

# The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

## High Risk Warning: New Zealand losing its future specialist workforce

For good reason New Zealand prides itself in training a high quality specialist workforce. This is a tribute to both those who train and those who are trained. What we train has been and needs to continue to be the basis of our future specialist workforce in district health boards. Of equal importance to the ability to train well is the ability to retain what we train. But now New Zealand finds itself in high risk territory as increasingly we are training for an international market, particularly neighbouring Australia since the pattern of large collective agreement settlements commenced in 2006, especially in branches of medicine where fiscally attractive private practice options don't act as a buffer to uncompetitive remuneration.

**But now New Zealand finds itself in high risk territory as increasingly we are training for an international market, particularly neighbouring Australia...**

There are no official statistics kept on the number of specialists emigrating each year. However, an OECD paper conservatively estimates 29% of New Zealand doctors are working overseas, giving New Zealand the second-highest expatriation rate in OECD countries (behind the mighty Luxemburg).<sup>1</sup> A survey by the ASMS found that in the 18 months to July 2007 New Zealand lost at least 80 specialists to Australia alone – the equivalent of a senior medical specialist workforce at a regional hospital.<sup>2</sup>

### Push, Push and Pull, and plain straight Pull

There is a range of "push" and "pull" factors that motivates specialists to leave. Key factors identified by delegates at the ASMS Annual Conference 2008 included: "onerous" on-call hours; shortages of resident doctors as well as senior staff (resulting in more work for senior doctors); lack of administrative support; lack of real non-clinical time; adversarial attitudes from

management; unstable staffing with high dependence on locums; time for mentoring young doctors; and increasing numbers of staff working part-time putting more pressure on full-timers; as well as remuneration.

"Push" factors have been critical in this westwards trans-Tasman medical migration. But there is also mounting evidence that "pull" factors are also becoming increasingly important in their own right even where "push" factors are non-existent or minimal. One simple salary fact sums it up. It is possible to develop a notional average Australian staff specialist salary scale based on averaging the state scales. The top specialist step (15) in New Zealand is somewhere between Steps 1 and 2 of the notional Australian national scale. This is before considering other benefits such as higher superannuation, salary sacrifice and greater senior registrar support.

...there is also mounting evidence that "pull" factors are also becoming increasingly important in their own right even where "push" factors are non-existent or minimal.

## Waitemata Forensic Registrars

Forensic psychiatry at Waitemata DHB has always been an attractive place for registrars to work and it invariably has no vacancies for any great length of time. However, the experience of the last four advanced trainees in forensic psychiatry, three of whom are now working as specialists and one who should become a specialist in the near future, confirm an alarming trend.

*continued overleaf*

### ASMS

Executive Director  
**Ian Powell**

Assistant Executive Director  
**Angela Belich**

Senior Industrial Officer  
**Henry Stubbs**

Industrial Officer  
**Lyn Hughes**

Industrial Officer  
**Lloyd Woods**

Executive Officer  
**Yvonne Desmond**

Membership Support Officer  
**Kathy Eaden**

Admin Officer  
**Terry Creighton**

Admin Assistant  
**Ebony Lamb**

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

Ph 04 499 1271

[www.asms.org.nz](http://www.asms.org.nz)

---

In fact the major constraint keeping salaried doctors from migrating to the 'lucky country' seems to be family commitments. But while this has been significant for the specialists of today, it is much less relevant for the specialists of tomorrow.

### Kiwi registrars morphing into wallaby specialists

An ASMS national survey and telephone interviews with 112 training directors across five major specialties (psychiatry, anaesthesia, surgery, general medicine and intensive care), undertaken at the end of 2009, found that half of New Zealand's registrars in their final year leave to take up their first specialist positions with overseas employers. The most common reason for leaving, according to the training directors, was for better salaries and conditions.

Better salaries and conditions were cited by respondents twice as many times as "training and experience" as reasons why registrars leave for Australia. Lack of available positions in New Zealand once registrars complete their training was also identified as a major reason for heading across the Tasman.

Similar results were found in an unpublished survey<sup>3</sup> carried out in 2009, following up a 2002 survey of trainees' career intentions in anaesthesia. The 2009 survey showed that while 80% of the 2002 cohort had intended to eventually work as a specialist in New Zealand, only 64.5% were working in New Zealand seven years later. In 2002, 13% stated Australia as their preferred destination while

twice that amount (26%) were working there in 2009.

Significantly, this 2009 survey found that 75% of respondents currently working overseas agreed or strongly agreed that salary was an important influence on choosing their country of residence, whereas respondents working in New Zealand indicated lifestyle and family ties as the main reasons for staying.

The international literature also often points to personal and family factors, as well as the importance of pay and conditions, as common reasons for migration or staying put. Generally, the more independent and career-minded the person, the more open they are to moving. But, as one Canadian study found:

*Despite expressions of discontent with involuntary long hours of work, or inadequate social infrastructure, research capacity or social amenities, discussion invariably settles on relative incomes as the chief determinant of migration...<sup>4</sup>*

### Government and DHBs must face up to the risk

The unprecedented national stopwork meetings and support for industrial action by ASMS members during the last MECA negotiations, which came to a head in 2007, indicates pay and conditions in New Zealand are also key factors in many specialists' career decisions. Feedback from ASMS members suggests the issue of remuneration is not merely a matter of how much they are paid but also how it impacts on other factors that determine the ability of their DHB to recruit and retain staff, which in turn impacts on the conditions in which they work.

### Waitemata Forensic Registrars (continued)

One specialist (New Zealand born, bred and trained) resigned last week for what are essentially financial reasons, ie, to earn around \$280,000 (AU), over a six month period as an Australian locum.

Another specialist (also New Zealand trained) has been contemplating his salary package. It remains unclear as to whether he will accept a specialist position that has been offered. If he goes to Australia he may be doing locums and if he remains in Auckland will work a lot of time in private.

A third person (New Zealand born, bred and trained of the student loan era), who should become a specialist within the next six months, plans to go to Australia to complete a short-term locum, probably as a specialist, and then look for a permanent position. It remains unclear which country this will be in.

The fourth person, (again New Zealand born, bred and trained) will probably stay in his current position due to family commitments but, with peers moving overseas, is feeling somewhat unsettled.

In contrast with the past there is a clear pattern of forensic psychiatrists being trained to a high level ready for the Australian market. In addition, there is the ever increasing pattern of more senior specialists cutting down their time in the public service and more senior colleagues being attracted to Australia. The pattern of people working full time in the public service is now unusual and the majority of specialists within forensic psychiatry now only work 6/10 public (and 4/10 private).

The pay gap has significantly widened since a series of large collective agreement settlements in Australia, beginning with a landmark settlement in Queensland in 2006. These settlements are now being renegotiated in a further round. Already a pattern of salary increases of around 4% per annum is emerging as the recently renegotiated settlement in Queensland suggests. This further widens the specialist pay gap and further incentivises our registrars to shift to greener pastures increasing the barrenness of our domestic soil.

...if the government and DHBs do not face up to this risk of the increasing loss of registrars to specialist positions overseas, an economic analysis might challenge why New Zealand continues to train young doctors.

The question is raised therefore that if the government and DHBs do not face up to this risk of the increasing loss of registrars to specialist positions overseas, an economic analysis might challenge why New Zealand continues to train young doctors. If we can't retain the future specialists we train there is no return on the considerable investment the country commits to this costly training. It is completely bizarre, but such a cost-benefit analysis might logically conclude that we would be better closing down a medical school and instead investing that money in recruiting from overseas. Absurd but logical if the risk continues.

**Ian Powell**

Executive Director

- 1 Zurn, J-C Dumont. Health Workforce and International Migration: Can New Zealand Compete? OECD Health Working Paper No 33, 2008.w
- 2 Association of Salaried Medical Specialists (ASMS), Survey Summary, 29 July 2007. Available at: [www.asms.org.nz](http://www.asms.org.nz).
- 3 Moran EML, French RA. A comparison of anaesthetic trainees' career outcomes with previously expressed intentions. This article is expected to be published soon.
- 4 M Benarroch, H Grant, 2004 "The interprovincial migration of Canadian physicians: does income matter?" Applied Economics, 36 (2004), 2335-2345, November

## ASMS services to members

### As a professional association we promote:

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

### As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for around 3,000 doctors and dentists, over 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

## Other services

### [www.asms.org.nz](http://www.asms.org.nz)

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

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

### ASMS job vacancies online

#### [www.asms.org.nz/system/jobs/job\\_list.asp](http://www.asms.org.nz/system/jobs/job_list.asp)

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

Substantial discounts are offered for bulk and continued advertising.

### ASMS email broadcast

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

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden in the national office at [ke@asms.org.nz](mailto:ke@asms.org.nz)

## How to contact the ASMS

Telephone	04 499-1271
Facsimile	04 499-4500
Email	<a href="mailto:asms@asms.org.nz">asms@asms.org.nz</a>
Website	<a href="http://www.asms.org.nz">www.asms.org.nz</a>
Postal Address	PO Box 10763, Wellington 6143
Street Address	Level 11 The Bayleys Building Cnr Brandon St & Lambton Quay Wellington



## Heroes and Vigilantes

Most hospitals are designed for the nineteenth century. Most doctors don't know how to share power. Most patients with complicated problems don't receive coordinated care.

So rang the clarion in April's Harvard Business Review. Kindly sent to me by a CEO. To enlighten, convert, inform or seek debate? The premise of three opinion pieces is that doctors are not natural team players, that stories of heroism reinforce autonomy at the expense of patient outcomes, that we must strive to simultaneously address predictability and ambiguity and, most of all, that any reforms must come from within us.

Our health system measures the hard work of hard workers by how many patients they manage to see or tests or procedures they call for. How well patients eventually do is often only measured by the touchstone of sentinel events or the Health and Disability Commissioner. These monitors repeatedly show that individual clinicians, and even hospitals, have only limited control over the fate of their patients. Thomas Lee argues that superior coordination, information sharing, and teamwork across disciplines are required if outcomes are to improve, but that medicine's altruistic core values actually reinforce practitioners' resistance to change.

He goes on to claim that a profession that attracts idealistic people who want to do good, and selects out the smartest, hardest-working and most competitive people in society, is hobbled by their fierce autonomy. Doctors have historically seen themselves as their patient's sole advocates, with the rest of the world divided into those who are helping and those who are in the way. And people prefer binary options, as Koechlin's recent work on frontal lobe function illustrates, which may explain much of our dichotomous approach to even complex decision-making. We debate dilemmas, not trilemmas. We seek second opinions, or our patients do.

In fact, says Atul Gawande, the second opinion is a tremendously flawed institution. You do not get to pick the best outcome, just to pick from two different options. What you really want is for those two doctors to talk to each other. He also argues very strongly for checklists, and for changing the stories we doctors tell ourselves about what it means to be great. Change from the fables of heroism of infallible lone healers to tales of great organisations and brilliant teamwork that make for great care. But moving toward teams collides with the image of the all-knowing, heroic lone healer. Doctors must accept that to be all-caring is different from being all-knowing or all-controlling.

Yet if our medical schools did not train us in leadership and teamwork, can we be expected to have naturally assimilated the skills and attitudes required? Those of us now asked to lead teams and serve teams are the products of a medical mindset twenty to forty years out of date - it was current when we were selected and trained. When medicine was a cottage industry of autonomous artisans. That is how our beliefs and morals were formed. And when we are challenged to change we argue from what we know.

Yet many of the reasoned arguments we make about why we have certain beliefs are mostly post-hoc justifications for gut reactions. The social psychologist Jonathan Haidt says, although we like to think of ourselves as judges, reasoning through cases according to deeply held principles, in reality we are more like lawyers, making arguments for positions that have already been established.

There is hope. In our collective stories. In our collective intelligence. This notion from economics is that what determines the inventiveness and rate of cultural change of a population is the amount of interaction between individuals. We are sharing and telling our stories in the modern medical age at an unprecedented rate. Which holds out hope that we will prosper mightily in the years ahead because ideas are having sex with each other as never before.

Our medical culture will evolve because, as Matt Ridley espouses, exchange makes cultural change collective and cumulative. It becomes possible to draw upon inventions made throughout medical society, not just in your health neighborhood. The rate of progress depends on the rate at which ideas are having sex.

In the recent past we have forced ourselves into silos of specialisation, or been forced into silos of geographical isolation. Our CHE then DHB boundary riding, or primary vs secondary vs tertiary territorialism, has made any innovation as vulnerable as island species, suspended in webs of significance we ourselves have spun.

In the modern medical world, innovation is a collective enterprise that relies on exchange, swapping things and thoughts. As Richard Bohmer elegantly outlines, modern health care organisations must be capable of simultaneously optimising the execution of standardised processes for addressing the known and learning how to address the unknown. Health care providers need to excel at performing three discrete tasks simultaneously: (i) vigorously applying scientifically established best practices for diagnosing and treating diseases that are well understood, (ii) using a trail-and-error process to deal with conditions that are complicated

*continued right*

## John Edward Hawke Hospital Dentist and Oral Surgeon

The following tribute to former ASMS National President is from Dr James Judson, intensivist at Auckland DHB, ASMS Life Member and former Vice President, and close friend and colleague of John Hawke.

JOHN PASSED AWAY ON MONDAY 10 APRIL 2010 in his 80th year after a long illness. He was born in Auckland and educated at Parnell School and Auckland Grammar School. He studied dentistry at Otago University where he stayed at Knox College. In 1954 he graduated BDS, was appointed dental house surgeon to the Auckland Hospital Board and was rotated to the Plastic Surgical Unit at Middlemore Hospital under William (later Sir William) Manchester.

In 1974, after some years in private practice, he entered whole-time public hospital practice and remained there for the rest of his long career. He spent many years working in the Plastic Surgical/Dental Unit, especially with patients with cleft lip and palate. During this time he developed skills in oral surgery on the job and was very good at it. He was always available and provided excellent service for patients with facial injuries.

John loved working in public hospitals as part of a team. His work took him to Auckland and Green Lane Hospitals as well as Middlemore Hospital and he was readily accepted as a member of the senior medical staff. For some years he was Chairman of Senior Medical Staff at Middlemore Hospital. He was well-known at all the hospitals as a good-natured, cheerful man dedicated to the public hospital system. He had a wonderful sense of humour and was full of anecdotes about current happenings. He respected, supported and encouraged other staff of all levels and was respected and loved in return.

He often did not see eye-to-eye with managers, who tended not to share his views on what was right, fair and just, or what should happen to clinical services. Many of his humorous anecdotes were about managers. Nevertheless he was well-respected by managers and able to negotiate successfully with them. He demonstrated to us all that the

way to get things done is by collective effort, not by solo performance with an ego to feed. He played a major role in laying the groundwork for future management/clinician working partnerships.

He raised the profile of hospital dentistry into a mainstream hospital service and immensely helped the development of maxillo-facial surgery as a medical speciality within the hospital setting.

In 1979 he worked on the identification of bodies after the Erebus disaster and for many years afterwards was forensic consultant to the police.

He served as President of the Auckland Branch of the NZ Dental Association and the NZ Hospital Dentists Association. In 1989 he was instrumental in the setting up of the Association of Salaried Medical Specialists (ASMS), a new union for salaried medical and dental staff. He was president of ASMS from 1995–97 and was the first Life Member.

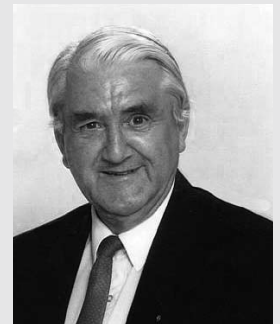
After retirement in 1995 he worked for five years as Clinical Director of the ORL service at Green Lane Hospital.

He was awarded Officer of the NZ Order of Merit for services to dentistry in the Queens Birthday Honours List in 1998.

In retirement John maintained an interest in ASMS affairs and attended Annual Conferences until ill-health prevented him. In his final illness he maintained a positive attitude without complaint and he retained his sense of humour until near the end.

John had a close loving family and is survived by Pam, his wife, John and David, his sons, a daughter-in-law and two grand-children.

*He was a truly good man and we will miss him.*



John Hawke 1929–2010

or poorly understood, and (iii) capturing and applying the knowledge generated by day-to-day care.

We cannot excel at this as lone heroes, as doctors, as craft groups, as organisations. Our collective intelligence has more chance when we take a stance for national services, for national clinical networks, for regional solutions. Provided we are always vigilantes for the complexity of patient care in which predictability and ambiguity exist side by side.

Our cumulative innovation is driven by ideas having sex, and by the new heroes who use checklists, who tell stories of great organisations and brilliant teamwork that make for great care, who drive national and regional solutions. Vigilantes who enable ideas to be a whole lot more promiscuous.

**Jeff Brown**  
National President



# Workforce Innovation: bottom-up or top-down physician assistants

The planned physician assistant pilot at Counties Manukau DHB has become an interesting lesson in the merits of top-down and bottom-up approaches to health workforce innovation. This particular pilot is for 12 months in the department of general surgery. The commencement date has been movable. For much of the time the DHB has been working on 1 July but it has recently been pushed out to 1 August and even achieving this is debatable. It has been described by the DHB as the “pilot for the pilots” with more pilots to come, possibly commencing before the Counties Manukau pilot is completed in the other three northern DHBs – Northland, Waitemata and Auckland.

Counties Manukau had a tender accepted by Health Workforce New Zealand (the government's new workforce body headed by Professor Des Gorman and part of the Ministry of Health), although there was no competitive process. It began and has continued on a confusing basis with the former calling it a ‘pilot’ and the latter calling it a ‘demonstration’. The latter's argument seems to be that it is a demonstration of how physician assistants *might* work in New Zealand while others, including the Council of Medical Colleges, bristle that it is demonstrating how it *would* work.

## What is the pilot

In summary, two physician assistants (both from the United States) would work under the supervision of specialists within a scope of practice. They would have an undergraduate qualification in a health related area and a post-graduate qualification as a physician assistant. They will not do surgery or prescribe in contrast to their role in the United States.

The pilot is headed by a chief executive sponsors group comprising the four chief executives from the northern DHBs (Northland, Waitemata, Auckland and Counties Manukau) and the Dean of the Faculty of Medical and Health Sciences (University of Auckland). There will also be three steering groups – regional, regional clinical governance, and Counties Manukau implementation. Funding is from Health Workforce NZ.

The physician assistants in the pilot will, in a legislative sense, be unregulated because they can't be covered by the Health Practitioners Competence Assurance Act. The onus will be on the DHB to ensure necessary standards and processes are in place to protect staff and the public.

It remains to be seen how this ‘pilot for pilots’ will pan out.

To date this has not been handled well and has been too top-down. If it had been more bottom-up the general surgeons would have focussed on better use of existing occupational groups (particularly nursing) and with acutes, not electives, but they were ignored for much of the time.

## Bad start

The pilot/demonstration got off to a bad start with the rigid insistence on electives contrary to the advice of the general surgeons over how best to utilise the pilot; the general surgeons advised that they should work with acutes. After being ignored for some time, the general surgeons declared that enough was enough. They resolved unanimously to withdraw from the pilot unless this issue was resolved (in effect they pulled the plug on it and for a short period it seemed the pilot was no more).

Within a day of making this decision, however, there was a u-turn. Instead of working with electives at the ‘super clinics’ they will now assist house surgeons in acutes at Middlemore Hospital. It is hard to beat raw surgical power. Surgeons certainly don't have ambiguity issues. We need more of it.

There are confused messages over the future of any physician assistant pilots after Counties Manukau. On the one hand, there is speculation over a forthcoming pilot in Hawke's Bay. But no-one seems to have informed Hawke's Bay.

On the other hand, it is possible that the Counties Manukau pilot may be the only one (if it actually proceeds) with a shift to running different pilots involving better utilisation of the existing non-medical practitioner workforce. If so, this would be welcome as it is what should have happened in the first place. Before creating a new occupational group it makes more sense to examine and pilot whether existing occupational groups can be better utilised. This would also help demonstrate whether there is a gap between realisable potential and actual need, and if so, whether a new occupational group is necessary.

## Suspect recipe

Despite the success of the general surgeons in shifting the use of the physician assistants from electives to acutes, there are still problems. For example, the pilot is now one of low complexity. It is an unpopular trial imposed on the Counties Manukau workforce at high cost to the taxpayer, including

two American physician assistants working at a lower skill level than they are trained for and earning more than other local health employees that they would be working alongside. This is not a recipe for success.

It is debatable whether the pilot proposal will provide meaningful information to assist in the better utilisation of the existing non-doctor health workforce. This is unfortunate because the objective of better utilisation is commendable.

The physician assistant pilot may or may not be a good idea, and may or may not produce some useful outcomes to learn from. But the lesson is that if those at the top and those at the bottom are not fully connected then a dog's breakfast is the most logical outcome. It is not so much either top-down or bottom-up but rather where the top and bottom meet. To date this connection has not been well managed because of the lack of an identifiable coherent message from Health Workforce NZ and the northern DHBs and because those at the clinical 'coalface' have not been able to have the level of leadership that they should have to make it work.

The continuing inability of innovative, good, intelligent people such as those driving the pilot to practice the ABCs of effective engagement with health professionals never ceases to amaze (and disappoint) me. But why am I not surprised?

**Ian Powell**  
Executive Director

## Survey: Rate your DHB on clinical leadership!

Last year, the Minister of Health issued *In Good Hands: Transforming clinical governance in New Zealand*. The aim of *In Good Hands* is to promote greater clinical leadership in the DHB system. On its release, the Minister stated that: 'The new Government is serious about re-engaging doctors and nurses in the running of front line health services and we expect DHBs to act on this report'.

ASMS is exploring the extent to which *In Good Hands* has been implemented in DHB hospitals and has partnered with researchers at the University of Otago to survey our membership. The survey is to be mailed to all members in June and we are hopeful of a high response rate.

If you have not received the survey by the end of June, please contact the national office **04 499 1271** or **asms@asms.org.nz**

## Resident Doctors Association 25th celebration

THE RESIDENT DOCTORS ASSOCIATION (RDA) has turned 25. All past and present RDA members are invited to celebrate this momentous occasion at a black tie event.

**Saturday 4 September 2010**

**The Langham Hotel, 83 Symonds Street, Auckland.**

**Registrations by 20 August 2010.**

For more information on the event and how to register, please visit

**[www.nzrda.org.nz](http://www.nzrda.org.nz)**





Assistant Executive Director

# Vote Health for 2010/2011 is not enough to maintain DHBs at current levels

The money allocated to DHBs in the 2010/2011 budget will not be enough to maintain District Health Boards at their current level of performance.

Prior to the budget CTU Policy Director, Doctor Bill Rosenberg ascertained that \$555 million new operational spending was needed in Vote Health to maintain current levels of services.<sup>1</sup> This estimate allowed for population and inflation increases and picked up on Treasury's estimate for what needed to be allocated for new treatments. This estimate included \$454 million new spending to run DHBs at their current level.

The new spending actually allocated to DHBs to meet these cost pressures, in Finance Minister Bill English's budget delivered on 20 May, is \$343 million. The Government has also allocated \$158 million for new services. Even allowing for the Treasury estimate of productivity savings of \$40 million it is clear that these new services will have to come at the expense of cutting existing services. The shortfall works out at about \$111 million.

This is a different story than the \$512 million new spending on health that

the Minister of Health has talked about in his press releases<sup>2</sup>. This \$512 million is made up of the new policy initiatives including implementation of the Horne report, breast reconstruction surgery, Well Child and the national electives initiative most of which will be controlled by the Ministry. There is also unspent money from last year's appropriations.

Essentially the new initiatives have been taken at the cost of existing services. Because different DHBs have received different levels of increase in their funding from population based funding and any new initiatives will not take place equally at all DHBs there is likely to be impacts of differing degrees of severity at different DHBs.

Since 2002/2003 Vote Health has had increases ranging from 10.2% (2006/07) to a low of 5.5% (2009/2010). The high year included the nurses pay jolt and there is some expectation that the very high percentage increases would taper off as health spending caught up with normal OECD levels. However, the Ministry of Health has reported (figures are always a few years behind) that costs have been increasing at a

trend that works out at around 6% a year. It is likely that this year's increase works out as substantially below that. This means that clinicians will be trying to meet greater needs with fewer resources in some DHBs and in many services within DHBs.

ASMS members working for rural hospitals in the Southern DHB region are also expecting a difficult year as prices are frozen at 2008 levels while costs continue to increase. Our members at high needs GP practices have also lost access to some funding streams threatening the viability of the practices.

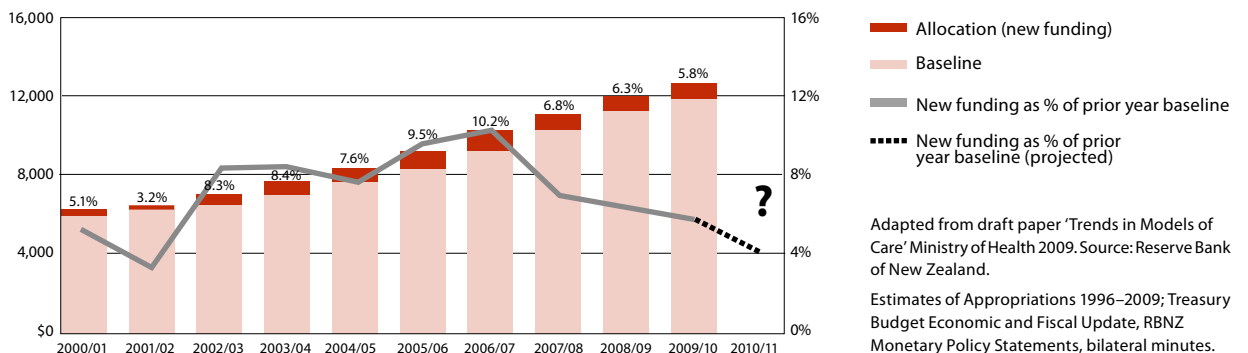
Close readers of 'The Specialist' may remember the diagram showing the trajectory of Vote Health over this century (see below). The figures are not complete for the 2010/2011 year but it seems clear that the line is heading down.

**Angela Belich**  
Assistant Executive Director

1 The full analysis can be accessed either through the ASMS website [www.asms.org.nz](http://www.asms.org.nz) or on the CTU website [www.unions.org.nz](http://www.unions.org.nz).

2 See for instance 'Government Protects Health's Spending Power' [www.beehive.govt.nz](http://www.beehive.govt.nz)

## Vote health: new funding as a percentage of total operating expenditure (NZ\$ millions, GST exclusive)





## Introducing General Practice New Zealand

**GENERAL  
PRACTICE NZ**  
*The Heart of Health Care Networks*



In February 2010, ASMS signed an historic statement with IPAC (Independent Practitioner Associations Council), the national organisation that provides strategic leadership, support and advocacy for general practice networks and teams.

The reason - putting patients at the centre of a joined up health system where we are all working more closely together. It may have a political aura, but it was the joint commitment to patient care that drove the statement, and will form the basis of our future working relationship.

IPAC has more recently shed its IPA branding to better fit the future, and along with our nursing leader colleagues in the General Practice Nursing Alliance (GPNA) have formed General Practice NZ. We take the agreement with ASMS into this new entity.

Briefly then, who are we and where did we come from?

IPAs were founded approximately 18 years ago throughout NZ by groups of GPs, in order to contract with the then Regional Health Authorities (regional funding bodies which functioned for a short period in the 1990s) on behalf of their practice members. They soon discovered the power of collectivism, and having developed these relationships rapidly realized their potential for clinical innovation to support and augment general practice services.

Computerisation of practices was occurring at the same time, and with these new tools population health became an additional focus for IPAs.

IPAC (the IPA Council of NZ) was formed in 1999 by the IPAs, to provide strategic leadership, national advocacy and support for general practice networks at the time a national contract was first developed. IPAC members ranged from very large organisations (over a hundred practices) to single practice entities, across much of NZ.

Over time, the focus of IPAs has become much more team based, and a few have morphed into Primary Health Organisations (PHOs) over the past decade. Others manage PHOs.

Regardless of label, our members have remained committed to clinical leadership and general practice irrespective of the political ideology of the times. They are now looking to the next important step in their evolution - forming new relationships with allied professionals

and secondary care clinicians, in expanded networks supported by information technology.

Nationally GPNZ needs to be forming parallel alliances, to support members as they move into these wider networking relationships. The agreement with ASMS is an important step in this direction, and will assist members as they move into new alliance agreements with DHBs. Alongside this, we are working with pharmacy, physiotherapy, and midwifery at a national level.

GPNZ'S 14 member networks care for approx 2.5 million patients through their affiliated practices. We are served by a national Executive which alongside GPs and practice nurse representatives, has a practice management observer. The wider Council meets 3 times per year, and the member CEOs meet monthly. The latter form the "virtual management team" who support the small Wellington office, and ensure the national body retains its relevance to members across the country.

Earlier this year we relocated our Wellington office to adjoin that of the Royal New Zealand College of General Practitioners. The symbiosis between the College and GPNZ is obvious, as many College quality programmes are delivered through our member networks. We are jointly engaged in the quality and information strategy for general practice /primary care. GPNZ has taken on the "information" projects, and is becoming a "centre of gravity" for health information development in general practice.

This year we are joining with our colleagues from Australia, the Australian General Practice Network, to host an international conference in Auckland under the banner of World HealthCare Networks, with the theme "Transforming Health Systems through HealthCare Networks" ([www.whcnetworks.com](http://www.whcnetworks.com)). The conference is attracting considerable interest, as the focus on "joined up care" and new service models extends across many OECD countries. We are delighted that Ian Powell will be speaking at the conference, and welcome ASMS colleagues to join us in Auckland, July 22-24.

We look forward very much to working with ASMS to provide better coordinated care for New Zealanders through our collective efforts. It is time to "put flesh on the bones" of our joint statement, and the climate is right.

**Dr Bev O'Keefe**  
Executive Chair GPNZ

# Being honest and open



Providing care after an adverse outcome poses major challenges to any doctor. Mark O'Brien, of MPS's Educational Services, offers some advice on how to proceed.

One of the most difficult challenges a doctor faces in clinical practice is responding professionally and effectively to a patient who has suffered a serious adverse outcome under their care – whether it be the result of a recognised complication of treatment, the unfolding consequences of serious underlying pathology or, most challengingly, an error. How effectively a doctor does respond can be significantly influenced by their emotional reaction, their communication skills competence and the degree of specific training they have received in how to manage such situations.

Every day, doctors begin with the best of intentions to improve the quality of their patients' lives, within the limits of the resources available. However, despite these best intentions, not all patients will do well. Recognised risks will occur, serious pathology will manifest and errors and mistakes will be made.

As doctors, we need to acknowledge and be cognisant of the fact that no matter what our intentions or how hard we work, a small but important part of our professional practice will always reside in the "disappointment business". Yet for most doctors, comprehensive training in recognising the key elements of, and designing effective strategies to work with, patient disappointment has been absent or rudimentary. In this most challenging area, many doctors report that their only form of teaching or training was ad hoc observation of a senior colleague whom they either copied or vowed never to copy!

Patient and societal expectations of the standard of professional and ethical behaviour required of doctors when disappointment occurs have been climbing significantly. Professional regulatory authorities and healthcare systems across the world have been increasingly defining and promulgating the key expectations they have of a doctor's response following a serious patient adverse outcome. The Health and Disability Commissioner and the Medical Council of New Zealand have released public documents outlining these expectations.<sup>1,2</sup>

These rising expectations have been a major contributor to the development of movements calling for greater transparency and more effective communication after an adverse outcome – often called "open disclosure" or "open communication". Providing the highest quality of care is an ethical duty that does not decrease because a patient is disappointed, angry or upset. Doctors intuitively know

their ethical duty is to respond effectively to an adverse outcome, as doing so:

- Helps patients to recover psychologically
- Ensures patients are fully informed when making decisions about future care
- Provides opportunities for self-reflection and analysis, so that lessons can be learnt and practice improved, if required.

Research undertaken into patient expectations following an adverse outcome clearly shows that patients wish to be told the truth, to have their experience acknowledged by their doctor, have their questions answered, and to negotiate an agreed plan for ongoing care and follow-up. In addition, patients often expect an expression of regret or sorrow and information on how similar outcomes could be prevented in the future, if possible.<sup>3</sup>

This is nothing less than we ourselves would expect if we suffered an adverse outcome while under the care of a healthcare professional. However, responding effectively

## Support service for doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members an important support service.

The support service provides access to a free professional counselling service.

Doctors seeking help can call **0800 225 5677 (0800 Call MPS)**. The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling or support. The service is completely confidential.



*We make it easy*

can be easier said than done. Doctors have no difficulty in recalling the intensity of feelings and emotions they experienced when a patient suffered a serious adverse outcome under their care – especially where they believed an error or mistake on their part may have contributed.

Doctors can have well-founded fears that patients may take some sort of action against them, that their reputation could be damaged and that they may not be able to communicate important messages effectively to the patient and family. A doctor may also be grappling with acknowledging that they have made an error or mistake – something that is never easy to do. So, while patients' needs are easy to define, doctors may find responding effectively difficult, given these feelings and concerns.

Important research into the motivating factors as to why patients commence action against a doctor following an adverse outcome is now widely available, and identifies communication failure as one of the most important precipitating factors leading to a patient making a complaint or claim against a doctor.<sup>4</sup>

A common concern expressed by doctors about discussing an adverse outcome with a patient, particularly where an expression of regret is considered, is that harm may be done to their chances of successfully defending an action taken against them by a patient, or that MPS may take a negative view of undertaking such a conversation. It is important that this widespread misconception is challenged. In the MPS member handbook, the following advice appears: "In our experience many complaints arise from poor communication. Once you have established the facts we advocate a policy of full and open communication. An explanation may be all that is needed to reassure a patient and avoid any escalation.

"A wall of silence after an adverse incident can provoke formal complaints and legal action. If it is clear that something has gone wrong, an apology is called for and it should be forthcoming. Contrary to popular belief, apologies tend to prevent formal complaints rather than the reverse. We can advise you on how to handle such a situation if you are concerned." The ethical undertaking of an effective conversation with a patient after a serious adverse outcome is fully supported by MPS. It is, however, essential to highlight the importance of discussing facts – not speculation. Speculation should be avoided. Questions should be answered honestly, including an acknowledgement that a question cannot be answered with the current available information if this is the case.

Doctors should also confine any discussion to care provided by themselves alone and should not seek to represent the actions of another clinician or institution, without their prior knowledge or consent.

As mentioned earlier, very few doctors have received formal training in the most effective way to undertake the often difficult and emotionally-charged discussions that are required following a serious patient adverse outcome.

Fortunately for MPS members in New Zealand, MPS Educational Services now offers the Mastering Adverse Outcomes workshop to address this need. This interactive three-hour workshop is a comprehensive examination of the issues that arrive in undertaking an effective discussion with patients after an adverse outcome and includes:

- An examination of the latest research findings
- An exposition of important regulatory and legal issues in New Zealand that doctors should be aware of in undertaking such discussions
- An exploration of the key expectations that patients have following an adverse outcome
- A discussion of the emotional and psychological impacts of an adverse outcome on a doctor
- Comprehensive and easy instructions on the key communication tasks and skills required.
- Any member is able to contact MPS to seek specific advice on the management of a patient adverse outcome, particularly if they are uncertain as to the correct way in which to respond. MPS encourages members to make such contact.

### In Summary

- There are important ethical and legal obligations on doctors to communicate with patients following a serious adverse outcome.
- Research has identified failure to communicate effectively after an adverse outcome as a major precipitator of patient action against a doctor.
- MPS fully supports effective communication with patients after an adverse outcome.
- MPS offers members in New Zealand the opportunity to attend a three-hour comprehensive training programme in how to undertake effective interactions, called *Mastering Adverse Outcomes*.

- 
1. Paterson R (Health and Disability Commissioner), Guidance on Open Disclosure Policies (March 2007).
  2. Medical Council of New Zealand, Good Medical Practice (December 2004).
  3. Vincent C, Young M et al, Why do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action, *The Lancet* 343: 1609-13 (1994).
  4. Beckman HB, Markakis KM et al, The Doctor–Patient Relationship and Malpractice: Lessons from Plaintiff Depositions, *Arch Int Med* (1994).

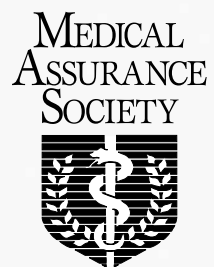
# A whole bunch of reasons to get living insurances from us



- If you're diagnosed with one of up to 45 serious illnesses such as cancer or a heart attack, **Recovery Insurance** provides a lump sum payment that you can use for anything you like.
- Also, with our **Income Security insurance**, you'll receive a weekly benefit of up to 75% of your previous income should you be off work due to serious illness or injury.
- You'll enjoy **competitive premiums**.
- You'll have your own **personal advisor** who will work with you to make sure you get the right cover.
- You'll enjoy all the benefits of being part of an organisation whose members are **professionals like you**.
- You'll be able to **relax** knowing you and your family are covered.

Call us today **0800 800 MAS (627)**

Email [society@medicals.co.nz](mailto:society@medicals.co.nz)  
or visit us online at [medicals.co.nz](http://medicals.co.nz)



*We make it easy*