Royal Australasian
College of Surgeons
Te Whare Piki Ora o Māhutonga

Level 3, 8 Kent Terrace
Wellington 6011, New Zealand
PO Box 7451, Newtown,
Wellington 6242, New Zealand
T: +64 4 3858247
E: college.nz@surgeons.org
www.surgeons.org

09 September 2025

Dame Helen Stokes Lampard
National Chief Medical Officer
Health New Zealand - Te Whatu Ora

GUIDELINES TO MANAGE SECONDARY EMPLOYMENT - CONFLICTS OF INTEREST

Tēnā koē Dame Helen

Te Whare Piki Ora o Māhutonga – the Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Aotearoa New Zealand and Australia. Our mission is to improve access, equity, quality and delivery of surgical care that meets the needs of our diverse communities. Health advocacy is a central competency of a surgeon, and a core value of this College.

The RACS Aotearoa New Zealand National Committee, which includes representatives from the nine specialist societies, has considered and discussed your draft *Guidelines to manage secondary employment – Conflicts of Interest*.

We acknowledge the necessity for such a document for some areas; however, it is not yet suitable for its intended purpose and should not be advanced until it undergoes significant revisions. We are keen to meet and collaborate in developing a more nuanced set of guidelines for health professionals who hold dual roles in public and private healthcare settings.

A significant number of surgeons are simultaneously employed by Te Whatu Ora, affiliated with RACS and ASMS, and possess employment, contracts, or shares in members of the NZ Private Surgical Hospitals Association or other private entities. It is not clear whether you regard dual employment in other settings – such as universities, medical colleges, and the health agencies (Manatū Hauora – Ministry of Health, Te Tāhū Hauora – Health Quality and Safety Commission, Te Kaunihera Rata o Aotearoa – Medical Council of New Zealand and others) to be covered by this document.

For some surgeons, Te Whatu Ora is their ‘secondary employment’ with the roles in private or alternative settings serving as their primary source of income. Consequently, the premise of the guidelines should be duality of paid roles, rather than categorising them as primary and secondary.

RACS is deeply invested in ensuring the Guidelines accurately reflect this reality of our members’ professional lives; they should be clear, widely available, well understood, and consistently applied.

The existing document primarily addresses the needs and perspective of Te Whatu Ora and fails to acknowledge the broader commitments of doctors in working across the public and private healthcare sectors – particularly the significant probono work provided to Te Whatu Ora by many doctors.

We contend the Guidelines, as currently drafted:

- would disadvantage patients, trainees and Fellows, in ways we will explain
- would lead to either:
    - an increase in the number of surgeons opting for primary employment in the private sector, adversely affecting public health services
    - an increase in the hours spent by surgeons dedicated to alternative employment than that within the public system, particularly in the private sector, again impacting public health services

Committed to
Indigenous health

- must explicitly acknowledge the growing involvement of surgeons and other medical professionals in outsourced surgical waiting lists and training in private facilities, including a provision to supervise registrars in the private sector during their own or outsourced lists
- assumes all hours working outside of the advertised/rostered schedule are lost from public activity for Te Whatu Ora, when the reality is a significant amount of probono work provided by surgeons for Te Whatu Ora to enhance patient care occurs while doctors are performing public work outside of publicly contracted hours.

Scope (clauses 2 – 4)

This section says the Guidelines are intended to assist "Health NZ's health professionals to engage in secondary employment within a limited-resource environment". They recognise dual employment as a common practice for many health professionals, allowing employees to expand their experience and skills, whilst having flexibility and autonomy in their work.

Unfortunately, the remainder of the document changes shifts from the concept of 'dual employment' to dictating and regulating the conduct of Te Whatu Ora employees in relation to their 'secondary employer' or their 'non-Health NZ' commitments.

Disclosure (clauses 6 -11)

We do recognise the need to have explicit policies and guidance around disclosure for the small number of doctors who fail to adhere to their contractual and ethical requirements concerning their employment and/or private investments.

The section should be renamed and rewritten to focus on the ***disclosure of 'other paid roles or shareholding' in the health sector,*** rather than disclosure of 'secondary employment'.

The words 'secondary employment' should be removed in each instance in this and all other sections of the Guidelines to clarify the intent and remove any confusion. Some surgeons perceive the guidelines do not apply to them if their obligations to Te Whatu Ora form their secondary employment.

The Guidelines should also explicitly reflect the increasing involvement of surgeons and other medical professionals in outsourced surgical waiting lists and training in private facilities.

We recognise in this context it is likely to be increasingly necessary for Te Whatu Ora employees to declare their other paid roles with, or shareholding in private healthcare providers.

The Guidelines already include references to the following:

- Health NZ Conflicts of Interest Policy
- The need to maintain Conflicts of Interest Registers at regional and district level
- The provision in the ASMS collective agreement which "provides that the health professional must not knowingly allow their engagement with private work to compromise their contractual obligations to Health NZ, and upon request will advise their employer of their secondary employment".

On reviewing the draft, some of our members perceived the Guidelines as a considerable overreach in relation to privacy and private sector employment. To ensure balance and mitigate this reaction, the section should also include reference and links to the following:

- Employment Relations Act requirement for genuine reasons on reasonable grounds and restrictions no broader than necessary
- ASMS collective agreement recognition of a right to private practice
- MCNZ workable disclosure and management framework.

Scheduling of Health NZ work and on-call duties (clauses 12 to 19)

It would be useful for this section to explicitly recognise the baseline of *"Scheduling Health NZ work and on-call duties"* and what this means entails in practical terms for surgeons.

The reality of employment with Te Whatu Ora is that, in addition to the 40 hours scheduled workplan, rostered sessions and on call time, the job requires a significant amount of invisible pro bono work. In the current environment of understaffing, increased emergency and urgent patient, long waiting lists, the agreed work plan is frequently unfeasible. Surgeons are required to cover additional sessions pushing ward rounds, administration and CME into their personal time – all provided pro bono. Surgeons often attend the hospital in their own time when they are not rostered on call to assist colleagues in theatre or to attend to their own patients when unwell. This significantly enhances patient care – but at the cost of the surgeon's personal time. Surgeons who have dual employment may also take phone calls, offer advice and assistance for Te Whatu Ora patients during their alternative employment.

The official response from Te Whatu Ora management is along the lines 'the extra hours required are reflected in the job size and thus in the remuneration for a fulltime equivalent (FTE) position'.

If surgeons and other clinicians were expected to accept this meant they cannot engage in private work during on call hours, provided suitable cover arrangements are made, a significant number might choose to resign from Te Whatu Ora and move completely to the private sector. Many may also choose to "work to rule" and no longer provide the significant probono work for Te Whatu Ora. This would likely lead to a reduction in work and productivity and in some instances an inability to run a service:

For example the Plastic surgery service where senior medical officers (SMOs) are on call for a whole week (168 hours continuously). During these weeks, they continue their private lists scheduled on non-Te Whatu Ora days in accordance with their regular weekly roster and are available for major cases and emergencies or ensure alternative cover during this time. During the non-Te Whatu Ora days, they are available for advice and support of their senior registrars performing straightforward acute case such as tendon repairs. If this current document was upheld, none of these acute cases would be undertaken and the acute wait would increase substantially.

Each region has interpreted the collective agreement and how it functions day to day quite differently. Some of this is historic and means even within the same department clinicians may have different stipulations within their contract:

- each region interprets how non-clinical and on-call work is managed
- within the same region, different specialties run their on-call and non-clinical work differently.

Hours need to be flexible as everyone has a different work schedule.

The guidance needs to also respect and value the considerable probono work provided by surgeons who are paid to be on-call with only a small availability allowance which doesn't adequately compensate their time; are required to attend to assist colleagues with no extra renumeration; and face the ongoing necessity to respond to calls and address Te Whatu Ora matters in their private work hours, holidays or free time.

A surgeon is not paid sessionally in most centres to provide on-call provision; instead they receive a minimal availability allowance for this time. Consequently, many surgeons find it unreasonable this time cannot be used for engaging in private work, provided appropriate

cover is organised by the surgeon to ensure Te Whatu Ora public patients receive appropriate emergency cover.

The majority of surgeons agree it is not appropriate for surgeons to conduct private practice when they are rostered and paid by Te Whatu Ora to conduct non-clinical duties and agree with this provision in the guidelines. It was noted by some surgeons there is insufficient support for performing non-clinical tasks in the hospitals, particularly with the removal of offices and computers, and the need to "hot-desk", making it challenging to complete non-clinical work within the hospital environment. Some surgeons may choose to either reduce their FTE or move completely to private work if this aspect is enforced.

Many surgeons dedicate their evenings and weekends at home to performing clinical administrative tasks, such as checking of results and letters, which, although often categorised as non-clinical time, is not truly non-clinical.

The provisions in this section are crucial and must be clear and well understood, once the terminology has been changed as above, including removal of the term 'secondary employment).

Referrals between public and private practice (clauses 20-29)
Communication with patients about private treatment (clauses 30 to 32)

These sections as drafted are an overreach, with Te Whatu Ora focusing on restraining its employees in the interests of the organisation without due recognition of health professionals' obligation to advocate for the interests of patients. It difficult not to interpret these sections without concluding they undermine a patient's right to make informed decisions about their health care.

We suggest you seek advice from the Health and Disability Commissioner (HDC) about the significance of not discussing the option of private treatment with patients. HDC has previously found against a practitioner who did not discuss the option of private treatment with a patient, and against oncologists for not informing patients about treatments only available privately.

Clinicians must be able to initiate discussion of clinically appropriate options, including ACC-funded private treatment where relevant, while disclosing any material financial interest and presenting reasonable alternatives. The onus cannot be on patients to raise options they may not know exist. Clause 32 contradicts the principles of transparency and informed consent.

We do not believe there is a substantial issue with public patients being siphoned to the private sector (other than through outsourcing agreements) and much of the detail surrounding this is unnecessary and excessive. This provision may cause unnecessary delays for the patient if they are required to be referred to another doctor who doesn't work in private practice to discuss the potential options before referring them – mostly likely to the initial doctor. In some regions there may only be one surgeon working in private practice or none who do not work in private, making it impossible to enable a referral to private.

Non-poaching and non-solicitation (clause 33)

Clause 33 is problematic.

- "Health NZ health professionals should not directly or indirectly solicit or encourage other professionals in Health New Zealand to leave their employment with Health New Zealand and join any other country or private business with which they are associated. Health NZ clinicians should not induce or entice Health NZ colleagues to engage in private work, where the private work would be at the expense of work for Health NZ."

Giving colleagues information about career opportunities is a professional courtesy, and the meaning of the second sentence is ambiguous.

Further, we suggest you seek advice from the Commerce Commission, as this clause may contravene anti-competitive behaviour provisions of the Commerce Act 1986. From the Commerce Commission website "Some businesses have substantial market power. This in itself is not illegal. However, under the Commerce Act it is illegal for a business with a substantial degree of market power to engage in conduct that has the purpose, effect or likely effect of substantially lessening competition in a market." Given the matter has been raised by one of our members, it would be useful to clarify whether this requirement applies to a Crown entity.

There is a contradiction between clauses 34 and 35 in relation to junior staff at Te Whatu Ora:

- "34. Health professionals should not ask Health NZ colleagues, particularly more junior staff, to support them to deliver private work during Health NZ time."
- "35. In some circumstances it may be appropriate for another staff member to accompany a health professional in private work to give them exposure to care contexts or procedures not readily available in public settings.".

As above, the Guidelines must explicitly reflect the increasing involvement of surgeons and other medical professionals in outsourced surgical waiting lists and training in private facilities. The clauses above should be reviewed alongside the current and newly developed training agreements between Te Whatu Ora and private hospitals. Lack of alignment would be unacceptable as Te Whatu Ora moves to implement significant and important agreements for training in private facilities.

Use of Health NZ facilities and resources (clauses 36-39)

It is not unusual for patients to forget or omit aspects of their medical history that are important in safely providing their medical treatment. Access to as much information as possible will make decision making better and patient care safer and should therefore be as straightforward as possible while still respecting privacy and consent.

All private patients should be able to sign a consent form (or not) agreeing to access to the records in the public health system. Ideally there should be a seamless interface of information between the public and private systems regarding patient health information.

Conclusion

Across the surgical and wider medical profession, we all have an interest in the matters covered in the Guidelines being clear, widely available, well understood, and applied consistently.

As outlined above there are significant problems with the way the Guidelines are currently drafted, particularly in terms of references to 'secondary employment' and not explicitly reflecting the increasing involvement of surgeons and other medical professionals in outsourced surgical waiting lists and training in private facilities. The lack of valuing of surgeons significant probono contributions to Te Whatu Ora may have unintended consequences that are damaging to the public health care system.

We believe the Guidelines as drafted would disadvantage patients, trainees, and Fellows in numerous ways as set out above, and would lead to an increase in the number of surgeons choosing their primary employment in the private sector with consequences for public health services.

We were pleased to have the opportunity for brief discussion of these matters with you and your colleagues when you attended our Annual Scientific meeting last week. We have offered and would like to explain and discuss our comments in more detail. We will make every effort to do so in a way which supports your commitment to finalise the Guidelines quickly.

Finally, we are grateful for your address to and engagement with the RACS Aotearoa Annual Scientific Meeting last week.

We heard clearly your commitment to working with RACS and the other medical colleges, and your request for us to bring the issues to you and use our collective influence between CMC, the colleges, unions, Te Whatu Ora, Manatū Hauora and the third sector in the interests of patients and an effective healthcare system.

I was particularly struck when you said, “We all want the same stuff from different perspectives’ and “We need safe places to talk, not in the media”. We agree with you on this matter.

Nāku noa, nā

Ros Pochin

Chair

Aotearoa New Zealand National Committee

RACS represents more than 8300 surgeons and 1300 surgical Trainees and Specialist International Medical Graduates across Aotearoa New Zealand and Australia. We are the accredited training provider in nine surgical specialities. Surgeons are also required by RACS and Te Kaunihera Rata o Aotearoa - Medical Council of Aotearoa, to continue with surgical education and review of their practice throughout their surgical careers.