THE SPECIALIST

THE MAGAZINE OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

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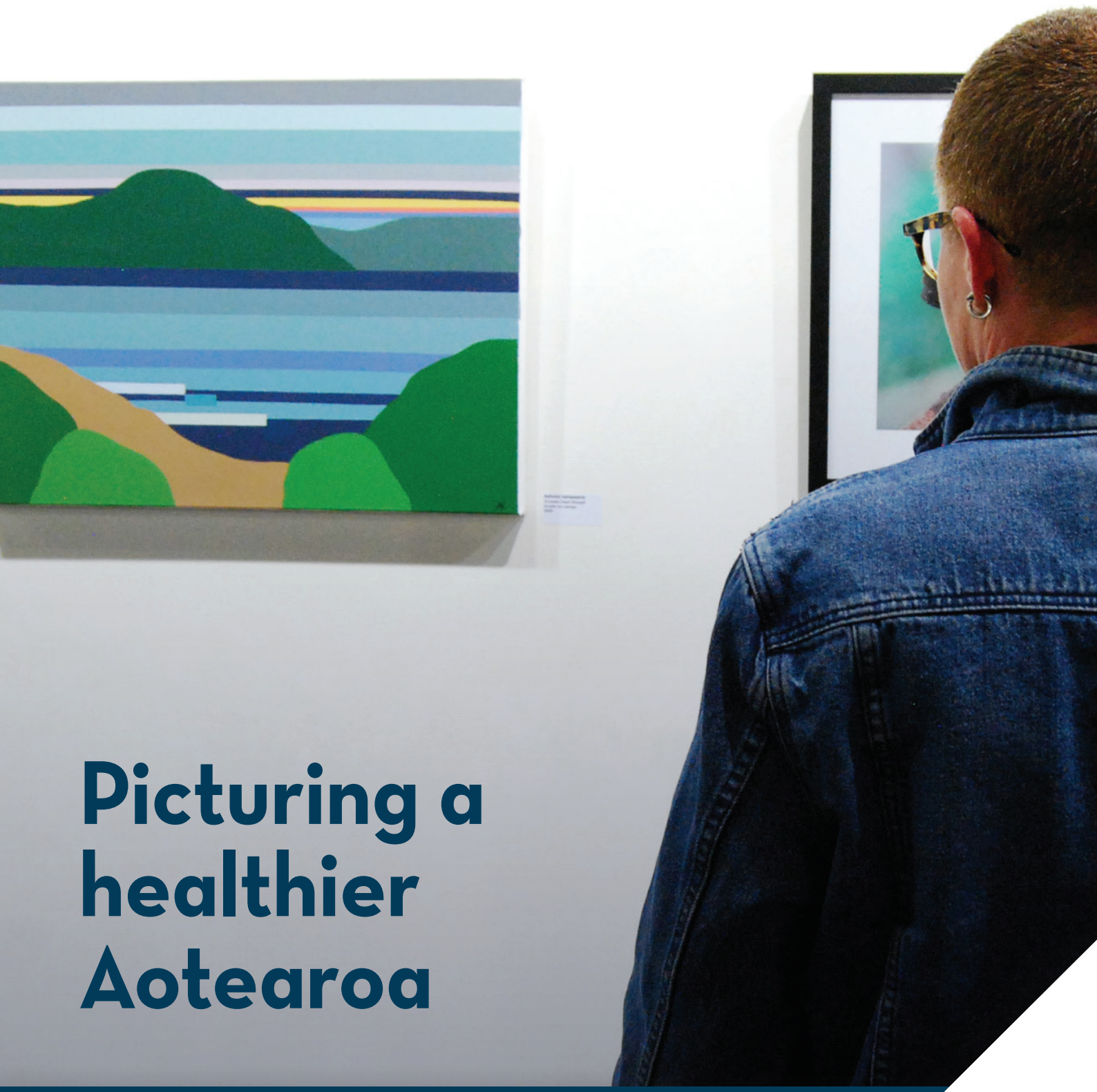

Picturing a healthier Aotearoa

INSIDE: Our psychiatrists on the frontline of the mental health crisis

ASMS
TOI MATA HAUORA
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If you have any feedback on the magazine or contribution ideas, please get in touch at **asms@asms.org.nz**.

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Sticking to the script?

Dr Julian Vyas | ASMS President

While the New Zealand Health Charter is not yet published, indications are that it will put partnership with service users, and the workforce, at its heart.

Andrew Norton (Culture, Change and Workforce Lead at the Health Transition Unit) has said the Charter is "essentially a way to support the culture, behaviour and respectful relationships we wish to see between those who work in the health sector." If this once-in-a-generation initiative is to avoid being an albatross around the Government's neck, proper engagement with workforce stakeholders is essential.

If this once-in-a-generation initiative is to avoid being an albatross around the Government's neck, proper engagement with workforce stakeholders is essential.

Many members' experience of their DHB is very different from the aspirations of the Health Charter. While DHBs frequently espouse notions of 'togetherness', 'communication' and 'respect', the prevailing reality is a 'command and control' paradigm that denies the professional mana of clinical staff. Members are often frustrated by the dysfunction in their DHBs, which (amongst other things) prevents consultation over pertinent decisions – consultation that is an obligation under the MECA. Due discussion is not easily or quickly done. Members who hold clinical leadership roles can often find that they are simply not allocated enough job-sized time (or clerical support) to allow proper SMO/SDO engagement on relevant service issues.

The changes on the 1st of July 2022 will be transformational for the lives of people and communities who are currently denied equitable access to services. ASMS wholeheartedly endorses improved health delivery for these patients. Perhaps naïvely, the statement about the Health Charter leads me to expect the same transformation around workplace issues, creating genuine partnership with all staff.

I would strongly urge the new health boards, and their soon-to-be-appointed senior leadership teams to not relapse into a divisive attitude towards health care staff.

Culture change vital

I believe that cultural change around staff engagement is vital to ensure the success of the health reforms. At present, ASMS members face a government pay restraint policy that is a pay cut in real terms. This compounds the pre-existing damage to morale from longstanding DHB inertia to do anything about severe and persistent under-staffing of the SMO/SDO workforce. Lack of adequate staff, in turn, results in fatigue and disillusionment, if not burnout, and increases the risk that members quit the New Zealand state health sector – for reasons of self-preservation. If the new system fails to properly engage with senior dental and medical staff, any residual goodwill that our members still have could be lost forever. It would seem sensible not to needlessly antagonise senior clinical staff who are already disaffected.

Many of our current managers will move across to the new Health New Zealand/Māori Health Authority regime. I would strongly urge the new health boards, and their soon-to-be-appointed senior leadership teams (at national, regional, hospital and community levels) to not relapse into a divisive attitude towards health care staff. Future senior leaders of Health New Zealand/Māori Health Authority must ensure that the line managers they oversee do not inadvertently alienate an already disenchanted workforce. It is also important that those line managers are supported and adequately trained, to break from any indoctrination they have suffered by the current system.

If the new system fails to properly engage with senior dental and medical staff, any residual goodwill that our members still have could be lost forever.

This is a watershed moment. Slavish adherence to managerialist dogma will squander any residual SDO/SMO goodwill. Conversely, a genuinely collaborative approach will be a significant step in building a system where all Kiwis get the health care they deserve. I hope common sense prevails and the new health organisation(s) evolve to have a more mature relationship with their staff.

Leading into the future

Sarah Dalton | Executive Director

In the last couple of months, we have been supporting physicians who are being denied clinical voice over care for Covid-19 inpatients, public health specialists who are not being paid for the lunchtimes they work through every day, obstetricians who are trying to support a crumbling on-call roster that is so grossly understaffed it defies description – I could go on...

These casual abuses of senior doctors and their colleagues are increasingly normalised in hospitals all over the country. Short-staffing and unsafe scheduling are almost endemic. We wrote a media column recently describing moral injury and explaining what that means for the hundreds of doctors who are forced to explain cancelled procedures and overdue waits for appointments, for treatment, for care – to patients and families who have a not unreasonable expectation that, even in a pandemic, our health system might provide at least some of the care they need.

These casual abuses of senior doctors and their colleagues are increasingly normalised in hospitals all over the country.

CTU remits

In October, the Council of Trade Unions (CTU) conference passed a raft of remits. There are two of note. The first is that the CTU calls for user charges in primary care services (including dental) to be abolished, while the second is to endorse the living wage to be the basis of the minimum wage.

You will find both these recommendations in our Creating Solutions and Health Matters publications. The momentum is building as more of us call for a joined-up, accessible and proactive health system.

We will continue to work hard at both ends of this system as advocates for those of you at the pointy end of providing care, and in the political arena, building awareness about the focused investment our health system urgently needs.

I mention access to primary care and the living wage as just two of several steps which the Government must take to help relieve the impossible burden that is piling up in our public hospitals.

In particular, he listened carefully to our concerns about the health system's failure to provide basic dental care to adults.

A member wrote to me on another matter, and mentioned in passing, that a mental health patient waiting for access to an inpatient bed had thrown a fridge through an ED window. This horrified me; but is all in another day's work for so many of you. The challenges facing those on the frontline of our mental health services is something we have chosen to shine a light on this year. You can read all about our latest report on p6.

Paying attention

On another note, we put some of these questions and concerns to the Associate Health Minister Peeni Henare at our annual conference. While it is clear we have some work to do in helping our health ministers fully comprehend acute-staffed bed shortages in our hospitals, he was both interested in and open to championing our calls for better access to primary care. In particular, he listened carefully to our concerns about the health system's failure to provide basic dental care to adults. We will be following up with him in the new year.

He also appears to be paying attention to our MECA negotiations. He acknowledged that public sector pay restraint is a contentious issue, perhaps even within Cabinet. He also spoke about the work of the futures group. This is a high-level response to several issues we have tabled at bargaining, and which are not easily addressed through our collective agreement. These include safe staffing, access to appropriate IT and admin support, and systems-level wellbeing measures. It is somewhat encouraging that attention is starting to be paid.

Hard slog

Nonetheless, we know that to get to a settlement this time round still involves a hard slog. At the moment, the Government is not moving and is not easily swayed from the hard line it has taken towards those earning more than $100,000. Work is already underway to develop campaigns and strategies beyond the current set of negotiations, including formal engagement with Health NZ and Mana Hauora Māori.

At the moment, the Government is not moving and is not easily swayed from the hard line it has taken towards those earning more than $100,000.

I hope that you all find time to take a break and reflect, that you can rest, and that you can find some time to play – with whānau, friends, even colleagues – and find solace and refreshment in the beauty of our summer, be it at the beach, in the hills, or at home wherever you live.

Ngā mihi nui ki a koutou katoa me te Kirihimete me te tau hou.

MECA update

Since the stopwork meetings in August, ASMS and the DHBs have had three days of mediated MECA negotiations which happened in November, with another two days scheduled this month.

While progress has been slow, the DHBs are starting to show some understanding of our core concerns and priorities. However, the envelope is still very small and largely inadequate to address critical aspects of our claims.

It would also be fair to say that the DHBs are finding the public sector pay restraint instructions difficult, with Kevin Snee, as the Chief Executive responsible for our MECA negotiations, having to check in quite regularly with his superiors. That said, at least he is now at the table. It's essential that at least some of the decision-makers are in the room for these mediated discussions to be worthwhile.

So, the DHBs have listened to member feedback from the stopworks, mediation is in place, and decision-makers are in the room.

We are starting to get traction on safe work guidelines with a technical discussion booked to develop some detail around that in December. The bones of this draft clause include the following undertakings:

The parties are committed to:

- The design and delivery of safe and sustainable services
- Taking a considered/systematic approach to reviewing services that are vulnerable or at risk.

We hope to develop a screening tool that will be used where concerns are raised pertaining to any of the following: work environment, workload, workforce.

Taking things to a higher level

Since the stopworks, ASMS has also started a higher-level meeting group, including our three National Executive office holders Julian Vyas, Andrew Ewens and Nathalie De Vries, Executive Director Sarah Dalton, DHB Chief Executive Kevin Snee, and Andrew Norton from the Transition Unit. This group is focusing on issues around safe, sustainable work that don't fit easily into traditional negotiations. It is not yet clear whether there will be binding outcomes from this, although initial progress is positive. And, it is clear from the Associate Health Minister Peeni Henare's speech to the Annual Conference that the work of this group is being tracked at ministerial level.

Which leaves the money. The Government's pay restraint policy means that the outcome of these negotiations will be below our expectations and will not adequately recognise the frontline pressures the medical workforce is under, particularly through the Covid-19 pandemic. ASMS is making it clear to the DHBs and the Government that any agreement reached needs to be for a short term and we'll be back at the table talking with the new employer, Health NZ, very soon.

Current offer

The DHBs are currently offering a $5,000 lump sum for the first year (but no links to your own CME balances) and the possibility of a 1.5% increase on the rate in a second year of a term. In return they want to revert from a five-year automatic accumulation of CME funds (a special Covid-19 arrangement) to the traditional three-year accumulation. This would still allow for individual arrangements to extend accumulation as per MECA clause 36.2(a).

We have reinstated our shift allowance claim – focusing on lifting up the worst paid emergency departments – to address existing inequities in remuneration around the country. We have also maintained our claim for all work done on public holidays to be paid at T2 (currently T1.5).

There is still some way to go before we achieve a settlement, but the signs are pointing towards the potential to achieve an outcome, before we hit MECA expiry at the end of March 2022.

If you have questions or comments about the MECA negotiations, write to us at **meca@asms.org.nz**

Inside the frontline of the mental health crisis

Dr Charlotte Chambers | Director of Policy & Research

Aotearoa New Zealand is in the midst of a mental health crisis. Earlier this year ASMS documented the grim story of rising demand, reduced bed capacity and stressed services in our research brief *What Price Mental Health?* We wanted to follow that up and learn how our psychiatrists are faring against that backdrop. Our latest Health Dialogue – *Inside the Frontline of the Mental Health Crisis* – details their experiences.

The Health Dialogue report is based on a survey of ASMS' psychiatry members. The survey was sent to 526 psychiatrists, and 368 responded – a 70% response rate.

Psychiatrists serve as cornerstones of the teams responsible for the delivery of mental health services. This research tells us they continue to put their own personal wellbeing on the line to ensure high quality mental health services are provided to those who need it. And they are struggling in the face of unprecedented demand.

In 2018, the Government Inquiry into Mental Health and Addiction stated demand for mental health services was expected to decrease because of promised funding increases. This statement was met with frustration and incredulity by many respondents who suggested it bore no resemblance to reality.

In terms of wellbeing, while over a third were found to be suffering from high levels of burnout and job stress, there were pockets where rates were higher than others. For example, Waikato and Hawke's Bay DHBs had over half of their psychiatrists in the survey scoring with high rates of burnout (61% and 58% respectively).

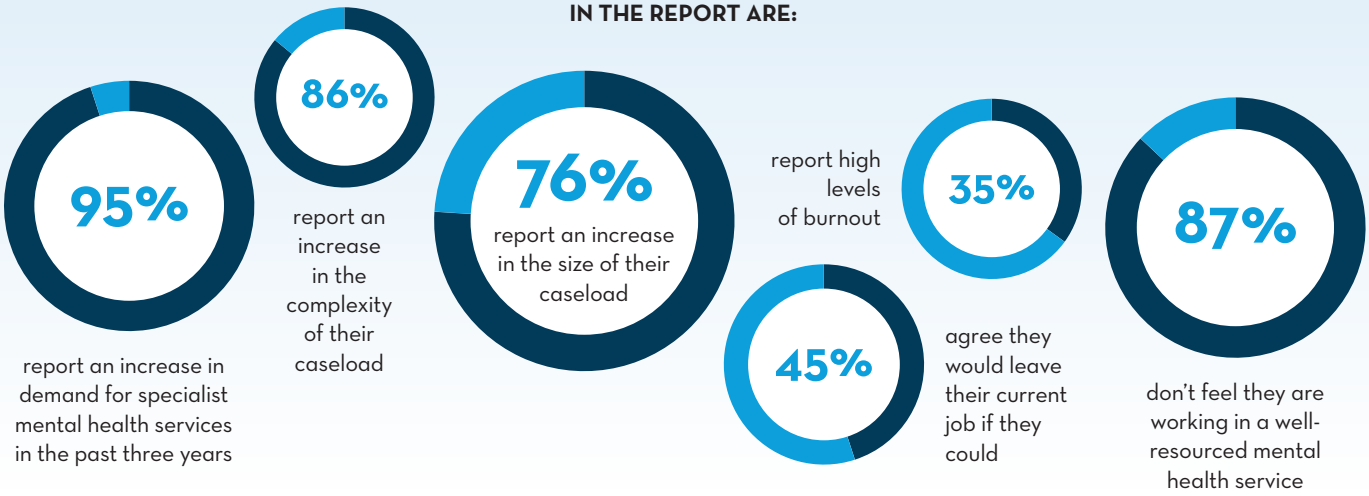
Non-clinical time and support

Other notable factors in this research include the likely positive impact on wellbeing of enabling clinicians to access their non-clinical time. At present, the ASMS MECA recommends 30% allocation of non-clinical time, but many respondents suggested that access to non-clinical time was extremely rare and is generally used to catch up with clinical administration tasks.

Other studies have suggested that regular access to as little as two hours a week of non-clinical time is likely to reduce the likelihood of doctors experiencing burnout. Ensuring access to genuine non-clinical time is a relatively cost-neutral change that could be readily implemented if resourcing and staffing were better matched to demand for mental health services.

Another aspect that the research highlighted was the importance of having adequate administrative support. Those respondents who reported good levels of administrative support were 28% less likely to find their job stressful and 37% less likely to experience burnout.

SOME OF THE KEY FINDINGS IN THE REPORT ARE:



SOME OF THE COMMENTS INCLUDE:

"I love working with my clients/patients however the current system is unsustainable. We do not have enough staff or resources to retain staff, the staff around me are burnt out."

"WHEN I LOOK BACK ON PATIENT FILES, I AM REMINDED HOW MUCH CARE WE COULD PROVIDE FIVE, TEN AND FIFTEEN YEARS AGO TO SPECIFIC PATIENTS COMPARED TO NOW."

"Very distressing to see very unwell patients who are unable to be admitted due to lack of beds."

"Due to high caseloads, patients are not seen as often as required by best practice guidelines, often slowing their recovery."

"WE OFTEN FEEL LIKE PATIENTS ARE BEING DISCHARGED TO THE COMMUNITY TO FAIL. THIS FAILURE TAKES THE FORM OF SUICIDE, HOMICIDE, ESTRANGEMENT AND HOMELESSNESS."

"I AM REFERRED MORE COMPLEX PATIENTS BUT WITH LESS RESOURCES AND TOO LITTLE TIME."

WHERE TO NEXT?

Workforce planning

The findings from this Health Dialogue emphasise the human cost of the swelling growth in demand for mental health services and must serve as a clarion call to those with responsibility for workforce planning. It amplifies our earlier calls for an urgent workforce census, and the re-allocation of resources into mental health to enable more sustainable workloads in the short term.

Service sizing

The finding that 40% of respondents are routinely covering their colleagues' workloads further suggests the need for better modelling of FTEs. ASMS recommends that mental health services are urgently service sized to ensure demand is aligned with the number of psychiatrists able to provide care and to ensure existing staffing can deal with vacancies and leave cover in a sustainable way.

A challenge for Health NZ

This research lays down a challenge for the new national health employer, Health NZ, to ensure staffing rates are adequate in mental health services across the country. It must also ensure that buildings and infrastructure are fit for purpose. Comments provided in this report point to the impact of poor physical work environments, absence of functional IT systems and other logistical challenges.

Funding

It is simply not good enough to run our forensic, in-patient, and community-based mental health services on an assumption that only 3% of our population is deemed to have the most severe need. Evidence shows that figure is closer to 5%, and it is imperative that funding is increased to better account for this demand.

Since the completion of this study, Covid-19 continues to have a significant impact on the wellbeing of the health workforce. It is likely that demand for mental health services will continue to escalate as well as the pressures on health care workers to continue to provide care in these uncertain and stressful times.

Additionally, work to amend the Mental Health Act may also institute changes to working requirements and the demands on psychiatrists. It will be important to monitor the impact of both these issues closely.

The full 52-page *Inside the Frontline of the Mental Health Crisis* report is packed with more detailed data, analysis, and discussion. It is available on the ASMS website (**www.asms.org.nz**).

Ward 11 is located in the old nursing home

Mental health crisis – a case in point

Victor Billot | Dunedin Journalist

The future of core mental health services at Southern DHB is uncertain, with plans to close local facilities at Wakari Hospital, located in the outer suburbs of Dunedin.

Wakari has a number of mental health services on site. However, the state of the complex has been found to be unfit for purpose, and Ward 11 at Wakari will be shut, although the timeline for closure is unclear.

Staff members and family members of patients have contacted media with their concerns, and a major internal report completed this year identified how morale and safety concerns are impacting staff.

The DHB has signalled it will contract out services to private operators, saying there are no immediate plans to shut the ward.

The situation at Wakari is an example of common pressures facing mental health services throughout New Zealand, says consultant psychiatrist Dr Chris Wisely.

Some of his patients are admitted to the acute ward at Wakari, Ward 11.

Speaking as ASMS' Otago Branch President he says he was surprised when he heard the facility was going to be closed.

The facility definitely needs improvements, he says, but he was concerned shifting the provision of services could just be moving problems elsewhere.

> ***"I often say the number of patients has doubled since I started (1993), staff numbers have stayed the same, and bed numbers have halved."***

"If there are options locally, they still have to be staffed, they still need beds available."

Chris says proper community care is expensive and does not necessarily mean cost savings. It can be difficult and stressful for patients and family if the appropriate support is not in place.

Moving things towards community-based care was sometimes driven by funding priorities and also ideological reasons.

"Deinstitutionalisation wasn't altruistic. If you don't have adequate resources, it goes wrong. Whatever model you go with, it has to be adequately staffed. Whatever model you use, we have still got a crisis in this sector."

Demand for services had increased with an expanding population and complex needs, he says.

"I often say the number of patients has doubled since I started (1993), staff

numbers have stayed the same, and bed numbers have halved."

Chris says the situation is a systemic one facing the whole country, and work pressures on staff were enormous.

Ongoing underfunding of mental health was a key part of the problem, with major discrepancies of remuneration and conditions between those working in the public and private sectors.

The severity of mental health issues had grown. Drugs and alcohol are aggravating factors, with addiction and side effects of methamphetamine use creating volatile and violent situations.

Assaults and violence

"Security is an issue. There have been a number of assaults at Wakari, which can improve by it being well resourced and having appropriate staffing. If this is absent, the risk of violence increases. No one wants to go to work thinking they are going to be assaulted."

"No one wants to go to work thinking they are going to be assaulted."

One example was problems with security monitors for staff not being up to scratch.

Violence affected not just staff and the patients involved, it was also extremely disturbing for other patients who were already unwell and their families.

The stress faced by frontline staff also could be around administrative processes.

Chris says despite the growing numbers of cases, staff had to maintain the same standard of documentation, which now includes electronic records.

One of the most stressful things for practitioners was getting a complaint, which could take a huge amount of time and energy to resolve, he says. The system for managing complaints was not working as the number of complaints grew and escalated in the system, with staff having to find time to engage in the process on top of their already heavy workloads.

"There's more and more to do with less resources ... people say you should just leave if it is too much, but you don't want to let your patients down."

Chris says there are positive developments in the sector, one example being the Whirlwind initiative in Kapiti, which was a community-based programme working to prevent men's self harm. Other similar groups were active.

An inquiry into mental health services at Wakari was commissioned by Southern DHB, and its findings were released in August 2021.

Time for Change – Te Hurihanga identified widespread concerns from staff, consumers and other stakeholders in mental health, addiction and intellectual disability services.

Unsafe facilities

The report from Synergia Consultants found facilities to be unsafe and to pose ongoing and significant risk to staff and patients.

The authors noted in the review, "The level of emotion and the sense of despair was very strong."

Ward 11 is a clinical rehabilitation and overflow ward with 16 beds, and previous reports have noted patients having no access to outside spaces, insufficient space in patient rooms, and limited office space for staff.

A business case that went to Cabinet in August suggested the Government has accepted it will need to fund a replacement for Wakari Hospital.

Other sections under review are Ward 9b, an intensive/acute mental health unit with 13 beds, and Ward 10a, a 13-bed medium secure unit.

The bulk of the $167 billion mental health budget has historically gone towards "hospital-centric treatment", says Southern DHB CEO Chris Fleming.

"The level of emotion and the sense of despair was very strong."

Mr Fleming has claimed redirecting resources towards community services and providers would mean people could be treated earlier and closer to where they lived.

Yet for those on the coalface, problems with service provision are largely to do with ongoing underfunding of the sector, not who is providing the services.

Wakari Hospital

Dr Chris Wisely speaking at an ASMS meeting

Lurching from crisis to crisis in cancer care

Elizabeth Brown | Senior Communications Advisor

"Few patients will get their treatment in the timely manner that they should."

That is clinical director of radiation oncology Dr Scott Babington's assessment of what is happening with cancer services in Canterbury.

He paints a grim picture in which early last month there were 365 patients waiting for radiation therapy, some with treatment delays of up to four months.

"We are meant to be treating patients with aggressive cancers within two weeks but cannot because we don't have enough staff or capacity to meet this demand. It's unacceptable.

"Our demand has far outstripped our capacity, and we have been trying our hardest to do everything we can to avoid a waitlist. But there is only so much that you can do."

The picture is equally distressing in medical oncology. Medical oncologist Dr Matthew Strother says patients can now be waiting up to 12 weeks just to get a first specialist appointment, during which time they have no cancer management beyond their GP or surgical referral service.

"Unless we can magic up another 4-6 SMOs, we are going to be running a wait list for years and there will be harms ranging from distress to uncontrolled symptomatic progression that arise from that for which my colleagues and I feel immense personal responsibility and distress over."

"We are meant to be treating patients with aggressive cancers within two weeks but cannot because we don't have enough staff or capacity to meet this demand. It's unacceptable."

Having to run a wait list is a direct consequence of a service operating over clinical capacity with an understaffed medical oncology team working over 40 hours a week, trying to juggle the number of patients already on the books, and those needing a first specialist appointment.

An ASMS job sizing two years ago determined a shortfall of eight FTEs in terms of SMOs, not to mention the need for more RMOs and nurse specialists.

Despite some additional FTEs this year, Matthew says the service is no better off than it was during an acute staffing crisis last year. There has been staff illness, the loss of locums and recruitment difficulties. That's all before accrued annual leave is factored in, which cuts into clinical activity.

He says to resolve the waitlist within a year as opposed to two to three years, they would need four additional SMO FTEs now. To resolve it within six months would require closer to 6 FTEs. He stresses that at this point with a waitlist, patients are experiencing harm, and excess deaths are likely.

The department is running 3.3 FTEs short of budgeted SMO requirements with no confirmed replacements, and no foreseeable short-term recruitment possibilities.

"The only way to resolve that acutely would have been to have made a decision about getting additional resource in a year ago," says Matthew.

Gaping mismatch

Against that backdrop the number of referrals for medical oncology has been higher than historical projections.

"A year ago, we were in crisis because we had too many patients on service, and we couldn't sustain any loss of productivity or else all the patients became unmanageable.

"We're short of doctors, nurses, radiation therapists, and physicists. Even with the best will in the world we're not going to be able to recruit these staff tomorrow."

"This time we have held more of a line in that we have created off our own backs a medically managed prioritisation scheme and a wait list," Matthew says.

Triaging 30–35 referrals a week and updating waitlist prioritisation on up to 70 patients at a time takes precious time that should be used for treatment. There is also a gaping mismatch between forecasted referrals and available SMO time.

Matthew says his clinical team has raised medicolegal liability questions around who is responsible for any harm caused to patients due to the unsustainable model of care they are being forced to run because of underinvestment in cancer services.

To add complexity, any time Pharmac approves funding for a new drug, it adds a new cohort of patients who come on to the service's books and require ongoing treatment.

Matthew cites the example of the breast cancer drug Palbociclib (Ibrance). Funded two years ago, it meant 30% of the breast cancer patient population was suddenly eligible for a drug that extended their life, but the additional time in the care of a medical oncologist was never accounted for.

"So, you took a major disease population, extended their time on service for two years with no corresponding increase in resource," he says.

There are 30 oncology drugs awaiting potential funding in Pharmac's lists.

"We need recognition that any new drugs or new approaches to care that increase patient longevity need to be accounted for and we need to build resilience into our service. That could be a mixed model of service delivery. We will certainly need additional consultants now and in the future in order to offset those demands."

Repeated warnings and frustrations

What the medical oncologists find particularly frustrating is that the situation comes despite repeated and well-documented warnings and lobbying for solutions.

Matthew says his clinical leadership team has been signalling problems around insufficient staffing in relation to work volumes, going back at least four years.

"During the entire time there has been an active effort to bring to the attention of Canterbury DHB leadership that medical oncology as a service was approaching, and then going through and then reproaching and now repeating, crises in the ability to deliver care," says Matthew.

Scott Babington, who began in radiation oncology as a registrar in 1997 when patients were being sent to Australia for their radiation treatment, says the current crisis was foreseeable. But getting timely investment has been difficult with the focus on year-on-year budgets when long-term planning was required.

"We have high-quality data, from a national collection since 2014, showing projected increases in demand for radiation oncology. These projections turned out to be pretty accurate."

However, "the current fiscally constrained environment doesn't allow the type of service planning and budgeted ongoing investment that oncology needs. That's really the missing link," he says.

"Unless we can magic up another 4–6 SMOs, we are going to be running a wait list for years and there will be harms..."

Scott says two extra SMOs have been approved and the advertisements are up, but getting suitable staff is difficult. He acknowledges there aren't many radiation oncology specialists in the world to draw on.

He also notes that with five out of the ten SMOs in his department potentially retiring within the next ten years, the writing is on the wall.

"Training enough future SMOs is a massive issue for us. We just don't have enough funded training positions for radiation oncology registrars nationwide."

What particularly grates is that his department has "shown largesse" by agreeing to work differently to manage demand. They spent time and effort training up a radiation oncology nurse practitioner – the second in Australasia – to take complexity out of the doctors' jobs and free them up, but the DHB has not yet funded the role.

"We're short of doctors, nurses, radiation therapists, and physicists. Even with the best will in the world we're not going to be able to recruit these staff tomorrow," Scott says.

"Moving forward we are keen to pursue quality long-term regional service planning under Health NZ. When we trust the data, we can make plans accordingly."

"We need recognition that any new drugs or new approaches to care that increase patient longevity need to be accounted for and we need to build resilience into our service."

Moral injury

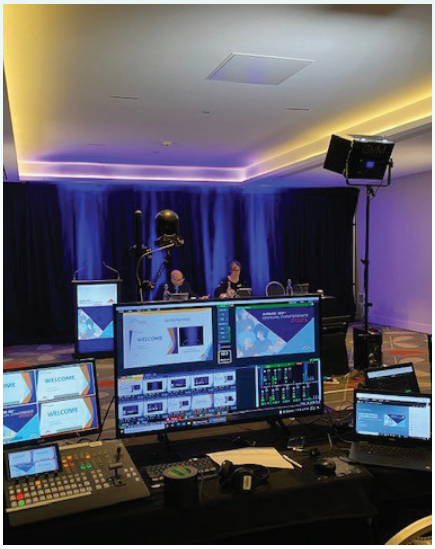
Then there's the moral injury, which is defined as knowing patient care could be better but being unable to make the necessary changes due to constraints that are beyond a doctor's control. This can lead to feelings of hopelessness, distress, often depression and increased burnout risk.

As Scott says, "It's so hard seeing patients and saying, 'Look, I'm terribly sorry we can't treat you as soon as we would like.' Imagine being in pain and being told that you have to wait for weeks to get a treatment slot."

Matthew agrees, saying it's something which affects the whole department.

"We have receptionists and booking clerks who are having to send out letters saying, 'We'll see you sometime in the next three months.' We have distressed families calling in and distressed referrers who are other SMOs or primary health care providers calling in saying 'What do you mean you can't see them for months?' It's extraordinarily distressing."

Annual Conference goes virtual



The Covid-19 pandemic served up a vastly different Annual Conference this year. The August outbreak of the Delta variant led National Executive to take the decision, reluctantly, to hold the 33rd Annual Conference virtually, with a reduced, one-day programme. Unfortunately, that meant conference goers were locked onto their screens and couldn't enjoy the pleasures of a face-to-face event.

Beamed out of Wellington's InterContinental Hotel, the conference was opened by ASMS President Dr Julian Vyas who acknowledged the turbulence of the past year and reiterated the important voice ASMS has in the health landscape of Aotearoa New Zealand.

The Associate Health Minister steps in

The Health Minister Andrew Little had been scheduled to speak but was called to Auckland at the last minute. His spot was filled by the Associate Health Minister Peeni Henare who joked that if anyone had hard questions, they should send them through to Mr Little.

During a brief speech, he touched on the health reforms, new health system indicators and accountability frameworks, as well as managing Covid sustainably. He stressed the need for health practitioners to be culturally competent and thanked ASMS for its support in this area.

Acknowledging "we can't just continue to squeeze the people we have," he spoke about the Futures Group which ASMS is taking part in along with DHB and Transition Unit representatives. The Minister said he is hopeful it can contribute to a plan of action which Health NZ can use to drive workforce investment in the future.

Mr Henare briefly touched on the MECA negotiations. "I encourage the parties to continue to engage and work together constructively to reach agreement as soon as possible," he said.

During the rest of the hour-long session, members fed in some tough questions.

He was challenged over the Government's inflated estimates of the number of fully funded and fully staffed ICU beds, and ongoing public sector pay restraint. While he acknowledged wage growth difficulties and the need to retain health workers, he stuck firmly to the political line that the Government must be fiscally responsible in the face of Covid, and the priority is on lifting those at the bottom first. We told him 'thank yous' only go so far.

Mr Henare was pressed on the need for different models of primary care to remove cost barriers, along with free adult dental care to improve health equity. We challenged him to champion free adult dental care as a priority, and he agreed to accept that challenge.

Health reform update

The conference heard from the acting CEO of interim Health NZ Martin Hefford, health sector expert Dr David Galler, interim Māori Health Authority board member Dr Mataroria Lyndon, and interim Health NZ Board member Dr Curtis Walker about progress on the health reforms. They reiterated the importance of having clinical voice across both boards and outlined the five key system changes which need to happen, including having health and care workers who are valued and well trained. Dr Lyndon said Covid had further exposed inequities particularly for Māori, but it had also encouraged innovation with Māori health providers and collaboration which he hopes will flow through into the new agencies. Some members had questions about the amount of money being spent on the reforms, and the implementation timeframe given the Covid pandemic.

New life member

Dr Paul Wilson was confirmed as a life member of the Association.

The Bay of Plenty anaesthetist was first elected to the National Executive in 1999 and went on to hold the positions of Treasurer and National Secretary. He did not seek re-election this year.

ASMS President Dr Julian Vyas says, "in speaking with colleagues who served on the Executive with Paul, they talk about his strong sense of altruism, his – at times – esoteric knowledge, his eye for fiscal detail and his ability to consider a situation from an unorthodox perspective, which often provided a novel insight into the matter at hand."

Paul says what he's most proud of during his time on the National Executive is what ASMS has achieved to improve the terms and conditions supporting members who are new parents.

Congratulations Paul!

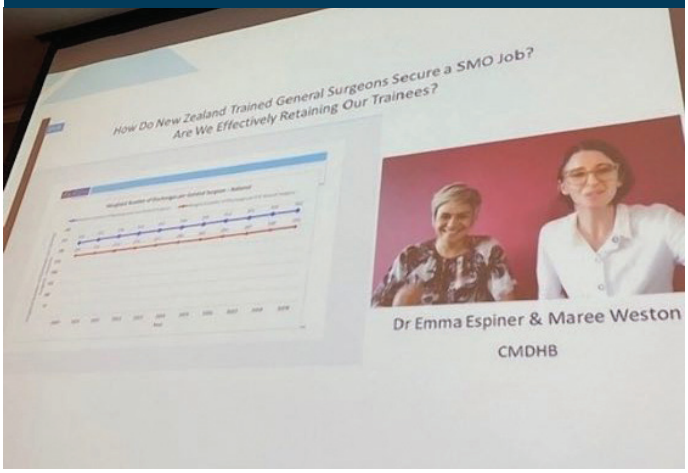
Retaining NZ-trained general surgeons

Looking towards the next generation, and addressing issues of recruitment and retention, was the focus of a presentation by Drs Emma Espiner and Maree Weston from Middlemore Hospital. Their research 'How do New Zealand-trained general surgeons secure an SMO job and are we effectively retaining our trainees?'. The answer is no, and it is a situation they describe as "depressing and disheartening."

The research is based on interviews with 16 general surgeons who were post-fellowship training and in their first year of a specialist job. It outlines the difficulties they have in securing positions and points out that in ten years' time, general surgeons will be doing 9% more work.

Their presentation sparked lively feedback with many commenting the same problems are evident across other specialties.

Emma and Maree's research paper is awaiting publication and we hope to be able to feature more about it in a future edition of *The Specialist*.



Acknowledgements

Dr Julian Vyas acknowledged the work and contribution of Drs Angela Freschini and Annette van Zeist-Jongman who have stood down from the National Executive. We also learned that immediate past-President Professor Murray Barclay was retiring from the Executive after seven years – the past three of those as President. We hope to acknowledge his contribution more fully in the new year.

If you are interested in watching the conference presentations and the question-and-answer sessions which followed, the videos are up on the ASMS website **www.asms.org.nz** under the **Conference** tab. Go and check them out.

Art critics

Beyond the Mask – artistic talent on display

"In these trying times, art has the ability to soothe us all."

So said one of the judges at the ASMS *Beyond the Mask* exhibition. The exhibition, held in conjunction with the Academy of Fine Arts in Wellington, featured about 50 paintings, drawings, and sculptures, showcasing the creative talents of doctors and dentists.

The exhibition had been planned as the opener for Annual Conference, but with the conference going virtual, it was a somewhat scaled back event.

Nonetheless it featured work from well-known doctor artists such as Dr Brad Novak and photographer Dr Roger Wandless as well as pieces from first-time exhibitors.

The gallery directors noted the high standard of all the works.

With sponsorship from the Medical Assurance Society (MAS) and the Medical Protection Society (MPS), there was $10,000 in prize money available.

The winners:

Best Overall Artwork – *It Looks Clean Enough* – Dr Ashvini Kahawatta (anaesthetist, Wellington)

Best Artwork by First Time Exhibitor – *Not a Clockwork Orange* – Dr John Mathy (plastics specialist, Auckland)

Merit Award for First Time Exhibitor – *Red Rock Bay* – Dr Erin Doherty (medical specialist, Northland)

MAS and MPS Sponsors' Choice Award – *The Circumnavigators* – Dr Alec MacDonald (retired psychiatrist, Wellington)

People's Choice Award – *I Would Have to Grow Roses Out of My Nose to Drink Dandelion Coffee* – Dr Annie Judkins (GP, Porirua)

Best Overall Artwork winner Dr Ashvini Kahawatta was as delighted with her award as she was to have rediscovered painting. Recovering from a knee operation earlier this year, she picked up her paintbrush for the first time in 16 years. "I am having such fun painting – it's an amazing feeling that I haven't had since high school." Now she's started again she doesn't intend to stop, and hopes to exhibit more of her work in the future.

People's Choice Award winner Dr Annie Judkins – an ASMS member and GP with Ora Toa Health Services in Porirua – was both surprised and thrilled by her award, especially as she was a last-minute entry. Her piece was painted in 1993. Sold on opening night, Annie says she will be sad to see it go because it has been hanging on her wall for the past 30 years, but is happy it's going to a good home.

Dr Alec MacDonald, who won the MAS and MPS Sponsors' Choice Award, says art has long been a welcome escape in his life and during his career. "Art is what kept me alive through my years as a psychiatrist," he says.

As a first-time exhibitor, Northland medical specialist Dr Erin Doherty says winning the Merit Award "didn't feel like a victory, but rather an affirmation telling me that the time spent engaged in colour and space was exactly where I needed to be". She too finds art is an antidote to her professional life and allows her to "indulge in something without expectation".

The *Beyond the Mask* exhibition ran for two weeks at the Academy of Fine Arts Gallery, attracting many visitors and successful sales for many of the artists involved.

Sponsors' Choice winner Dr Alec MacDonald

Best Artwork for a First Time Exhibitor

People's Choice winner Dr Annie Judkins

'Bird in suit',
Dr Brad Novak

Merit Award for First Time Exhibitor

Dr Mariam Parwaiz

Centre stage in the Covid pandemic

Elizabeth Brown | Senior Communications Advisor

Our public health medicine specialists used to be a somewhat hidden workforce, but Covid has changed all that. What does daily life look like?

With Auckland in the midst of the Delta outbreak, Auckland Regional Public Health Service (ARPHS) is running akin to a military operation.

An incident management team co-ordinates the service's overall Covid response – a response that has been running, continuously, for almost two years.

The public health medicine specialists work as clinical partners at the leadership level of that operation. Their role is a strategic one in which they try to understand the outbreak as a whole, and then advise on where the immediate and future issues might be and plan the response.

ARPHS specialist Mariam Parwaiz says the classic definition of public health is the art and science of preventing disease, prolonging life, and promoting health through the organised efforts of society.

Patients as population

In the Covid context that means trying to ensure the wider public is not exposed to the virus.

"As public health specialists we don't provide personal health, so if someone says I have a sore tooth, chest pains, broken leg, we would be saying you need to call 111 or see your GP.

"It's hard to explain, but our patients are the rest of the population – those we're trying to protect from getting ill in the first place," she says.

"It's hard to explain, but our patients are the rest of the population – those we're trying to protect from getting ill in the first place."

As an example, Mariam says if a Covid case is found in a prison, her job is to liaise with Corrections staff, consider the vaccination status of the contacts, think about who might need to be tested, analyse risk, and advise on an action and management plan.

"The work we do is remote in that we don't come face to face with cases and contacts that we manage. It's all through phones, emails and Zoom, so our teams build quite a unique skill set in that regard."

Much of Mariam's day is spent liaising with organisations and businesses and those vital public health teams involved more directly with patient management, contact tracing and testing.

Incredible support

Over the past 18 months ARPHS has designed, staffed, and operationalised a whole new Covid Response Unit, a seven-day-a-week operation that has adapted and grown through each outbreak.

With a team of just 9.5 FTE public health medicine specialists, ARPHS has been well supported by other DHB public health specialists along with nurses and allied health staff. Other public health units around the country have also sent staff to boost numbers during outbreaks and worked as 'virtual teams'.

Mariam says that support has been incredible.

"All the work we've done in this pandemic has been through team-work and collaboration," she says. "I would really like to acknowledge all my colleagues at ARPHS who have been working tirelessly for many months, as well as the colleagues from other parts of the health system who have supported us."

Other work must go on

While effort goes into managing Covid outbreaks, there is other communicable disease control work which must continue. Things like managing TB, meningococcal disease, and notifiable gastro bugs. Some of that work has had to take a back seat to Covid.

"For me personally, Covid has always occupied 80 to 100 per cent of my time. But for some of my colleagues, their workload has considerably shifted. They've had to pause or re-prioritise work so they can focus their attention on the most pressing issues," says Mariam.

Ironically though, she points out that some of the societal changes brought by Covid such as lockdowns, hand washing, and mask wearing have helped with other disease control.

"Although it's not a notifiable disease that we manage, influenza is one such illness where public health measures and little international travel have significantly reduced its incidence."

In non-Covid times, some of ARPHS' work would also focus on health improvement activity such as reducing harm and chronic illness from hazardous substances such as alcohol and tobacco, plus mitigating the impact of unhealthy food.

Mariam says a lot of this work has been in an unfortunate holding pattern but will be back on the agenda as soon as it can be.

The opportunity to be involved in managing a global pandemic is not lost on Mariam even though pandemic preparedness and response is very much part of a public health medicine specialist's training.

"I've only been a specialist for around two years, so to have something this big and so major at an early point in my specialist career wasn't what I anticipated."

"I've only been a specialist for around two years, so to have something this big and so major at an early point in my specialist career wasn't what I anticipated."

Going into the health reforms it's hoped that talk by the Transition Unit about the importance of population and public health will turn into resource. That means investment in staff and workforce.

Covid has placed a huge burden of ongoing work on our public health medicine specialists, not to mention the intense public interest and scrutiny of the response.

ASMS has been actively supporting them and advocating for short- and long-term improvements to make their work less onerous and sustainable and ensure they are protected so they can continue to protect us.

Championing equity in our emergency departments

Elizabeth Brown | Senior Communications Advisor

In emergency departments around the country a unique grassroots effort is underway to bring excellence and equity in emergency care for Māori.

Te Rautaki Manaaki Mana is a strategy launched by the Australasian College of Emergency Medicine. Middlemore Hospital ED specialist Dr Kate Anson co-chairs a group behind it and is passionate about doing the mahi.

Its aim is to reflect and uphold the mana of those who seek emergency care in Aotearoa New Zealand and for that care to be culturally safe and equitable. The concept is embraced in the name Manaaki Mana, which was gifted to the group by Māori community leader Dame Naida Glavish.

Kate says, "As individuals in the organisations we work for, we need to be culturally safe, anti-racist, pro-equity and good Treaty partners.

"If we don't get it right in ED, people leave before being seen, self-discharge against our explicit advice, don't trust or follow our recommendations, or don't come at all unless they're critically ill."

The strategy has four broad aims:

- Grow the Māori ED workforce, specifically Māori FACEMs to at least population parity – currently only 2% of FACEMs and 5% of trainees are Māori.
- Explore and define the standards of excellence and equity for Māori in the ED context.
- Train and grow a culturally safe workforce.
- Enhance the ED environment through manaakitanga and in its physical space.

Translating that into meaningful action led to an idea of establishing a network of Manaaki Mana champions, or kaikōkiri. There are now Manaaki Mana kaikōkiri in most EDs around the country, leading efforts to effect change in their local hospitals.

A sabbatical ED road trip

Last year Kate set out on a three-month sabbatical, visiting 32 EDs ranging from the large accredited EDs to small rural hospitals with EDs run by rural hospital generalists and GPs.

She wanted to meet those who'd already put their hands up to be Manaaki Mana kaikākiri, see what work was underway, seek out other champions and allies, and help link EDs and Māori health teams.

Along the way she spent time on marae and met with clinical groups and representatives, including Māori health professionals, who shared their perspectives, advice, and experiences.

In some cases, her visit prompted the first champion meetings and a chance to talk about the goals of Manaaki Mana.

"As individuals in the organisations we work for, we need to be culturally safe, anti-racist, pro-equity and good Treaty partners."

"It was a bit of an awareness-raising exercise and for some people became a 'lightbulb' moment," Kate says.

"There's no one silver bullet that's going to solve health inequities. I think we have to look at the reasons for them – colonisation, institutional racism and personal racism, and how the health system hasn't been set up for Māori."

Step change on the ground

Step change is happening at various levels, supported by the Manaaki Mana champions.

"It's not for Māori to fix inequity, it's the system and us who need to change. We need to do some of the heavy lifting here."

In Rotorua, Kate joined staff in a daily ritual of karakia and waiata to start the day. There are whakataukī on the walls of the ambulance bay in Whanganui. Several EDs now have comprehensive bi-lingual signage in both public and staff areas, more ED doctors and nurses are embracing te reo Māori themselves, and in Gisborne 40% of the ED nursing workforce is now Māori.

On a systems level, Kate says more EDs are starting to internally audit things like the numbers of people who didn't wait or who left without discharge papers. They are more likely to be Māori.

Kate would also like to see DHB-funded Māori health teams embedded in EDs.

"Often we only get cultural support from Māori health in a crisis moment, and that's not the best way to work. We should work alongside each other day by day, building relationships."

Eyes opened

For Kate, creating the Manaaki Mana strategy and educating and encouraging others has become a very personal journey.

As a Londoner she knew very little about colonisation or empires. She moved to New Zealand in 2002, but also did a year's ED training in Alice Springs in 2008 where she saw the impacts of colonisation on indigenous Australians "writ large".

"I had my eyes opened about history and racism and how it has become institutionalised. Once your eyes are open you can't turn them away again.

"I had my eyes opened about history and racism and how it has become institutionalised. Once your eyes are open you can't turn them away again."

"It's not for Māori to fix inequity, it's the system and us who need to change. We need to do some of the heavy lifting here. I want to be a good ally and I'll be around so long as my Māori colleagues want me to be around."

Work to encourage and support Manaaki Mana champions is continuing. In October a virtual hui was held with groups of champions to raise their skills and confidence. It was attended primarily by ED doctors but also involved nurses and allied health champions.

"You can't create a culturally safe equitable ED just by looking at the doctors alone. We are very much a team sport," says Kate.

She adds that the Manaaki Mana kaikōkiri model can be adopted to suit other specialities, and already ICU and rural health doctors have expressed an interest.

What you can do

- Learn some te reo Māori – at least enough to pronounce names and places correctly.
- Learn about the history of Aotearoa New Zealand and local history related to your workplace.
- Learn about decolonisation.
- Take some implicit bias tests.
- Examine your assumptions.
- Honour the Treaty and learn what it means to be a good Treaty partner.
- Commit to being anti-racist.
- Be pro-equity and start auditing how your department is performing.
- Work alongside and be guided by your local Māori health professionals.

Kate Anson (left) visiting Māori health providers as part of her sabbatical road trip

A DIY approach to clinical safety

Andrew Chick | Senior Communications Advisor

When Covid arrived in New Zealand a Northland emergency doctor came up with a plan to ensure his hospital didn't run out of face masks.

Dr Eugene Fayerberg admits the arrival of Covid scared him. In particular, he was worried his hospital wouldn't be able to provide personal protective equipment (PPE) for all the staff who would need it. Eugene recalls thinking, "we need to do something because we're going to run out of N95 [face masks] and I'm scared".

Originally from the US, Eugene has worked in the Emergency Department at Whangārei Hospital for almost two years. Back in March 2020, the Government was trying to source 40 million N95 masks to meet the PPE needs of the country's health workers and, globally, the per unit price for a mask had risen from 30 cents to $2.80.

"We had multiple email exchanges - helping us figure out a re-sterilisation protocol on how to best 'cook' the masks."

"Hospital leadership was focussed on multiple things," he says, "but to me the PPE problem was the most pressing. There was no vaccine at that time, and I heard horror stories from the US".

So alongside some colleagues, he decided to develop a local way to re-sterilise N95 facemasks using UV light after reading medical posts in the US.

Eugene had never worked with UV light before and initially was not sure the best way to go about putting this together.

"I was actually very fortunate. I somehow got in touch with a specialist in UV technology at Auckland University - Mohammed Farid – he's a professor in chemical and materials engineering.

"We had multiple email exchanges - helping us figure out a re-sterilisation protocol on how to best 'cook' the masks. He was incredibly helpful in guiding us with the project."

The whole project took just over a month to complete.

"I ordered UV lamps from an Auckland company, and they were able to deliver them to me right before lockdown happened. Then I had a colleague and friend of mine, who used to be a submarine engineer, build a metal box to encase the UV lamps due to their dangerous nature. I shopped at the local electrical shop for the wiring and did a Bunnings run.

"We collected used N-95 masks and stored them in my garage. In the end the UV box could sterilise about 15 masks at a time. "You'd sort of grill them for 10 minutes on each side until they were just right".

"Then I had a colleague and friend of mine, who used to be a submarine engineer, build a metal box to encase the UV lamps due to their dangerous nature."

Eugene says he appreciated the support of the hospital leadership for his project.

"They fully funded it. I told them what I was doing, and they were like, 'yep, yep, sure... whatever you need to do'. I felt very supported by the DHB during this period."

Today the e-Mask-u-Later 3000 remains in Eugene's garage. "Luckily we never needed to use it, but we had it and I think it was comforting to us to have this plan B."

Final ownership of the prototype also remains unclear. "I actually brought that up with my manager the other day because my wife keeps asking me what I'm going to do with this large box. It's taking up a lot of space."

He's suggested auctioning the machine and giving the money to charity.

End of Life Choice Act – what you need to know

Dr Margaret Abercrombie | Medicolegal Consultant at Medical Protection & Adam Holloway | Partner at Wotton Kearney

The End of Life Choice (EOLC) Act came into effect on 7 November. It has the potential to affect every medical practitioner even if you don't think it's an issue that will arise in the course of your work.

Homicide and aiding and abetting suicide are unlawful under the Crimes Act 1961. Notwithstanding this, the EOLC Act provides a process that, if followed, will allow 'eligible' people to choose to die and be assisted to die by a medical practitioner.

Conscientious objection

A health practitioner is not under any obligation to assist any person who wishes to exercise the option of receiving assisted dying under the EOLC Act if the health practitioner has a conscientious objection.

However, if you do have a conscientious objection and a patient informs you that they wish to exercise the option of assisted dying, you must tell the patient:

- of the fact of your conscientious objection
- of the patient's right to ask the Support and Consultation for End of Life in New Zealand Group (SCENZ) for the name and contact details of a replacement medical practitioner.

Assisted dying must not be initiated by a health practitioner

A health practitioner who provides any health service to a person must not, in the course of providing that service:

- initiate any discussion with the person that, in substance, is about assisted dying under the EOLC Act
- make any suggestion to the person that, in substance, is a suggestion that the person exercise the option of receiving assisted dying under the EOLC Act.

This has implications for advance care planning, as doctors will need to avoid raising the topic of assisted dying while being alert to patients making a request to exercise that option.

Obligations if you are not a conscientious objector

Not being a conscientious objector does not mean you must accept the role of Attending Medical Practitioner (AMP) if one of your patients informs you of their wish to exercise the option of receiving assisted dying. GP practices and hospices are not required to offer assisted dying as a service; however, there is an expectation that each DHB will have a policy to manage requests made by patients. Further, the EOLC Act does not exclude the professional obligations of practitioners as set by the Medical Council. Doctors should only take steps under the EOLC Act if they have the competence to do so in accordance with their professional standards. If you do not wish to take on the role of AMP, patients should be advised how they can access assisted dying care. This could be by a clinical referral to a colleague, or by contacting SCENZ for the name of a replacement medical practitioner.

If you are an employee or contractor, you should check with your employer/principal as to whether the practice/DHB offers assisted dying as a service. It is expected most assisted deaths will occur in the community, at home. Hospital patients can make requests however, and there may be patients whose care needs to transfer to a hospital setting part-way through the EOLC Act process.

If you do wish to be the AMP for one of your patients, you should reach out to SCENZ for advice and assistance, including more information about how the service is funded and how to access that funding. For doctors who become the AMP for a patient, section 11 of the EOLC Act sets out your initial set of obligations. These include:

- Give a prognosis and information about assisted dying.
- Stay in touch with the patient.
- Ensure the patient understands their end-of-life care options.
- Ensure the patient knows they can change their mind.
- Encourage the patient to discuss their wish with others (but tell them they are not obliged to).
- Ensure the patient has had the opportunity to discuss their wish with whom they choose.
- Do your best (including by conferring with others) to ensure the patient expresses their wish free from pressure.
- Record the actions taken.

Medical Council position

The Medical Council has not adopted a specific standard for the EOLC Act process. It has, however, published an analysis of which existing standards may be relevant. It is recommended that doctors familiarise themselves with the guidance statement on the Medical Council website.

Summary

It is a good idea to think in advance about how you will respond if assisted dying is raised with you and how you will engage with the person. Ask yourself if you're equipped to have a respectful and appropriate conversation and how you will fulfil your obligations under the EOLC Act.

Identify in advance the approach your organisation has taken, and whom you can refer to inside the organisation. DHBs are likely starting to adopt policies to implement the EOLC Act now, and there may be opportunities to provide feedback on draft policies. If you are the owner of a practice, consider trying to reach a consensus view with your partners about how you will approach the new law.

Where can I find out more?

A more detailed version of this advice is available on the ASMS website **www.asms.org.nz**. The Ministry of Health website **www.health.govt.nz** includes a range of detailed information, guidance, and resources.

Readying the groundwork for health reform

Legislation has been introduced into Parliament that will set up the foundations and legal framework for the largest reform of the health system in a generation.

The Pae Ora (Healthy Futures) Bill was introduced on 20 October by the Minister of Health, Andrew Little, and had its first reading on 27 October. It was then referred to a parliamentary committee, which invited submissions with a deadline of 9 December.

If enacted, the bill will replace the current New Zealand Health and Disability Act 2000 and result in a major restructuring of the health sector, which will take effect on 1 July 2022.

HNZ will be the largest employer in the country, with a workforce of about 80,000.

On that date, DHBs will be disestablished and every DHB employee will become an employee of Health New Zealand (HNZ) on the same terms and conditions. This does not include DHB chief executives.

All DHB assets (including public hospitals) will be vested in HNZ, and all rights, liabilities, contracts, entitlements, undertakings, and engagements of a DHB will transfer.

HNZ will be the largest employer in the country, with a workforce of about 80,000, an annual operating budget of $20 billion, and assets worth about $24 billion. It will lead the health system operations, planning, commissioning, and delivery of services working with the new Māori Health Authority (MHA).

A welcome objective

Notably, one of the objectives of HNZ in the bill is "to promote health and prevent, reduce, and delay ill-health, including by collaborating with other social sector agencies to address the determinants of health". This is not an objective for DHBs under the current legislation, and one which ASMS considers a positive change.

The bill establishes the MHA as an independent statutory entity to co-commission and plan services with HNZ, commission kaupapa Māori services, and monitor the performance of the system for Māori. Initially, it will have a commissioning budget of $100 million over four years, although this is expected to increase over time. The MHA has a similar objective to HNZ for Māori health, including to address the determinants of Māori health.

The Ministry of Health will continue to be the chief steward of the health system and principal advisor to the Minister with overarching responsibilities for strategy, policy, regulation, and monitoring. A new Public Health Agency will be established as a business unit within the Ministry, bringing together the 12 public health units. It will have policy, strategy, promotion and protection, and surveillance functions.

There is a stronger commitment in the bill for the Crown to give effect to the principles of te Tiriti o Waitangi.

The Minister has established an interim MHA and interim HNZ as departmental agencies within the Ministry and has appointed board members. The boards are currently advising the Minister, including on the structures and leadership teams of the new entities. It is expected that interim Chairs and members will continue when the entities are permanently established in 2022. Acting CEOs of the two interim entities have also been appointed, neither of whom are interested in the permanent roles.

An Interim Health Plan, developed by the interim HNZ and interim MHA, will apply when the bill comes into effect next year.

Our submission

ASMS has analysed the bill in terms of its implications for members and the impact on the wider health sector. Here are the key points from our submission:

- ASMS generally supports the intent of the Pae Ora (Health Futures) Bill and the repeal of the New Zealand Public Health and Disability Act 2000.
- We agree with restructuring the health system and establishing new Crown entities – the Māori Heath Authority (the Authority) and Health New Zealand (Health NZ).
- We do not support shifting the emphasis of the health system to primary and community services, as it is too simplistic. We believe there must be greater focus on developing and supporting an integrated health care system.
- We strongly support the aim of achieving health equity for Māori and for Māori decision-making and power-sharing to reflect the Crown's obligations under Te Tiriti o Waitangi (the Treaty of Waitangi).
- We support the legal recognition of iwi-Māori partnership boards, the health system principles, and the development of a Government Policy Statement on Health and a New Zealand Health Strategy, Health Plan and Charter.
- We strongly support the establishment of a Public Health Agency and a population health focus. We believe it should be a stand-alone agency.
- We believe that the health budget must be significantly increased to provide health care to meet the needs of all New Zealanders.
- We believe there must be greater focus on building and valuing the health workforce, and greater attention to investing in the public health system infrastructure.

Our full submission is on the ASMS website **(www.asms.org.nz)**.

Raising concerns about another doctor

ASMS has raised a few red flags about proposed changes by the Medical Council on its advice on what a doctor should do when they have concerns about another doctor.

The Council released a draft revised statement in September. The intention is to give more emphasis to patient safety and maintaining the public trust and confidence in the medical profession as grounds to act on concerns about another doctor's conduct, competence, or health.

In our submission on the statement, we have said the revision has shifted from a regime intended to help doctors address concerns they may have about a colleague. In particular, contextual information and advice in the existing statement has been removed.

The existing statement outlines where thresholds of 'risk of harm' and 'risk of serious harm' lie in relation to raising concerns about a colleague's competence. It also advises that a doctor needs to use their own judgement on what to do about their concerns. The revised statement omits this information. In doing so, it suggests there are no thresholds of concerns to consider before notifying the Medical Council.

The draft statement appears to create an expectation that doctors should make complaints to the Medical Council about any concerns they may have about another doctor, whether they work with them or not. We questioned why the Medical Council wishes to widen the scope from a colleague to any doctor.

We acknowledge that the Medical Council's role is to protect the health and safety of the public by providing mechanisms to ensure doctors are competent and fit to practise. Our submission suggests that it can achieve this purpose without making some of the proposed amendments. For the most part, we believe that concerns about a doctor's conduct, competence and performance may be addressed within an employment relationship framework, and policy should require notifications to the appropriate employer as a matter of preference.

ASMS expects to discuss these matters further with the Medical Council.

FIVE MINUTES

with Dr Carl Horsley

Dr Carl Horsley is an ICU specialist at Middlemore Hospital in Auckland. He is also the clinical lead for patient safety at the Health Quality Safety Commission. With a Twitter following of more than 3,200, he has been an active voice in the debate over ICU capacity during the Covid pandemic.

What inspired you to get into your field of medicine?

Like many of us who end up in intensive care, it wasn't something I originally planned. I had trained in emergency medicine and at the end of that a mentor invited me to do a year as an ICU Fellow.

From the outside it can seem like ICU is all about technology and procedures, whereas it's really this hidden world of teams coming together to work on complex problems. So, it was the combination of challenging problems, great people to work with, and the privilege of helping patients and whānau navigate difficult times.

What are some of the challenging aspects of your job?

The challenge of any job changes over time. At the start, it was the challenge of navigating uncertainty, making time-pressured and consequential decisions when the answer was sometimes less than clear. I think that's the reality of being a specialist in any field, it's about judgement in uncertainty.

Now, the challenges are mainly related to how to provide care to all those who need us. We are constantly short of nurses, who remain the key resource for ICU, a situation made more challenging due to high house prices and better pay overseas. Without enough nurses, our job becomes harder as we juggle our limited resources to keep people safe.

What do you find rewarding about your job?

It's a privilege to be part of some of the most challenging times for patients and their families. We can't always change the outcome, but we can always make it better than it would have been through good communication and the care we provide.

I also love the creative part of ICU, whether finding a path to recovery for an individual patient or imagining some future for our unit that better meet the needs of our community. It's always interesting and challenging, but you never do the mahi alone, we do it together. I really value that.

What do you see as the biggest challenge facing the health system?

The coming reforms are a time of both opportunity and risk. We have reached the limits of the ways of thinking that became embedded in the 1990s, with the focus on ever increasing efficiency. Those approaches are increasingly mismatched to the realities of everyday work and have come at a huge cost to equity as well as staff wellbeing.

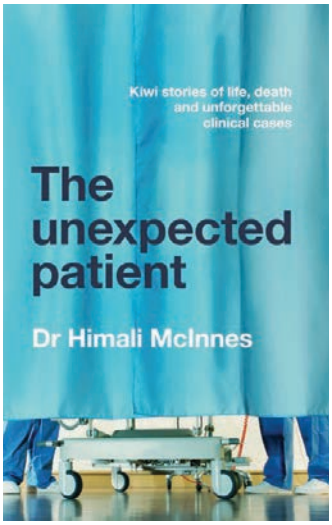
Change won't be easy. It will require new ways of working, including a shift to supporting the realities of the people within the system, to building networks across traditional boundaries, and new models of governance. It is all possible, but we risk falling back into comfortable dysfunction rather than taking the opportunity to grow a system better suited to the future we face.

What keeps you happy outside of work?

I love mountain biking because you can't think about anything else when you're riding, so it allows you to relax and just concentrate on where you are. Muddy mindfulness!

ICU can also distort your sense of normal, so it's vital to reconnect with my family, ideally through exploring this amazing country we are so lucky to live in.

Book Review - The Unexpected Patient



Dr Eileen Merriman

Dr Himali McInnes' thought-provoking collection of essays, *The Unexpected Patient,* opens with a Māori proverb: *'Ko te kaha kei te tinana, ko te mana kei te wairua. The strength is in the body, but the power is in the spirit.'* These words came back to me, repeatedly, as I read through the stories of the patients and their healthcare providers.

McInnes is a family doctor who works in a busy Auckland general practice and in the prison system. She is also a well-known writer of short stories, essays, articles, flash fiction and poetry.

The introduction begins with the Covid-19 pandemic and the first of New Zealand's lockdowns: 'Just like that, the swell of patients in our waiting rooms dwindled to a trickle'. Around this time, McInnes was asked to write an essay for *Newsroom* on the effects of Covid-19 on general practice. After a second commission was published, Harper Collins approached her to write more. *The Unexpected Patient* is the result. The book is in three parts: 'Sudden events,' 'The things we carry,' and 'Time proves everything.'

This is not merely a collection of medical anecdotes. There is an overarching theme which is hard to ignore. "Over time," McInnes writes, "I've started to think about the invisible things that push and pull us. It's made me realise, time and time again, that what I see on the surface of another human being is not the main thing, or the only thing".

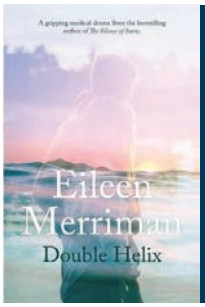
In a similar vein, each of McInnes' 14 essays are not just a scratch beneath the surface, but a deep dive into the person behind the malady, and often, the generations of trauma and cycles of poverty that have culminated in that disease or illness. The section that affected me most was 'The things we carry,' which is perhaps not surprising given the title. Two of these essays contained unsettling truths.

The first focuses on a paediatric registrar's encounter with a Cambodian girl with the pseudonym 'Bopha' at Middlemore Hospital's busy emergency department. The registrar is Jin Russell, now a fully qualified paediatrician and passionate advocate for public health. Bopha is brought in by her father with an exacerbation of asthma. When Russell asks where Bopha's mother is, Bopha's father tells her that she is working night shift at a chicken factory. It is at this point that Russell has an 'epiphany' when she realises the magnitude of disadvantage that children such as Bopha face: poor quality housing with mould on the ceilings, overcrowding leading to increased transmission of infectious disease; parents who are migrants with poor English, leading to a greater risk of miscommunication and inadequate healthcare; fragmented parental care due to parents having to work long, unsociable hours. This is the sobering reality that those working at the coalface encounter day in, day out.

The next chapter that stuck with me relayed the author's encounter with a Māori patient in his fifties with a chesty cough. 'Arama' is a lifelong smoker with a drinking problem. He and his partner are living in a cold, draughty garage. McInnes encourages him to stop smoking, discusses community services to help him reduce his alcohol intake, writes letters to Housing New Zealand to plead his case. Arama continues to turn up with the same ailments. One day, he lets slip that he was molested as a child. McInnes listens, lets the appointment run half an hour over so that she can take notice, for the first time, of his 'iceberg' - that submerged clod of memories, experiences, and beliefs we drag around with us - the things we carry from our childhood. 'The thumbprints of our ancestors on our souls.' McInnes considers the generational ramifications of trauma on health, including the ongoing effects of loss of land and culture on the health of their descendants.

Other essays bring insight into the lives of those working in rural medicine, the changing face of general practice, and the importance of palliative care, along with a brief mention of the euthanasia bill and its potential ramifications.

McInnes is to be congratulated for her extremely readable, thought-provoking, wise, and at times heart-wrenching collection of essays that will strike a chord with both healthcare providers and the public alike. It is only by understanding the root causes of many diseases and the behaviours that we can ever hope to reduce rates of "lifestyle" disease such lung cancer, diabetes, addiction, and obesity.



Reviewer Eileen Merriman is an Auckland haematologist and a best-selling author who has a new book out herself.

Double Helix is described as a gripping new medical drama tracking the life and love of two medical students and the devastating hereditary disease which hangs over them. It is a good one to wrap up for Christmas or set aside for a great holiday read.

Smokefree Aotearoa, in capital letters

As a member of Health Coalition Aotearoa, ASMS added its name to an open letter calling on the Government to fully implement the whole of the Smokefree Aotearoa 2025 Draft Action Plan, released by the Ministry of Health in April this year.

ASMS Executive Director Sarah Dalton was on hand for the presentation of a giant version of the letter to the Associate Minister of Health, Ayesha Verrall on the steps of Parliament last month.

Addressing the Minister and the small crowd gathered for the presentation Sarah said, "our hospital systems are under strain as we are already living with resource constraints and the added challenges of Covid.

Working together to address the social and commercial determinants of health, like reducing the harm of tobacco, is how we get ahead of the curve and create a healthier Aotearoa."

Correction

We'd like to apologise for a caption error in the September edition of The Specialist.

In our story featuring our Hospice negotiating team we unwittingly caused a case of mistaken identities. The correct version is: Dr Di Winstanley from Mercy Hospice on the right in the photo, while Dr Julia Holyoake from Nurse Maude Hospice is in the middle.

Did you know

About time in lieu over public holidays

Time in lieu for working a public holiday can only be claimed once. That means, where a public holiday is Monday-ised, if you work both the actual day and the Monday, you can only claim one alternative (or lieu) day. You will be paid at the appropriate rate for all days you work, but one public holiday only generates ONE alternate day of leave.

This holiday season Christmas, Boxing, New Year's Day and 2 January all fall on a weekend, so all generate alternative holidays: Monday 27 and Tuesday 28 December; Monday 3rd and Tuesday 4th January.

This means if you work on both of 25th and 27th December, only one counts as the public holiday. You are entitled to normal public holiday rates, plus one lieu day. If you work neither day, you are still entitled to the paid public holiday.

There are a few exceptions to this advice. If you seldom work on a Monday, for example, you are probably not entitled to be paid for a public holiday that falls on a Monday.

This is all laid out in Clause 24 of the DHB MECA but if you have any queries or concerns about public holiday arrangements, pay, or lieu days, please get in touch with your industrial officer.

Meri kirihimete

Everyone at ASMS – your National Executive and National Office staff – want to wish you and your whanau a very Merry Christmas and a happy holiday season.

Our National Office will close on Thursday 23 December and reopen again on Monday 10 January.

For any queries during this period, please check the ASMS website **www.asms.org.nz** for contact details.

We look forward to seeing you in 2022.

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 5,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

Other services

ASMS job vacancies online

Check out **jobs.asms.org.nz** a comprehensive source of job vacancies for senior medical and dental specialists/ consultants within New Zealand hospitals and health services.

Contact us

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Postal address: PO Box 10763,
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