

THE SPECIALIST

The Magazine of the Association of Salaried Medical Specialists | **ISSUE #134** | **MARCH 2023**



INFECTIOUS OPTIMISM Interview with Minister of Health Dr Ayesha Verrall **P.4**
AN UNSETTLING QUESTION Findings from ASMS's latest Future Intentions survey **P.17**
WE SIMPLY HAVE TO MAKE IMPROVEMENTS Ex Te Whatu Ora Board Chair Rob Campbell **P.26**

ISSUE #134 MARCH 2023

This magazine is published by the Association of Salaried Medical Specialists and distributed by post and email to union members.

Executive Director: Sarah Dalton

Magazine Editor: Andrew Chick

Journalist: Matt Shand

Designer: Twofold

Cover Image: Sezeryadigar/iStock

The Specialist is produced with the generous support of MAS.

WANT TO KNOW MORE?

Find our latest resources and information on the ASMS website asms.org.nz or follow us on Facebook and Twitter.

Also look out for our ASMS Direct email updates.

If you have any feedback on the magazine or contribution ideas, please get in touch at asms.org.nz

PREFER TO READ THE SPECIALIST ONLINE?

We have listened to your feedback and are aware that some members prefer not to receive hard copies of the magazine.

If you want to opt out of the hard copy, just email membership@asms.org.nz and we can let you know via email when the next issue is available to read online.

ISSN (Print) 1174-9261

ISSN (Online) 2324-2787

The Specialist is printed on Forestry Stewardship Council® (FSC®) certified paper.

Proposed position for FSC logo and text. Please align to bottom of this margin.



IN THIS ISSUE

UPFRONT

- 02** Recruitment, retention and 'the SECA'
- 03** He harore rangatahi – don't be a one-day mushroom!



04

PROFILE: AYESHA VERRALL

Infectious optimism

Newly appointed Minister of Health Dr Ayesha Verrall speaks to The Specialist about her appointment and the challenges facing the health care sector.

FEATURES

- 10** Capturing the Covid crisis
- 14** In orders of magnitude
- 17** An unsettling question
- 20** Family emergency – Returning to work made SUPER
- 22** Room for improvement
- 24** When the patient just says 'no'



26

PROFILE: ROB CAMPBELL

We simply have to make improvements

Former Te Whatu Ora Board Chair Rob Campbell talks through what 2023 will bring as part of the health care system overhaul and about hang ups from the handover.

IN BRIEF

- 30** The importance of Te Aka Whai Ora
- 30** Calls to expand free lunches to end food insecurity for children
- 31** Did you know?
- 31** Specialist redesign
- 31** Dunedin Hospital update
- 32** Most people don't see the dentist annually and cost puts them off
- 32** ASMS in the news

RECRUITMENT, RETENTION AND 'THE SECA'



JULIAN VYAS, ASMS PRESIDENT

Kia ora tātou,

First up, I would like to congratulate Dr Ayesha Verrall on her appointment as the new Minister of Health and salute her achievement steering the Smokefree Environments and Regulated Products (Smoked Tobacco) Amendment Bill through Parliament.

At our November conference, Minister Little acknowledged the biggest threat to the success of Te Whatu Ora and Te Aka Whai Ora is the lack of workforce.

You also told him, in no uncertain terms, exactly why we are frustrated, disillusioned and angry with the current problems.

A priority for the new Minister is to ensure funding is in place to enable the significant recruitment needed throughout the health sector – and not least for senior doctors and dentists.

The major problems we face did not abate over the summer, and there is evidence suggesting things got worse. To give one example, a patient with an acute mental health problem had to wait in ED for 50 hours before they could be admitted. In another, a specialist investigation unit has lost 30% of its highly trained nursing staff in just 12 months.

On top of that, the Planned Care programme shows 5,500 more people are waiting more than four months for surgery or for a first specialist appointment, and the taskforce has recommended 101 systemic changes to tackle the lack of capacity in the system. The fact the taskforce could identify 101 different shortcomings is deeply worrying.

If 'crisis' is not the correct word, perhaps 'shambles' is?

Secondly, I want to mention our upcoming collective bargaining with Te Whatu Ora. What can our SECA (single employer collective agreement) claims achieve in the face of these problems? The changes to members' pay and conditions that we shall propose in bargaining all aim to increase the likelihood that senior medical staff will come to work in New Zealand – and stay here.

While we should be training more medical graduates here in Aotearoa, the reality is the medical workforce is an international labour market. We will always need to attract new colleagues from overseas and retain the ones we have. There is high global demand for health professionals. Countries such as Canada, USA and Australia are all suffering shortfalls in specialist numbers. We need to be in direct competition with these countries and their higher pay rates.

It's time the Government took stock of our global position. In a 'post-pandemic world', we are being exhorted to return to normal. But normal is not suppressing wages for frontline health workers and thereby encouraging them to take up better offers across the Tasman. Normal is about valuing our workforce, and building our health system.

The health workforce took a real-terms pay cut over the last two years. With inflation running at around 7% for the last year, it's time the Government addressed income shortfalls across the health sector.

I hope Te Whatu Ora takes a mature approach to bargaining this time, and recognises that paying staff fairly should be seen as a crucial part of long-term investment in the health system. If, like last time, they dismiss some claims out of hand while generally showing an inertia to negotiate, things risk dragging on. In that event, your willingness for collective action will be crucial to our progress.

Ngā mihi nui.

“If 'crisis' is not the correct word, perhaps 'shambles' is?”

- JULIAN VYAS

HE HARORE RANGATAHI

DON'T BE A ONE-DAY MUSHROOM!

SARAH DALTON, EXECUTIVE DIRECTOR



**Somewhere
in the calm
between the
floods and
the storms,
the Council of
Medical Colleges**

**(CMC) and Te Ohu Rata o Aotearoa
(Te ORA) managed to launch a
Cultural Safety Training Plan for
Vocational Medicine in Aotearoa.
The plan, along with the companion
Literature Review and Environmental
Scan, provides timely advice and
support to the medical colleges and
to you – our members – to build
our individual and organisational
capability to work in ways that are
culturally safe.**

I hope you will be given time and space to read – and also to discuss – the information and opportunities these documents present, including the important differences between cultural competence, cultural safety, and hauora Māori.

Some colleges are already well under way in this work; others not so much. Wherever your college sits, the Medical Council of New Zealand has clear expectations that you will demonstrate the ability to learn, grow, and reflect on your practice in this regard. We, therefore, also have shared obligations to support each other in building our knowledge and understanding of what culturally safe medical practice looks like in your workplace.

Which brings me to the title of this column – about not being a one-day mushroom. This whakataukī was shared at the launch. It reminds us that this is a kaupapa for the long term. Cultural safety is a project of sustained development and change. These booklets are not for picking up and putting back on the shelf – here is a framework providing support over the course of our careers.

Julian Vyas writes about our key priority for 2023 in his column – negotiating a new collective agreement with Te Whatu Ora. By the time this edition of The Specialist lands in your mailbox you will have received a MECA update, and bargaining will most likely be imminent or underway. But another strategic priority for ASMS is to build our equity kaupapa – hence our strong support for the new CMC–Te ORA framework – and our recent statement in support of the Māori Health Authority.

We have written to each of the political parties explaining why we support Te Aka Whai Ora, and asking each to respond to five questions:

1. How does your party propose to meet the Crown's obligations to Māori health equity under Te Tiriti o Waitangi?
2. What investment is your party dedicating (in the short term and long term) to Māori health equity?
3. What is your timeframe to achieve equality in life expectancy outcomes?
4. How will your party work across the House of Representatives beyond the three-year parliamentary term?
5. What is the evidence base supporting your policy and plan?

Each parliamentary party has acknowledged receipt of these questions, and we will report on their substantive responses in due course.

Meanwhile, we remain increasingly concerned that the Workforce Taskforce is fiddling while Rome burns. Nor are health leaders fronting up with strategies and resourcing that meet the staffing crisis. We know many services continue to operate under massive risk. While it is good to hear Rob Campbell speak bluntly about the extent of workforce underinvestment and shortfall, we have yet to see concrete solutions. And the recent Tertiary Education Commission decision not to fund further places at Otago Medical School is another blow to the cause of growing our medical capacity for the longer term.

We continue to raise these issues in discussions with Te Whatu Ora, in the media, and at the highest levels, with the relevant ministers. With MECA negotiations and a looming election, this year may be the time we need you, as members, to stand with us to leave health funders in no doubt as to what is required of them, if they want any kind of health system at all, let alone a culturally competent one.





INFECTIOUS OPTIMISM

INTERVIEW BY MATT SHAND

Newly appointed Minister of Health Dr Ayesha Verrall speaks to The Specialist about her appointment and the challenges facing the health care sector.

Dr Ayesha Verrall is an infectious disease physician having completed her specialist training in Wellington and Singapore. She has a PhD in tuberculosis studies, which was completed in Indonesia. This experience led her to become a contact and trace expert, and she worked closely with government agencies on the Covid-19 response before entering politics. She was trained in Dunedin and served one year as President of the Otago University Students' Association before graduating.

What do you hope to bring to the role as Minister of Health?

I think optimism is the key thing. We certainly have our challenges in the health system, and it's great we debate them. But we also have the biggest opportunity in our generation to transform the health system and improve outcomes for our people.

What are the biggest priorities for you now?

In the short term there are a set of pressures on the system that we have to take serious, coordinated action on. Those are the 'three W's': workforce, winter, and waitlists. By winter I mean acute demand. In the long term we have to realise the potential for transforming the health system and deliver it, so we have a system that prevents illness and that provides accessible primary care and communities that keep people well and out of hospital.

In terms of these three W's, what do you see as the levers you can pull to make improvement?

There are many, and we've got to use all of them. For the workforce, Minister Little had a set of actions announced late last year around nursing recruitment and retention and some general practice trainee recruitment. We have to keep aggressively recruiting, and trying to address our workforce shortages, while also building this into a medium-term plan to really have a more deliberate approach to our staffing. We've made immigration changes as well.

Then the winter, we've got to make sure we have a strong, flowing Covid vaccination programme this year. One estimate said we had saved 300 lives with the antiviral package we introduced last year. So, making sure that continues to perform well.

Then there are all the additional things we can do to incentivise primary care and manage flow as efficiently as we can within the hospital.

Again, there's no silver bullet.

“It [being a doctor] helps give me a depth of experience against which to interpret advice and information. And so I hope that means I can cut through a bit more to find out what the issues are too.”

- DR AYESHA VERRALL

You've been visiting hospitals, emergency departments and clinicians since taking on the role. What are they telling you?

Exactly the same things I used to hear when I was there as a worker. I think it's important to be grounded in that and not see everything through the lens of the debates we have in the media. That's why I do that [visit EDs]. I also think it's an important form of accountability to our workforce to be there directly talking to them when they are doing it tough.

You've been hearing doctors feel overworked and under-resourced. Do you have anything else to add about your goals to attract and retain medical professionals in New Zealand?

It never comes down to one single thing. It is not just industrial issues. It's not just about working conditions – but those things are incredibly important. I think an important opportunity enabled by the health reforms is, across the country, we can take coordinated action to make sure our highly trained professionals' skills are being used for things only they can do. And that we're modernising information technology and using other workforces in order to get the whole team performing at the top of their scope and not burdening specialists with paperwork and so on.

Do we have enough staff for this upcoming winter flu season?

Net staffing numbers are increasing. For example, DHB/Te Whatu Ora positions show nursing has increased approximately 4,200 FTE, about a 20 per cent increase since 2017. We are making progress. We will continue to be challenged by staffing this winter, but it will be better than the last one.

Health care workers have borne the brunt of the public sector pay restraint and, with ASMS entering bargaining this year, is the Government committed to giving more support, or lifting this pay restraint?

So that's a process led by Te Whatu Ora. Of course, I know the value that is provided by our specialist workforce, and I know we are drawing on them a lot at the moment.

So, is the 'year of pain' over?

There's a process to go through.

What about the amount of money going into Vote Health. Is it sufficient?

This Government has increased health funding back to historic levels. We have made major investments in operations and the operational budget. Pharmac's budget increased 45% across the time this Government's been in, and there has been investment in capital as well ... so there have been substantial increases. What we need to see now is a focus on delivery of the initiatives that were funded so we can keep seeing better outcomes and keep making the case for further investment.

Speaking of capital investments, are you looking to find ways to fund the \$200 million shortfall for the Dunedin Hospital Rebuild Project or looking to make changes there?

So, we have put in an extra \$110 million into the initial budget of \$1.4 billion. It was already the most expensive capital project ever undertaken in the health portfolio. It will be a state-of-the-art building for the people of Dunedin and the region.



We have 100 health capital projects that we're working on, and we have to see how those investments support the health of the whole region. We need to think about facilities Invercargill needs, and investments in Central Otago to make sure the whole region functions as a whole.

On that basis, can we take it that the remaining \$90 million of the shortfall won't be funded?

Yes. That was a decision that Minister Little made. I should add the clinicians involved in the redesign have worked out a plan that includes a staged rollout of certain parts of the project. They see that as a helpful solution to the alternative of just not having facilities built ... I'd like to respect the fact that they did that work to come up with what they, I think, correctly identified as a better solution for the hospital and patients.

Did we learn anything from the Dunedin Hospital project that will take effect in future capital investments moving forwards?

I think part of why I've invested time, and asked officials to invest time, talking to the [Dunedin] community is because I think we need to improve. Basically, the community was not hearing from us what they needed to about the development, and so I can understand why they felt surprised. We needed to go down to make sure we're explaining to them what the situation is. I think that's the main lesson to be learned from it.

How do you feel your clinical experience and training will help you in this role?

It helps give me a depth of experience against which to interpret advice and information. And so I hope that means I can cut through

a bit more to find out what the issues are too. Identify the issues that could make a difference to people, whether that's the public or staff.

It's incredibly helpful to have hundreds of in school classmates, former colleagues in medical specialties and general practice, and nurses who you can draw on to sense check what you're thinking about and what you're hearing.

Did you experience burnout when you were working as a clinician?

Maybe a little. I was thinking about my first year as a doctor. I think I went through that learning curve of your first year as a house surgeon and feeling that I didn't know what I was doing in terms of turning around 12 discharges a day.

I just wondered if I was making a difference, and there were long hours. Part of growing out of that was getting more confidence and also understanding just how you were able to make the system function better for those you are caring for. It's similar to being a politician.

It's what they mean when they say it's the art of the possible. In a complex system with many problems, you have to be optimising and find the things you can change to make a difference.

And those things are the three W's?

So, the thing with the three W's is we are going to have to focus on what's possible but, as I said, there is a longer-term priority about having those transformative changes in the health system reorientate us towards prevention. That is the real opportunity we have now.

FEATURES



10

Capturing the
Covid crisis

14

In orders of
magnitude

17

An unsettling
question

20

Family
emergency -
Returning to
work made
SUPER

22

Room for
improvement

24

When the
patient just
says 'no'





“I hope these stories from people on the front line, who put their lives on the line, go some way to sway people who were naysayers – those who didn’t believe in Covid or wearing masks – to see the impact on people treating patients first hand.”

- DR PAUL TROTMAN



CAPTURING THE COVID CRISIS

BEHIND THE MASK

Side-lined during the Covid-19 pandemic, Doctor Paul Trotman used his time in lockdown to create a documentary on the impact of Covid-19 on health care professionals across the world.

“I was being paid by the government to sit at home during lockdown and I wanted to make good use of that time. I started emailing colleagues, here and overseas, asking them to do the same.”

- DR PAUL TROTMAN



RECREATION SHOTS WERE FILMED IN A UNUSED WARD AT DUNEDIN HOSPITAL

A wall of names of more than 3,000 health care workers who died because of Covid-19 appears at the end of Paul Trotman's documentary *Behind the Mask - On the Frontline against Covid*.

The sombre list takes nearly three minutes to scroll past and serves as a poignant testament to the toll the virus has taken on people across the world and those at the front line of care.

"I realised early on Covid-19 was going to be a lot bigger than anyone expected and there was likely going to be some political will to forget the efforts of my colleagues during this time," Dr Paul Trotman said.

"I didn't want that to happen."

Trotman has always had an interest in film and theatre and says his doctoring supports his filmmaking. Early in his career as a doctor he worked as a locum in the United Kingdom while writing pilots for radio sitcoms.

He has produced films about human cadaver dissection and about Joseph Merrick ('the Elephant Man'), and he even starred as Dr Know in an American-produced film likened to 'medical MythBusters'.

Trotman was taken off active duty when Covid-19 appeared in New Zealand due to his immune-compromised status.

"I tried to find something I could do via phone. But, in a small rural hospital, there was not

much space for me. It was a frustrating time until a friend told me to make a film about it.

"I was being paid by the government to sit at home during lockdown and I wanted to make good use of that time. I started emailing colleagues, here and overseas, asking them to do the same."

This approach meant Trotman was conducting interviews about Covid-19 in the time before vaccines, when countries overseas were seeing the worst of the infection take hold.

The confronting nature of the voices within his documentary reflect the confronting times health care professionals faced as the virus swept across the world.

"I conducted more than 110 interviews and received more than 200 hours of footage," Trotman said.

"It was easy to have people open up. I have a conversational style and go into interviews without an agenda. I spoke to people quite early on in the process, when coronavirus was still raw and people were very freaked out.

"If you interviewed people now you would get a different level of emotion and different stories. There are vaccines and Covid-19 is not the monster it was back then."

Those stories included tales of the lack of medical supplies, the lack of beds and the tough choices being made in first-world hospitals about who could, and would, receive the best treatment.



COVER ART FOR DR
PAUL TROTMAN'S FILM
'BEHIND THE MASK'

First-hand accounts from medical professionals who dealt with families who lost people to Covid-19, and one who lost everyone and chose to refuse treatment for himself, make for a powerfully surreal narrative about the human impact of Covid-19.

"I haven't done my job if people are not slightly uncomfortable with what they've heard," he said. "I hope these stories from people on the front line, who put their lives on the line, go some way to sway people who were naysayers - those who didn't believe in Covid or wearing masks - to see the impact on people treating patients first hand."

Trotman was assisted by Dunedin Hospital, which gave him access to an unused emergency department ward to recreate scenes of people being intubated and extubated to use within the film.

"We generally had people doing the jobs they were trained to do," he said. "The nurses who were extubating people were experienced in what they were doing. We even had the emergency department kit up in full PPE for an hour and allow us to film them doing their jobs."

Being a registered medical doctor is a key part of Trotman's filmmaking process.

"It keeps me honest," he said. "It also gives me ideas for films and access to places I would not normally have access to. I don't think I would have gotten access to film in the cadaver dissection room had I not been through it first."

"It also means, when I am interviewing people, I am speaking the same language."

The film received accolades across the world including Best Medical Film at the Mannheim Arts and Film Festival 2023 and Best Medical Film at the Berlin Indie Film Festival in 2022.

Trotman is looking for his next film idea and has plans to either tell a story about dementia in New Zealand or take an in-depth look at the decision-making behind sending the country into lockdown.

"I think both would be fascinating stories," he said. "I've always been fascinated with following a story on dementia but am yet to find the right story to tell. I also think learning about the lockdown process would be fascinating."

ASMS IS ORGANISING FUNDRAISING SCREENINGS OF BEHIND THE MASK IN WELLINGTON AND INVERCARGILL IN JUNE. IF ANY OTHER BRANCH OF ASMS WOULD LIKE TO ORGANISE A SCREENING, WE CAN HELP WITH THE LOGISTICS. EMAIL ANDREW.CHICK@ASMS.ORG.NZ.

IN ORDERS OF MAGNITUDE

MATT SHAND, JOURNALIST



CAROLINE
MCELNAY
IMAGE: RNZ

“I’m not sure what it was, maybe it was just a feeling, but something seemed significant about that alert. My colleague also had a funny feeling about it, so we got together and started to act.”

- CAROLINE MCELNAY

Two ASMS members have received significant New Year Honours, with Dr Jane Skeen becoming a member of the New Zealand Order of Merit for her contribution to paediatric oncology and Dr Caroline McElnay receiving a Queen’s Service Order for her work as Director of Public Health during the Covid-19 lockdowns.

The right person at a challenging time - Caroline McElnay

For most people, Covid-19 only affected their everyday life when lockdown became a sudden reality in March 2020. But for Queen’s Service Order recipient Dr Caroline McElnay it had been part of everyday life as soon as 2020 began.

“We received a notification from the World Health Organization, something that happens quite a lot,” she said. “I’m not sure what it was, maybe it was just a feeling, but something seemed significant about that alert. My colleague also had a funny feeling about it, so we got together and started to act.”

McElnay says she relied heavily on her experience as a registered medical practitioner during this time.

“I was registered and a member of ASMS,” she says. “Many people working at the Ministry of Health have a medical background, but not in a role requiring you to be registered. I think it’s invaluable to have working medical practitioners from ASMS in these organisations to do these jobs.”

McElnay’s early actions to protect public health from the ‘Wuhan flu’ were mainly bringing together technical advisory groups and medical experts to develop advice and create the systems to allow New Zealand to react once the virus reached our shores.

“There was no reason to think New Zealand would not get Covid-19 and, indeed, there were some notifications coming through before we went into lockdown that this was the case,” she said.

“We knew once the virus spread it was incredibly difficult to contain. We had our team in place and were able to adapt the pandemic plan as part of our response.

“We first adopted a keep it out and stamp it out approach. That first lockdown allowed us to effectively stamp out the first wave and we had a period in New Zealand where there was no Covid-19 in New Zealand.”

McElnay says the biggest threat to New Zealand was the capacity of our health care system to cope with a mass crisis. “We knew we didn’t have enough intensive care beds. There were discussions about ventilators and it was made clear we would not have the level of care needed. We would be facing tough decisions, as we saw in the UK, where people had to decide who would be put on a ventilator and who wouldn’t.”

When the daily briefings started, McElnay started appearing on television screens across the nation. She remembers, vividly, announcing the first Covid-19 death in New Zealand.

“It was hard,” she said. “It made things feel more real. I felt for the family. This is a family who lost someone. It can be hard to give that message to the country in a way that’s compassionate. The first one and subsequent ones were all difficult. We were on a roll of death at one time. Colleagues and friends commented that every time I was on television there was another death.

“I think we will all look back at that time and realise it was quite surreal. I would forget that watching the p.m. briefing had become a sort of religious thing. Sometimes I would realise that I might be being watched by the entire country – you don’t always remember it when you are there with the reporters.”

McElnay says the pandemic response showed the importance of public health, but she worries the high-profile response could mean the public view public health measures as only being about communicable disease control.

“I think the pandemic showed people why you need public health professionals,” she said. “It showed the benefit of public health. But it would be disappointing if public health was seen as only relevant in that function. The essence of public health is to look after the health of the entire population. Clinicians treat individuals; public health’s role is to treat populations. Our medicines and interventions are different. GPs have drugs or counselling services, and the public health physicians look at social determinants and can use policy and politics as part of their toolkit.”

McElnay said she did not expect to be nominated for the honour. “It feels strange just to be trying to do your job, trying your best, and you get recognised for it,” she said.

“I feel I got found out over others. I’m flattered to say it was colleagues who nominated me. It’s a big honour that colleagues I worked with thought I should be nominated.”

McElnay retired from her position as the Director of Public Health to travel and look for new opportunities. “I knew I had come to the end of what I could contribute,” she said. “Covid is morphing into something endemic and we are learning to live with that. A friend said to me, and I respect it, that I was probably the right person to be the Director of Public Health at that time, and I take that as a reflection of the background I have. I aim to continue making a difference in as many ways as I can.”

“Medicine is never a nine-to-five job, and you never truly switch off even if you’re not on call.” - JANE SKEEN



JANE SKEEN

Caring heart for children with cancer – Jane Skeen

Jane Skeen has been a paediatric oncologist since January 1981. In her role at Princess Mary Hospital for Children in Auckland, which became Starship Children’s Hospital, she has worked with hundreds of families at a very difficult time in their lives.

“The survival rate was not as good then as it is now,” she said.

“It was about 60 to 65%, whereas it is now 85%. A third of the children with cancer died when I first started in paediatric oncology.

“This really highlighted the need for dedicated paediatric palliative care. Starship led the way with the only dedicated paediatric palliative care service in New Zealand.”

Building connections with patients and their families is what attracted Skeen to working with children with cancer.

“You have to learn what support the families need and how much information they require, at each stage of their child’s journey,” she said.

“If people hear something they do not want to hear they can often switch off. This makes it important to repeat the information and never assume they’ve heard it because you’ve told them once,” she said.

“You also need to know how to look after yourself. You need to know who your supports are, how you spend your time away from the hospital, and what re-energises you, enabling you to return to work day after day.

“Medicine is never a nine-to-five job, and you never truly switch off even if you’re not on call.”

This commitment to cancer treatment has been reciprocated in the families she has treated. Through her work at the Child Cancer Foundation, where she was the health professional representative to the National Board for 33 years, she sees families giving back to help others.

“Parents whose children have died have committed many hours over a large number of years to the Foundation,” she said. “They always want to help others.”

Her work took her beyond New Zealand, when she helped form and lead the Pacific Working Group

of the National Child Cancer Network to help treat children with cancer from the Cook Islands, Fiji, Samoa, Tonga and Vanuatu.

“We were seeing patients referred down [to New Zealand] for treatment – often with late-stage disease, many comorbidities, often with very poor outcomes – with excessive expenditure for the referring Pacific country. Citizens of Tonga, Samoa, Vanuatu and Fiji are not eligible for free health care in New Zealand. We thought there had to be a better way of doing it in-country,” she said.

“Initial funding enabled a small team to travel to Pacific islands. We had no intention of just flying in to ‘tell them what to do’ but to work with our Pacific colleagues and ask them what their priorities were regarding childhood cancer.

“Working collaboratively, we developed country-specific models of care.”

Modified treatment protocols were developed according to resources, capacity and capability in each country. As expertise, capacity and capability in each country improved, treatment protocols were intensified, also ensuring availability of resources, medications and imaging for supportive care.

“Being part of the team to help children get the best treatment available, and to give them the best chance of survival, was extremely rewarding – especially to see on regular visits (pre-Covid) to the Pacific the increasing numbers of children who have completed their cancer treatment.”

Skeen says she is honoured to have been recognised as a Member of the New Zealand Order of Merit (MNZM), and it was a relief to finally be able to share the news with friends and family on the 31st of December, having been notified 14 October 2022.

“I’m appreciative of the supportive team – clinical and managerial – behind me at Starship Blood and Cancer that allowed me to do the work that I did,” she said.

Though retired now, Skeen is still looking for ways to give back to children with cancer in the Pacific.

“I would still like to, now that travel is on the cards again, return to Tonga, Samoa and Vanuatu, to further the dialogue with Pacific colleagues that I have long-standing relationships with, on a model that aligns to their existing health system.”

AN UNSETTLING QUESTION

MATT SHAND, JOURNALIST

ASMS's latest Future Intentions survey finds double the doctors and dentists are considering leaving Aotearoa New Zealand. Only two-thirds are confident they'll be working in the same place in five years.

The number of doctors and dentists intending to leave New Zealand permanently has doubled in the past five years, according to the latest ASMS survey.

The Future Intentions of the Senior Medical Workforce survey asks doctors and dentists about their plans for the next five years, including practising overseas, retirement and levels of private practice.

The latest results highlight coming challenges to attract and retain international medical graduate (IMG) doctors, with the number of IMGs intending to leave permanently doubling, from 4.2% to 10.9%.

Across all doctors and dentists, the intention to leave medicine was up from 2% to 18%. Meanwhile, solid commitment to continue in current employment was down from 83% to just 62%. In that context 42% said they were likely to reduce their hours working in the public system.

"Compared to the 2017 results, SMOs are actively considering all their options," ASMS Director of Policy and Research Harriet Wild says.

"Of note, consideration of overseas practice is becoming a stronger option. One in ten members have expressed an interest to relocate overseas permanently. With the initial period of the Covid-19 pandemic behind us, I would say that everything's on the table for our SMOs."

Intentions to reduce public sector work was another significant finding. But SMOs are not dropping public hours to increase private work; rather, they are trying to claw back some work-life balance.

The rising intention to leave New Zealand coincides with falling rates of job satisfaction.

The survey looked at nine job satisfaction measures. "The steep drop in job satisfaction is significant," Harriet says. "It's clear from these results SMOs feel undervalued and unsupported. While the grass is not necessarily greener elsewhere, there is a strong sentiment of 'it has to be better than this' coming through the qualitative results."

Working hours, remuneration and physical working conditions saw the biggest reductions in satisfaction, with drops between 14% and 17% across each category.

The measure with the lowest level of satisfaction was being recognised for good work. Only 41% of respondents felt satisfied in this category.

Comments from those surveyed, anonymised for the report, paint a grim picture.

"Looking to exit medicine in a timely manner," one wrote. "Have been working 50+ hours per week during med school and throughout medical career – so nearly 3 decades now. It is increasingly complex and under-resourced in the public health sector."

Those declaring both an intention to leave New Zealand, and an intended destination, showed Australia to be the favourite, with 63.2% of respondents reporting they would relocate there.

The next most-preferred destination is the United Kingdom on 17.9%, with North America on 8.9%.

"The British Medical Association's New Year Message noted that, of the 33% of doctors there looking to practice abroad in 2023, 42% were considering Australia," Harriet says.

"This is more than double those considering Aotearoa New Zealand. The 2022 Medical Council of New Zealand workforce report notes 2,187 New Zealand-trained doctors were already practising in Australia in 2019."

The survey found better working conditions was the main reason for choosing Australia.

One wrote: "Very unhappy and do not want to continue in the public health system in NZ. Moving to Australia for better conditions and pay. Unsure if will return to NZ."

Another said, "My husband and I are already scoping out work in Australia for just over 5 years' time. We plan to work the last 15-20 years of our working life in Australia."



**OVERALL
SATISFACTION
RATE**
2017

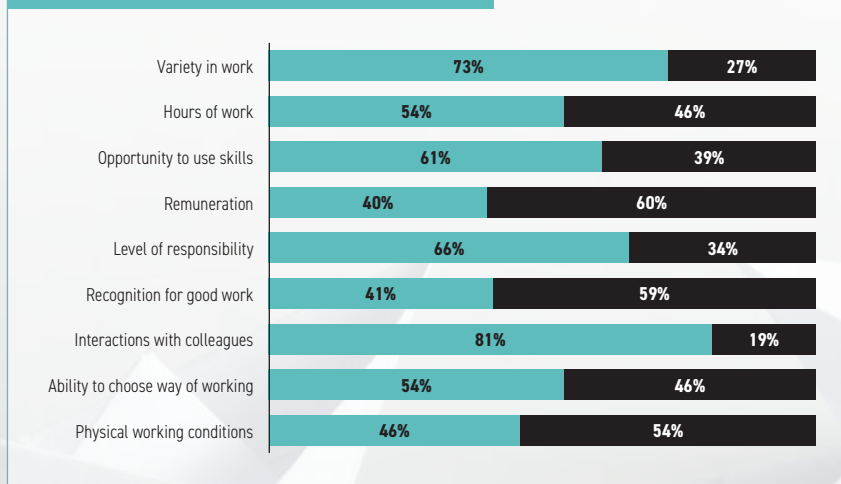
81%



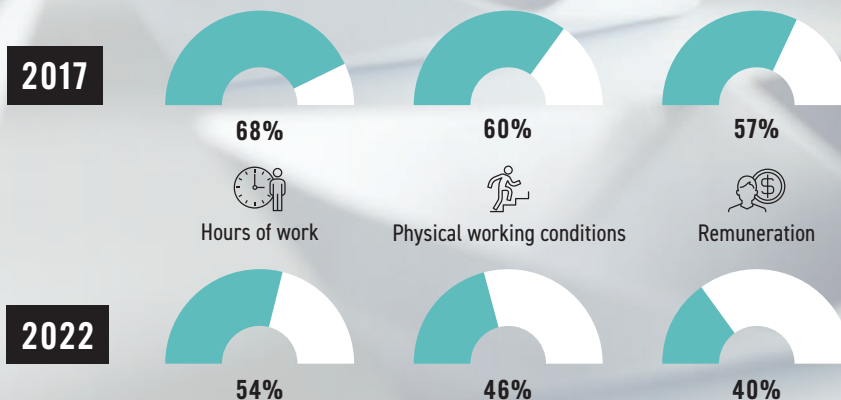
**OVERALL
SATISFACTION
RATE**
2022

57%

JOB SATISFACTION IN 2022



INDICATORS SHOWING GREATEST DROP IN SATISFACTION 2017-2022



“This year has pushed many of us over the edge.”

CONTINUING IN CURRENT EMPLOYMENT

Intention to stay in current role and workplace.

Year	Percentage
2017	83%
2022	62%

SMOs considering moving abroad.

Year	Percentage	Category
2017	4.2%	
2022	10.9%	PERMANENTLY
2022	12.7%	TEMPORARILY

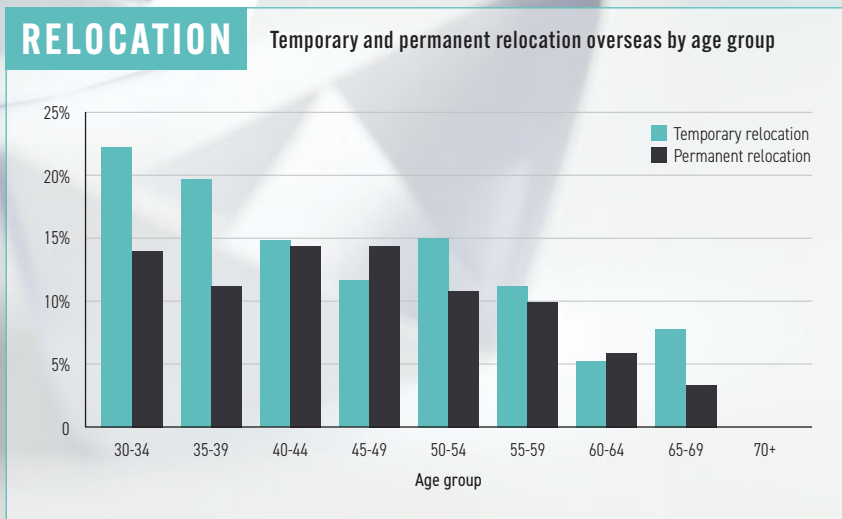
MORE SMOS LOOKING TO LEAVE AOTEAROA THAN IN 2017

3X as many doctors looking to move abroad short-term in 2022 than in 2017

START/INCREASE PRIVATE PRACTICE **42%** **2022**

YOUNGER SMOS ARE MORE LIKELY TO RELOCATE OVERSEAS

SMOs aged **under 50** were more likely to **consider moving overseas** to practise compared to their older colleagues.



“Very unhappy and do not want to continue in the public health system in NZ. Moving to Australia for better conditions and pay.”

THE FULL SURVEY RESULTS WILL BE PUBLISHED ON THE ASMS WEBSITE.

“We advocate people take breaks – we’re not very good at that in emergency medicine.”

FAMILY EMERGENCY

RETURNING TO WORK MADE SUPER

ANDREW CHICK, COMMUNICATIONS ADVISOR

Returning to work after having children can be challenging, but emergency medicine specialists Jennifer Heyes and Laura Wilkinson are SUPER-charging the experience.

In this instance SUPER stands for Skills and Updates for Parents in Emergency Medicine – a free, full-day course for parents looking to return to work in emergency medicine after a period of parental leave.

“Your whole identity changes when you become a parent,” Heyes said.

“The idea of returning to work can be quite intimidating – you feel this pressure to perform under a fog of fatigue, and you have those pangs of separation from your child.”

First run by the Australasian College for Emergency Medicine (ACEM) in Australia in 2019, Heyes decided to bring it to New Zealand at the end of 2020 after attending a SUPER course in Melbourne.

“We have made the course New Zealand-focused,” she said.

“In Australia a lot of people do go back much earlier than we do here.

“I’ve also really increased the amount we talk about non-clinical aspects of going back to work.”

The goal is to help clinicians become good advocates for themselves.

“There are no general provisions for a return-to-work programme in emergency medicine – I can only speak for emergency medicine – but a part of the course ends up being a lot of education,” Heyes said.

“Departments don’t know what individual clinicians are going to need on their return. And the rostering is very frequently done without any understanding of the return-to-work period.

“Even now, there are clinicians returning from parental leave, from an extended time away from medicine, who have absolutely no special provisions unless they put their hand up and request it.

“We have clinicians returning – and these are real cases – to full-time work but starting on night shift as the registrar in charge of a department.”

Heyes says it’s not safe.

Heyes found the SUPER course invaluable when she returned to work.



LAURA WILKINSON
AND JENNIFER HEYES

"It was very, very tiring when I returned to work for the first time," she said.

"I was anxious. I'd had a year off and my child was waking multiple times a night. SUPER reassured me that I was not the only one who felt these anxieties. It was helpful to meet people who had been through the same experience and to hear their journeys. It honestly made me feel excited about returning and gave me the confidence to do so."

Hayes says there are practical things SUPER suggests to make returning to work safer and better.

"Starting with shorter shifts – maybe six or seven hours, because you're just not going to be productive for the rest of the shift," she said.

"Also, being supernumerary for the first couple of weeks, if that can happen with your department.

"We advocate people take breaks – we're not very good at that in emergency medicine. If you need an extra five minutes, then you should just be able to go and do that."

While on parental leave, there's also 'keeping in touch' hours.

"No one really knows about them," Hayes said.

"You have a right to these. If you want to be paid to attend some teaching, or maybe some consultant meetings, or even just have a few hours on the floor, that is something that you should be able to talk to your department about."

Wilkinson is currently working with management at Te Whatu Ora – Capital, Coast and Hutt Valley to establish a safe return-to-work programme for RMOs and SMOs. Heyes has recently moved to Taranaki and is doing the same there.

Both hope the results can be rolled out across New Zealand.

Without it, she says, new parents will just leave the workforce rather than carry on.

"Before children, people are doing their part one exams and they've only got themselves and maybe their partner to 'look after'," she said.

"Then they have a child. Now they're required to manage childcare, and doing that around shift work is a nightmare.

"I have seen a whole lot of clinicians, excellent clinicians, we have lost from emergency medicine.

"They've done the exams they had to and just couldn't manage to return to work. They weren't supported, so they left the ED.

"I am still in contact with quite a few of them, and they are doing wonderful things in their communities, but some regret that they could not continue."

Hayes is keen for as many emergency medicine doctors – male or female – who are returning to work after a period of parenting to benefit from the SUPER course. It's the fourth time the course has been run in New Zealand, and Heyes' aim is to hold it in Wellington every six months – in January and July (just prior to RMO changeover).

"No parent is good at focusing on themselves, especially at this return-to-work time. In order to go on the course, it's much better if you've got a colleague that says, 'Hey, look, this course is available, do you know about it? We recommend you do it.'" Let's spread the word.

**TO REGISTER YOUR INTEREST IN THE NEXT SUPER COURSE EMAIL
JENNIFER.HEYES@TDHB.ORG.NZ.**

ROOM FOR IMPROVEMENT

ANDREW CHICK, COMMUNICATIONS ADVISOR

Sometimes people get sick outside of usual business hours. Everyone recognises that – it’s self-evident. But it seems hospital managers can be oblivious to the equally self-evident implications of non-business hours work for their employees, such as overnight accommodation.

Overnight accommodation has become a bugbear for specialists at almost every public hospital in the country. The provision of appropriate overnight accommodation is a MECA obligation, but a systematic evaluation last year by ASMS has identified many hospitals are non-compliant.

The MECA says the Joint Consultative Committee meeting is the place “to develop an agreed solution”. But on the North Shore they’ve been having that discussion for a decade.

Waitematā Branch Vice President and intensive care specialist Annemarie Mitchell says it has been a constant issue for at least 10 years but there have been no permanent solutions. “In the overnight accommodation for ICU you have to walk to another block for a shower. The sleep room backs onto the staff tearoom and you hear it every time someone opens the fridge.

“There is a Quest hotel across the road. If you personally book a room the hospital will reimburse you. But when O&G tried to organise a group booking they found they couldn’t.”

In February plans to build on-site accommodation for eight SMOs at North Shore were put on

indefinite hold because of an inability to find \$1.5m to fund the work.

In the Hutt Valley an O&G specialist reports things aren’t much better – despite the space being ‘newly renovated’.

“Previously they were, frankly, disgusting – without curtains that closed and unbelievably worn-out mattresses.”

While the ‘new’ rooms are tidier, they are a long way from the rest of the hospital. “They’re down several long and poorly-lit corridors, which I personally do not feel safe in at night. There is no sleep space for SMOs on the birthing suite.”

Instead, they choose to sleep on an inflatable mattress in their office, though they have been told off for doing so.

The patterns are clear. Anaesthetists in Nelson choose between a bed at the back of a shared office or a camping bed in the department. In Hawke’s Bay ED, SMOs use a couch in the back of the Head of Department’s office right in the heart of the department. Although – most notoriously – some doctors took to using an unoccupied operating theatre.



access via a swipe-card stairwell and walk through this corridor, right past the room. There are two doors that they have to walk through at each end of the corridor – with beeping of the security cards and slamming of the doors.

“If they don’t shut the doors properly there is a continuous beeping which only stops if you get out of bed and shut it yourself.”

MECA clause 53 states accommodation must be sufficient, good quality, secure, private, quiet, self-contained and within reasonable walking distance of the workplace.

The MECA also spells out specific amenities – bedroom or bed-sitting room; private bathroom with toilet and shower facilities; access to basic kitchen facilities for cooking or heating food; a television set, a comfortable lounge chair and a work-station or desk with telephone, computer terminal and internet access.

“Failure to provide accommodation is a breach of the collective,” ASMS Industrial Officer Georgia Choveaux says. “ASMS continues to systematically raise compliance concerns and seek solutions. We may have to pursue compliance action for those districts that remain in breach.

“For example, at Waitemata, having approved compliant designs and the space to build but Te Whatu Ora refusing to fund this will not be tolerated.”

In Dunedin in 2019, SMOs in O&G agreed to share offices to create a spare office they could use as a sleep room. “The thing photos don’t capture,” says O&G specialist Jana Morgan, “is the noise, making it virtually impossible to actually get any sleep in this room.

“There was already a very noisy, rattling, air conditioning vent. Then two years ago they changed how people access the hospital after hours. In the past, overnight staff would come in via the main hospital doors and the sleep room was on an unused corridor with locked security doors at either end – it felt reasonably secure. Now overnight staff



WHEN THE PATIENT JUST SAYS 'NO'

WITHDRAWAL OF CONSENT AND DOCTORS' OBLIGATIONS

DR LUCY GIBBERD, MEDICOLEGAL CONSULTANT AT MEDICAL PROTECTION

The right to refuse treatment is fundamental in the ethics of modern medicine. In New Zealand this right was formalised in section 11 of the New Zealand Bill of Rights Act 1990.

"11. Right to refuse to undergo medical treatment
Everyone has the right to refuse to undergo any medical treatment."

Right 7 of the Code of Health and Disability Services Consumers' Rights covers the right to make an informed choice and give informed consent, and in subsection 7(7) it also lays out:

Every consumer has the right to refuse services and to withdraw consent to services.

The fact this is included in the Right concerned with informed consent shows how important it is that a patient should be fully informed if they are declining to consent to treatment.

Competent patients have the right to refuse treatment, even if their treating clinician thinks this decision is very unwise. If the clinician considers that the patient may be lacking in competence, then this must be clarified. If the patient lacks competence, other options for consent to treatment may need to be considered.

Doctors can think that when a patient has refused to undergo an operation or a treatment, their obligations finish there, but this is not the case. Every year, Medical Protection sees complaints that arise following patients refusing treatment.

As an example:

Mr A was a 72-year-old man, on immunosuppressive treatment following transplant surgery. He presented with a biopsy-proven, histologically aggressive, squamous cell carcinoma near the bridge of his nose. When he presented for a wide excision, the lesion was not visible to the naked eye, as it had been largely removed by the biopsy. The patient questioned why further surgery was necessary and said he did not want to go ahead unless the surgeon could guarantee he would 'get it all out'. The surgeon explained he could not make that guarantee, so the patient declined to go ahead with the surgery and opted for 'close observation' as an alternative. When the cancer later became locally invasive and required majorly disfiguring surgery, the patient complained that his refusal of treatment was not fully informed, as he had not been aware of the possible consequences of refusing surgery.



The issue in this case is that the patient had initially agreed to the wide excision and only refused to proceed during a discussion in the pre-op area. The patient was having other skin surgeries that day, and the other surgeries went ahead. Because the discussion occurred in the pre-op area, it was not well documented and there was nothing in the notes recording that the patient had been told about the possible consequences of not going ahead with surgery. The surgeon in this case clearly could not proceed with the recommended surgery, in the face of the patient's withdrawal of consent – but what could he have done to avoid a later complaint?

It is not uncommon for conversations that occur in the pre-op area to be poorly documented. Often the patient is being seen in between cases in theatre, there may be no facilities to dictate or record a file note, and it may not be obvious where such conversations should be recorded. There may also be concerns about the patient's competence to make a reasoned decision in this situation, particularly if they have been given a pre-med. If a patient refuses treatment in this situation, it is probably better to arrange to meet with them later and have a full, documented discussion about the possible consequences of declining the treatment. If the patient does not wish to agree to or attend such a follow-up meeting, then a letter to the patient (and GP) recording the discussion, the matters set out below and the offer of a follow-up consultation should be sent.

Doctors are now increasingly aware that when they are 'consenting' a patient to have a procedure or treatment, they must carefully record the possible complications that have been explained to the patient. However, when a patient is refusing a recommended treatment, it is probably even more important that the conversation is carefully documented. Medical Protection would recommend the following:

- There should be clear written documentation that the patient has been offered a treatment but has declined it.

- There should be documentation that the possible consequences of declining the treatment have been explained to the patient, including the worst possible outcome.
- Alternative treatments should be discussed, and the pros and cons of these treatments should be discussed and documented.
- A follow-up appointment should be arranged to give the patient a chance to reconsider and to again discuss other treatment options.
- If possible, it is helpful if a relative or support person accompanies the patient to the follow-up appointment, both to support the patient and so that the family is aware of the choices the patient has been offered.
- There is no legal requirement for the patient to sign a document saying they have refused treatment. In fact, good contemporaneous notes, where it is clear the patient has been warned of the possible outcome of declining treatment, are probably better than a signed document where this detail has not been clearly laid out.
- If a patient refuses treatment, it should be made clear to the patient whether it is possible to undertake the treatment in the future if they change their mind, and if so, what pathway the patient would follow to achieve this.
- Giving the patient written information about the proposed treatment is always helpful, and exactly what has been provided should be documented in the notes.
- If there are any concerns that the patient may not be competent to consent to or decline treatment, a formal competence assessment may be advisable.

THIS IS GENERAL ADVICE. MEDICAL PROTECTION MEMBERS ARE WELCOME TO CALL 0800 225 5677 TO TALK TO ONE OF OUR ADVISERS TO LEARN MORE.



“There’s too much administering what the system is rather than trying to lead what it could be.”

- ROB CAMPBELL

WE SIMPLY HAVE TO MAKE IMPROVEMENTS

This interview was conducted in January while Rob Campbell was in his role as Te Whatu Ora Board Chairperson. Campbell was dismissed from his position on February 28 by the Minister of Health.

**Te Whatu Ora
Board Chair
Rob Campbell
talks through
what 2023 will
bring as part of
the health care
system overhaul
and about hang
ups from the
handover.**

When Te Whatu Ora Board Chair Rob Campbell took over the reins he talked about a “decade-long” transformation towards an improved health care system. But speaking to clinicians at the front lines has changed this view.

“We simply must achieve significant improvements over five to six years,” he said.

“Do we have the full answer at this point? No, we don’t.”

Campbell has been a key contributor to modern unionism and an advocate for improving workers’ conditions. He has worked as an economic consultant, as a director of state-owned enterprises, and as an investment manager for organisations before being appointed the Chair of Te Whatu Ora’s board.

Campbell dislikes the term ‘coping’ to describe the health care system. He says the term is thrown around too often in management circles, and he says coping is a term used to describe a system under stress, not thriving.

“If doctors are going into wards with half the staff they need, they will ‘manage’ to cope,” he said.

“They’ll cope because there is no alternative. They’ll leave shattered. Their patients may not get the care they needed. But they will cope. So, it’s not a good word to measure the system. We need to be focused on goals and improvements, not coping.

“There is a lot of ‘just coping’ built into the health care system.”

Campbell says despite being a new organisation, the old health care system inherited by Te Whatu Ora is one of the largest restraints to change and can even put a handbrake on the pace of change.

“We started in July with the same people, the same money, the same relationships, the same buildings, the same technologies and the same capital expenditure projects the old system had,” he said.

“Those projects run years into the future and as frustrating as it is internally and externally, that dictates what the pace of change can be. What we have had to do is work through that and establish a new organisation, which just takes time.”

For now, the majority of changes have been focused on the management side of Te Whatu Ora, with a flurry of new appointments last year.

“The truth is there is not any point making any big promises about what we are going to see at the front line,” he said.

“Until we have the right management in place, any improvements at the front line are going to be incremental, and I don’t think it’s helpful to make promises that are not going to be fulfilled.

“For example, if you take waiting lists, the simplistic view would be to set up some system to clear the

waiting lists by the end of 2024. But everyone in the system knows that will not happen in practice until the system is robust enough.

"The more I am in this system the more sensitive I am to setting end goals for things instead of viewing things as a process.

"I think what was wrong with the old system is it was not sufficiently responsive to change."

Campbell said there are things he would have structured differently if he had started the job with the knowledge he has now six months ago, and the Pae Ora legislation is not a perfect solution.

"The structure we are working with is substantive and prudent, but it is not perfect, and there are things retrospectively you would do differently," he said.

"There's too much administering what the system is rather than trying to lead what it could be," he said.

"At all levels I am keen to bring in fresh thinking. One of the issues we have had amongst non-clinical roles is we had large numbers of people who were administrators rather than health managers.

"We need to draw the distinction. The old system was probably structured to have people who administered funding that was allocated according to old rules and contractual arrangements, and we need to lift that to what I would call an active health manager as a leader."

A big challenge for Te Whatu Ora is lifting the working conditions of clinical staff across health care. Calls for better working conditions and better pay strengthen across the workforce, particularly as work pressure mounts. Campbell says money is just one factor in the health care upheaval process.

"Do we need more money to pay doctors? Yes," he said.

"Do we need more money to pay nurses? Yes.
Do we need more pay parity outside the hospital sector? Yes.

"The message can sound trite, but it is genuine. We really appreciate the work people within the system are doing, and we understand the pressure and understand the frustrations."

"More money is not simply the answer. You can pour money into the system, make bad capital decisions, and for that additional funding not to be helpful. The pressure is really on that. A lot of funding flowed into health in the past as a result of political pressure rather than health service pressures. So the issue of misallocation is as important as the total amount of allocation.

"We could use more money in the health system. It's also true New Zealand spends too little on housing. If we spend more money on some areas of housing we may put less pressure on other parts of the health system."

There has been scrutiny on existing capital expenditure projects like the New Dunedin Hospital build in recent months. Campbell says many projects were inherited on 1 July and hopes to see changes for any new projects with a whole of New Zealand approach.

"To be frank, in relation to something as far advanced as the Dunedin Hospital, doing a full review would probably be a negative thing at this stage," he said.

"It's now a matter of doing the best we can with the current commitments and to make sure we can deliver them.

"Where we will improve over time is making better national and regional decisions about what sort of facilities we need. The old system was not the best for getting national and regional outcomes from having 20 different regional decision makers. I imagine it would have been different if scoped under Te Whatu Ora.

"We now have to look at capital expenditure as what is already committed, look at what has not reached that stage and ask if we would really want to build that way and revisit the plans and we have our new capex decisions.

"We have brought in experienced commercial property and legal experts to ensure we are contracting in a way that is adding accountability."

With Prime Minister Jacinda Ardern's resignation and the appointment of new Health Minister Ayesha Verrall, Campbell says it is important the health care system focuses on sensible decision making.

"We're building a health system for 50 years," he said.

"We have to be doing things so sensible that no conceivable government would want to sustainably change them. That's the approach we're taking. We're aiming for long term, sensible decisions and accept democracy will deliver a government that does not want to overturn sensible decisions."

Campbell was dismissed from his role as chair on February 28. "I regret losing the role to political manoeuvring," Campbell said. "I remain committed to the kaupapa of the reforms. I have been an advocate for much stronger clinical leadership and feel we have further to go on that. I have been a firm advocate for safer staffing levels across the clinical space and regret that we have not been able to shift the wider government on this."

"Do we need more money to pay doctors? Yes."

- ROB CAMPBELL



The importance
of Te Aka Whai Ora

Calls to expand
free lunches to
end food insecurity
for children

Did you know?

Specialist redesign

Dunedin Hospital
update

Most people don't
see the dentist
annually and cost
puts them off

ASMS in the news

IN BRIEF

IN BRIEF

NEWS FROM AROUND THE MOTU

THE IMPORTANCE OF TE AKA WHAI ORA

Political parties currently in Parliament have been asked to respond to a paper released on Waitangi Day by ASMS addressing the importance of the Maori Health Authority.

The paper, available at asms.org.nz/five-reasons-we-need-a-maori-health-authority, discusses how successive governments have acknowledged the impact of healthcare inequalities on whānau Māori but failed to make sufficient and sustained investment.

The Crown's failure to meet its obligations under Te Tiriti o Waitangi has been detailed through the Waitangi Tribunal's Wai 2575 Health Services and Outcomes Inquiry and the subsequent *Hauora Report*.

"Inequity has been baked into our health system as well as in housing, education, justice and social development," the paper says.

"It has been compounded by the impact of colonisation, racism, and the social, economic, and commercial determinants of health."

The paper gives five primary reasons we need Te Aka Whai Ora:

1. Health services can be commissioned according to kaupapa Māori values.
2. The life expectancy gap between Māori and European/other ethnicities persists.
3. There has been sustained underinvestment in Māori health equity.
4. Inequities in access to health services and health outcomes continue.
5. Our understanding of health and wellbeing must be holistic and multidimensional.



As we move towards a general election later this year – currently set down for Saturday 14 October - ASMS has written to every political party currently in Parliament to ask them 5 questions in relation to Te Aka Whai Ora:

1. How does your party propose to meet the Crown's obligations to Māori health equity under Te Tiriti o Waitangi?
2. What investment is your party dedicating (in the short term and long term) to Māori health equity?
3. What is your timeframe to achieve equality in life expectancy outcomes?
4. How will your party work across the House of Representatives to achieve sustained change beyond the three-year parliamentary term?
5. What is the evidence base supporting your policy and plan?

We hope to be publishing their responses in the next issue of *The Specialist*.

CALLS TO EXPAND FREE LUNCHES TO END FOOD INSECURITY FOR CHILDREN

Calls to expand the Ka Ora Ka Ako healthy school lunch programme are being made by Health Coalition Aotearoa (HCA).

Currently the programme is only available for schools rated in the lower 25 per cent of the Government's Equity Index, which means many children experiencing food insecurity still miss out on the programme.

A recent study in the Hawke's Bay region found 16 per cent of students from mid-decile primary schools and 11.7 per cent from high-decile schools had either run out of food at home or had gone to school hungry as there wasn't enough to eat.

Health Coalition Aotearoa is calling for an expansion of funding and eligibility to allow at least 50 per cent of tamariki to receive free healthy lunches.

"Not only does it mean tamariki are more focused, more likely to attend school and more ready to succeed, but it supports whānau who're doing it tough at the moment," HCA Co-chair Lisa Te Morenga said.

Te Morenga added the programme had benefits beyond food security.

"The lunches are nutritionally balanced, but they also provide local employment, the opportunity for kids to eat together, and to learn about new foods and cultures," she said.

"When healthy kai is integrated into the curriculum it's an opportunity to set kids up for healthy eating for life and prevent non-communicable disease.

"What could be a more 'bread and butter policy' than school lunches?"

ASMS IS A MEMBER OF HEALTH COALITION AOTEAROA

DID YOU KNOW? SPEAKING OUT

ASMS members have a legal right and professional duty to speak out publicly and engage in public debate on matters relevant to their professional expertise and experience. This is particularly important now, at a time of increasing waiting lists, unmet need and staff shortages at all levels of health care service.

For members employed by Te Whatu Ora, the right is derived from MECA clauses 39 and 40. ASMS has published further advice on the issue at <https://www.asms.org.nz/advice/speaking-up-for-patients-and-staff/>. If you intend to speak out on issues relevant to your employer, you need to have previously advised and/or discussed those issues with your employer. Notwithstanding any policy your employer may have about 'clearing things first' with the communications team, you have no obligation to do so and do not require your employer's consent before going public.

Nevertheless, any comments you make that are directly or indirectly critical of your employer should be measured and fair. If in doubt, seek advice from ASMS through a member of our industrial team.

SPECIALIST REDESIGN NEW YEAR, NEW LOOK FOR THE SPECIALIST

The first edition of *The Specialist* was printed in October 1989 under the name "ASMS Newsletter". It looked very different from today's publication.

The first edition featured a distinctive blue banner, a characteristic that was changed by edition two in favour of the red and white masthead that has now featured for almost 33 years.

It was not until Issue 38 in March 1999 when the title "The Specialist" appeared at the top of the newsletter. But, from there, the look remained unaltered until Issue 101 in December 2014, when there was a substantial redesign. In particular, the entire front cover was given over to a dedicated image and a more prominent ASMS logo was added.

March 2023 marks the next stage in the publication's evolution, with a fresher look and feel.

The changes are an ongoing process, both for look and content, and we welcome feedback from our members. Please feel free to forward any comments to andrew.chick@asms.org.nz.



DUNEDIN HOSPITAL UPDATE

Despite the words of the new Minister of Health (reported in this issue of *The Specialist*), the fight to retain the original design from the New Dunedin Hospital continues to escalate with a 'fighting fund' established by Dunedin City Council to oppose changes.

On January 31, council voted to allocate \$130,400 to fight changes to the city's new hospital design which will see it open with fewer operating theatres, beds and MRI units.

The Council motion came after ASMS reported on concerns from members about changes to the hospital design in December 2022, due to a \$200 million shortfall in funds. Clinicians and district leaders have outlined the negative impact these reductions in capacity and services will have.

While the Government has committed an additional \$110 million to fund the shortfall, the Minister has now said no to the remaining \$90 million.

Dunedin City Councillor David Benson-Pope put forward the notice of motion at the meeting and urged council to stand up against changes to the hospital.

He said the debate was about health decisions not being driven with the best interests of the community at heart.

"Redesign equals risk and redesign also equals risk of considerable extra money and further delay," he said.

"Any change in the size or scope of new Dunedin Hospital and any demand for significant redesign with accompanying consultant costs and demands on clinical staff time will have a widespread negative effect on the reputation and expectations of the new Dunedin Hospital project and facility."

Also on the chopping block is a bridge between the outpatient and inpatient buildings, along with the

non-clinical pavilion building which would have increased workspace for staff.

Te Whatu Ora chief infrastructure and investment officer Jeremy Holman said the removal of these design elements was a substantial part of the cost-saving measures.

A petition calling for the rollback of any proposed cuts had reached almost 2,500 signatures at the time of print.

ASMS Executive Director Sarah Dalton said doctors, nurses and the community deserve to have the hospital design arrived at through four years of consultation.

"Costs have risen but costs always rise," Dalton said. "It will never be cheaper to build than now and the hospital should be built to the standard clinicians felt best matched their model of care for Dunedin."

MOST PEOPLE DON'T SEE THE DENTIST ANNUALLY AND COST PUTS THEM OFF

More than 70 per cent of adults put off visiting a dentist due to the cost of treatment, a new Association of Salaried Medical Specialists survey reveals.

Following the release of ASMS' *Tooth Be Told* report, which makes the case for universal dental care in New Zealand, Talbot Mills Research was contracted to conduct a nationwide survey to discover dental and oral health care habits.

The results show 72 per cent of people put off visiting a dentist due to costs, while only 43 per cent of people visited a dentist in the last 12 months.

More than a third of respondents said it had been longer than two years since their last visit.

Last year, ASMS found evidence that the average EFTPOS payment per dental visit was \$353.

"Dental care is unaffordable for many New Zealanders,"

Executive Director Sarah Dalton says. "This adds to the health inequities that plague our system."

The new survey shows overwhelming support for government funding to be extended to include dental care in New Zealand, with 74 per cent saying adult dental care should be funded, and only seven per cent in disagreement.

The poll found supporters of both major political parties showed high levels of support for universal dental care.

"These results show there is wide support from voters of all stripes, to improve New Zealanders' access to dental care," Dalton says.

"ASMS wants to see more subsidised dental care for adults, more options for dentists to work in the public system and a workforce plan to ensure dental services are fairly distributed nationally."



ASMS IN THE NEWS

A SUMMARY OF RECENT MEDIA COVERAGE FEATURING THE VOICE OF ASMS

MINISTER AT ODDS WITH STAFF OVER SHORTAGES

NZ Herald | RNZ - 10 February

New Minister of Health Dr Ayesha Verrall says she expects improvements to staffing levels at Middlemore Hospital's under-pressure emergency department before the start of the next flu season despite comments from frontline healthcare workers who says the hospital's ED is haemorrhaging staff.

Association of Salaried Medical Specialists executive director Sarah Dalton said poor pay and conditions for hospital doctors and nurses had driven far too many people out of the country.

"The loss of experienced staff is a massive problem."

Dalton said both doctors and nurses would return to the bargaining table this year and if Te Whatu Ora was serious about addressing the workforce shortages seen in hospitals like Middlemore, it would need to put its money where its mouth was.

HOSPITALS HIT 100 PER CENT OCCUPANCY 600 TIMES

TVNZ - February 9

Hospitals hit 100 per cent occupancy more than 600 times last year, figures released to 1News reveal. In the year to last November there were 656 instances when a hospital was at or over 100 per cent occupancy.

Australasian College of Emergency Medicine's Dr Kate Allan says it's an issue that's been building for years. The Association of Salaried Medical Specialists' Sarah Dalton said hospitals hit a critical point long before 100 per cent occupancy.

"It says that our hospitals aren't large enough to cope with admissions. It also says that we don't have enough community facilities to allow patients to be discharged out of hospitals."

Dalton said the impact of the issue on staff is massive.

"When hospitals hit 100 per cent on a regular basis what that means for staff is huge amount of stress, huge difficulty in providing best care for patients."

KIRSTY MACNAB JOINS ASMS STAFF



ASMS is welcoming its newest industrial representative Kirsty Macnab who

will be working in the Canterbury and West Coast regions.

Kirsty has a wealth of experience in unions having worked for five in her previous roles across public service, engineering, rail, nurses and education.

"I think unions keep people safe," she says. "They advocate for terms and conditions of employment."

"We can resolve any issues or problems our members may have in the workplace so they can focus on what they need to do."

"I've been reading up on the health sector and I am happy to be working for ASMS and look forward to meeting members and getting to work."

Kirsty can be reached on Kirsty.macnab@asms.org.nz or on 021 280 7526

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.

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

Association of Salaried Medical Specialists

Level 9, The Bayleys Building, 36 Brandon St, Wellington


Postal address: PO Box 10763, The Terrace, Wellington 6140

P 04 499 1271

E asms@asms.org.nz

W www.asms.org.nz

FOLLOW US

 /asms.nz

 /ASMSNZ

Have you changed address or phone number recently? Please email any changes to your contact details to: asms@asms.org.nz

If you have reason or need to seek a reduction or waiver to your annual subscription, please write to us. Our constitution allows for this in certain circumstances.

Emails should be addressed to sarah.dalton@asms.org.nz

ASMS STAFF

Executive Director

Sarah Dalton

COMMUNICATIONS

Senior Communications Advisor

Andrew Chick

Journalist/Communications Advisor

Matt Shand

INDUSTRIAL

Senior Industrial Officers

Steve Hurring

Ian Weir-Smith

Industrial Officers

David Kettley

George Collins

Kris Smith

Georgia Choveaux

Jenny Chapman

Tanja Bristow

Georgia Bates

Greg Lloyd

Kirsty Macnab

POLICY & RESEARCH

Director of Policy and Research

Harriet Wild

Health Policy Analyst

Lyndon Keene

SUPPORT SERVICES

Manager Support Services

Sharlene Lawrence

Finance and Technical Support Advisor

Vanessa Wratt

Membership Officer

Saasha Manson

Support Services Administrator

Cassey van Riel

Join the KiwiSaver provider driven by purpose, not by profit.

The KiwiSaver provider that's inspiring healthier communities and a healthier planet.
Join today. mas.co.nz/kiwisaver



Signatory of:



Medical Funds Management Limited is the issuer of the MAS KiwiSaver Scheme.
The PDS is available at mas.co.nz.