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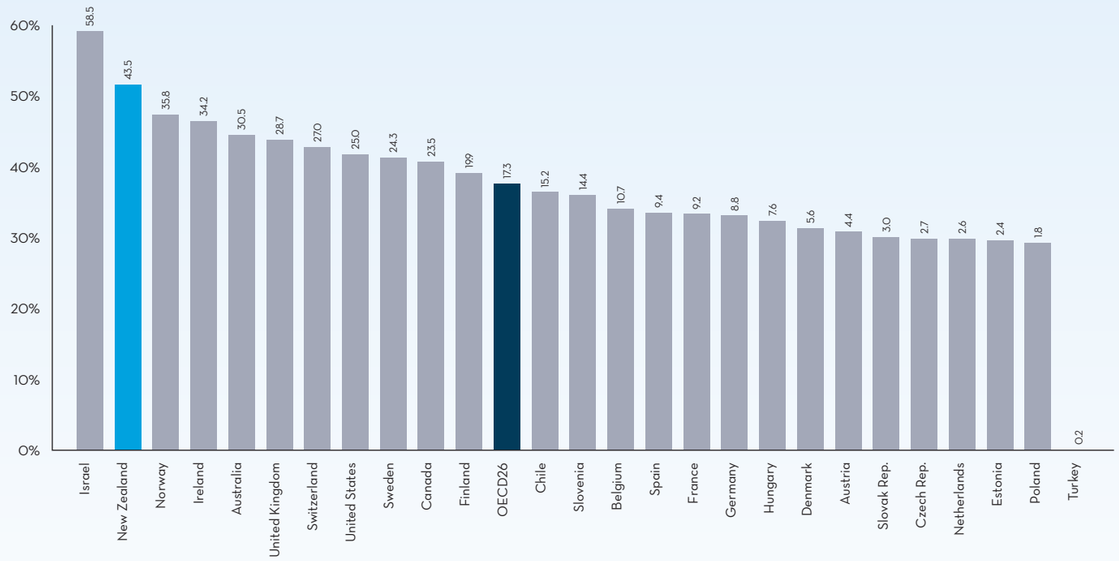


FIGURE 1: SHARE OF FOREIGN-TRAINED DOCTORS IN THE OECD COUNTRIES, 2013

MEDICAL MIGRATION - IS NEW ZEALAND PULLING ITS WEIGHT GLOBALLY? THE DATA TELLS A STORY

PROF MURRAY BARCLAY | ASMS NATIONAL PRESIDENT

At the special 30th anniversary conference of ASMS in June, we were fortunate to have some stellar international speakers, including Dr Otmar Kloiber, Secretary General of the World Medical Association (WMA).

The WMA was initiated by 27 international medical associations after World War II, partly in response to war crimes and the need to establish ethical guidelines for world physicians. The WMA now has 112 National Medical Associations from around the world representing more than 9 million physicians.

In addition to medical ethics, WMA has a focus on the maldistribution of health resources worldwide in relation to the global burden of disease. Numbers of doctors per capita globally is one extreme example of this maldistribution, ranging from about two doctors per 100,000 population in parts of Africa to 500 per 100,000 in affluent Western countries.

Medical migration is a major contributor to this maldistribution, with doctors migrating to more affluent countries for better income and quality of life. Clearly this migration disadvantages poorer countries and needs to be prevented when possible. One way to reduce medical migration is to ensure good working conditions and salaries in each country.

It appears that New Zealand has a very significant problem with medical migration from a global perspective. Figure 1 shows that New Zealand has the second highest percentage of foreign-trained doctors in the OECD, with an increasing trend over time that is not shown here.

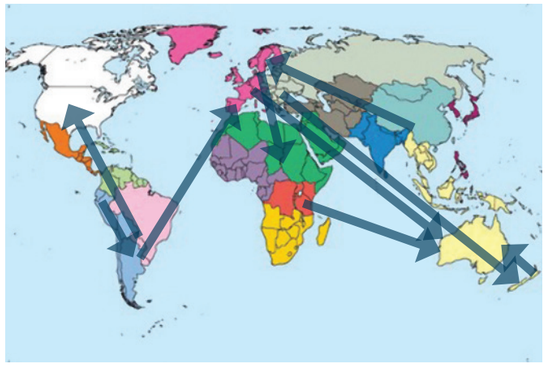


FIGURE 2: GLOBAL PATTERNS OF MEDICAL DOCTOR MIGRATION, COURTESY OF DR OTMAR KLOIBER, SECRETARY GENERAL OF WORLD MEDICAL ASSOCIATION

"Medical migration disadvantages poorer countries and needs to be prevented when possible. One way to reduce medical migration is to ensure good working conditions and salaries in each country."

So why is New Zealand so dependent on foreign-trained doctors? Are we not training enough? Or do our own trained doctors emigrate? It is probably a mixture of both but with emigration being the main contributor, presumably to achieve better salaries and/or working conditions elsewhere.

The WMA also has data on where doctors are migrating to globally and figure 2 from Otmar Kloiber is illuminating. This shows that we tend to import doctors predominantly from Europe and the UK (who are replaced by doctors from Africa and Asia) and that our own trained doctors migrate mostly to Australia.

There are many anecdotes suggesting that medical salaries are significantly higher in Australia than in New Zealand. ASMS has looked at this in the past and comparison between the countries is fraught with difficulties due to the multiple different pay arrangements in Australia, from state to state, hospital to hospital, between universities and hospitals, and with the range of tax-reducing arrangements in Australia.

However, if New Zealand is to try to reduce medical migration, for our own country's benefit and to help poorer countries retain their own doctors, it is incumbent on us to have salaries and conditions that are competitive with Australia and other similar countries, which means gaining a better understanding of conditions in these countries.

Whilst reviewing some of the data above, I assessed other OECD international comparisons with New Zealand. Figures 3 and 4 below are enlightening.

Health ministers over the years repeatedly reassure New Zealanders about how well the Government is doing in health spending, and make political mileage from anything extra that they fund in health. Meanwhile our overall health funding as a percent of GDP, and in real dollar terms, has become progressively more abysmal, especially when compared internationally.

The figures below illustrate just how poorly New Zealand compares from an OECD perspective, with respect to patient services in the form of consultations, and on our spend on medicines. There are of course many factors that can influence such aggregrated data used by the OECD, and it could be that the health of New Zealanders is so much better than the rest of the world that we don't require as many consultations or as many medicines as in other countries, but I know of no data that would support that hypothesis.

The progressive under-spending on New Zealander's health cannot be without consequence. In the last few years, demand on hospitals has grown at a rate that is markedly out of proportion to population growth and age patterns. It is hard not to conclude that this might be due to progressive under-spending on health and the consequences thereof. New Zealanders deserve better.

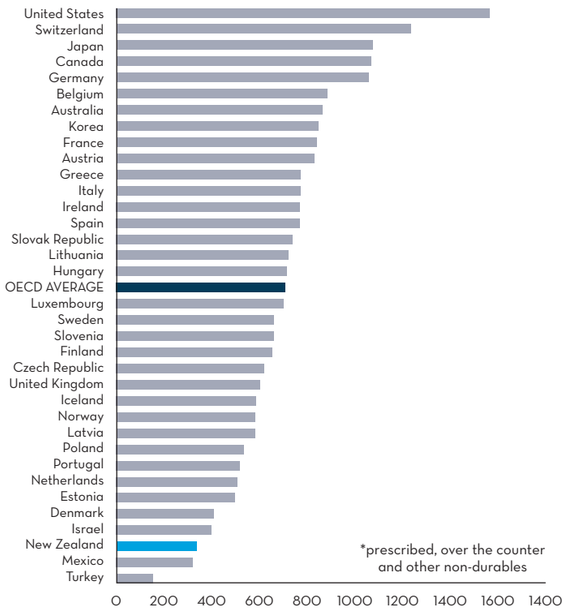


FIGURE 3: SPEND ON PHARMACEUTICALS PER CAPITA IN 2018 IN US DOLLARS

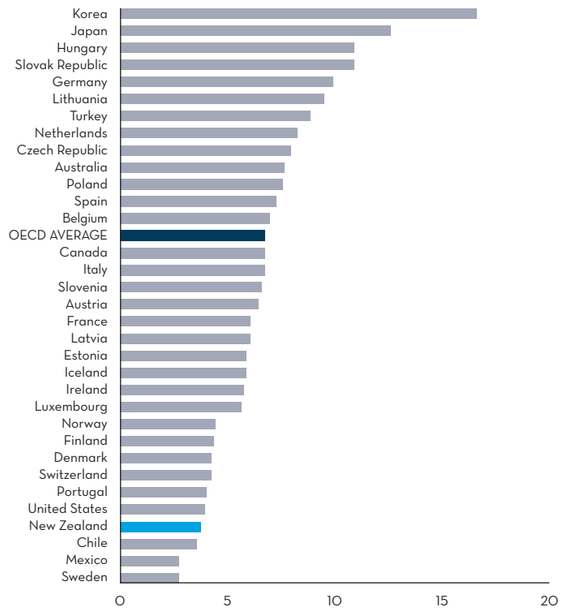


FIGURE 4: DOCTOR CONSULTATIONS PER CAPITA IN 2017

WAS IT ALL WORTH IT?

IAN POWELL | ASMS EXECUTIVE DIRECTOR

At its meeting last August, the National Affiliate Council of the Council of Trade Unions (which includes ASMS and NZNO) adopted a resolution highly critical of the DHBs' collective bargaining strategy towards RMOs represented by the Resident Doctors' Association (RDA). It included the statement that their strategy had the potential to be union busting. Union busting is not simply about employers seeking to eradicate an irritating union; it is about undermining its effectiveness to advocate on behalf of its members.

THE DILEMMA

Although the issues sitting behind this protracted bitter dispute, including several strikes, are complicated, it was avoidable. Over many years the RDA has sought to reduce RMO fatigue by trying to make their hours of work safer through collective agreement negotiations.

The dilemma is that enhancing safer hours requires more RMOs, which fragments the relationship between specialists and registrars. This, in turn, fragments the continuity of training along with consequential effects on clinical handover and patient care. To date, the only way of addressing these complexities is through collective bargaining for the main RMO multi-employer collective agreement (MECA).

This dilemma and its unintended consequences have been around for many years. In 2016-17, the RDA sought to further improve the safety of working hours in their national MECA with the DHBs by introducing two additional requirements – a maximum of 10 consecutive working days and 4 consecutive night shifts – along with consequential rostered days off. After acrimonious negotiations, which included two national strikes, the RDA succeeded, with an agreement known as Schedule 10 added to the national agreement.

THWARTED ASMS INITIATIVE

As a result, this dilemma deepened further. Anticipating further conflict following the commencement of negotiations for a new MECA, and recognising our unique role representing those who train the doctors and dentists in training, last September ASMS proposed a collaborative and non-confrontational process to figure out how to deal with this dilemma of managing safer hours obligations without compromising continuity of training.

We invited the DHBs and RDA to meet with us to explore how we might do this, as the issues are too complex to address through the blunt instrument of collective bargaining. The RDA responded positively to our initiative, but the DHBs declined, preferring to address their concerns through the blunter and adversarial process of collective bargaining. Had the DHBs agreed to participate, the industrial confrontation could have been avoided. Earlier this year they rejected a similar initiative from the Medical Council.

CHIEF EXECUTIVES' STRATEGY

The chief executives' strategy on behalf of the DHBs was to take advantage of legitimate concerns over the impact of safer hours on continuity of training and continuity of patient care, rather than work through with us and the RDA the nuanced complexities of the challenge.

Critical to this strategy was significantly reducing the influence of the RDA, preferably leaving it as an ineffective rump (ie, union busting) so that its gains could be rolled back and it would never be able to make future gains. This included actively favouring a smaller competing union set up with the sole objective of removing Schedule 10.

This was not a strategy fully shared by all chief executives. It was largely driven by those from the larger tertiary DHBs. While negotiating at a snail's pace with the RDA, they quickly concluded an alternative MECA with the new much smaller STONZ (Specialty Trainees of New Zealand) union which both removed Schedule 10 and other key protections previously negotiated, including reducing the ability of the union to effectively represent its members and contained financial inducements for RDA members to leave and join STONZ.

The chief executives then only needed to wait until 28 February this year when the legal obligation to offer the expired RDA-negotiated MECA to new RMOs or RMOs who changed DHBs ended, leaving them with the only obligation being to offer their STONZ MECA to those who depended on them for their training.

"The DHBs claim that their collective bargaining strategy was worth it. Yeah, right!"

"ASMS proposed a collaborative and non-confrontational process to figure out how to deal with the dilemma of managing safer hours obligations without compromising continuity of training."

They were able to ensure no agreement was reached before 28 February by proposing claw-backs to various rights and protections in their 'negotiations', knowing full well that the RDA would never accept (conditions that the RDA had fought hard to achieve over many years).

Ironically, the DHBs did not seek the removal of Schedule 10 from the RDA MECA despite it not forming part of the STONZ MECA. This approach assumed that the RDA's membership would plummet as a result of their strategy to the extent that the continuation of Schedule 10 would not have mattered.

The DHBs tried to argue that the issue was to ensure that decisions on rostering arrangements were made locally but, in reality, it was about whether chief executives should have ultimate control over determining the rosters of a young transitional workforce dependent on them for their training.

LEGAL FACILITATION

There was a series of strikes which the DHBs publicly attempted to downplay, despite costing these DHBs an additional $20 million and resulting in high levels of fatigue among an already burnt out senior medical workforce. The dispute ended up in a legal process conducted by the Employment Relations Authority (ERA) called facilitation (ie, non-binding but persuasive arbitration). This was initiated by the RDA and initially challenged by the DHBs before changing their position.

The ERA took this seriously and worked hard on developing a recommended settlement which both parties accepted. The chief executives' spokesperson has claimed that through their collective bargaining strategy the DHBs achieved most of what they wanted, particularly around reducing the RDA's role in rostering decisions. But is this the case?

Not so in my assessment.

The ERA accepted the core premise that because of their dependency on DHBs for their training, RMOs are a vulnerable workforce. Accepting the DHBs' position required the ERA not accepting this premise and instead accepting that the benignity and good judgement of chief executives were sufficient protections.

OUTCOME

Some of the protections the RDA was fighting to retain (and equally the DHBs fighting to remove) will remain. The most noteworthy is the requirement for the agreement of two-thirds of affected RMOs before rostering changes can proceed. Removing this provision was precious for the DHBs. Other protections have been expressed in a different way (using agreed rather than consulted processes) but in a way that the RDA is comfortable with and short of what the DHBs were striving for.

There is also a new management of change clause in the new MECA that neither the DHBs or RDA claimed for, but the ERA recommended and they accepted. This may be a good thing. But a possibly unintended consequence for the DHBs is giving the RDA more influence than they previously had because (a) it widens the scope of what the RDA can be lawfully required to be consulted or engaged with over and (b) there are more process steps for DHB managers to trip up over and then be challenged and halted by RDA should it choose to do so.

Most significant is that the RDA has retained its membership levels and remains a force to be reckoned with. Because it will cover many more RMOs than the STONZ MECA, DHBs will be legally obliged to offer the RDA-negotiated MECA in the first instance to new appointments. Union busting failed.

The STONZ union favoured by the DHBs and Minister of Health as a rival to RDA has around 800 members, which sounds impressive until one learns that a majority (maybe three-quarters) are also RDA members and eligible to be covered by the new RDA-negotiated MECA. Perhaps the DHBs and STONZ have inadvertently created a Trojan Horse within STONZ. Who knows!

SO, WAS IT ALL WORTH IT?

In considering this, tally up the following:

- The RDA is as strong now as it was before the MECA negotiations commenced (possibly stronger) and, given the acrimony of the industrial dispute, more wary of DHB intentions.
- Schedule 10 is more entrenched now than it previously was.
- Over $20 million has been unnecessarily wasted because of the dispute.
- Many already fatigued or burnt out SMOs have been subjected to additional fatigue.
- There has been a loss of many RMOs from DHB employment during the dispute through, for example, some UK graduates returning home earlier than employed and others disappearing to countries such as Australia and the UK. The number is not verified but may be as many as 300.
- Many RMOs who we depend on becoming our future DHB specialists are likely not to see DHBs as their employer of choice. This is at a time when DHBs face specialist shortages of around 22%.

The DHBs claim that their collective bargaining strategy was worth it. Yeah, right! If only they had listened to ASMS last September, or to the Medical Council earlier this year.

"Union busting is not simply about employers seeking to eradicate an irritating union; it is about undermining its effectiveness to advocate on behalf of its members."

NEW ASMS EXECUTIVE DIRECTOR APPOINTED

ASMS Industrial Officer Sarah Dalton has been appointed to lead the organisation when Ian Powell departs at the end of this year.

Ms Dalton will take the reins on 1 January 2020.

Since joining ASMS in 2015, Ms Dalton has been an active and effective member of the industrial team.

As well as serving as Industrial Officer for Northland, Auckland, and Waitemata DHBs, and until recently, Counties Manukau DHB, Ms Dalton has promoted networking opportunities for women members through various initiatives.

Ms Dalton's background is teaching, and she held several roles in education, including that of Assistant Principal at Aotea College and Head of Department for English at Upper Hutt College.

She also worked at the PPTA for seven years, initially on professional matters and subsequently on employment relations matters for principals and teachers.

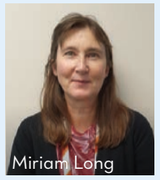
Mr Powell said he was delighted with the appointment.

"I feel chuffed about being replaced with someone of Sarah's calibre. She has been an outstanding industrial officer demonstrating strong insight, intellect, and emotional intelligence."

Last year Mr Powell signalled his intention to depart at the end of 2019 after leading ASMS since its formation in 1989.

A profile of Ms Dalton will be published in the December edition of *The Specialist*.


Sarah Dalton


Miriam Long


George Collins

INDUSTRIAL TEAM GROWING

ASMS' industrial team is growing. Miriam Long has been hired as an additional member of the team. She will be working with the Northern DHB team with Steve Hurring and Sarah Dalton. A recruitment process is under way to replace Ms Dalton when she takes up the role of Executive Director. Ms Long has worked as a lawyer for many years; her most recent role was in the Ministry of Business, Innovation and Employment.

Dianne Vogel left ASMS this month after accepting a role as a senior solicitor with the New Zealand police. Her replacement is George Collins, a lead organiser at E tū. He joins ASMS in late September.

COMMUNICATIONS TEAM CHANGES

Director of Communications Cushla Managh has left ASMS after accepting the role of Strategic Communications and Engagement Manager at Community Housing Aotearoa, the umbrella organisation for community housing.

ASMS Executive Director Ian Powell thanked Ms Managh for her work.

"Cushla has in her five and-half years as our first Director of Communications made a significant contribution to ASMS' effectiveness as the voice of salaried senior doctors and dentists.

"This includes in the much improved flagship publication *The Specialist*, our internal communications, and social media. She has been a tremendous asset for ASMS, and I wish her the best in her new journey working in community housing," Mr Powell said.

Ms Managh said: "It's been a privilege working with ASMS members over the past few years to articulate the things that matter to some of this country's most senior doctors and dentists."

A recruitment process is under way to appoint a new Director of Communications.

Meanwhile, Senior Communications Advisor Eileen Goodwin will be taking 12 months' parental leave later this year. She will be replaced during her leave by experienced journalist Liz Brown.

RESEARCH AND POLICY SWITCH

The two members of the ASMS research and policy team have effectively switched roles as part of a long-signalled succession plan.

Dr Charlotte Chambers, who had been Principal Analyst, is now Director of Research and Policy. The previous Director, Lyndon Keene, is now its Senior Researcher. Mr Keene intends to reduce his working hours next April, from 30 hours per week to 15 hours per week.

SUPPORT SERVICES TEAM CHANGES

Vanessa Wratt, ASMS' new Senior Support Officer, joined the team following the recent departure of Maria Cordalis, who has moved to London for her OE.

She has a wide range of skills suited to the role and has worked in many senior administrative roles before joining ASMS.

Executive Director Ian Powell and ASMS National President Professor Murray Barclay cut the 30th anniversary cake


Health Minister David Clark


Conference attendees gather for a group photo

THIRTY YEARS OF PUBLIC HEALTH SERVICE ADVOCACY

ASMS celebrated its 30th anniversary in June with a one-day conference in Wellington.

The day was a chance to celebrate past gains while looking critically at the challenges in health nationally and around the world.

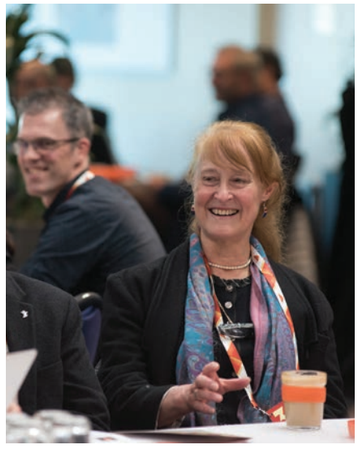
The speakers included: Professor Martin McKee, of the London School of Hygiene and Tropical Medicine, World Medical Association Secretary General Dr Otmar Kloiber, Health Minister David Clark and Royal New Zealand College of General Practitioners President Dr Samantha Murton. About 150 people attended.

Dr Clark praised ASMS for its impact in the sector, and thanked members for their hard work.

"You do make a major difference to the health and well-being of New Zealanders on a daily basis across the country. And I don't think you are thanked often enough for your contribution in a profession that is dedicated to service."

In turn Dr Clark, however, faced some tough questions from attendees, about the state of mental health facilities, specialist shortages and burnout, ED wait times, and funding levels.


30
YEARS
SUPPORTING NEW ZEALAND'S SALARIED SENIOR DOCTORS AND DENTISTS SINCE 1989




30
YEARS
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YEARS


30
YEARS
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YEARS

WHAT OUR MEMBERS SAY

ASMS enjoys a strong membership base with high levels of activity and engagement.

Here are the views of four members about their involvement with the union:

JOHN MACDONALD

"Congratulations to ASMS on its 30th anniversary. I joined ASMS early because, as a specialist in a small rural hospital, I realised the importance of having widespread and powerful allies in the changing medical climate. I remained an active member for the rest of my career because I enjoyed the friendship, stimulation and learning gained by meeting a large number of very capable people across a broad variety of regions and jobs. ASMS has always exceeded my reasons both for joining and remaining and I wish it well for the future."

KEN CLARK

"Happy anniversary ASMS and thank heavens you've been around for the bulk of my consultant career. The early 1990s were trying times as we SMOs attempted to come to grips with a whole new take on health and the place of the doctor in the world ahead. ASMS was critical to us not splintering in multiple directions and to us regaining our identity and our sense of worth. We never doubted our importance to patients but for a time we didn't know our value to the system or in some cases whether we should even continue to bother."

DAVID GALLER

"Unions have played an important role in improving working conditions – but their power has waxed and waned over time, in response to political and economic influences. Years ago, when I joined the executive of the Association of Salaried Medical Specialists, I had a conversation with the then head of the CTU, Ken Douglas. We spoke about unionism in general and specifically about my concerns that our Association of well-paid health professionals could be seen as being primarily motivated by self-interest. His advice to me was to align our interests with those of the public at large and be seen to act in their interests to improve the quality of the public health service on which so many New Zealanders rely. That has been the motivation for my ongoing commitment to the Association over the thirty years of my career."

CAROLYN FOWLER

"I was privileged to be a member of the National Executive for a time which was incredibly valuable as it broadened not only my understanding of the challenges facing my own DHB but also importantly others in NZ. It allowed me a way to contribute positively not only to my own and my colleagues working conditions but also to the healthcare system for the NZ public."

"Psychological treatments have proven efficacy in the treatment of anxiety and depression as stand alone treatment, or with medication. This strategy requires funding and time."

MENTAL HEALTH STRATEGY NEEDS MORE SPECIALIST INPUT

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

A retired psychiatrist and former Mental Health Commission advisory committee member fears a once-in-a-generation opportunity to overhaul mental health services could be lost.

With mental health at a crossroads, and the Government still making up its mind on how to allocate funding, Dr Brian Craig says specialist services were under-emphasised in the Mental Health and Addiction Inquiry and subsequent report.

He says hospital services could become swamped in the coming years if moves to shift resources into the community are not well planned.

Dr Craig is a former specialist psychiatrist with training and expertise in the diagnosis and treatment of psychiatric disorders at the more severe end.

The report emphasises wider social problems feeding the mental health crisis, and Dr Craig says it's important to acknowledge that specialist services are only part of the solution to problems like poverty, homelessness, and family violence.

"But we should be allowed to get on with what we do best."

New community initiatives will help in the long-term but will increase pressure on stretched specialist services in the early years because of more people seeking help, and implementation difficulties.

He says it's time to properly fund non-specialist community services and fix gaps that policy-makers left after poorly implemented deinstitutionalisation several decades ago.

But that doesn't mean specialist services should be ignored.

"We need to put the community back into mental health. The old mental hospitals used to provide asylum, support, graduated transitions, and supported work and accommodation.

"When they were closed, inadequate funds went back into the community, and mental health continued in its more isolated way but without a sense of community as services and facilities were never adequately funded," he says.

Dr Craig, an ASMS life member, says the inquiry took too little heed of considerable specialist input into the process, something that became evident in its report, entitled *He Ara Oranga*. The psychiatric workforce was glossed over in the inquiry, and data was aggregated for clinicians of all disciplines, including vacant positions.

PSYCHIATRIST NUMBERS

Accurate numbers of psychiatrists and DHB vacancies are difficult to obtain, and Ministry of Health figures have been disputed.

A Royal Australian and New Zealand College of Psychiatrists survey in 2014 identified 333 College fellows and 158 affiliates who are foreign college psychiatrists, without the local fellowship qualification. This would equal 491 specialists in New Zealand, most of them employed either full-time or part-time in the public sector. At that time around 50% were overseas graduates, and a quarter indicated they were likely to retire in the next five years.

New Zealand Medical Council figures in 2016 showed 566 vocationally registered psychiatrists in New Zealand, the majority in public practice. DHB vacancy rates vary, but have been around 7-10%. Current figures would represent about 12 psychiatrists to 100,000 population. The OECD average is 16 to 100,000.

"Throughout many of the DHBs I have visited over the years, facilities are older, dilapidated, and rarely fit-for-purpose, especially when you compare them with other medical facilities."

The Mental Health and Addiction Inquiry contends that the official target of meeting the needs of the most severely unwell 3% of the population has been met. However, a Ministry of Health 2006 study suggested the percentage of adults with severe mental health needs was actually 4.7%.

"There are clearly significant psychiatric workforce shortages which create difficulties around service access, particularly if community input increases referrals in the initial years," Dr Craig says.

He believes there is a risk of staff being lost from DHB-run specialist services to community-based providers. Training enough staff for the sector is a major problem, and there is no clear solution to the workforce issue.

"Specialist staff will need increased time for consultation and liaison with the community to support, train and supervise staff in new community services, due to the lack of specialist expertise in the community.

"This is not always built into job plans and descriptions," Dr Craig said, adding he had experience of this in the 1990s when he was a service director setting up youth psychiatric services in Canterbury.

REBUILDING THE MENTAL HEALTH COMMISSION

Dr Craig was a specialist advisor to the now-defunct Mental Health Commission in the late 1990s. He is concerned that the revived Commission, being formed as a response to the inquiry, may lack influence and scale. Its proposed annual budget, $2 million, is a red flag, he says.

Before being scrapped in 2012, the Commission's annual budget, adjusted for inflation, was just over $3 million, and that was less than it needed at the time.

A properly resourced Commission is crucial for oversight and leadership, especially with new services and training models being formed.

Other elements Dr Craig considers crucial:

- Improving service transitions from inpatient to outpatient and to the community. Suicide risk is elevated in the immediate discharge period.
- Ring-fenced funding, at an adequate level, is crucial to prevent mental health money being used to prop up other areas of need.
- Better recognition of physical health problems in those with mental health issues. People with severe mental illnesses die on average 15 to 20 years earlier than the general population.
- Recruiting Māori, Pacific Island and Asian staff.
- New training programmes are essential.
- Significantly increased psychiatric services to prisons.

SUICIDE PREVENTION

A co-author of a guideline involving assessment and management of people at risk of suicide, for the defunct New Zealand Guidelines Group, Dr Craig says there is potential to waste money on prevention strategies that don't work.

"A lot of money was spent on suicide prevention in Australia with little demonstrated impact.

"The best prevention, for which there is evidence, is early identification and treatment of mental illness." Suicide is often the result of mental illness, but low resilience and social disconnection are also very important.

Dr Craig is in favour of removing financial barriers to psychological services in the community, thereby increasing access to a proven therapy.

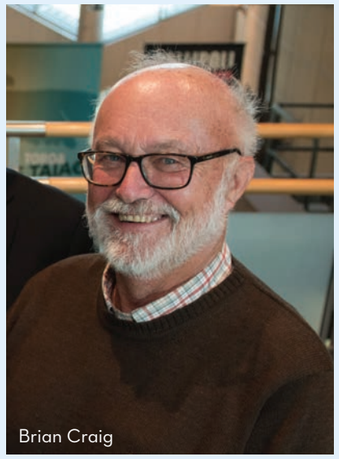
"This has already happened in the United Kingdom, where access to NHS funded psychological treatments has been significantly increased.

"Psychological treatments have proven efficacy in the treatment of anxiety and depression as stand alone treatment, or with medication. This strategy requires funding and time."

He is dismayed by the physical state of many of the country's mental health facilities. The rundown state of Princess Margaret Hospital, where he used to work, is the best-known, but is far from alone.

"Throughout many of the DHBs I have visited over the years, facilities are older, dilapidated, and rarely fit-for-purpose, especially when you compare them with other medical facilities."

Dr Craig is critical of Health Minister David Clark's lack of action in remedying the physical state of facilities, saying the Government seems content to let DHBs struggle on with grossly inadequate mental health facilities.



Brian Craig

"Until we change the societal norms which continue to frame women as holding primacy in the domestic sphere, women and anyone who has commitments outside of work will be disadvantaged by this model of work."

Charlotte Chambers

SHINING A LIGHT ON GENDER ISSUES IN MEDICINE

ASMS Director of Research and Policy Dr Charlotte Chambers discusses her ground-breaking qualitative research into the experiences of women in the New Zealand senior medical workforce. Her study will be published as a *Health Dialogue* and will be sent to members with the December issue of *The Specialist*. The research involved long-form interviews with 14 women about the pressures of working in medicine, specialist training, gender bias, and juggling work with family.

WHY DID YOU DECIDE TO DO THIS RESEARCH?

One of the main findings from our original burnout study in 2016 was the discrepancy in burnout rates by gender. Women across all ages had significantly higher rates than their male counterparts. We discovered a spike in burnout rates for women aged 30-39; 71% of the women who responded were scoring as likely to have very high levels of burnout. I designed a study to enable us to speak to women in this age bracket about their experiences in medicine to see if anything stood out that might help us understand why.

WHAT DID YOU FIND OUT?

The similarities in the cohort were striking. I discovered that burnout for this age group is related to age and stage, but it wasn't the whole picture. Women in this cohort will be experiencing challenges associated with transitioning to a specialist, but so will their male counterparts. Women may also be experiencing significant life events, including having children, but so are their male counterparts. What I argue in my research is that there is something peculiar about being a woman in the medical profession that makes a difference as to how these issues are experienced.

I found that women grapple with issues of work-life balance in distinctly gendered ways; work is constructed as being something that needs to have primacy in their lives in a way that feels oppositional to their professional commitments. If you have significant domestic commitments, 'juggling' work and 'life' becomes even more of a challenge. On top of this, women are expected to somehow bear the mental responsibility for domestic affairs. We talked about this as the mental load. For example, if kids get hurt at school or fall sick, often it's the mother who gets called up and asked to sort it out or to rearrange her working day to accommodate. When women have children, research suggests this can have a much greater impact on their medical careers than their male counterparts; some women talked about feeling that they had to erase their other lives as parent or caregiver when at work in order to be taken seriously as a doctor and some women spoke of having some very tough decisions to make in order to accommodate their career aspirations as well as personal choices.

Medical work is also expected to have temporal primacy; making time to complete medical work is paramount and work is expected to spill over into personal time, you don't leave work until the job is done. But what I found is that for women who are socialised to have primary responsibility for domestic affairs, the temporal primacy of medicine can pose significant practical and emotional burdens. Some of the women who were working part-time in my research described themselves as feeling like a bit of a slacker or second class because their domestic commitments meant they couldn't work full time. Interestingly, the original burnout research suggested that working long hours is a strong correlate of burnout; but working long hours is very much a norm in medicine. If you try to reduce your hours to assist with work-life balance, it's not necessarily going to be protective if you're also internalising a sense that you are not pulling your weight or if you are feeling second class compared with your colleagues who are able to work full time and long hours. It's a really tricky situation.

YOUR RESEARCH TALKS ABOUT THE IDEA OF THE UNENCUMBERED WORKER. CAN YOU EXPAND ON THIS?

The term comes from the scholarship of Joan Acker who uses it as a phrase to describe the 'ideal worker': one who can turn up to work every day and stay as long as the work requires them to stay. The 'unencumbered worker' is, in other words, unfettered by constraints on their availability for work and is free from

"I found that women grapple with issues of work-life balance in distinctly gendered ways; work is constructed as being something that needs to have primacy in their lives in a way that feels oppositional to their professional commitments."

other commitments that might impede their ability to work. They don't have responsibility for domestic duties, they have no mental load, and historically, unsurprisingly, they have all been men! To cite Acker, she states: The 'worker' under capitalism is implicitly defined as unencumbered by any obligations other than those to the job, and work is usually organised on the basis of this assumption. Historically, women have been seen as encumbered wives and mothers and thus not real workers and not entitled to the rewards and rights of real workers.

It's an interesting concept to think about in the context of medicine and burnout because in many respects, medicine is a form of work which expects doctors to leave everything at the door and to stay until the job is done. Historically men have been able to work this way because they have had someone at home. Until we change the societal norms which continue to frame women as holding primacy in the domestic sphere, women and anyone who has commitments outside of work will be disadvantaged by this model of work. Again, to draw on Acker's words: "Equality may be defined now as the transformation of women into neoliberal gender-neutral unencumbered workers whose main efforts go to the job. This path to gender equality is impossible for many women, and some men, for whom it constitutes a fundamental contradiction: work expectations and family needs do not mesh."

I think this concept is relevant for medicine because it challenges business as usual ways of doing medicine; increasingly male doctors are wanting to work differently, either because they value life outside of medicine or because they too are encumbered by their domestic obligations. This is a good thing! But it means rethinking traditional models of work because they are putting people's wellbeing at risk. I think burnout will continue to be inevitable if you are struggling to keep pace with huge and complex workloads and simultaneously you are also carrying the mental load for your domestic responsibilities and returning home at the end of your paid working day to undertake the 'second shift'.

WHAT ROLE DOES GENDER BIAS PLAY IN WOMEN'S EXPERIENCES OF THE PROFESSION?

Why does it matter if you are constantly having to assert yourself as a doctor instead of a nurse? Why does it matter if your nursing staff are less than helpful to you in clinical settings? Why does it matter if you are asked to fetch nappies while on ward rounds? I used the concept of emotional labour to argue that all these small acts of misidentification and gender-based behavioural assumptions accumulate over time to require women to work harder to have their professional status as doctors recognised.

GENDER IS DEVELOPING INTO A KEY RESEARCH AREA FOR ASMS. WHY IS IT RELEVANT FOR OUR MEMBERS?

I guess gender is relevant at a whole range of levels. We now have more women graduating from medical school than men. This is so exciting and a huge step forward. And yet we have a slightly pejorative way of describing this shift as the 'feminisation' of medicine. I find this term problematic because it suggests the growing number of women is somehow 'gendering' medicine whereas historically the preponderance of men has never been an issue. Having a lens on gender should also enable us to consider how some of the issues that our members face may be symptomatic of wider systemic gender bias. We have been hearing from our members for a long time about the possibility of a gender-based pay gap. We have commissioned researchers at MOTU to look at this. Watch this space.

MEDICAL COUNCIL ESTIMATES SUGGEST FEMALE DOCTORS COULD OUTNUMBER MALE DOCTORS IN NEW ZEALAND BY 2025. WILL THINGS IMPROVE FOR WOMEN AS MORE ENTER THE SPECIALIST WORKFORCE?

Many commentators seem anxious that the growing number of women entering medicine will somehow taint the profession. Arguments in this regard focus on the tendency for women to work part-time, self-select into specialties that offer greater control over work hours, and take career-breaks. I think the issues surrounding the growth of women in medicine are much more complex to resolve than simply an add and stir approach. I'm sceptical that the numerical growth on its own will garner genuine change. Yes, the growth in women will have a positive effect but we need to encourage a wider examination of the assumptions that circumscribe ideals around how best to practise medicine.

THE PROPORTION OF WOMEN WORKING IN SURGERY REMAINS LOW. IS THERE ANY SIGN OF THIS CHANGING?

One thing that came out strongly in my research is that surgical stereotypes continue. It's vital that we have positive role models in surgical specialties to show how surgery can be done differently, by people who don't behave in the manner of what one of the women described as a hyper-masculine alpha male beating their chest. There are more women entering surgical specialties and some are making ground-breaking changes, but things remain tough. If you are the only woman in your department and you have, for example, significant domestic commitments, I think you're going to face a subtle set of pressures that perhaps your male colleagues may not be attentive to.

WHAT CAN DHBS AND THE PROFESSIONAL COLLEGES DO DIFFERENTLY AS EMPLOYERS AND CERTIFYING BODIES?

There is a huge amount of helpful suggestions, including mandatory gender-blinding of CVs for job applications and promotions. I think the medical colleges could do some internal auditing to consider how some of their policies may inadvertently make things harder for doctors who may require breaks in their training. From the DHBs, staffing services and rosters could be organised differently. It's likely that we will need more people to form medical teams.

Tim Mathews pictured on his block of land in Tauriko

GRATUITY CASE ABOUT FAIRNESS

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Ear nose and throat surgeon Tim Mathews recently won a landmark Employment Court case against the Bay of Plenty District Health Board concerning retirement entitlement.

When Tim Mathews was 17, he had a choice.

Stay in South Africa and enter compulsory military service, or escape to university in the United Kingdom to avoid serving the Apartheid regime.

But there was another way – entrance to Cape Town medical school and interim exemption from regular service by going to medical school and then serving as an army doctor.

"Morally I could get my head round that.

"My father wouldn't allow me to go into the South African army, but when I got into medicine, he said: 'That's alright as you're going to treat everybody as equal human beings. You're not going to use a weapon to support the system'. Morally my father gave me the green light and I was able to stay."

Medicine brought him to New Zealand in the 1980s as an ear nose and throat surgeon, first to Rotorua, and then Tauranga. After retiring from the Bay of Plenty District Health Board in 2013, Dr Mathews got into a legal fight over his retirement gratuity entitlement. He won the case in the Employment Court this year. It was about fairness, he says.

Arriving in Rotorua in 1987, he found another unfairness – an 18-month waiting time for children's glue ear.

"It was terrible."

"I went to the superintendent and said 18 months to wait is unethical."

Initially he was told no; there was no money. He says the superintendent at the time was a good person, constrained by funding and lack of staff. Dr Mathews persisted, and a special clinic was set up which he ran without renumeration. When he left for Tauranga a few years later, the waiting time was down to three months.

Most of the children, who are at risk of deafness and underperforming in education, were Māori.

What's remarkable, he says, is that in parts of the East Coast it was considered abnormal if a child didn't have a runny ear.

He recalls a Ruatoria teenager he treated in Whakatāne who had been acting up in class.

"She was frustrated with the world.

"The poor girl couldn't hear. We got one ear dry, she had total perforation [of the eardrum]. We operated and got a beautiful result. We operated on the other ear.

"Eventually she had normal eardrums and normal hearing and by that time she was just such a pleasant girl. You could see over the months her face just lighting up.

"When I finally discharged her, she gave me a silver mug. This was quite tear-jerking. In Ruatoria you don't go and buy silver mugs every day of the week. That was very special," he says.

Despite his advocacy for disadvantaged patients, Dr Mathews is dismissive of what

"I don't want to knock it. If you can get into the public service, you can get fantastic service. But the problem is getting in."

he sees as a race-based approach to social policy and healthcare.

His views on race were shaped by his upbringing, alongside people from varied backgrounds.

"People don't understand South Africa.

"People think there is white and there is black. There must be 16 major African tribes. The whites are English or Afrikaans. My parents, being British, were politically on the left.

"People give us a bit of a hard time being South African, but I think we are far more comfortable with many races than a lot of other people."

Dr Mathews grew up on a farm in the Northern Transvaal.

"All my friends were African. All the kids I played with were African. You don't know there's a difference when you are a kid. You swim in the same dam and kick mud in the same puddle."

His family did not shy away from the politics of the day; his mother was active in the anti-Apartheid Black Sash movement.

"My mother was on the front page of the Sunday Tribune newspaper, the only white on the beach protesting against a white-only beach. People were kicking sand at her.

"It was a very brave group of women," he says.

At medical school, about 35% of the students were "non-white" South Africans. Treated as equals at medical school, they were second-class citizens in everyday life.

"People who go to med school reunions tell me there is still a lot of bitterness for that period of time."

They had to travel much further to attend class. Many of them were exceptionally bright, he recalls.

"It had been tougher for them. And the tough ones got through.

"I don't know if I would have got into medical school if it had been a completely fair entrance. The African people in our class were really bright people."

His first posting with the army was in Zululand. Snake bites, bullet wounds, and stabbings were typical presentations. One day, a nurse approached to say a patient had made an appointment to see him. No, he told her, patients don't need to book. She told him he had misunderstood; the patient was Goodwill Zwelithini, King of the Zulus.

The King insisted on seeing an army doctor. He recalls being led in with his regal patient, in Nongoma. Members of the tribe crowded the hallways and bowed to the ground to show respect.

"I thought, 'I could get used to this'."

Eventually he made his way back to the city, working as a consultant in Cape Town where he again faced a choice – whether to go public or private. Unlike New Zealand, doctors tend to stick with one or the other. His friend, New Zealand head and neck surgeon Randall Morton, encouraged him to consider New Zealand. After making a few enquiries, he received five job offers from different parts of the country.

"I thought that was funny, the offers came without even applying. In '86 I came out for a look to see what New Zealand was like. To see if the Kiwis could do anything else rather than play rugby."

Satisfied it would be a good home for his wife Sally and two young children, he accepted a position in Rotorua, which had a long-term ENT vacancy.

Soon after settling in New Zealand, the family size doubled when his wife gave birth to twins.

"We got absolute hospitality in Rotorua. The superintendent organised dinner with all the other consultants in the hospital.

"I was joking that when we went to Rotorua it was 'thank you for coming'. Then we came to Tauranga, it was a bit more snooty and the impression was 'how did you get in'?"

But he fitted in well in Tauranga, where he was the third ENT surgeon when he arrived in 1993.

He was always struck by the contrast between public and private, especially as ear complaints disproportionately affect children. He became adept at wording his referrals correctly to meet access thresholds.

"I don't want to knock it. If you can get into the public service, you can get fantastic service. But the problem is getting in."

He was surprised when the Bay of Plenty DHB tried to refuse his gratuity payment in 2013 using the argument that he was still working as a private consultant. Retiring friends at other DHBs had had no issue with gratuity payments. The Employment Court ruled in Dr Mathews' favour, and the DHB was ordered to pay the entitlement.

Now 68, he is quietly winding down his private practice, too.

When not in clinic, he enjoys working on the land, and spent 20 years developing an avocado orchard. Now that's sold, he enjoys working on his recently acquired 18ha block in Tauriko, a third of which is covenanted bush, including 1.4km of the Omanawa River.

EMPLOYMENT COURT RULING OVER RETIREMENT GRATUITY CASE

STEVE HURRING | ASMS INDUSTRIAL OFFICER

When a District Health Board refused to honour its contractual obligation to pay a retirement gratuity, ASMS took the case to the Employment Court on their behalf and won. ASMS Industrial Officer Steve Hurring explains the background to the case.

HISTORY

Retiring gratuities were traditionally a one-off payment in recognition of public service with local authorities, including hospital boards.

In 1962 the then government passed regulations to ensure that retiring gratuities were paid uniformly across all hospital boards in accordance with a strict payment scale based on years of service. The only qualification was at least 10 years' service. There was no age requirement. The maximum payment was six months' salary after 40 years' service. These provisions subsequently became contractual entitlements in industrial awards.

These provisions remained unaltered for 30 years. With the loss of award coverage in 1992 and the break-up of Area Health Boards in 1993, individual Crown Health Enterprises (CHEs) began negotiating different terms and conditions of employment.

Some CHEs started clawing back many provisions that had formerly been universally enjoyed in the hospital service (e.g. long service leave).

Retiring gratuities were a valuable contractual entitlement. Senior Medical Officers, despite employer pressure, resisted giving up these provisions. Instead, between 1992 and 2003, many CHEs grandparented these provisions, recognising the entitlement for existing staff, but not offering them to new employees.

The first MECA in 2003 finally grandparented retiring gratuities in those District Health Boards where they had not already been grandparented.

TIM MATHEWS' CASE

Something strange happened at Western Bay Health Limited (Tauranga Hospital) in the 1990s. Its managers decided they had discretion to pay retiring gratuities at a rate less than the contractual scale, and sometimes not at all. They neither consulted nor negotiated this change in practice with SMOs.

This only became apparent when Dr Tim Mathews applied for his retiring gratuity on his retirement in 2013 and the DHB claimed he had no contractual entitlement to a gratuity.

ASMS took the matter to the Employment Court on Dr Mathews' behalf. The Court found in Dr Mathews' favour.

KEY ASPECTS OF THE JUDGMENT:

- In respect of retiring gratuities, retirement does not mean ceasing all future employment
- The term "may" in a contractual entitlement can mean "shall" where the intention is that if a set of conditions is met, the entitlement will be honoured
- Collective agreements negotiated by ASMS have always been minimum rate agreements which underpin (not override) any individual conditions of employment
- A policy can have contractual force if incorporated into an employment agreement.

Some DHBs have refused to grant retiring gratuities in recent times using the same incorrect reasoning applied by Bay of Plenty DHB. That has now been addressed by the Employment Court ruling.

If you think your circumstances are covered by the Court's judgement, please contact your Industrial Officer for advice.

A copy of the judgement can be found here: **https://www.employmentcourt.govt.nz/assets/Documents/Decisions/2019-NZEmpC-49-Mathews-v-BOP-District-Health-Board-jud-020519.pdf**

Specialist clinical nurse for vascular access Clare Odell, health services assistant (vascular service) Ilona Koppan, and anaesthetist Sarah Jackson pictured in Wellington Hospital.

TEAM APPROACH TO CLINICAL LEADERSHIP REAPS BENEFITS

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

ASMS is profiling examples of distributed clinical leadership. In the first, Wellington Hospital anaesthetist Sarah Jackson speaks about the benefits of a multidisciplinary approach to a vascular access procedure at Wellington Hospital.

Specialists, nurses, and allied health staff worked together to overhaul the model of care for peripherally inserted central catheters (PICCs) at Wellington Hospital, and patients are reaping the benefits.

The service switched from a specialist model to a multidisciplinary one supported by nurses and anaeasthetic technicians and that has cut wait times and costs.

"Doctors don't insert PICC lines in adults anymore in Wellington Hospital," says anaesthetist Sarah Jackson, who until last year was clinical lead of vascular access.

For the past five years, the service has been Monday to Friday, 9am to 5pm. Indirect supervision is provided by on-site anaesthetists.

Before, it was dependent on an anaesthetist being available for each procedure. Under that model, about 30% of patients waited longer than 48 hours for a PICC. Then, PICCs competed with other urgent demands on anaesthetists' time. The change allows anaesthetists to focus on other duties.

Now, less than 5% of patients wait more than 48 hours. This means faster drug treatment, fewer cannulas, faster discharges, and more capacity for home-based drug infusion.

While financial savings had not been quantified, Dr Jackson says a more efficient process has inevitably reduced cost.

Initiated in 2011, it took time to establish a training regime and 9-5 roster, and Dr Jackson says it's important to allow time for a significant model of care shift.

"There's no point looking back after a year - change happens slowly, particularly in large organisations. That's some of the advice I give to younger consultants, you have to be resilient and persistent."

She says a couple of nurses were already inserting PICCs, and one of them, the charge nurse of the post-anaesthesia care unit, suggested a new approach.

This involved a technique change to an electrocardiogram-guided insertion, rather than X-ray, which Dr Jackson agreed to supervise, and setting up a training programme.

"We both had a vision of trying to improve access to PICC insertions for patients, so the first thing we did was employ a specialist nurse who worked for two days a week inserting PICCs. This was the start of a vascular access team, and from there it's grown to a five-day a week service."

Dr Jackson believes that when practitioners work to an extended scope of practice they take a lot of care, potentially enhancing the safety of the procedure.

Management was supportive but "it wasn't the DHB that asked us to do it, it was very much that we had seen a need for patients and worked over a period of five to six years to implement it".

A collaborative approach was essential.

"It's very difficult to achieve change just by yourself. You have to have a collaborative approach and work with other health care professionals."

It's hoped the service can be extended to weekends and after-hours, as staffing resources allow.

ASMS is encouraging DHBs to adopt and encourage more distributed clinical leadership initiatives because of the benefits to patients and the health system as a whole.

"Contrary to some mythology financial retrenchment appears to have brought out the deficiencies rather than strengths of leadership at this level."

LITTLE PROGRESS IN DISTRIBUTED CLINICAL LEADERSHIP

IAN POWELL | ASMS EXECUTIVE DIRECTOR

Distributed clinical leadership (leadership from senior doctors and dentists) is one of the most important things advocated by ASMS. This is because it provides the most effective means of ensuring that DHBs can deliver services based on the best evidence adapted for local needs. It is much broader and extensive than formal clinical leadership (for example, clinical leaders and heads of departments).

ASMS has now conducted three national surveys of DHB-employed members on commitments to distributed clinical leadership (DCL). The most recent was conducted over late 2018 and early 2019. The previous surveys were conducted in 2013 and 2015.

The latest results reveal a disappointing and alarming situation, including a lost opportunity for improving both the quality of care for patients and the financial performance of DHBs.

The full survey is available as an ASMS Snapshot publication: **https://www.asms.org.nz/wp-content/uploads/2019/08/commentary-on-the-DCL-survey-2019_172201.5.pdf**. Care needs to be shown, however, given the 26% response rate, particularly when considering the results for the smaller DHBs.

RATING DHBS' COMMITMENT

Unfortunately there is little change in terms of members' views concerning the culture of their DHB in supporting DCL from the first two surveys in which DHB performance was already underwhelming to say the least. Twenty-four percent believed that the culture of their DHB encourages DCL, 53% said it didn't, and 22% did not know. While fewer in the third survey answered 'no', there was a slight decrease in those answering 'yes' and the proportion of people who were undecided had grown. But the net result is that less than a quarter believe their DHB encourages a positive culture, more than half have the opposite view. Very poor overall.

Very little had changed in terms of members' views concerning whether their DHB was genuinely committed to DCL in its decision-making processes. When broken down by DHB, the 2019 responses revealed more than half of respondents held positive views in South Canterbury (64%) and Whanganui (53%), with Canterbury a close third (49%).

This was a change from the 2015 survey where Canterbury, Northland and Hawke's Bay were ranked in the top three (53%, 53% and 50% responding 'yes' respectively). Wairarapa DHB fell to the bottom of the rankings in 2019 (0%).

Whanganui was an interesting case where a change of chief executive had led to a less polarised climate and higher rating than in 2013 and 2015.

RATING CHIEF EXECUTIVES

Chief Executives are also rated poorly but with a sharp decline since the

"The 2018-19 survey results highlight the need to improve the quality and culture of DHB leadership, the wasted opportunity to improve, and the need to urgently address the serious SMO shortages as the first step to improving quality of and access to patient care and the financial performance of DHBs."

first survey in 2013. A much larger proportion (35%) disagreed that their Chief Executive was working to enable effective DCL; nearly double that of the 2013 survey. The proportion of those answering either 'a great extent' or 'some extent' had declined since 2013 from 58% to 36%. It is likely that this noticeable decline in the assessment of their commitment is linked to the struggle of chief executives to cope with the compounding effects of successive years of relative underfunding. Contrary to some mythology financial retrenchment appears to have brought out the deficiencies rather than strengths of leadership at this level.

The smaller DHBs of Whanganui and South Canterbury again topped the table with over 50% of respondents from Canterbury also agreeing that their Chief Executive was working to enable DCL. No respondents from Wairarapa agreed with this sentiment and very few thought their Chief Executive was enabling DCL at Tairawhiti and Southern. It is noteworthy that Lakes DHB (Rotorua-Taupo) was ranked 4th, its then chief executive was ranked 12th. On a positive note, Hutt Valley DHB significantly rose in the rankings from 19th in 2015 to 7th in 2019.

A very similar trend was found in members' views concerning the role of their DHBs' senior management. Those who believed that senior management had no commitment to DCL increased from 25% in 2013 to a huge 46%.

TIME FOR DCL

In the 2019 survey we introduced a suite of new questions to investigate DCL in more detail. These gauged whether members feel they have sufficient information about DCL and adequate opportunities for training and time to engage with DCL in practice. While a third feel they have sufficient information regarding DCL, they felt they had limited opportunities for training, and little time.

Lakes was the only DHB where more than 50% of respondents agreed they had sufficient time for DCL. For as many as 10 DHBs less than 20% agreed (three of which were as appallingly low as up to 10% - Wairarapa, Taranaki and MidCentral).

The deadly combination of increasing clinical workload ('clinical creep') and SMO shortages is the driver of this alarming situation. The responses to this question highlight the level of SMO shortages, which based on best ASMS estimates is around 22%.

OPENNESS TO SPEAKING OUT ON CONCERNS OVER STANDARDS

A further new question asked members whether they feel able to speak out on issues concerning minimum standards. On the positive side of the ledger the vast majority felt able to speak to their colleagues about such issues. Further, more than half agreed they felt able to speak out to their clinical head, ASMS and respective service managers.

But, on the negative side, less than half of respondents felt able to speak out to their Chief Medical Officer. Standout CMOs were those at South Canterbury, Lakes and MidCentral (the last is especially significant because on other questions this Manawatu-Horowhenua based DHB was rated more towards the end of the pack; unfortunately the incumbent has subsequently retired). Waitemata and Wairarapa were the lowest rated (since the survey was conducted the latter has a new CMO).

Even more negative was the fact that only a quarter felt able to discuss these issues with their Chief Executive. Again, Whanganui and South Canterbury topped the ratings with Wairarapa and MidCentral at the wrong end (the former also has a new incumbent since the survey was conducted).

The 2018-19 survey results highlight the need to improve the quality and culture of DHB leadership, the wasted opportunity to improve, and the need to urgently address the serious SMO shortages as the first step to improving quality of and access to patient care and the financial performance of DHBs. This requires political leadership from the top but unfortunately this has been lacking from successive health ministers.

THE HEALTH AND DISABILITY SYSTEM REVIEW: WHAT'S NEEDED

LYNDON KEENE | ASMS SENIOR RESEARCHER

ASMS has submitted a series of papers to the Health and Disability System Review detailing what we think is needed to achieve the overriding aim of securing a "sustainable and forward-looking Health and Disability System that is well-placed to respond to future needs of all New Zealanders". The review is considering the overall function of the system to ensure the system is "better balanced towards wellness, access, equity, and sustainability". (The panel's interim report was released shortly before *The Specialist* went to print. An analysis of the report will be published in the December edition).

> *If there is one thing you need to know, it is how to develop constructive relationships. Constructive relationships are the currency of delivery...*
>
> - Paul Zollinger-Read, 2010

As Professor Martin McKee said during his visit to New Zealand in June, much of the demand on public health systems is a consequence of the failings of policies of other sectors. Barriers to accessing timely treatment ultimately add to that demand. These points are raised in ASMS' submissions to the Health and Disability System Review. But of the health system itself – the services delivering health care – Paul Zollinger-Read, quoted by Richard Bohmer in a King's Fund paper on the value of medical leadership, encapsulates the key message in ASMS' submissions.

Dr Bohmer writes: "At the fundamental 'atomic' level in any health system is the interaction of a patient and a caregiver, either in an inpatient, outpatient, community or home setting." The evidence shows that individual health practitioner excellence is necessary but is not sufficient to generate good patient outcomes. The quality of the patient-practitioner interaction and the quality of the interactions and relationships of the health care teams and all those involved in the supporting processes also determine the performance of health care delivery systems.

A 'forward-looking' health system, we argue, must be supported by forward-looking policy that recognises this. It requires a shift from the often simplistic 'cause and effect' approach to policy-making which underpins policies focused on production, targets, and the robbing-Peter method of 'better balancing' resources. It requires a shift from top-down control approaches to one that focuses on the question of how to develop constructive relationships. It starts from the 'atomic' centre, reflecting the clear and unifying purpose of the health system: doing what is best for the patient. This is discussed in depth in the ASMS *Health Dialogue:* Path to Patient Centred Care.

HEALTH DIALOGUE: PATH TO PATIENT CENTRED CARE

The concept of patient-centred care has been around for some decades. Broadly, it is about having a health system where people receive more individualised and holistic care and are demonstrably equal partners in managing their health. Considering an individual's needs as a whole rather than treating medical problems in isolation, providing flexible care that tailors support according to an individual's personal needs, and forming collaborative relationships between patients and their doctors are all self-evidently good practice. That it has also been shown to be a cost-efficient way of delivering care makes it doubly so.

There is a wealth of evidence showing patient-centred care leads to better health outcomes through improved adherence to prescribed treatment, improved recovery, shorter hospital stays, improved psychological adjustments and mental health, fewer medical errors, and improved self-management of chronic illness.

A critical factor for successful patient-centred care is the quality of the patient-doctor interaction. When it is good, the quality and safety of health care rise, costs fall, and levels of patient and staff satisfaction increase.

In short, patient-centred care ticks many of the boxes for addressing challenges policymakers around the world are grappling with – not least the cost factor.

For the patient-centred care approach to succeed, however, policies must be in place that nurture and support high-quality interactions between patients and clinicians and between health professionals in the system. This enables stronger collaboration and integration of care between health professionals, managers, senior leaders and government officials.

Such policies must address commonly identified barriers to delivering patient-centred care, including time constraints, workload, poor patient health literacy, inadequate communication skills and cultural competency, lack of leadership and, for some clinicians, an unwillingness to change. From the senior medical officer (SMO) workforce perspective, a common factor, directly or indirectly, is time.

These issues are among those examined in the *Health Dialogue*, 'Path to Patient Centred Care'. Some of these issues, and more, are examined in depth in other papers sent to the review panel. In summary:

RESEARCH BRIEF: DOES MORE ACCESS TO PRIMARY CARE AND A GREATER FOCUS ON PREVENTING ILLNESS AND PROMOTING HEALTH REDUCE PRESSURE ON HOSPITAL SERVICES?

The Government has signalled its intent for a greater focus on primary care and illness prevention and health promotion with a key aim to take pressure off hospital services. However, the evidence shows increased use of primary care and an emphasis on prevention and promotion policies have not relieved pressure on hospital services. Instead, acute hospital admissions have continued to increase well above population growth rates.

This *Research Brief* examines the reasons for this and makes the case for a 'systems' approach to reduce pressure on hospitals, including strong integration between hospital services, primary care and social services, to provide a patient-centred continuum of care.

RESEARCH BRIEF: PATH TO INTEGRATED CARE

The evidence shows that in order to relieve increasing pressure on hospitals and community-based services a whole-systems perspective is needed, adopting an integrated approach recognising the complexities of modern health care. This *Research Brief* looks at lessons from the evidence on how to implement changes to achieve better community-hospital integration.

Integration is dependent on high levels of dialogue, debate and discussion at all levels to achieve shared understanding about quality problems and solutions. This requires collective leadership; that is, leadership that is not focused on a few 'heroic' individuals in formal leadership roles but is shared and distributed as a collective responsibility.

RESEARCH BRIEF: COLLECTIVE LEADERSHIP: HARNESSING THE KNOWLEDGE AND SKILLS OF CLINICIANS TO TRANSFORM HEALTH CARE

This discusses the many benefits, clinically and financially, of collective clinical leadership, based on the premise, and supporting evidence, that those with intimate knowledge of the day-to-day workings of a hospital are best placed to understand how to optimise organisational performance and influence health care practice.

When frontline clinicians and other health professionals have an opportunity to lead, with support from their organisations, they have been shown to have a meaningful impact on reducing acute admission hospital rates, reduce unwarranted variation in medical practice and improve the performance of their organisation financially and clinically in multiple ways.

RESEARCH BRIEF: ASSESSING THE EXTENT OF THE SENIOR MEDICAL OFFICER (SMO) WORKFORCE SHORTAGES

Two separate approaches to assessing New Zealand's senior hospital doctor workforce requirements indicate we are approximately 1000 specialists short to adequately meet the country's growing health needs.

In order to provide genuine patient-centred care, SMO workforce shortages must be addressed. High workload and time pressures hinder strong multidisciplinary teamwork and effective integration with other services, both of which are critical for patient-centred care.

RESEARCH BRIEF: FORECASTING NEW ZEALAND'S FUTURE MEDICAL SPECIALIST WORKFORCE NEEDS

This investigates issues surrounding the future stability of the specialist workforce. Ministry of Health workforce and service demand modelling show New Zealand's need for health services is projected to increase at a higher rate than the projected growth of the specialist workforce during the next 10 years.

Specialist workforce growth rates are hampered by poor retention rates, especially among newly qualified specialists and overseas-trained specialists.

DETERMINANTS OF ILL HEALTH, THE IMPACT OF FRAILTY, AND FUNDING

In an extended letter to the review panel, ASMS also outlined three further important topics for consideration: determinants of ill health (focusing on poverty, obesity and alcohol abuse), frailty (produced in collaboration with former National Executive member Tim Frendin) and inadequate funding. This is available as a submission on the ASMS website.

The final report to the Minister is due by 31 March 2020.

Note: Health Dialogues, Research Briefs and submissions are available on the ASMS website in the 'Publications' section.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ASMS 31ST ANNUAL CONFERENCE

THURSDAY 28 & FRIDAY 29 NOVEMBER 2019, THE OCEANIA ROOM, TE PAPA, WELLINGTON

DINNER AND PRE-CONFERENCE FUNCTION

A pre-conference function will be held at The Boatshed on the evening of Wednesday 27 November. The function includes a sector farewell for Executive Director Ian Powell, who departs at the end of the year.

A conference dinner will be held on Thursday 28 November at Te Wharewaka o Pōneke.

LEAVE FOR CONFERENCE

MECA Clause 29.1 includes provision to attend ASMS meetings and conferences on full pay.

WOMEN'S BREAKFAST

The Women's Breakfast will be held on 29 November in the Icon Room, Te Papa.

TRAVEL ARRANGEMENTS

ASMS makes all travel and accommodation arrangements for delegates attending its 31st Annual Conference. Register your interest today with **angela.randall@asms.org.nz**. Registrations close on 18 October.

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DID YOU KNOW

... ASMS MEMBERS CAN ATTEND THE ASMS ANNUAL CONFERENCE ON FULL PAY AND AT NO COST?

ASMS members who are elected to attend the ASMS Annual Conference are entitled to leave on full pay to attend. All costs of travel and accommodation are paid by ASMS. The Annual Conference will be held on the 28 and 29 November in Wellington.

If you want to come along talk to your DHB ASMS representatives or contact **angela.randall@asms.org.nz** as soon as possible. Make sure to give the DHB early notice and please be aware that MECA clause 29 provides that leave "shall" be given: **https://www.asms.org.nz/clause-29/**

... ABOUT TIME IN LIEU FOR CME TAKEN ON A NON-DHB WORK DAY?

Approved CME or professional development taken on a weekend, a New Zealand public holiday, or rostered day off or on a day that you do not work for the DHB entitles you to a CME day in lieu and is equally applicable to both part-time and full time SMO's. Generally, you might need to make this clear to the DHB but as long as you do so and your CME is debited for the day, a day's time in lieu is applicable.

DR DARA DE LAS HERAS IS A GASTROENTEROLOGIST AT WAIKATO DISTRICT HEALTH BOARD AND THE ASMS WAIKATO BRANCH PRESIDENT.

"I love the diversity of my job, from consults, to ward rounds with junior doctors, to a bit of research and teaching."

"I think some of the challenges we will face as hospital doctors will be integrating technology into our practice while maintaining a human approach, accessing more appropriate and expensive treatments, shifting towards more patient-driven care, having happy doctors with a good work-life balance, and more access to multidisciplinary support for complex conditions."

WHAT INSPIRED YOUR CAREER IN MEDICINE?

I loved most subjects in school. I fitted in the profile of a nerd. I liked studying, learning and I wore glasses! I particularly enjoyed literature and languages. I am from Spain and at that time unemployment was particularly high. So I chose science, in which I thought I would have more job opportunities. But my heart was set on a career where I could interact with people and understand humans better. My best friend's father in high school was a radiologist. He suggested I spend the day with him while he was on-call on a Saturday. At the age of 15 or 16, I immediately loved the hospital vibe and I thought the pager was so exciting. So I applied to medical school. My love for pagers lasted until I started working in a hospital.

I went to medical school in Alicante where my parents lived. During medical school, I went to Germany and London as part of European training programs.

I wanted to do a medical specialty. I chose gastroenterology because I was inspired by an excellent teacher at university. I was very lucky to get placement in Hospital Clinic, Barcelona. This hospital has an international reputation for its liver unit. I did all my training there, working long hours, regular on-calls five to six times a month for 16 to 24 hours on top of my regular working hours. I developed a passion for hepatology. I was young and I worked hard and partied hard. After my training I stayed in Hospital Clinic to do research in ascites and renal failure in cirrhosis for almost two more years. Altogether I lived in Barcelona for 10 years. I really enjoyed the city and the social and cultural opportunities. After finishing my research project, I took a career break to do a tropical medicine course. I worked for a few months in Central African Republic with MSF.

In 2006, I moved to the UK. My partner was British and she felt there were better job opportunities there than in Spain. I found a job as a consultant in Inverness, Scotland. For several years, I worked hard to fit in a different health system. But I loved the Highlands, the remoteness, and the rurality and beauty of the region. I also loved working for the NHS.

After nine years in the UK, I needed a proper summer and I requested a year of unpaid leave to work in New Zealand. I felt at home here and decided to stay. I loved this country immediately. I love my gastroenterology team in Waikato Hospital, the beauty of the Coromandel and the humanity of New Zealanders.

WHAT DO YOU LOVE ABOUT YOUR JOB?

As a doctor, I feel privileged people trust me and tell me private human stories to help me understand the journey of their medical conditions. I still find disease fascinating, how the body adapts when systems don't work well. It is really rewarding when patients get better and they can have their lives back. I love being able to support other human beings in those difficult moments of sickness.

Gastroenterology is a broad specialty. I always had a particular interest in liver disease which allowed me to deal with conditions like severe alcoholic hepatitis. This is often accompanied by multi organ failure and high mortality. It is challenging to look after these patients, who are often young. But when they do well, they often recover to a normal life.

My liver clinics are varied with a very diverse population from drug users, migratory populations, and liver transplant patients. I've always felt lucky to have an interest in the liver. That allowed me not to talk about poo in clinic much, like most of my gastro colleagues do.

I love the diversity of my job, from consults, to ward rounds with junior doctors, to a bit of research and teaching.

I love working in a hospital. I feel my job is only possible as a part of a team.

I also like studying and being up-to-date. Gastroenterology is a very broad specialty, I feel privileged with the CME allocation in New Zealand and the travel opportunities that come with it.

I am passionate about travelling. My job has given me the opportunity to work and live in different countries including places as exotic as Central African Republic.

WHAT ARE SOME OF THE MOST CHALLENGING ASPECTS OF PRACTISING MEDICINE IN THE CURRENT HEALTH ENVIRONMENT?

There are increasing expectations from the population to live longer and better. Hospital care has become more complex with an aging population, increasing comorbidities and novel therapies to consider. I think some of the challenges we will face as hospital doctors will be integrating technology into our practice while maintaining a human approach, accessing more appropriate and expensive treatments, shifting towards more patient-driven care, having happy doctors with a good work-life balance, and more access to multidisciplinary support for complex conditions. In hepatology, for example there is an increasing cases of fatty liver disease. In fatty liver, managing metabolic risk factors is crucial such as weight or diabetes.

WHY DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

There was a vacancy for the role of Branch President for Waikato DHB. I thought this role would help me to understand better the structure of Waikato DHB through attending JCC meetings. It would also allow me to consider other aspects of being a doctor. I often narrow my views to my job as a gastroenterologist. This role allows me to have insight into the challenges of other specialties.

WHAT HAVE YOU GAINED OR LEARNED FROM YOUR ASMS INVOLVEMENT?

I have learnt the structure of my DHB, better understanding of the MECA and the role of ASMS with recruitment, quality improvement, preserving work-life balance for SMOs and priorities for future MECA negotiations. ASMS staff are excellent and very supportive. Being a more active member of ASMS has helped me to reflect on other aspects of being a doctor, like reasonable working hours, diversity at work, parenthood, bullying and gender diversity. I am still learning about the job., but I feel very honoured in my role.

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.ORG.NZ**) UNDER 'ABOUT US'.

WHOLE-TIME SENIOR MEDICAL OFFICERS' ASSOCIATION

BIENNIAL GENERAL MEETING 13 JUNE 1973

REPORT

I attended this Meeting at which representatives of whole-time senior medical officers from Wellington, Auckland, Tauranga and Rotorua were present. I tended apologies from Doctors Wright-St. Clair, Kempthorne, Lomas, Rose and Hall.

Proposals for revised Constitution: I recently circulated these within the hospital and these proposals were passed and the Constitution revised with the two following alterations:-

1. General Meetings of the Association will be held more frequently than every three years at the request of no fewer than ten members.

2. The move of the Executive to Dunedin after Auckland completes its present Executive role has not been at this time confirmed - the decision has been deferred for a year.

Other matters arising from the biennial General Meeting were as follows:-

1. The current Executive Committee was reinstated for a further year.

2. The Balance Sheet was presented by the Treasurer, Dr. E.A. Harris, 162 Victoria Avenue, Remuera, Auckland. This showed a credit balance of $1026.00.

3. The Whole-Time Senior Medical Officers' Association Executive is making submissions to the Central Specialist Committee to be included in the C.S.C. submissions to be made to H.M.O.A.C. on the triennial salary review later this year.

Initial submissions made to the Central Specialist Committee by W.T.S.M.O.A. were turned down by the full committee. These were relating to a possible new Contract of Service for whole-time medical officers.

The Executive Committee in Auckland is making fresh proposals to the Central Specialist Committee through the C.S.C. working party from Auckland.

It is clear at this time that there is a willingness to make

concessions to some extent on the part of the Part-Time Medical Officers on the Central Specialist Committee in the face of repeated submissions from the Whole-Time Medical Officers' Association.

In general, the Auckland Executive welcomes the concept of an active branch in the Waikato area. The representatives from Rotorua and Tauranga Hospitals expressed a willingness to join a local branch based on Hamilton. The Auckland Executive would use the local Waikato Branch representative as a "mail box" through which they could ensure contact with all whole-time medical officers. This from areas outside our own may not always be easy.

My own personal opinion is that the Whole-Time Senior Medical Officers' Association needs and requires active support from all possible members at this time and in the future. I think that those members of our Senior Staff who have expressed interest and who are not currently financial members should send their $2.00 subscriptions to Dr. E.A. Harris at the above address. In the meantime I shall attempt to make sure that information from Auckland (the Executive Committee) is disseminated to all full-time hospital staff within the hospital. Conversely if members of the whole-time staff wish to hold local branch meetings then I will undertake to convene such meetings as and when required.

The other point which was made was that decisions as to the siting of the new incoming Executive in a year's time should not be made at this time without consultation with the membership.

M.R. WALLACE

June 1973

RESEARCH WITHOUT INFORMED CONSENT IN NEW ZEALAND: PERHAPS?

DR MARGARET ABERCROMBIE| MEDICAL ADVISOR, MEDICAL PROTECTION

Informed consent is an important component used to protect participants from harm in the provision of health care and when participating in research.

In New Zealand, patients who lack capacity to consent are generally excluded from participating in health care research and are therefore unlikely to benefit from improvement in health care to the same extent as those who can consent.

There is a move to enable research involving patients who are unable to give consent, and when research of significant benefit for future health care and necessary, there are various regulations that would enable all groups to participate. Many consider it inequitable to exclude those without capacity to consent because this group has greater need and is more vulnerable. Various overseas guidelines could enable New Zealand patients without capacity to participate in research.

ETHICAL TENSION

At the core of the debate is the underlying tension between the ethical positions of utilitarianism, and deontology. The utilitarian view supports research because overall it is for the benefit of (future) patients, provided there is minimal harm to the individual. Conversely, deontologists state that non-consensual research cannot be justified because the patient is being used as a 'means to an end' without due consideration for their current best interests (Resnik David B 2018).

These opposing views are polarising. However there is increasing support to find the right balance of restrictions and safeguards in order to protect vulnerable participants from harm and exploitation while allowing inclusion of all patients including those who may not be able to consent (Health and Disability Commission 2018, p.1).

Current New Zealand legislative frameworks were developed in response to a series of unethical non-consensual research, including the Cartwright Inquiry. The legislation was developed to maximise protection and reduce the risk of harm. Currently research is restricted or impermissible in groups of patients who are temporarily or permanently incapacitated. Such patient groups include those with brain injury, dementia and intellectual or learning disability.

Recently there is an increasing concern that a position of exclusion and over-protection results in an inequitable distribution of health care, particularly if the ongoing use of unproven clinical care and potential harm continues unchecked.

Proponents of a more inclusive approach to research advocate that a proportional approach to balancing the harms and benefits involved in research is required rather than an exclusive focus on harms. This approach requires an augmented effort to value the interests of the vulnerable. Consultation with representative groups should enhance understanding and clarify assumptions made about the potential benefits and harms.

"In New Zealand, patients who lack capacity to consent are generally excluded from participating in health care research and are therefore unlikely to benefit from improvement in health care to the same extent as those who can consent."

"Current New Zealand legislative frameworks were developed in response to a series of unethical non-consensual research, including the Cartwright Inquiry."

The current movement toward a precedent of inclusion in research proposes that all should share the benefits and burden of research equally. Risks of harm should be assessed for the particular context of the research project and participant vulnerability (Council for International Organisation of Medical Sciences 2016) (Rebers *et al.* 2016; Resnik David B 2018; Douglass and Ballantyne 2019, p.386)

NEW ZEALAND FRAMEWORK AND LIMITATIONS

The HDC Code of Rights sets out the requirement for informed consent before research participation. 'Health research' is defined in the Health Research Council Act (s2) and the Code of Rights (s9) extends to cover research.

Patient protection is further supported in the NZ Bill of Rights, specifically, 'Every person has the right not to be subjected to medical or scientific experimentation without that person's consent" ('New Zealand Bill of Rights Act 1990' 1990 Right 10). In addition, 'no welfare guardian has the power to consent to that person's taking part in in any medical experiment other than one to be conducted for the purpose of saving that person's life or of preventing serious damage to that person's health' (PPPR Act. ('Protection of Personal and Property Rights 1988,'). In some jurisdictions such as the US, the substituted decision-maker is recognised and the patient's representative may provide assent or dissent, a non-specific indicator of attitude to research participation.

When a patient is incapacitated and there is no legal representative who can consent, the provision of health services should be within the patient's 'best interests' according to the Code of Rights. For interventional research, there is uncertain or no potential benefit for current participants, therefore research cannot be considered in the participant's 'best interests' and is of dubious permissibility in those who lack capacity under current New Zealand legal frameworks.

Capacity is not defined in the Health And Disability Commissioner Act but a presumption of competence is assumed under S5 of the PPPR Act for the purposes of research, capacity should specifically include a requirement for the understanding of the difference between treatment and research purpose and protocols including randomisation and placebos.

Council for International Organisation of Medical Sciences (CIOMS) have recently revised the research framework in order to enhance medical care while providing a framework that balances potential burden and risk of harm (Douglass and Ballantyne 2019).

The 2016 revised CIOMS guidelines promote inclusion and suggest that proposed research be grouped according to various benefit thresholds:

- For those projects that have the *potential to benefit* those unable to give consent, the risk must be minimised and outweighed by the potential benefit.
- For research with *no (or uncertain) potential individual benefit*, two conditions apply:
  - The necessary evidence cannot be obtained from consenting participants
  - Risk must be no more than minimal.
- Research with *compelling social value* may be conducted, and the research committee may permit a minor increase over minimal risk.

Most research has uncertain or no potential benefit, so would fall into the second category. This research must

"Necessary research that provides data on conditions specific to those unable to consent should be possible."

be 'necessary'. Research is 'necessary' when the information cannot be gained from alternative sources or consenting participants. The 'necessary' criteria could stipulate that research be specific to the condition that affects the incapacitated group. Harm could be minimised by enrolling the minimum numbers necessary for the minimum duration, consulting with representative communities, having clear independent monitoring throughout, and transparent withdrawal processes.

New Zealand Ethics Committees are accountable to the Minister of Health and work according to various guidelines including New Zealand Health Research Council Guidelines and international guidelines (New Zealand Health Research Council 2018).

A strengthened framework in line with a specific code reference to research would be required in New Zealand to provide for participants who cannot consent, to protect participants, and include all researchers and research. Changes are needed to modify the 'best interests' standard for research to perhaps permit research with 'minimal or no harm' rather than 'best interests.

CONCLUSION

If we are to achieve equal outcome measures for all groups there needs to be careful review of the current exclusion of some groups in research. It will be necessary to moderate the protectionist approach that excludes some vulnerable patients from research and its future benefits. Necessary research that provides data on conditions specific to those unable to consent should be possible.

When there is compelling evidence of likely benefit with minimal harms, robust review processes would enable more groups of patients to be included and benefit from relevant healthcare improvements.

**Dr Abercrombie has been a medical adviser at MPS since 2016, based in Auckland. She currently works clinically for Family Planning and has previously worked in General Practice.*

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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

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

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

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