLAND ANAESTHETIST DR JUDY BENT HAS RETIRED AFTER A LONG CAREER IN MEDICINE AND ACTIVE INVOLVEMENT IN THE ASMS AT BOTH THE BRANCH AND NATIONAL LEVEL. SHE WAS FIRST ELECTED TO THE ASMS NATIONAL EXECUTIVE IN 1997, AND HAS ALWAYS BEEN VERY INVOLVED IN ASMS DECISION-MAKING. SHE HAS ALSO BEEN A MEMBER OF THE ASMS NEGOTIATING TEAMS.

I have enjoyed my various additional roles in supporting colleagues and in helping shape the future for the DHB and for patient care.

WHAT INSPIRED YOUR MEDICAL CAREER?

Though medicine and anaesthesia have served me well as a career, medicine was actually my third choice.

I sought advice during my final year at school and the top recommendation was maths or computation, but at that time all jobs in maths other than teaching or lecturing were specified male-only (including government actuarial jobs), and I didn't want to teach. Anything to do with computers had the reputation of being staffed by only nerds with no social skills, so that was discouraged.

Next came engineering, but at that time there were no women in engineering school, and I knew I wasn't suited to be the first. From what was left I picked medicine, it having the added advantage of being at Otago.

HOW DID YOUR CAREER UNFOLD?

I did 15 months as a House Surgeon (Waikato) then some GP locums in the Waikato area, followed by a stint in New South Wales before heading overseas to London.

My loose plans were to stay in UK for about a year while doing the Diploma in Anaesthesia, then to return to GP practice in New Zealand, with perhaps the provision of GAs in the rooms (a practice not uncommon and quite acceptable then). I enjoyed anaesthesia and recognised its opportunities for travel and part-time practice, so went the FFA route through the various grades in London teaching hospitals. I also enjoyed living in London, with Europe on its doorstep.

In the end, I remained away for 9 years (including a year in Montreal) before returning to New Zealand for family reasons in 1985.

My training and experience had been heavily biased towards cardiac and paediatric anaesthesia. With family in Auckland, it was a no-brainer to take a job at Greenlane Hospital. That was a great place to be working, not only for the clinical experience, but also for its collegial and friendly atmosphere, and a benevolent and supportive management.

I jumped ship from cardio-thoracic before its move to the Grafton site, to remain at Greenlane doing short stay anaesthesia, as well as being the Clinical Director of the unit, until my retirement earlier this year.

WHAT HAVE BEEN SOME OF THE HIGHLIGHTS AND CHALLENGES OVER THE YEARS?

It's hard to identify specific career highlights. The clinical work has always been enjoyable and rewarding, and the rapid expansion of knowledge in the field, along with the dramatic technical innovations that have occurred, have meant it has always also been interesting. If anything, the highlights have been peripheral to my salaried position, with opportunities to use my skills when travelling and in roles outside classic anaesthesia practice.

Along the way, I have also enjoyed my various additional roles in supporting colleagues and in helping shape the future for the DHB and for patient care.

One of the greatest challenges that seems most significant, at least in hindsight, was coping with the difficulties of working while sleep-deprived after a busy night or 3-day weekends, as many of us did during training and our 'early' days as an SMO. On top of this I did a 2-year MBA course (1998-2000) while still working full-time, though my colleagues did allow me to do less than my full share of night/weekend call during that period.

Fortunately, rosters for trainees are better now, and many SMOs get recovery time after onerous call, though I am aware that this is not universal. Latterly there have been the added frustrations, for most ADHB employees at least, of the changed management style and the environment within the DHB.

My career in medicine has served me well and set me up for a comfortable retirement, and I have no regrets about the choices I made. However, there are so many more opportunities for young people now, especially for women, that I wouldn't have chosen medicine if I was a school-leaver today, and that's what I tell young people who ask me.

HOW DID YOUR INVOLVEMENT WITH ASMS COME ABOUT?

I joined ASMS when it was established, then attended the first (and all subsequent) annual conference(s), and joined the Auckland Central Branch committee sometime in the first year. I was keen to understand and help shape the future for specialists in DHBs, plus assist colleagues, and this seemed an effective route.

One way and another my involvement increased, and I joined the National Exec in 1997. I really enjoyed my time on the exec, not only for the contributions I hope I made, but for also meeting colleagues from around the country, and understanding the issues that are particular to some DHBs, and those that are common to all.

HOW ARE YOU FINDING THE TRANSITION TO RETIREMENT?

The transition to retirement, after 43 years in medicine and 40 in anaesthesia, has been very easy. While on paper I have worked full-time-plus till retirement, in fact I had accrued a lot of leave and I used this up a day or two most weeks over the past few years, as well as the longer periods for travel, so effectively I worked part-time.

I'm still catching up on deferred tasks, and doing more of what I did on days off, and am enjoying life. The biggest downside is seeing less of colleagues who became friends, and whose company I enjoy. I will need to work on maintaining contact with them once I am back from my next trip.

I will continue to travel, and now I have the advantage of not needing to work around departmental requirements or conference schedules.

My career in medicine has served me well and set me up for a comfortable retirement, and I have no regrets about the choices I made.

VITAL STATISTICS

In 2015 there were approximately 131 specialists per 100,000 population employed in Australia.

At the same time, there were approximately 117 specialists per 100,000 population in New Zealand.

For New Zealand to have the same number of specialists per population as Australia, an additional 670 specialists would have been needed, or 12.6% of the current workforce.

NOTE:
Excludes specialists in training and provisional registrants.

SOURCES:
MCNZ: Medical Register, June 2015.
Statistics New Zealand population estimates, June 2015.
National Health Workforce Data Set (Australia). Medical Practitioners, 2011-2015.
Australian Bureau of Statistics: Population estimates June 2015.

ASMS 29TH ANNUAL CONFERENCE

THURSDAY 23 & FRIDAY 24 NOVEMBER 2017
THE OCEANIA ROOM, TE PAPA, WELLINGTON


© TE PAPA

DINNER AND PRE-CONFERENCE FUNCTION

A pre-conference function will be held at The Boatshed on the evening of Wednesday 22 November, and a conference dinner will be held on Thursday 23 November at Te Marae, Te Papa.

These are a great opportunity to mingle with conference delegates and others in a relaxed social setting and, of course, to enjoy some of Wellington's fine hospitality!

LEAVE

Clause 29.1 of the MECA includes provision for members to attend Association meetings and conferences on full pay.

DELEGATES REQUIRED

The ASMS makes all travel and accommodation arrangements for ASMS delegates to attend its 29th Annual Conference. Register your interest today to **ke@asms.nz.** Registrations close on 5 October.

ASMS
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DID YOU KNOW

...ABOUT THE NEW MECA (2017-2020)?

LONG SERVICE LEAVE

Those employees who did not have an entitlement to long service leave before this MECA came into effect will now have a right to two weeks of extra annual leave after every 10 years of service, but only service from 3 July 2017 will be recognised. (These DHBs were unwilling to bring in a provision that would grant long service leave immediately).

However, for SMOs at DHBs that have always had an entitlement, and for SMOs who transfer to such a DHB, then the SMOs total service as a medical or dental practitioner in the New Zealand health system will count.

Where the existing long service leave provision is better than the new provision, the existing provision will carry on for current SMOs.

At some DHBs the entitlement to long service leave was for a finite number of years. At these DHBs the new provision will pick up where the old provision left off.

TIME IN LIEU FOR CME TAKEN ON NON-DHB WORK DAY

Previously the MECA provided an entitlement for employees who undertook approved CME on a weekend or public holiday to take a day-in-lieu on a day they normally work for the DHB.

Under the new MECA, this entitlement to CME lieu days has now been extended to rostered days off and days that you do not work for the DHB and is equally applicable to both part-time and full time SMOs.

PAID PARENTAL LEAVE

If you are in receipt of the statutory parental leave payment, you are now entitled to 14 weeks on full pay by means of the DHB topping up the difference between your full pay and the IRD payment. (The IRD payment is for 18 weeks and is currently capped at $516.85 before tax per week).

If you are not receiving the statutory (IRD) parental leave payment (including not being entitled to it), you are still entitled to 6 weeks on full pay (as per the previous MECA).

The new MECA does not change the amount of unpaid leave you can apply for (up to 6 months if you have less than 12 months service and up to 12 months if you have completed 12 months service) or the 2 weeks paid partner leave.

SALARY INCREASES

All ASMS members will be getting salary increases (average of 2%) for both the specialist and medical/dental officers' scales. The effective dates for these increases are 3 July 2017 (with back pay), 5 March 2018 and 1 April 2019.

There are also two additional steps added to the top of both the specialist and the medical/dental officer scales. Those who have been on the top step of the current scales for at least 12 months on 5 March 2018, will be eligible to advance to the first additional step on this date (step 14 for Medical and Dental Specialists and step 13 for Medical and Dental Officers).

Those who have been on the top step for less than 12 months on 5 March 2018, will be eligible to advance to the new step on their usual anniversary date. For example, if you advanced to the current top step on 1 May 2017, you will advance to the new additional step on 1 May 2018.

The effective date for the second additional steps is 1 April 2019.

HISTORIC MOMENTS

EACH ISSUE OF *THE SPECIALIST* WILL FEATURE A PHOTOGRAPH OR DOCUMENT FROM THE ASMS ARCHIVES. YOU CAN FIND MORE SLICES OF HISTORY ON THE ASMS WEBSITE (**WWW.ASMS.NZ**) UNDER 'ABOUT US'.

Whole Time Senior Medical Officers' Association
of New Zealand

President: *Honorary Secretary:*

Dr. M.R. Wallace,
Renal Physician,
Waikato Hospital,
Hamilton.

23rd November, 1973.

Dear Martin,

As you know the quorum executive of the Association agreed to remain in Auckland for one further year in order to complete the HMOAC negotiations. Unfortunately, the Governments wage freeze has meant that these negotiations cannot be carried out until after June 1974. The present quorum executive is reluctant to serve for a fourth year.

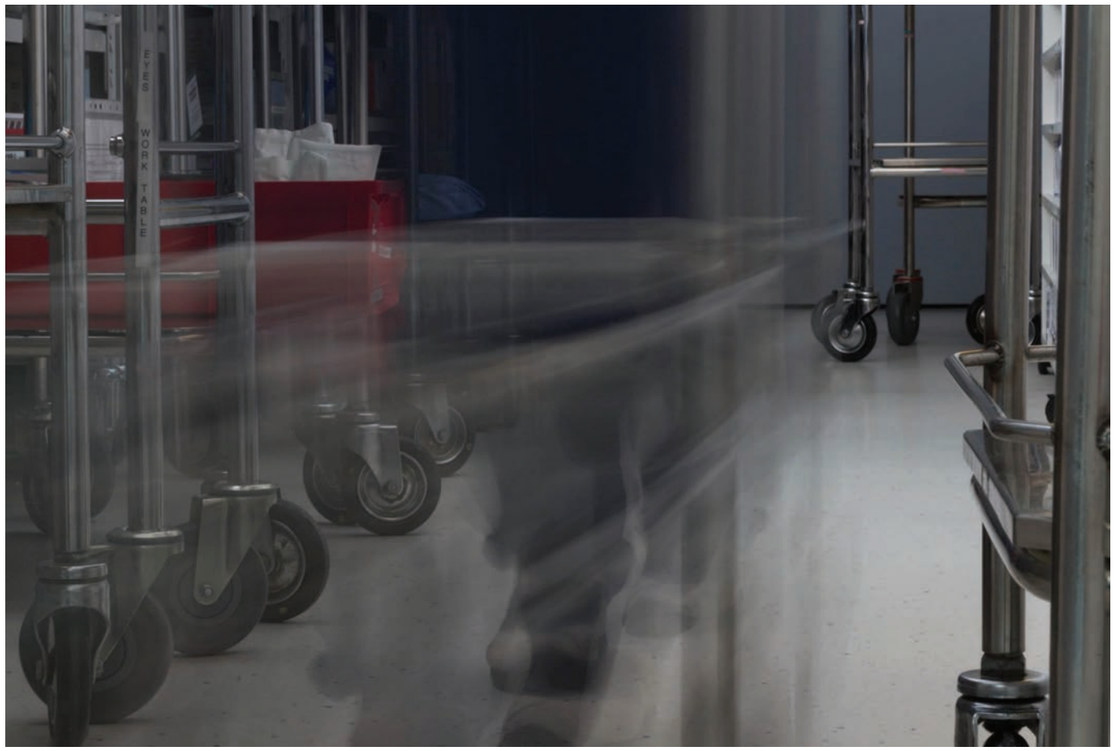
At the last general meeting you expressed some interest in the possibilty of the quorum executive moving to Hamilton. This would require the election of a President, Secretary, Treasurer and one additional delegate. Do you think there would be a chance of the quorum executive shifting to Hamilton next year? While the submissions regarding conditions of employment and salaries have been prepared it is most important that the next executive vigourously protect the interests of whole timers when joint negotiations with other sections of the medical staff are undertaken with the Government.

This is a personal and confidential inquiry, but should there be any interest in Hamilton in taking up this burden I would discuss it with the quorum executive in Auckland, and the rest of the executive in the various centres.

With kind regards,

Yours sincerely,

B.R. CANT.
Clinical Neurophysiologist.



INFORMED CONSENT IN AN EMERGENCY SETTING

AIMEE CREDIN | PARTNER AT LAW FIRM DLA PIPER, ON BEHALF OF MEDICAL PROTECTION

The goal of informed consent is to use shared decision-making to ensure that the patient reaches a decision which is 'right for them'. It is always the doctor's responsibility to provide the advice. There is no onus on the patient to ask the relevant questions. A patient cannot be expected to ask for information if they are unaware of its existence. This can be difficult in emergencies, especially so in an acute obstetric setting where urgent decisions have to be made. Often in such circumstances there is limited time for communication. What is expected of doctors in this situation depends on what is 'reasonable in the circumstances', taking into account time and resource constraints.

EMERGENCY SITUATIONS

If immediate action must be taken in an emergency to preserve the life or health of a patient, doctors can provide the essential services without consent. Only treatment necessary to preserve life or health should be performed at this time. Any procedure that can reasonably be delayed should be delayed until an opportunity can be given for the patient to consent.[1]

Clinical decisions to provide 'best interest' treatment in emergency situations will rarely result in a subsequent complaint or legal challenge. Most patients will be grateful for the skill and judgement exercised by professionals who may have saved their lives.

Although emergency treatment may involve tense and traumatic situations, the application of Right 7(4) of the Code of Health and Disability Services Consumers' Rights is likely to be relatively straightforward in such circumstances. Clause 3 of the Code clarifies what is meant by the term 'reasonable actions'. In practice, the quality and content of

The concept of informed consent can raise difficult practical questions about scope and content for doctors in an emergency setting.

What is expected of doctors depends on what is 'reasonable in the circumstances'.

consent (the level of detail required in the consent process) to treatment is more likely to be called into question in non-acute situations or cases involving longer-term issues of incompetence.

OBTAINING INFORMED CONSENT

The starting point for doctors in New Zealand is the Code, which states that every patient has the right to information that a reasonable patient, in that consumer's circumstances, would expect to receive (Right 6). Specifically, this includes an explanation of the patient's condition and an explanation of the options available, including an assessment of the expected risks, side effects, benefits and costs of each option.

However, the concept of informed consent can still raise difficult practical questions around scope and content for doctors in an emergency setting. This is a consequence of Right 7 of the Code. Right 7 states that services may only be provided where the consumer has made an informed choice and given informed consent. The only exception to this is where the law specifically provides otherwise.

In emergencies, Right 7(4) of the Code provides such an exception. Doctors may proceed with a medical procedure without actual or legally authorised consent where it applies. In such cases, the only course of action is to act in the patient's best interests. The decision as to what is in the patient's best interests is strictly a medical issue, and one that is expected to be professionally formed by the doctor concerned. Discussions with the patient's close family may assist the doctor in deciding where those interests lie if time permits, although the family's views are not determinative. The decision-making process must be documented in the patient's records.

This issue often arises in the obstetric setting, where time is of the essence and it is not always easy to talk a patient through all the risks, benefits and alternatives involved with a particular treatment option. The law recognises this, and the following Health and Disability Commissioner (HDC) decisions provide guidance on doctors' obligations in such situations.

Doctors may encounter highly stressful situations where prompt action is required. However, if there is still sufficient time to explain the available options and allow the patient to make an informed decision, and a doctor does not do this, he or she may be found to have breached the Code. By way of illustration, the HDC[2] determined that an obstetrician breached Right 6(1) of the Code by failing to assess the patient's current condition and discuss the option of a caesarean section, including the doctor's assessment of the urgency of the matter and his opinion of the safest course of action.

Of note, the HDC found that it was not necessary for the doctor to give another full explanation of all the risks and benefits of ventouse delivery given that two previous attempts at a ventouse extraction had occurred. It was reasonable for him to assume that another doctor had advised the patient of the risks associated with ventouse.

It is important, especially in emergency situations, to fully understand the scope and content of information that patients require in order to be put into a position where they can provide informed consent. This may change depending upon the patient's circumstances during the course of treatment. By way of illustration, a woman was admitted after spontaneous membrane rupture and was then monitored for 48 hours to see if labour developed naturally. By the following day, the labour had failed to progress and Syntocinon was introduced.[3] The HDC found there were two occasions where the patient needed information to allow her to consent to decisions about her care: first, when her membranes ruptured pre-labour, and secondly, when her labour failed to progress. The HDC found that the doctor, at both stages, failed to provide the patient with an explanation of her condition and a discussion about the relative risks and benefits of all the options. The doctor also failed to provide the patient with the option of a caesarean section. The doctor was found to have breached Right 6(1) of the Code.

It goes without saying that doctors must not assume a patient's preference for treatment. A good example of this is an HDC decision[4] concerning an obstetrician and gynaecologist who assumed that the patient did not want obstetric intervention in labour or delivery, and so did not consider forceps delivery or an emergency caesarean section. The HDC found there was no objective, reasonable and/or sound basis for this – he ought to have verified his assumption with the patient, and he should have informed her of delivery options that were clinically appropriate.

PRACTICAL TIPS

The United Kingdom's Royal College of Obstetricians and Gynaecologists provides some practical guidance to doctors when obtaining consent in commonly occurring situations in obstetrics.[5] These include:

- if consent is to be obtained from a woman during painful labour, information should be given between contractions
- informing women during the antenatal period about predictable problems that may occur in labour
- verbal consent only may be obtained for emergency procedures, such as caesarean section when it is in the best interests of the woman or the baby, but this should be witnessed by another care professional.

REFERENCES

1. Ian St George (ed), Cole's Medical Practice in New Zealand, 2013, p. 100.
2. O6HDC12769
3. O5HDC16711
4. 12HDCO0481
5. Royal College of Obstetricians and Gynaecologists, Clinical Governance Advice No 6, 'Obtaining Valid Consent' (UK guidelines).

ASMS SERVICES TO MEMBERS

As a professional association, we promote:

- the right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists.

As a union of professionals, we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

OTHER SERVICES

www.asms.nz

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

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

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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.

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In addition to *The Specialist*, the ASMS also has an email news service, *ASMS Direct*.

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