THE SPECIALIST

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SPEAKING OUT - A RIGHT AND A RESPONSIBILITY | P3

THE DERMATOLOGY WORKFORCE SHORTAGE – MORE THAN SKIN DEEP | P20

IMAGE: FAIRFAX NZ

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INSIDE THIS ISSUE

ISSUE 104 | SEPTEMBER 2015

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COVER OF *THE SPECIALIST:* NELSON MARLBOROUGH DHB PRINCIPAL DENTIST ROB BEAGLEHOLE SPEAKING OUT ABOUT THE HEALTH IMPACT OF SUGARY DRINKS.

THE IMPORTANCE OF SPEAKING OUT ON HEALTH ISSUES

CUSHLA MANAGH | ASMS DIRECTOR OF COMMUNICATIONS

When Professor Martin McKee addressed ASMS branch officers in Wellington last year, there was a particular slide in his presentation that made everyone sit up and take notice.

*'F*****g stupid cretinous s**t-headed dog-w*****g c**t-brained murderous d***less evidence-denying public health bastards.'*

And that, said Professor McKee, is what you get sometimes when you speak out publicly about controversial health issues.

The slide in question was a screenshot of a Twitter post from one of Professor McKee's critics who, rather than debate the issues with him, resorted to online abuse. And while that tweet was especially charmless, receiving personal abuse is not unusual. Other tweets have told Professor McKee from the London School of Hygiene & Tropical Medicine that his 'days are numbered' or have fervently wished that he was dead.

So why speak out publicly, then? Is it worth the hassle?

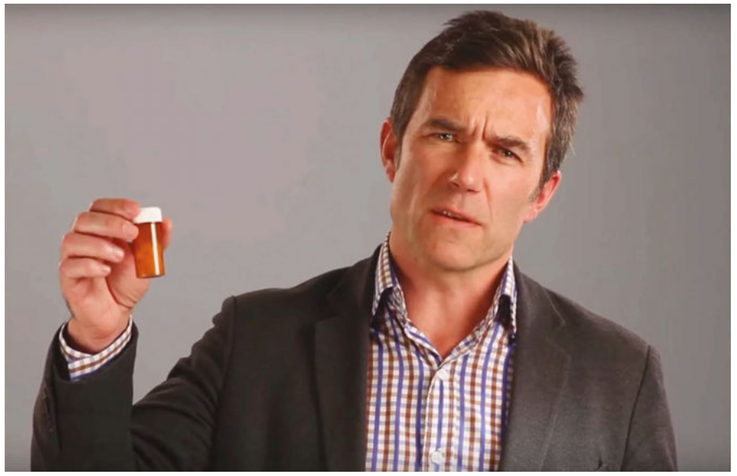
Yes, say a group of New Zealand senior doctors and dentists who have also spoken out about issues they consider important to the health of people in this country.

Auckland pathologist Joshua Freeman: "It's not easy but we have a responsibility to speak out. There are times when you feel that you're not the best person to speak up but in fact you're the only person available and willing so you just have to do it. You have to take the risk."

Canterbury forensic psychiatrist Erik Monasterio: "Doctors occupy a privileged position but it comes with responsibility. If you work in public health, you are trying to help those who are most vulnerable. If you know that changes are going to happen that will affect people who are already on the margins, then why wouldn't you fight on their behalf?"

Auckland medical oncologist George Laking: "Most of the people I deal with have cancer that can't be cured. I guess that's made me bold about speaking out about things like tobacco control that could make a difference. No matter what personal flak I might receive, I'm not in the same situation as my patients. They're the ones whose lives are really on the line."

Nelson Marlborough DHB's principal dentist Rob Beaglehole: "We have to stand



DR JOSHUA FREEMAN

DR GEORGE LAKING

DR ERIK MONASTERIO

up for the health and wellbeing of our patients. There's no point in just drilling and filling or cutting and slicing. We have to be proactive. Instead of being the ambulance at the bottom of the cliff, we have to become the fence at the top – and one way to do that is to speak out publicly."

Erik Monasterio, Joshua Freeman and George Laking have been at the forefront of a campaign to stop New Zealand's government signing the Trans Pacific Partnership Agreement (TPPA) without greater transparency and debate about the contents of the international deal and its potential impact on health in New Zealand. Rob Beaglehole has led the public discussion about the consequences of sugary drinks on children's oral health, obesity and type 2 diabetes, and has also spoken out publicly about the benefits of fluoridation.

They, and others, have run the gamut of criticism for expressing their views publicly: dismissed as irrelevant by the politicians they're trying to influence, slammed as one-eyed and inaccurate, and – perhaps worst of all – accused of harming the very people they want to protect.

When Rob Beaglehole organised a screening of the documentary 'That Sugar Film' at a cinema in Nelson this year, anti-fluoridation protesters gathered outside. 'Nelson is under attack,' shouted an anti-fluoridation website. In another run-in over sugary drinks, WhaleOil blogger Cameron Slater wrote that he had given the Nelson dentist "a sound kicking".

"When my DHB decided to promote fluoridation of the water supply, I came under attack online," says Rob Beaglehole. "I'm not too bothered. There are always people out there who talk about the nanny state, but the people I meet on the streets or at meetings to discuss these issues are all positive. They know these are serious matters.

> *"I see pain and suffering on a day-to-day basis, young children having their rotten teeth pulled out, and I know that something can be done to change that. As doctors and dentists we need to talk about what we're seeing, and back it up with evidence and science."*

Oncologist George Laking works in Auckland and Northland, is an advisor to Pharmac, and a spokesperson for the group Doctors for Healthy Trade. He has also spoken out publicly about the impact of climate change, and written articles for various newspapers.

"I've had some snarky responses to these and also had some things said that simply weren't true. It was actually a bit painful. I went off Twitter for a while as a result, then I decided that if someone was going to just be rude instead of engaging in the debate, I'd block them, so that's what I have done. You can get a lot of nastiness out in the public debate and the debate can become very personal. It's just the slings and arrows."

He says he is cautious before deciding to take a stand on a particular issue, thinking through the potential repercussions and making sure he understands the evidence. At the same time, he notes that he has never experienced any professionally limiting consequences of his public comments from his medical colleagues, his employers, or his College.

"I often reflect on our good fortune to live in an open society," says George Laking. "In other places and times, you can expect recriminations if you put up your hand. I have to speak out about things I believe in because the prospect of things remaining the same, or worsening within my lifetime, is not all that heartening."

Joshua Freeman, a pathologist at Auckland DHB and an outspoken critic of the Government's handling of the TPPA trade deal, also believes doctors have a duty to speak out.

> *"It does place a lot of pressure on you. You've got to think carefully about how to phrase things, how you might respond to certain questions. You have to be very accurate but also very succinct and able to simplify very complex issues. You're also mindful of your professional reputation.*

"I've learnt though that you get better at managing these things over time. There's always a tension between speaking out and being cautious, but it's possible to be too cautious. Doing nothing is also a decision. As doctors we are relatively privileged people within society, and a responsibility comes with that in my view."

Psychiatrist Erik Monasterio agrees. He spoke eloquently about the risks of the TPPA at the ASMS Annual Conference last year and has subsequently given presentations to ASMS members at various DHBs, as well as writing articles and doing media interviews. Before involving himself in the TPPA campaign, he spent many hours researching the subject to make sure he had the facts and figures he needed at his fingertips.

"I was already too busy with my clinical work so I felt some misgivings about embarking on something that I knew would require a lot of energy," he says.

> *"But I also knew that doctors have a responsibility to be a guardian and to be the voice of reason on issues to do with access to and the delivery of health care. I felt very strongly that failing to tackle this issue would be failing the people I wanted to serve."*

His background as a child growing up in Bolivia also motivates him to speak out. His mother was a New Zealander and Erik Monasterio moved here in his teens but he vividly remembers the difficulties of accessing health care in Bolivia.

"I know how difficult it is to reverse inequality and exclusion once it has set in so I want to protect what we have here in New Zealand," he says. "We have to bring logic and evidence to the debate and inform not only our colleagues, but also the public and the decision-makers."

THE RIGHT AND DUTY OF ASMS MEMBERS IN DHBS TO 'SPEAK OUT'

The right of doctors to 'speak out' and engage in public debate about the health service, including the delivery and operation of health services by their DHB, is unequivocal but not unconditional. At its most basic level, that right is derived from the ethical duties of medical practitioners.

HENRY STUBBS | ASMS SENIOR INDUSTRIAL OFFICER

Principle 11 of the NZMA Code of Ethics for the Medical Profession requires all medical practitioners to *'accept a responsibility to advocate for adequate resourcing of medical services and assist in maximising equitable access to them across the community'*.

Among a doctor's professional responsibilities under the Code (Responsibility 41) is the doctor's *'obligation to draw the attention of relevant bodies to inadequate or unsafe services'*. It goes on to say that *'they should first raise issues ... through appropriate channels, including the organisation responsible for the service, and consult with colleagues before speaking publicly'*.

Clause 14 of the Health Sector Code of Good Faith (set out in Schedule 1B of the Employment Relations Act 2000) confers a right on all health sector employees to comment publicly and engage in public debate on matters within their expertise and experience as employees but this is subject to some limitations, including prior notice and discussion with their employer and the employee making it clear that they are speaking in their personal capacity or on behalf of and with the authority of their union.

But the strongest and most comprehensive expression of an ASMS member's right to speak out and engage in public debate, including controversy that may include criticism of their employer's operations, is contained within the ASMS-negotiated MECA covering members employed by the DHBs.

This right is very clearly set out in MECA Clause 40, *Public Debate and Dialogue*. All district health boards are parties to the MECA and all expressly agreed to this clause when it was negotiated years ago. In many ways the MECA is much stronger and more empowering than both the NZMA Code of Ethics and the Health Sector Code of Good Faith.

Under MECA Clause 40.1 the employer expressly *'respects and recognises the right of its employees to comment publicly and engage in public debate on matters relevant to their professional expertise and experience'*. That very powerful right is however conditional on the requirement in Clause 40.2 that *'employees shall, prior to entering into such public debate and dialogue, where this is relevant to the employer, have advised and/or discussed the issues to be raised with the employer'*. It will be noted that this requirement, in slightly different form, is also found in the NZMA Code of Ethics and the Code of Good Faith provisions referred to above.

The right and duty of ASMS members to contribute to and on occasions even lead public discussion about the nature and quality of our health services, which may include public criticism of their employers operations, is a very important one but must be exercised with care, professionalism and appropriate restraint, when it includes direct criticism of their employer's business.

The MECA contains two other important provisions that complement ASMS members' rights to 'speak out', criticise and lead the public debate. Clause 39 deals with Professional and Patient Responsibility and Accountability, and Clause 41 deals with Patient Safety. Clause 39(a) is the very powerful recognition of *'the primacy of the personal responsibility of employees to their patients and the employee's role as a patient advocate'*. Clause 41.2 requires the ASMS and DHB to develop a process for resolving serious concerns that the employee(s) and the employer have been unable to otherwise resolve satisfactorily. By agreeing to these three clauses (39, 40 and 41) the DHBs have expressly recognised and accepted that ASMS members have rights and responsibilities to the wider community that extend well beyond their immediate obligations as employees.

A general rule of employment law is that employees should not undermine or harm the interests or reputation of their employers. However, in the case of ASMS members employed by DHBs that general rule is substantially relaxed and they enjoy considerable freedom to act fearlessly as patient advocates and watchdogs of our public health system, even when this may involve quite sharp criticism of their employers operations.

DR TIM FRENDIN

DR CAROLYN FOWLER

HAVING THE HARD CONVERSATIONS ABOUT LIVING AND DYING WELL

She's 85 and has a serious heart condition. Her ticker could give out at any time. Surgery is a possibility but her doctors think it's risky. There's a chance her health and quality of life would improve, but the odds are not great. After discussion, the patient and her family agree that surgery is not the answer and the patient returns home to enjoy what remains of her life. Then one night her heart stops working properly and she's taken to hospital. A decision is made under urgency to operate, and she goes to theatre.

Yes, the operation that everyone agreed would not be in her best interest takes place.

While this particular situation is fictional, it's a scenario that is all too familiar to ASMS National Executive members Carolyn Fowler, an anaesthetist at Counties Manukau DHB, and Tim Frendin, a specialist in geriatric medicine at Hawke's Bay DHB – and they find it maddening.

"So we won't do the operation electively in that situation because it's too risky for the patient, but then we carry it out when it's an acute situation and the odds of a good outcome are much less. Where's the sense in that?" asks Carolyn Fowler.

> *"We know anecdotally, and studies are emerging to back this up, that doing certain procedures on someone over the age of 80, the chances of them getting out of hospital or maintaining their quality of life is low, yet we still do it. There's a challenge here for us as medical specialists to change the way we practise medicine."*

Tim Frendin agrees.

"There are times we resort to actions, despite little likelihood of improving outcome, rather than having difficult clinical conversations. Chemotherapy towards the end of life is perhaps an example of this if futility is foreseeable. We do need to develop better ways of understanding limitations of some of our interventions to inform these challenging discussions."

"There needs to be a shift in the way we think about providing health care so that we do what is appropriate for each person and also use the resources we have available in a much more targeted way. When I started practising medicine back in the 1980s, probably about 10% of people who died were aged over 85. That's predicted to rise to about 60% by the year 2050, and we need to think about how we respond to that. It's not about rationing; it's about rationalising."

They both say it's about having the hard conversations within the medical workforce as well as within our wider community, and it's an opportunity for the ASMS to provide leadership in facilitating those conversations.

"Part of our role as doctors and as members of ASMS is to protect our patients from bad decision-making," says Carolyn Fowler. "That means we need to have discussions in the community about what is appropriate and what people want in terms of health care in their lifetime. Instead of throwing everything at a patient when they come to the hospital door, we need to be more mindful about what can be achieved."

Tim Frendin says the hard conversations need to include a discussion of what it means to 'die well', in addition to 'living well'.

> *"It's about the quality of life and living well until we die. Sometimes it's easier for us to treat people rather than talking about the prognosis."*

PHOTOGRAPHER: STEVE LOWE

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

BEHAVIOUR DOES NOT OCCUR IN A VACUUM

As I boarded the 7am flight I noticed two cabin crew members welcoming passengers. The more senior one pointed me to seat 4A on the right-hand side by the window. I made myself comfortable and, watching other passengers board, it was clear that they also noticed the unusual presence of two cabin crew members. This was a first for the Bombardier Q300 Gisborne-Auckland flight.

The more senior crew member made a brief public announcement welcoming us. She then asked for our attention and handed over the PA system to the second crew member before sitting in seat 1C. From where I sat I had a good view of both crew members. The announcements and safety briefing were delivered with a pleasant but clearly nervous smile, which was maintained throughout the address. The passengers were unusually quiet, giving her their full attention. I noticed that the seated crew member supported her by mouthing some of the words to her. There were two brief hesitations during the announcement but it was quickly sorted by a few whispered words from her colleague. When she finished, the whole plane erupted in a spontaneous round of applause! We were thanked for our support, seeing that this was the first ever public announcement that she has made. I thought to myself: that's a good example of a supportive apprenticeship model of training.

I recalled the above experience after the recent publication of the Resident Doctors Association (RDA) survey on bullying, harassment and inappropriate behaviour. Clearly some people have a different training/work experience compared with that of the well-supported cabin crew member. How must they feel after being subjected to such behaviours? They similarly rely largely on an apprenticeship model for their training. Don't they deserve the same level of support?

My thoughts wandered back to my own training and an incident from my final year as a medical student. Another student was asked to demonstrate a forceps delivery on a medical mannequin. After he finished the procedure, the professor slowly walked over, took the forceps from his hands and said: "now all you have to do is to take the forceps and hit the father over the head with it, then you would have wiped out the whole family". We did not think twice about such comments or ones much worse. That was just the way it was. However, that was the apprenticeship model used 30 years ago. The world has changed a lot since then and our understanding of what constitutes acceptable behaviour has also changed significantly. Has the health apprenticeship model kept up with the times? Has the health care system as a whole kept up? But as I continued to ponder this, I realised there is a much bigger picture - behaviour does not occur in a vacuum.

ASMS Deputy Executive Director Angela Belich and I recently met with the Council of Medical Colleges in New Zealand at their request to discuss a draft document, *A framework for Continuous Practice Improvement,* that was being finalised. There was one section I found of particular interest: "What is professional competence?" The following paragraph also caught my eye: "Specialists need to demonstrate both clinical competence (technical skills and knowledge) and behavioural competence (interpersonal and affective skills, such as the ability to communicate effectively, use judgement and empathy and manage relationships)." This is nothing new, but the document spelled it out succinctly.

Clearly bullying, harassment and inappropriate behaviour can be seen as a failure or lapse in behaviour competence. Is it that simple and straightforward? In my mind there are a few things missing here. As mentioned before, these behaviours do not occur in a vacuum.

What role does performance management or the lack thereof play?

Before I elaborate, just a reminder to please have another read of the ASMS Standpoint *Bullying in the workplace,* available from our website at http://www.asms.org.nz/wp-content/uploads/2014/08/ASMS-Standpoint-Bullying.pdf.

PERFORMANCE MANAGEMENT

We tend to consciously and subconsciously, and on a continuous basis (rightly or wrongly), judge other health care workers' performance (as we are being judged by others). However, there is a formal process of performance management. You can either undergo a regularly scheduled formal performance management process (eg, on an annual basis) or have responsibility to performance manage others, and we quite often find ourselves involved in both activities at different times. Obviously a complaint could lead to the process being activated as well.

> *An individual's performance depends on many factors, and performance is the end product of multiple influences.*

- Ability or competence: Does the individual have the necessary training and ability to successfully start and complete the tasks they are expected to do?
- Personal influences: Personality, personal health issues, family circumstances, fatigue, stress, to name but a few, can all play a role. Is there a problem with motivation, perhaps?
- Work environment and demands: Equipment, staffing levels, competing time demands, funding and resources but also importantly culture, collegiality, trust, respect etc.

As individuals are we accepting of being performance managed? Do we trust that there are fair, robust and non-threatening and supportive performance management systems in place? Similarly, do we have the confidence, should we report a lapse in behaviour or performance, that the same system will 'take care of' the concern raised in a timely manner.

If we take matters in our own hands, it is easy to imagine how a poorly executed attempt at performance management can be seen as inappropriate behaviour and repeated episodes or attempts at performance management can very quickly escalate to, or be perceived as bullying. During such an 'informal assessment' of someone's performance, do we consider what the influence of ability, training, personal problems and the demands of the work environment might have on the person before we (and I include managers) play judge, jury and executioner and deliver our verdict in front of others, or even worse, patients.

In my opinion it will be very difficult or near impossible to address any of these behaviours until the health care system lifts its performance management game at all levels and, by doing so, achieves wide acceptance. It would make a huge difference if the system can be trusted to assess a complaint fairly and, if found valid, to address aberrant behaviour in a timely manner.

On a more positive note...Is the health service all doom and gloom? What would the answers be to questions like:

- Did you receive any good/excellent teaching in the past year?
- Were there instances where you felt supported in the past month?
- Have you had a positive experience in the work place during the past week?
- Have you felt appreciated in the past month?

I recently did my Advanced Paediatric Life Support refresher and I am happy to report that I received excellent teaching in a supportive environment with lots of positive encouragement and feedback. Participants' level of experience ranged from PGY1 up to subspecialist level, yet this was no barrier to the formation of a trusting and collegial teaching environment where our performance was evaluated in a group situation, while performing multiple case scenarios over a period of three days.

> *I see daily good behaviours but these seldom make the front page or are the subject of surveys.*

FINAL THOUGHTS ON BULLYING

In the words of American science fiction writer Octavia E. Butler: "Not everyone has been a bully or the victim of bullies, but everyone has seen bullying, and seeing it, has responded to it by joining in or objecting, by laughing or keeping silent, by feeling disgusted or feeling interested".

There are no innocent bystanders when it comes to bullying, harassment and inappropriate behaviour. Each and every one of us needs to take a stance and make sure the health care system does move with the times. When you witness any of these behaviours it is your duty not to ignore it. If circumstances allow, speak up there and then, otherwise wait for the opportune moment to express your concern. You should feel safe to do so knowing there is a robust performance management process to back you up. That is the only way we will change the culture from within.

Once again, please take the time to read the ASMS Standpoint on *Bullying in the workplace:* http://www.asms.org.nz/wp-content/uploads/2014/08/ASMS-Standpoint-Bullying.pdf.

DISTRIBUTIVE CLINICAL LEADERSHIP IN DHBS

IAN POWELL | ASMS EXECUTIVE DIRECTOR

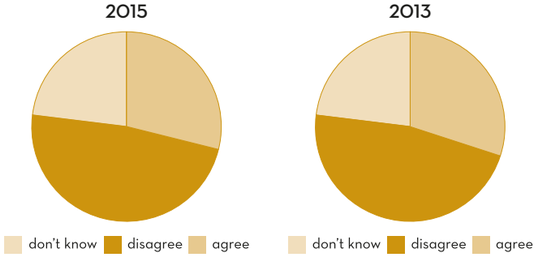
IN 2013 ASMS ELECTRONICALLY SURVEYED OUR DHB EMPLOYED MEMBERS OVER THE EXTENT TO WHICH THERE WAS DISTRIBUTED LEADERSHIP IN THEIR DHB.

It revealed a bleak picture confirming that the expectations of the Government's policy on clinical leadership, *In Good Hands*, had not materialised. This year we repeated the survey. In total 1,182 members responded (32% of those surveyed). There were four questions:

1. Do you believe your DHB is genuinely committed to distributive clinical leadership?
2. Do you believe that the culture of your DHB encourages distributive clinical leadership?
3. To what extent do you believe that your chief executive is working to enable effective distributive clinical leadership in your DHB's decision making processes?
4. To what extent do you believe that senior management (reporting directly to the chief executive) is working to enable effective distributive clinical leadership in your DHB's decision making processes?

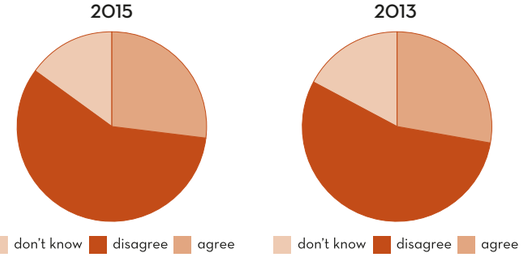
When aggregated on a national level the results were:

- In 2015, 29% of respondents believed their DHB was genuinely committed to distributive clinical leadership (down from a poor 30% in 2013) while as many as 48% disagreed (up by 1% from 2013). In only two DHBs did the affirmatives exceed 50% (Canterbury and Northland).



- In 2015, 56% of respondents had a partially or largely favourable rating of their chief executives' work to enable effective distributive clinical leadership (down from 58% in 2013) while 21% had a negative rating (up from 18% in 2013). Five chief executives had a negative rating of over 30% (up to 48%) compared with three in 2013 (up to 38%).
- In 2015, 58% of respondents had a partially or largely favourable rating of their senior managers (reporting directly to the chief executive). This is up from 53% in 2013. Negative ratings were unchanged at 25%. Six senior managements had a negative rating of 30% or higher (up to 69%) compared with seven in 2013 (up to 50%).

- In 2015, 27% of respondents believed that the culture of their DHB encourages distributive clinical leadership (down from an also poor 28% in 2013) while as many as 58% disagreed (up by 3% from 2013). In only two DHBs did the affirmatives exceed 50% (Hawke's Bay and Canterbury).



In summary, there has been a slight deterioration on the poor result of 2013. There are interesting insights when drilling down to specific DHBs although caution is required over statistical validity, particularly given the low numbers in small DHBs where there is a lower response rate.

In the following analysis, the assessments are further modified by our own direct understanding through delegates, industrial officer experiences and other membership feedback. Note Whanganui in particular. In this assessment we use the same four star grade rating (0 to 3) as we used in the earlier survey. In each group they are in order of north to south rather than ranked.

DO YOU BELIEVE YOUR DHB IS GENUINELY COMMITTED TO DISTRIBUTIVE CLINICAL LEADERSHIP?*

2015				
Ranking	DHB	Yes	No	Don't know
1	Canterbury	53%	28%	18%
2	Northland	53%	32%	15%
3	Hawke's Bay	50%	36%	14%
4	West Coast	42%	17%	42%
5	Whanganui	42%	50%	8%
6	MidCentral	35%	41%	24%
7	Nelson Marlborough	34%	48%	18%
8	Auckland	33%	46%	20%
9	Lakes	30%	49%	22%
10	Waitemata	30%	41%	30%
11	Bay of Plenty	29%	51%	20%
12	Counties Manukau	24%	40%	36%
13	Wairarapa	22%	56%	22%
14	Taranaki	18%	55%	26%
15	Capital & Coast	18%	45%	37%
16	Waikato	16%	66%	18%
17	Tairawhiti	13%	67%	20%
18	South Canterbury	13%	75%	13%
19	Southern	11%	71%	19%
20	Hutt Valley	6%	71%	23%

2013				
Ranking	DHB	Yes	No	Don't know
1	Canterbury	62%	23%	15%
2	Lakes	56%	28%	16%
3	West Coast	44%	22%	33%
4	MidCentral	40%	48%	12%
5	South Canterbury	40%	50%	10%
6	Tairawhiti	37%	37%	26%
7	Counties Manukau	34%	31%	35%
8	Waitemata	32%	55%	13%
9	Whanganui	31%	54%	15%
10	Hawke's Bay	29%	42%	29%
11	Capital & Coast	25%	48%	27%
12	Northland	25%	53%	22%
13	Taranaki	24%	48%	29%
14	Waikato	23%	51%	26%
15	Nelson Marlborough	20%	45%	34%
16	Auckland	18%	53%	29%
17	Bay of Plenty	16%	67%	16%
18	Southern	15%	68%	17%
19	Hutt Valley	10%	55%	35%
20	Wairarapa	0%	86%	14%

Percentages may not total 100% due to rounding.

DO YOU BELIEVE THAT THE CULTURE OF YOUR DHB ENCOURAGES DISTRIBUTIVE CLINICAL LEADERSHIP?

2015				
Ranking	DHB	Yes	No	Don't know
1	Hawke's Bay	57%	39%	4%
2	Canterbury	53%	32%	16%
3	Whanganui	50%	50%	0%
4	Northland	41%	50%	9%
5	MidCentral	35%	52%	13%
6	West Coast	33%	50%	17%
7	Nelson Marlborough	32%	59%	9%
8	Counties Manukau	31%	49%	20%
9	Waitemata	30%	53%	18%
10	Lakes	27%	59%	14%
11	Bay of Plenty	26%	66%	9%
12	Auckland	25%	58%	17%
13	Wairarapa	22%	56%	22%
14	Capital & Coast	21%	54%	26%
15	Taranaki	18%	63%	18%
16	Tairawhiti	13%	80%	7%
17	South Canterbury	13%	75%	13%
18	Waikato	10%	70%	19%
19	Hutt Valley	6%	81%	13%
20	Southern	6%	84%	9%

2013				
Ranking	DHB	Yes	No	Don't know
1	Lakes	63%	28%	9%
2	Canterbury	57%	30%	13%
3	MidCentral	40%	50%	10%
4	Counties Manukau	40%	34%	27%
5	Whanganui	38%	54%	8%
6	West Coast	33%	33%	33%
7	Waitemata	33%	56%	11%
8	Northland	31%	50%	19%
9	Taranaki	29%	52%	19%
10	Tairawhiti	26%	47%	26%
11	Hawke's Bay	26%	52%	23%
12	Capital & Coast	23%	55%	22%
13	Waikato	22%	63%	16%
14	Nelson Marlborough	20%	64%	16%
15	South Canterbury	20%	50%	30%
16	Wairarapa	14%	71%	14%
17	Bay of Plenty	14%	74%	12%
18	Hutt Valley	13%	63%	25%
19	Auckland	12%	67%	21%
20	Southern	11%	77%	12%

Percentages may not total 100% due to rounding.

HOW THEY PERFORMED: PRETTY GOOD ★★★

There were three DHBs in this grade arising out of the 2013 survey (Lakes, West Coast and Canterbury). This year there are four. Lakes drops off and Northland and Hawke's Bay are added.

NORTHLAND

Significant improvement including by chief executive.

This DHB has significantly improved in its commitment to and encouraging culture for distributive clinical leadership. This includes the rating of the chief executive (rated one of the best) and senior management. There is a particularly effective mix of Chief Executive, Chief Medical Officer and General Manager HR. In 2013 it was in the middle of the pack.

But this has to be qualified not only by the lower response rate but also:

1. Nearly one-third believed the DHB was not committed, with a further 15% not sure.
2. A concerning 50% didn't believe the culture was encouraging (only 41% thought it was).

Northland should take note of the declines of Lakes and Tairawhiti DHBs in the around 18 months between the two surveys.

HAWKE'S BAY

Further improvement but be careful.

Hawke's Bay has, like Northland, significantly improved since 2013 (particularly culture), although by a smaller degree (from a higher level in 2013) and probably influenced by a reduction in 'don't knows', especially over 'commitment'. There is a small decline in the chief executive's high rating. The rating of senior management remains high. The merging of the former separate funding and planning functions into the mainstream has been a positive move which may have also contributed to the positive rating because it removes a thorn in many senior doctors' side.

But the following qualifications should be noted (like Northland, the response rate was lower):

1. Over one-third believed that the DHB was not committed (only 50% thought it was).
2. The 'noes' on an encouraging culture were 39%.
3. The retirement of the highly regarded chief operating officer earlier this year leaves a challenge for his successor to maintain the high standard, although she inherits a strong foundation.

WEST COAST

Improved rating of senior management.

There is little change in the rating of this DHB's commitment and culture, although there is a reduction in the number of 'don't knows' for the latter (they are as high as 42% for the former). Worthy of note is the big improvement in the rating of senior management. West Coast shares the same chief executive as Canterbury. Caution is necessary with a DHB of such small senior doctor numbers but this is balanced by a high response rate.

CANTERBURY

Still impressive but worrying signs.

Canterbury remains in the top two DHBs but there is deterioration in commitment (slight for culture). The chief executive's rating is still high while there is little change for senior management. The response rate is lower than the national average, although this is one of the largest DHBs. But there are cautions:

1. Management has been slow to respond to stressful increased workload pressures, most noticeably in mental health (especially adult) and in the emergency department. Eventually they did. However, they can't afford for this to become the norm.
2. Canterbury has strong unifying factors – the earthquake devastation and external government pressures – which may have the effect of fudging over internal tensions.
3. The deterioration of the rating of DHB commitment should not be allowed to continue. In this high ranking DHB as many as 28% believed there was no commitment (23% in 2013) while those with a more favourable assessment fell from 62% to 53%.

COULD DO BETTER BUT SHOWING PROMISE ★★

There are six DHBs in this category compared with 10 in 2013 – Waitemata, Auckland (upgraded), Counties Manukau, Lakes (down), MidCentral and Nelson Marlborough. In the top two star grades there are 10 DHBs compared with 13 in 2013.

WAITEMATA

Little improvement except for chief executive rating.

Waitemata continues in this category. In the assessing of its commitment there has been a reduction in the negative rating but this appears to have largely transferred to 'don't knows' rather than to the positive rating where there is little change. There is also little change in culture. The chief executive's rating has improved to become one of the top rated but the rating of senior management is less favourable. Negative historical legacies may have affected the failure to improve much.

In addition to a lower response rate, there are also cautions:

1. As many as 41% said the DHB was not committed (only 30% said it was).
2. For encouraging culture, the negatives were as high as 53% (only 30% considered the culture to be encouraging).

AUCKLAND

Two categories upwards jump.

Auckland has moved up two categories, although it is not clear why. There has been an increase in the rating of both DHB commitment and culture along with a smaller reduction in the negative rating (also a small reduction in 'don't knows'). The chief executive's positive rating has noticeably increased, although her negative rating remains unchanged. The result for senior management is similar.

ASMS has major concerns with the ability of human resources to resolve employment-related matters (either unable or not allowed) and its lack of responsiveness to addressing concerns over a new leave recording system causes frustration. These threaten the progress made.

Auckland had taken a hard line position over the granting of sabbaticals in a very visible way. ASMS intervention led to management returning to the mainstream of DHBs. It is not

clear whether this initial hardline position or the 'putting right that counts' had greater impact in these ratings.

COUNTIES MANUKAU

Chief executive rating up and senior management down.

Like Waitemata, Counties Manukau remains in this category and its response rate was also lower. There has been a deterioration in the rating of the DHB's commitment (including one-third 'don't knows') and culture. On the other hand, the rating of the chief executive has improved (but declined for senior management). Nevertheless, Counties Manukau has a proud tradition of innovation which provides strong foundations for improvement.

LAKES

Fall from grace due to resting on laurels and siege mentality.

From being rated in the top three in the 2013 survey, Lakes has fallen from grace to the middle of the pack. In our assessment of the 2013 result we noted that Lakes "...risks deterioration if it rests on its laurels." Sadly, it did; please note Northland, Hawke's Bay, West Coast and Canterbury.

The negative rating of DHB commitment has increased from 28% to 49% (28% to 59% for culture) while the positive rating has fallen from 56% to 30% (63% to 27% for culture).

The overriding reason appears to be the siege mentality adopted in response to external pressures due to reduced relative funding. As management focuses on those things immediately in front of it, there has been a noticeable reduction in clinical engagement.

Lakes could have downgraded by two rather than one star category if it was not for strong historical foundations, an able chief medical officer keen to turn things around, and positive relationships with middle management at a more operational level. The Chief Executive appears to be responding positively, if cautiously, to overtures from ASMS representatives to work together to address the situation.

MIDCENTRAL

Mixed result with increasing 'don't knows'.

MidCentral continues in this category and has a higher response rate than most other DHBs. In the rating of both DHB commitment and culture, there is a mixed result. There is a reduction of both positive and negative ratings and an increase of 'don't knows'. As many as 26% believed senior management was not working at all to improve engagement. The DHB has a new chief executive who has got off to an encouraging start.

NELSON MARLBOROUGH

Mixed result but signs of improvement.

Although remaining in this category, there are signs of improvement in Nelson Marlborough. The positive rating of DHB commitment has increased but so has the negative rating ('don't knows' have reduced). There is a similar result for culture. Positive signs are the increased familiarity with the chief executive, who was new at the time of the 2013 survey, and an improved rating for senior management.

NEED TO REALLY LIFT THEIR GAME ★

There are four DHBs in this grade compared with three in 2013 – Bay of Plenty, Taranaki, Whanganui and South Canterbury (downgraded).

BAY OF PLENTY

This DHB remains in this category but there are positive signs that are promising for the future. Bay of Plenty also had the highest response rate. The negative rating of the DHB has fallen from 67% to 51% while the positive rating has increased from 16% to 29%. There are also similar improvements in culture.

While the chief executive's rating remains largely unchanged, there has been a noticeable improvement in the rating of senior management which was particularly poor in 2013. The appointment of a new chief operating officer has been important. But worthy of note has been the appointment of a new chief medical officer who has become proactive in resolving a number of employment issues, including a new sound CME policy and MECA application matters. Both have engaged well with the ASMS Industrial Officer and this is bringing benefits for all parties. The road ahead is looking better.

TARANAKI

Goodwill and deterioration.

It is not clear why because there is an atmosphere of goodwill in much of this DHB but rating of its commitment and culture have both deteriorated. There has been an improvement in the chief executive's rating, albeit from a low base in 2013, but a decline in the rating of senior management (but from a higher base in 2013).

It was a marginal call not to drop Taranaki to the lowest category. Keeping it here recognises some positive dynamics, including a benign leadership culture (even if it isn't grasping distributive clinical leadership) and by comparison with many other DHBs a well performing human resources unit.

WHANGANUI

Alienation and disengagement.

If Whanganui was rated on the basis of this survey alone then it should be in a higher category because it reports noticeable improvement. But this would lose credibility because of (a) the clash with the reality of local experience and knowledge and (b) while the response rate was consistent with the national average, as few as 12 members completed the survey. If it wasn't for the survey Whanganui would be in the lowest category.

Further, 50% said their DHB was not committed whereas 42% said it was. In fact, in the rating of culture it was completely polarised, with six saying yes and six saying no.

ASMS is acutely aware of high levels of alienation and disengagement. There are also concerns over bullying conduct. An unnecessarily protracted dispute over management's restrictive approach to the application of the CME entitlement (now resolved) has not helped. The Medical Staff Association has serious concerns over managerial overriding of clinical assessments in incident and relating reporting.

SOUTH CANTERBURY

Deterioration but chief executive stands out.

South Canterbury has clearly deteriorated and, if not for one factor it, would have dropped two categories rather than one. While only 16 members responded, the rate was 46%.

There have been significant declines in the ratings of both DHB commitment and culture. The 2013 survey reported a seriously low rating of the performance of senior management. This has further deteriorated, making it one of the poorest rated in the country.

The redeeming factor is the rating of the chief executive. In 2013 he was rated among the top chief executives and this continues in 2015. This is a remarkable performance given the circumstances. His 'no extent' rating has increased by 13% but from a base of 0% in 2013. His favourable rating has improved slightly to 81%. There is opportunity for improvement with the chief executive keen to engage with ASMS over moving forward. The problem is identifiable.

TO WHAT EXTENT DO YOU BELIEVE THAT YOUR CHIEF EXECUTIVE IS WORKING TO ENABLE EFFECTIVE 'DISTRIBUTIVE CLINICAL LEADERSHIP' IN YOUR DHB'S DECISION MAKING PROCESSES?

2015				
Rank	DHB	Some/great extent	No extent	Don't know
1	West Coast	83%	0%	17%
2	Whanganui	83%	17%	0%
3	South Canterbury	81%	13%	6%
4	Canterbury	80%	4%	16%
5	Northland	76%	9%	15%
6	Hawke's Bay	75%	14%	11%
7	Tairawhiti	73%	13%	13%
8	Waitemata	68%	7%	25%
9	Auckland	62%	22%	15%
10	Nelson Marlborough	61%	20%	18%
11	Lakes	59%	24%	16%
12	Counties Manukau	58%	12%	30%
13	Bay of Plenty	50%	26%	24%
14	MidCentral	48%	15%	37%
15	Southern	44%	36%	20%
16	Taranaki	42%	26%	32%
17	Capital & Coast	37%	31%	32%
18	Waikato	30%	32%	38%
19	Hutt Valley	23%	48%	29%
20	Wairarapa	22%	44%	33%

2013				
Rank	DHB	Some/great extent	No extent	Don't know
1	West Coast	89%	11%	17%
2	Canterbury	83%	3%	16%
3	South Canterbury	80%	0%	6%
4	Hawke's Bay	77%	3%	11%
5	Lakes	75%	9%	16%
6	Whanganui	69%	23%	0%
7	Tairawhiti	68%	11%	13%
8	Waitemata	66%	11%	25%
9	MidCentral	64%	24%	37%
10	Nelson Marlborough	61%	32%	18%
11	Wairarapa	57%	29%	33%
12	Southern	56%	27%	20%
13	Waikato	53%	14%	38%
14	Northland	53%	17%	15%
15	Bay of Plenty	49%	28%	24%
16	Auckland	49%	21%	15%
17	Counties Manukau	48%	14%	30%
18	Hutt Valley	45%	33%	29%
19	Capital & Coast	41%	22%	32%
20	Taranaki	24%	38%	32%

OMG: IN SERIOUS DIFFICULTIES (O STAR)

There are six DHBs in this lowest grade compared with four in the 2013 survey (three – Wairarapa, Hutt Valley and Southern – were there in 2013 while they have been joined by downgraded Waikato, Tairawhiti and Capital & Coast).

WAIKATO

New chief executive affected by reputation.

There has been a noticeable decline in the rating of DHB commitment (negatives up by 15% to 66% and positives down 7% to 16%) and culture (negatives up by 7% to 70% and positives down 12% to 10%).

Much of this is attributable to the new chief executive's rating who has not earned a honeymoon. The 'no extent' category has increased by 18% to 32% while the 'some/great extent' category has fallen a heavy 53% to 30%. Senior management's rating has also declined but by not as much. As a generalisation, senior management was more responsible for the negative rating in 2013 but this year the result was due more to the chief executive. It appears that reputation (previous experiences in Auckland, Southland and Vancouver's Fraser Health) rather than specific experiences in Waikato have contributed to this fall. There has been no particular incident that has triggered any major angst. A recent controversy over the use of threats of suspension and dismissal of non-flu vaccinated staff who decline to wear masks occurred after the survey was conducted. Unless he can establish a positive reputation over the next 12 months or so, this low rating risks becoming embedded.

TAIRAWHITI

Unhelpful hardline attitudes within senior management.

There are strong similarities between Tairawhiti and Lakes DHBs although the former has fallen further. There are also similarities with the South Canterbury chief executive rating.

There has been a large drop in the ratings of DHB commitment (negatives increasing by 30% to 67% and positives collapsing by 24% to 13%) and culture (negatives increasing by 33% to 80% and positives halving to 13%).

Tairawhiti was one of the better performing DHBs in 2013 but this has dramatically changed (for context 15 members responded – 30%). This is despite the chief executive's rating (largely unchanged) but there is a decline in the rating of senior management. ASMS is aware of some unhelpful hardline attitudes within senior management, including marginalisation of the chief medical officer. If this can be addressed then there is the potential to turn this situation around. The Chief Executive needs to take the bull by the horns.

TO WHAT EXTENT DO YOU BELIEVE THAT SENIOR MANAGEMENT (REPORTING DIRECTLY TO THE CHIEF EXECUTIVE) IS WORKING TO ENABLE EFFECTIVE 'DISTRIBUTIVE CLINICAL LEADERSHIP' IN YOUR DHB'S DECISION-MAKING PROCESSES?

2015				
Rank	DHB	Some/great extent	No extent	Don't know
1	West Coast	92%	0%	8%
2	Whanganui	83%	8%	8%
3	Northland	79%	15%	6%
4	Hawke's Bay	79%	14%	7%
5	Nelson Marlborough	70%	18%	11%
6	Lakes	70%	16%	14%
7	Canterbury	69%	11%	20%
8	Auckland	65%	21%	14%
9	Bay of Plenty	64%	20%	16%
10	Counties Manukau	58%	19%	23%
11	Capital & Coast	56%	22%	22%
12	Wairarapa	56%	22%	22%
13	Waitemata	55%	30%	15%
14	MidCentral	54%	26%	20%
15	Tairawhiti	53%	33%	13%
16	Taranaki	53%	21%	26%
17	Waikato	36%	43%	21%
18	Southern	33%	52%	16%
19	Hutt Valley	32%	39%	29%
20	South Canterbury	31%	69%	0%

2013				
Rank	DHB	Some/great extent	No extent	Don't know
1	Hawke's Bay	74%	6%	19%
2	Canterbury	73%	13%	13%
3	Lakes	72%	9%	19%
4	MidCentral	62%	29%	10%
5	Taranaki	62%	19%	19%
6	Whanganui	62%	31%	8%
7	Nelson Marlborough	61%	27%	11%
8	Wairarapa	57%	43%	0%
9	West Coast	56%	22%	22%
10	Counties Manukau	52%	14%	34%
11	Northland	50%	22%	28%
12	South Canterbury	50%	50%	0%
13	Capital & Coast	49%	25%	25%
14	Waitemata	48%	26%	26%
15	Tairawhiti	47%	21%	32%
16	Southern	46%	39%	14%
17	Auckland	45%	25%	29%
18	Waikato	43%	32%	25%
19	Hutt Valley	40%	40%	20%
20	Bay of Plenty	37%	40%	23%

WAIRARAPA

Departure of chief executive offers opportunities.

Wairarapa was also in the bottom category in 2013. There has been some improvement. The positive rating of commitment increasing seems impressive; less so when it was 0% in 2013 and the fact that the total number of respondents was nine (still consistent with the national average). The negative rating of commitment has decreased (from a high 86% to an unimpressive 56%). There is a similar trend for culture.

The damming indictment is the plummeting rating of the chief executive from an already low level in 2013. The 'no extent' category increased from 29% to 44% while the 'some/great extent' category fell from 57% to 22%.

On the other hand, there has been an improvement in the rating of senior management assisted by the appointment of a locally based manager (who contributed to an improved relationship with senior medical staff) rather than having the complete team being Hutt Valley based. There is also recognition that senior managers based in Hutt Valley also did their best in difficult circumstances.

There are opportunities to improve through the departure of the chief executive and the decoupling of the top-down relationship with Hutt Valley. Much will depend on the new yet-to-commence and unknown chief executive.

HUTT VALLEY

From worse to worse than worse.

Hutt Valley goes from worse to worse than worse. Along with Southern, arguably these two DHBs should be in a lower 5th category – in deep ####. It shared the same chief executive as Wairarapa.

DHB commitment falls from an already poor level. The negatives have increased by 16% to 71% (19th out of 20 DHBs) and the positives fallen by 4% to an embarrassing 6% (20th). For culture, negatives increased by 18% to 81% (19th) while positives fell by 7% to 6% (19th).

The poor 2013 rating of the chief executive further deteriorated – 'no extents' increased by 15% to 48% and 'some/great extents' collapsed by 22% to 23%. There was a small decline in the rating of senior management.

The overhyped top-down and poorly thought out sub-regional collaboration with Capital & Coast and Wairarapa (previously known as '3D', now a toxic brand in many quarters) has also been destructive. With better leadership this could have been a positive.

A new chief executive has just been appointed who was a key player in the fiasco over the destructive restructuring of the Wellington and Hutt Hospital laboratories arising out of a fatal top down decision-making process. On the other hand, he comes with reputational damage due to his involvement in the laboratories fiasco (including marginalisation of pathologists) and low esteem held by SMOs of the funding and planning division that he led, along with the absence of a track record to justify confidence. Time will tell.

Further, many members believe that having a shared Board Chair with Capital & Coast has made things worse and that this needs to change if a turnaround is to occur.

CAPITAL & COAST

Deterioration with pessimistic immediate outlook.

The positive rating of Capital & Coast's commitment has fallen by 7% to a low 18% while there is a slight decline in the previous low rating of culture. The chief executive's low rating in 2013 (somewhat harsh as she was relatively new to the role) has worsened as she has become more known. Senior management's rating if anything has improved although there are different experiences. These observations have to be qualified by the lower response rate although it is a larger DHB.

Further observations below suggest that there are good grounds for pessimism about the prospects of a turnaround with key leaderships indifferent to this need:

1. The appalling level of decision-making and approach to clinical engagement in the controversial laboratory restructuring, which included treating the laboratory staff as used furniture, has badly hurt the leadership's credibility.
2. Effective clinical engagement in mental health restructuring has been sub-optimal, including a focus on changing structures before developing a clinically-led model of care. This is significant given the relatively high number of psychiatrists in the senior medical workforce.
3. The chief executive appears to have striven to develop a Teflon leadership style but this is not working.
4. By not addressing these matters, the Board Chair is in effect affirming them.
5. Senior management is a mixed picture. On the one hand, the funding and planning side lacks practical experience, has provided poor advice on laboratory restructuring and lacks credibility with many senior medical staff. On the other hand, on the provision side, senior managers are generally respected and there appears to be a level of recognition that they are not responsible for leadership deficiencies above them.

SOUTHERN

Senior management culture dragging DHB down.

While not as marked as Hutt Valley, Southern has continued to deteriorate in both DHB commitment (19th) and culture (20th) – the positive rating for the former has fallen to 11% and for the latter to 6% (Southern had a higher response rate). The chief executive's failure to address this has dragged her rating down.

But the biggest problem is at the senior management level. The 'no extents' increased from 2013 to 2015 by 13% to 52% while the 'some/great extents' fell by 13% to 33%. This and the failure to address it is at the core of Southern's difficulties.

Some further observations:

1. There is inconsistency and a lack of coherency in the DHB's direction which includes too much short-term decision-making and a risk shifting mentality. This becomes destabilising for the workforce.
2. The new clinical leadership structure is struggling to breathe and suffering from high turnover. It needs oxygen.
3. The Commissioner (replacing the sacked Board) will be critical to addressing the obstructions and moving forward.

TOP RATED CHIEF EXECUTIVES

Nick Chamberlain (Northland)

Dale Bramley (Waitemata)

David Meates (Canterbury and West Coast)

Nigel Trainor (South Canterbury)

LOWEST RATED CHIEF EXECUTIVES

Nigel Murray (Waikato)

Carole Heatly (Southern)

Debbie Chin (Capital & Coast)

Graeme Dyer (Hutt Valley and Wairarapa; resigned)

TOP RATED SENIOR MANAGEMENTS

Northland

West Coast

Hawke's Bay

LOWEST RATED SENIOR MANAGEMENTS

Tairawhiti

South Canterbury

Hutt Valley

Southern

[Waikato also low rated but undergoing restructuring at time of survey]

A SERIES OF UNFORTUNATE EVENTS

LYNDON KEENE | DIRECTOR OF POLICY AND RESEARCH

THE SHORTCOMINGS OF THE PROCESS TO IMPROVE INTEGRATION OF LABORATORY SERVICES IN THE WELLINGTON REGION, WHICH HAS LED A DECISION BY THREE DHBS TO PRIVATISE ALL OF THE REGION'S HOSPITAL LABORATORY SERVICES, HAS BEEN EXTENSIVELY REPORTED ON BY ASMS OVER THE PAST YEAR.

But it took the release of papers under the Official Information Act (OIA), following a complaint to the Ombudsman, to better understand the mess that Capital & Coast, Hutt Valley and Wairarapa district health boards got themselves into.

In the spirit of encouraging learning from mistakes, and bearing in mind this concerns a deal worth more than $800 million of taxpayers money over 10 years, the following is a summary of unfortunate events revealed in the DHBs' disclosed papers (which were released publicly when they were released to the ASMS). These difficulties flow from the DHBs' decision not to engage senior doctors at the beginning of the process, certainly before any decision was made to outsource services, which had the effect of excluding their involvement because of actual or perceived conflicts of interest, given some work part-time in the private sector. This repeated the mistakes of the three Auckland DHBs over their Healthscope decision in the late 2000s. Many of the important decisions, then, were made behind closed doors. The DHBs also evidently underestimated the time needed to complete the process and allow a new provider to get established.

WHAT THE PAPERS SAY

The DHBs had been negotiating with the current community laboratories provider, Aotea Pathology, and Healthscope's Southern Community Laboratories (SCL, later to become WSCL) to provide all hospital and community laboratory services across the three DHBs. However, the papers show the relationship between the DHBs and Aotea had become strained. This was a problem because the DHBs needed Aotea's help to get them out of a tight spot.

The DHB boards had postponed their decision on the preferred provider at their combined board meeting on 30 January 2015 and time was ticking on. A new provider needed to be up and running by the time Aotea's contract expired at the end of October 2015. (Medlab, which provided community and hospital laboratory services for the Wairarapa DHB, was also finishing up at the same time.)

The DHBs asked Aotea to extend its services beyond October to enable a later start for the new provider. Aotea not only declined but announced its withdrawal from the procurement process in February, saying publicly the DHBs' plans were 'clinically unsound and financially unsustainable'. Blacked-out text in one paper (visible in the Association's copy) shows the Aotea director had given an undertaking to the CCDHB chief executive that no further comments would be made to the media. It is unclear whether that was under threat of legal action.

DHB board minutes of 6 March 2015 note there will be 'no community laboratory service at 31 October 2015'. The minutes also note 'there is insufficient time to re-tender for community laboratory services alone', besides which such a move would 'expose the DHBs to legal challenge from a range of perspectives'. Under the circumstances the boards approved SCL as the 'preferred' provider (which by then of course had become a misnomer) but they had still yet to negotiate a contract and, not surprisingly, 'This anticipates that the negotiation may result in consequential changes to the overall cost of delivery of the contract…'.

A DHB paper dated April 2015 (no precise date is given) shows negotiations were continuing. They had virtually just six months to reach a deal with SCL to take over all hospital and community and laboratory services in the region, which would require a major reorganisation of services, including ordering new equipment and establishing a new facility in the Wellington complex. And it gets worse. The paper warns:

> *'Should a decision not be made by the combined Boards at the 24 April 2015 Board meeting to enter into an Agreement with SCL by 1 May 2015, then SCL will withdraw their proposal and the DHBs will need to put contingency arrangements in place. Any delays will impact on the ability to have service coverage from 1 November 2015 and could expose the DHB to legal risk based on good faith negotiations.'*

The contingency plans involved either closing off the tender 'and contracting for community laboratory services separately', or having the 'DHBs undertake community work with a private partner'. However, the problem with the first was the question of who to contract with. The paper notes: 'There is potential for SCL to withdraw completely even from providing community laboratory services and the DHBs being 'stuck' with one potential provider for community services'. But the paper raises doubt as to whether the potential provider, Aotea Pathology, 'and more importantly its parent company still had an interest in providing the service. Events up till then suggest that would have been unlikely.

The problem with the second option was that among other things it would require the establishment of a legal entity to support this arrangement, 'which previous advice suggested was complex … with little benefit to the DHBs'. Furthermore: 'This option has not been tested with a community provider and it is not clear what appetite there would be for such an option. Given the complexity of such an arrangement, it is also unlikely that this could be agreed and put in place by 1 November 2015.'

The 'contingencies', then, contained a great deal of uncertainty. The DHBs were over a proverbial barrel and, whether they were ready or not, had got themselves into a position where they had no option but to sign a deal with SCL/WSCL on 24 April 2015. (The Association learnt that the deal was worth over $800 million over 10 years only because the figure was visible through the blacked-out text.)

The difficulties do not necessarily end there. Some form of contingency may still be needed if the facilities for the community laboratories are not in place by 1 November 2015. This is identified in the papers as a 'medium' risk with a 'high' impact.

> *There is also a 'high' risk that: 'If the level of disruption during construction [of the new facility] exceeds acceptable levels, the risk is that areas located in the CSB Building cannot fully function and service delivery is impacted.'*

Further: 'If the hospital and community referrers are not fully engaged, the risk is that there will be reduced confidence in the ability of the DHBs to successfully transfer the Integrated Laboratory Services to the preferred provider'. This is seen by the DHBs as a 'low' risk, though, as the ASMS has previously reported, the feedback from hospital referrers (ie, specialists) on this issue shows clearly they have felt disengaged up till now. Achieving 'full engagement' after the event may not be as simple as the DHBs appear to believe, but one thing that can be agreed on is that failure to achieve full staff engagement with the new set-up has 'high impact' consequences for services. Evidence from New Zealand and overseas shows the moves to integrating services or organisations usually fail if they are not supported by the employees.

Also revealing is the information the DHBs were not able to supply. The Association's information request included a request for documents providing evidence that supported the DHBs' claim that their proposal would achieve 8% savings and 'better value for money'. After receiving documents providing only aspirational statements, but with information withheld 'at this time, as the procurement process is not yet completed', the Association sought the information again, via the Ombudsman's office, following the deal sign-off in March.

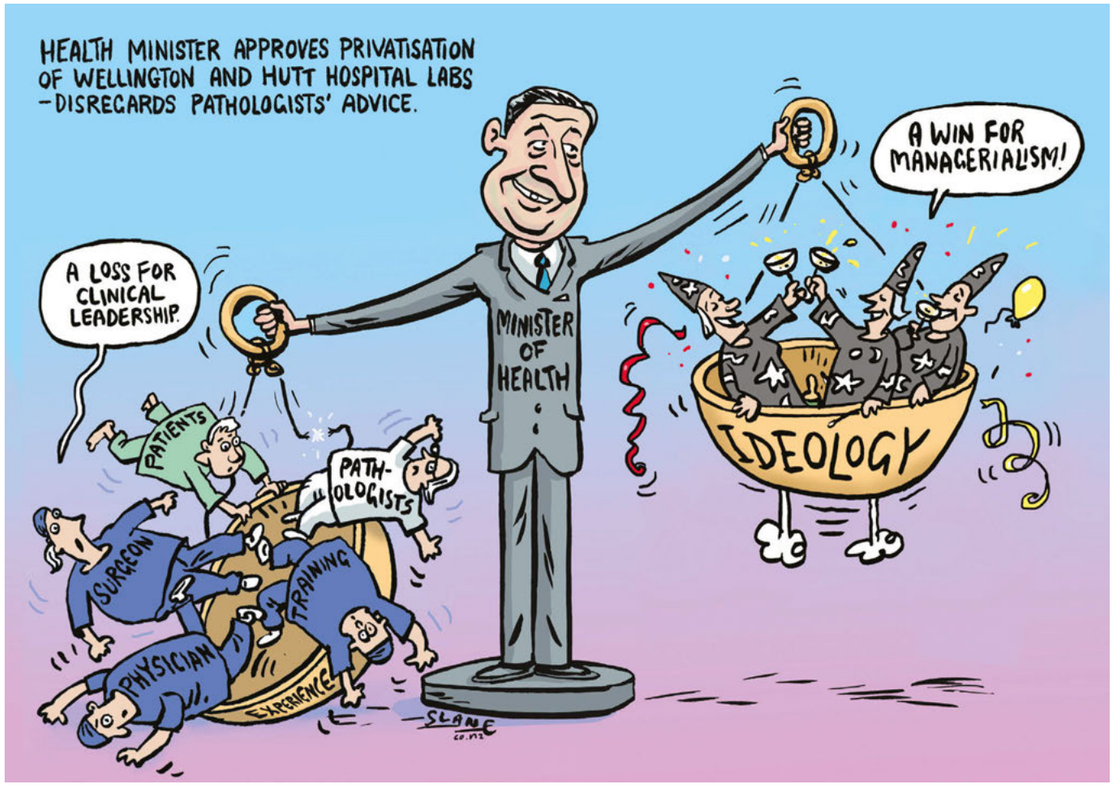
At the end of June the DHBs publicly released papers the Association had been seeking under the Official Information Act, including a brief summary of 'price indexing' and expected savings, with some information redacted, but scant information to indicate how the savings were arrived at, or how the deal would achieve 'better value for money'.

> *At the end of July, the Association received advice from the Ombudsman's office that the DHBs 'confirm that they have no further information concerning the "better value for money" and "8% savings", that hasn't now been released to you'.*

The upshot of all this is that the DHBs negotiated themselves into a cul-de-sac; it is costing taxpayers potentially $800 million-plus; it carries significant risks; and they have not been able to provide any substantial analysis to back their claims of future 'savings' and 'value for money'.

If there are questions about the clinical and financial viability of the planned new arrangement, as Aotea Pathology has indicated, still further questions arise about the future stability of the region's laboratory services with the announcement in June that Healthscope had just sold its pathology operations in Australia. Its decision was essentially about concerns over profitability and where best to financially invest.

It is a salient reminder that Healthscope's commitment to laboratory services in New Zealand is subject to making a healthy profit.



PIKETTY ON CONFLICTING LEADERSHIP CULTURES

IAN POWELL | ASMS EXECUTIVE DIRECTOR

MANAGERIALISM VERSUS CLINICAL ENGAGEMENT

While reading (as an indication of one of my fetishes) the *New Zealand Spectator & Cook's Strait Guardian* (22 September 1849) I was struck by a letter to the editor by 'A Working Man' on the theorist and leader of early colonisation in New Zealand, EG Wakefield. Responding to an earlier letter by Wakefield, the writer vividly attacked the founder of the New Zealand Company as being like "ingenious projectors of perpetual motion" by believing in his own infallibility when in reality his vision was impractical.

Wakefield was described as believing that large capitalists would "flock" to New Zealand, invest and provide "combined sources of employment" for all the "working class" to "receive full employment at liberal wages". This would enable workers to save enough to then become landowners. But instead of wealthy capitalists, the colony got mainly "poor adventurers from the middle classes of Britain". Few workers were able to purchase land. He concluded by describing Wakefield as one of the "greatest humbugs in existence".

This got me thinking about the leadership within our public health system and many of the policies that drive it. We certainly see the impracticality of particular policies (underpinned by a form of utopianism).

If you were a DHB specialist in the lower North Island you would note that what was described as something like "wealthy capitalists" coming to the rescue looks increasing like "poor adventurers" taking control of the Wellington and Hutt hospitals' laboratories.

But what particularly resonated was the expression "ingenious projectors of perpetual motion by believing in his (their) own infallibility". This summarises so much of our decision-making in health. As a result of failure to diagnose (due to a failure to engage right at the beginning with specialists) a perceived problem or challenge, an idea emerges of dubious quality. Its infallible "projectors" then promote it vigorously and repetitively through "perpetual motion" (and marginalise those with far greater expertise and experience in the subject matter) until such time as it becomes perceived reality.

IN BAD HANDS

Previously I've quoted the observation attributed to Winston Churchill that the Americans could always be relied upon to make the right decision once they had exhausted every other option. I previously argued that perhaps our health bosses, having exhausted the options of business competition and managerialism (management defines and decides; health professionals implement), would now recognise that the remaining option was clinical leadership (particularly when distributed throughout the senior medical/dental workforce). This was in the context of the *Time for Quality Agreement* between ASMS and the DHBs (2008) and the current Government's advice to DHBs on clinical leadership, *In Good Hands* (2009).

At the time I adopted the cup half full approach. Now I realise that someone has tipped the water out of the cup. Six years later it is evident that clinical leadership is in bad hands. The assessment of our DHB-employed members when recently surveyed electronically is damning (especially when compared with our earlier survey in late 2013). In summary, while 2013 was bad, 2015 was marginally worse. For example:

- In 2015, 29% of respondents believed their DHB was genuinely committed to distributive clinical leadership (down from a poor 30% in 2013) while as many as 48% disagreed (up by 1% from 2013). In only two DHBs did the affirmatives exceed 50%.
- In 2015, 27% of respondents believed that the culture of their DHB encourages distributive clinical leadership (down from an also poor 28% in 2013) while as many as 58% disagreed (up by 3% from 2013). Again, in only two DHBs did the affirmatives exceed 50%.

Rather than Churchill perhaps I should have looked to Albert Einstein for insight into the leadership of our public health service given that he described *insanity as doing the same thing over again and expecting different results*. Or: *the difference between stupidity and genius is that genius has its limits.*

My application of Einstein to what appears to be an enduring feature of our health leadership is that if at first you don't completely stuff it up, don't give up; give it another go!

CASE STUDY OF MANAGERIALISM

At the ASMS Annual Conference last November, in response to a question about the plan of the Capital & Coast and Hutt Valley DHBs to privatise their hospital laboratories, Health Minister Jonathan Coleman said he would be guided by the advice of the doctors (who in this case were primarily pathologists). But despite the DHB-employed pathologists writing to him recommending that he not approve this plan and despite a similar letter from the Society of Pathologists (New Zealand Committee of the Australian and New Zealand College), he approved it. His argument boils down to the assertion that whatever is in the contract between the private company and the DHBs will resolve concerns. In other words: returning to the narrow contractualism of the 1990s business competition era.

But:

- Unless corrective action is undertaken, he will have approved the 'gifting' to the controversial Healthscope of the most critical part of the laboratory workforce (hospital pathologists) needed to monitor and review the performance of the contract. The DHBs' lose their most important intellectual capital for this critical task. Instead they are treated like used furniture.
- After the Minister approved the privatisation, the parent company announced that it has sold its laboratory businesses in Australia, thereby cutting off a critical support base and leaving its New Zealand operations to sink or swim.
- When the other private company (Aotea) bidding for the contract pulled out because it believed that what was being required of them was both clinically and financially unsafe, the remaining bidder (Healthscope) privately threatened the same. All of a sudden it had the two DHBs over a barrel and, guess what, as successful hardnosed business operators, the company rolled the barrel over the hapless DHBs. This was only discovered by the ASMS' use of the Official Information Act.
- There is now alarm among the hospital pathologists that not all the specifications that they required and were agreed may have ended up in the final contract.

This is sweating material for the Minister. It is the price of not practising what one preaches, and giving more stock to hierarchical managerialism than clinical expertise and experience.

The hierarchy of the two DHBs persuaded the Minister to his view through the use of 'A Working Man's' notion of 'perpetual motion' to achieve their objective, including marginalising the pathologists and end user specialists as well as making it impossible for Board members to receive any advice that was contrary to their own infallible position.

The Minister should have followed another Einstein pearl of wisdom: *The only source of knowledge is experience.*

THE ALTERNATIVE

In November 2010, the DHBs and ASMS jointly concluded in a document known as *Securing a Sustainable Senior Medical and Dental Officer in New Zealand: the Business Case* (http://www.asms.org.nz/wp-content/uploads/2014/07/The-Business-Case-Nov-2010.pdf) that (a) there was considerable financial waste in DHBs and (b) millions of dollars could be saved by investing in the capacity (numbers) of DHB specialists to enable them to engage in process improvement initiatives (as well as the benefits of a stabilised workforce). This endeavour fell over because of unprofessional conduct by a small number of individuals in the national leadership of DHBs, linked to the settlement of our national collective agreement (MECA) at that time.

Patient-centred care is a universal objective for good reason. But it can't be provided without distributive clinical leadership, which is not just about the treatment of the patient but also improving the systems and processes that public hospitals - as the most complex and highly integrated part of our health service - require if the patient journey is to be closer to optimal than sub-optimal.

If we continue down our current ingeniously projected infallible path, with all its associated humbug, then patient-centred care becomes a slogan and a sound bite (along with models of care) without practical meaning. But if we go down the path of investing in the DHB specialist workforce capacity (time, numbers and roles) in order to achieve the full benefits (not just partial) of distributive clinical leadership, then we can put meaning into the language of the patient being at the centre of the care process because we would have the wherewithal to do so.

The Canterbury Initiative between community and hospital care has achieved so much for patients and taxpayers without sufficient investment in capacity. Imagine how much more could be achieved (including nationally) with this investment.

ADAPTING PIKETTY

With considerable license it is apt to adapt the neo-classical economist Thomas Piketty's theorem in this best seller book *Capital in the 21st Century*. In his data rich tome this outstanding empiricist developed the *r* and *g* relationship; the former is 'rate of return' and the latter 'economic growth'.

His conclusion was that when *r* is greater than *g*, inequality increases which is what he describes as the current economic status quo. Inequality reduces when the opposite applies.

Let's apply this to DHBs and distributive clinical leadership. Instead of *r* let's have *m* for managerialism and instead of *g* let's have e for genuine clinical engagement (at the level of distributive clinical leadership). Let's also throw into the mix *q* and *f* for quality and financial sustainability.

Consequently when *m* is greater than e, humbug managerialism increases. Further, *q* and *f* decreases. This is the norm in DHBs currently.

On the other hand, when e is greater than *m*, clinical engagement/leadership increases. Further, *q* and *f* increases. This is where DHBs should be but our serious leadership deficit at senior bureaucratic and political levels is the biggest obstruction.

ABOVE: DR DARION ROWAN
BELOW: DR AMANDA OAKLEY

CUSHLA MANAGH | ASMS DIRECTOR OF COMMUNICATIONS

THE PUBLIC DERMATOLOGY CRISIS THAT'S MORE THAN SKIN DEEP

THE NEED FOR DERMATOLOGY DIAGNOSIS AND TREATMENT IN THE PUBLIC HEALTH SYSTEM IS SET TO DOUBLE IN COMING YEARS BUT THE SERVICE WILL NOT BE ABLE TO COPE IF IT CONTINUES IN ITS CURRENT STATE, WARN DERMATOLOGISTS AMANDA OAKLEY AND DARION ROWAN.

They say the public system is desperately short of dermatologists and unless something significant is done to address this, more and more New Zealanders will find themselves unable to access the specialised medical care they need.

The two doctors are already seeing the evidence of widespread unmet need in their waiting rooms and clinics.

"We turn away about a third of people," says Darion Rowan, who has worked as a dermatologist at Auckland's Middlemore Hospital for more than 30 years.

> *"Some of them don't need to be seen by us, but we are also turning away people who should be seen. People are languishing out in the community with terrible skin conditions. It's very unsatisfactory, and you feel for the patients."*

That's echoed by Waikato District Health Board dermatologist Amanda Oakley.

"Just look in my waiting room. The people who are there often have terrible diseases. We don't see anything minor in the public hospitals."

The pair say there is a real shortage of training positions for emerging dermatology specialists, a serious shortage of funded public positions for trained specialists, and a lack of dermatologists to apply for the positions that are available. At the same time, the dermatology workload has been growing in recent years as a result of New Zealand's aging population, and the greater prevalence of skin cancers and obesity-related illnesses.

They believe the current situation is unsustainable, and their concerns are supported by a report on the state of the dermatology workforce published by Health Workforce New Zealand on the Ministry of Health website. The Dermatology Workforce Service Forecast was prepared by a group of dermatologists, led by Darion Rowan, and can be found at http://www.health.govt.nz/our-work/health-workforce/workforce-service-forecasts/dermatology-workforce-service-forecast.

The report identifies a number of problems, including:

- a lack of dermatology specialist positions in public hospitals
- limited access to publicly-funded dermatology services, varying greatly across DHBs and regions
- regional variations in the range of dermatology treatments offered
- a need for stronger dermatology training in New Zealand along with more dermatology education for GPs as services are increasingly provided outside of hospital settings
- difficulties accessing data on dermatology in New Zealand as this is not routinely recorded or centrally collected
- New Zealand lagging behind other countries in the development of standards, guidelines and pathways for dermatology.

Darion Rowan says the report's authors have recommended:

- every DHB to have a dermatologist-led team, requiring an increase to 30 dermatologists working in the public sector (up from the current figure of 16 FTE)
- comprehensive dermatology training provided, with public consultant posts available at the end of training
- dermatology services to be equitably accessible across New Zealand, with all DHBs to run a full dermatology service with improved access to paediatric dermatology
- a Centre for Dermatology Expertise to be established
- Increased public awareness of the role dermatologists play, particularly in the management of skin cancer
- better information gathering and data collection relating to the dermatology workforce and the conditions they are treating.

She says dermatologists are now looking to Health Workforce New Zealand and the country's 20 DHBs to ensure a good plan is in place to provide a sustainable public dermatology service now and in the future.

> *"The service must expand to address the current deficit, long waiting lists and predicted increase in demand, as well as providing equity of access to dermatologic services across the country."*

Dermatologists are trained to investigate, diagnose and treat a wide range of illnesses, including skin cancers, up to 30 common skin conditions such as eczema and psoriasis, and about 3000 rare skin diseases.

To become a dermatologist, medical school graduates work for three years in a public hospital. They then sit a physician training exam with the Royal Australasian College of Physicians before becoming eligible to enter advanced training in dermatology. That involves another four years of concentrated study, research and practice at a variety of approved training centres in New Zealand and overseas.

> *Dermatology has been recognised as a medical specialty in New Zealand for nearly 70 years. Back in 1948, it cost two guineas to join the new Dermatology Society in New Zealand, and eight people signed up. These days the Society has about 60 members, many of them in private practice, and there has been considerable sub-specialisation within the field.*

All DHBs provide some form of dermatology service, but few dermatologists work in public hospitals. Instead, the service is provided mostly by visiting specialists, locums or through private contracts.

GPs are often the first point of contact for a dermatology-related consultation, although Amanda Oakley and Darion Rowan say there is a limit to what they can do.

"For example, dermatologists are the best at diagnosing melanoma," says Amanda Oakley. "Other specialties remove many benign lesions unnecessarily in case they might be melanoma. That's a safe practice, but it is expensive and may be unnecessary, and there may be surgical complications."

Concerned by the high levels of unmet need she was seeing, Amanda Oakley banded together with several other dermatologists earlier this year to start up a telemedicine dermatology practice to contract to DHBs, GP organisations and other New Zealand health care providers that require clinical advice from a dermatologist. For example, they provide a diagnosis where this is uncertain, assist with triaging prior to a referral to a face-to-face service, and offer advice on investigations or the management of conditions.

"Some doctors cannot access a hospital appointment for their patients unless they require inpatient care, but most people don't actually require this," she says.

Darion Rowan says dermatology services in the private sector help to reduce the pressure on the public health system, but the reality is that these can be accessed only by people who are insured or able to pay for the service.

She is strongly of the view that the Ministry of Health should not expect GPs and other doctors, who are already over-worked, to bridge the gaps in dermatology services without the support and expertise of qualified dermatologists.

> *"It is not good practice and could put patients at risk due to incorrect diagnosis and treatment."*

And another problem looms on the horizon: the workforce forecast report says that 32.1% of dermatologists surveyed in 2009 had indicated they were planning to reduce their hours, retire or move overseas, compared with 20.8% who were thinking of increasing their hours.

"We have a number of dermatologists who really want to retire but they can't," says Amanda Oakley.

"There are others among us that can't see any succession planning. I don't plan to retire any time soon but I look at the calendar and my birthdays, and I can see that at some time it will have to happen."

PHOTOS FROM THE ASMS BRANCH OFFICERS WORKSHOP. MORE IMAGES ARE AT WWW.ASMS.NZ

MEETING OF ASMS BRANCH OFFICERS

THE NEWLY-ELECTED GROUP OF ASMS BRANCH OFFICERS MET IN WELLINGTON IN AUGUST TO DISCUSS ISSUES RELEVANT TO MEMBERS.

Most of the ASMS National Executive along with 32 Branch Presidents and Vice-Presidents attended the one-day meeting, with apologies from the few who could not make it.

ASMS National President Hein Stander welcomed branch officers into their roles and also introduced national office staff able to provide them with industrial, policy, communications and administrative expertise.

Presentations and group discussions during the day covered the following topics:

- planning for next year's national DHB MECA negotiations
- distributive clinical leadership
- duty of good faith and the ASMS Constitution
- the role of a branch officer
- 'Know your MECA' workshops
- fatigue: consultants and night work
- speaking out for better patient care
- taking up formal clinical leadership roles
- doctors' writing project.

Executive Director Ian Powell said it was a good opportunity for the branch officers to network with each other and to orient themselves in their role.

"We're fortunate to have a very effective and democratic membership support and decision-making structure within the ASMS," he said. "Our branch officers are essential to the effective operation of the ASMS."

YOUR ASMS BRANCH OFFICERS 2015 TO 2018

ASMS BRANCH OFFICERS WERE PHOTOGRAPHED AT THEIR RECENT WORKSHOP IN WELLINGTON. A FEW WERE UNABLE TO ATTEND, AND WE WILL BRING YOU THEIR PHOTOS IN THE NEXT ISSUE OF *THE SPECIALIST*.

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IAN PAGE

NORTHLAND
VICE-PRESIDENT
LISA DAWSON

WAITEMATA
PRESIDENT
JONATHAN CASEMENT

WAITEMATA
VICE-PRESIDENT
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LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

NEW ZEALAND'S HEALTH FUNDING – WHAT THE FIGURES SAY

A recent report produced by economics consultants Infometrics found real core crown health expenditure has fallen by a cumulative $1.7 billion since 2009/10, taking into account inflation and population growth. Their analysis is consistent with the Council of Trade Unions/ASMS health budget analysis, released in June, which found a cumulative shortfall of more than $1 billion in Vote Health's operational funding alone over the same period.

The analyses of both reports are not difficult to verify through Treasury's Budget data, though neither reports created much of a stir among the media. The Government's standard response is to point out more money is being spent on health every year, more patients are being treated, there are record numbers of doctors and nurses, and so on, all of which might be valid arguments if there were no population growth, no aging, no advances in technology and no inflation.

The apparent general indifference to negative health funding trends may have more to do with public perception that the health system is on the whole performing well. On one level such a perception may be justified. In a recent Commonwealth Fund report compiling 23 health system performance indicators across 11 comparable countries, New Zealand's performance overall falls in the middle.

However, while New Zealand health surveys indicate patient satisfaction with treatment from doctors and nurses is high, the Commonwealth Fund report shows 45% of New Zealanders believe the health system needs 'fundamental change' and a further 8% say the system should be 'completely rebuilt'. One explanation for the variance may be that New Zealanders have no issue with what the health system does, so much as what it does not do.

The Commonwealth Fund report shows New Zealand's performance is relatively poor in indicators about access to care, including waiting for specialist appointments, waiting for elective surgery, cost barriers, and avoidable deaths (mortality amenable to health care).

Another measure where New Zealand ranks lowly is in physician (ie, all doctors) numbers.

> *According to the OECD, in 2013 New Zealand was 30th out of 32 countries on a measure of hospital specialists per population.*

We were above Chile and Turkey. (The figures include trainee specialists.)

VOTE HEALTH OPERATIONAL FUNDING AS A PROPORTION OF GDP

Year	2009/10	2010/11	20011/12	2012/13	2013/14	2014/15	2015/16
TOTAL OPERATING FUNDING ($000)[1]	12,623,156	13,062,826	13,499,297	13,787,169	14,085,617	14,393,495	14,777,271
NOMINAL GDP FOR THE YEAR TO JUNE ($000)[2]	195,401,000	203,757,000	212,334,000	216,590,000	234,184,000	239,771,000	249,890,000
% OF GDP	**6.46%**	**6.41%**	**6.36%**	**6.37%**	**6.01%**	**6.00%**	**5.91%**
ADDITIONAL FUNDING IF % OF GDP REMAINED AT 2009/10 LEVEL ($000)	**-**	**99,876**	**217,479**	**204,545**	**1,042,669**	**1,095,712**	**1,365,623**

Compiled by ASMS 2015. Source: Treasury 2015

NOTES

1. Estimated operating expenditure for total Vote Health on Budget day (includes departmental, non-departmental and 'other' non-departmental). $49 million has been subtracted from the funding allocations for 2012/13 onwards to account for estimated health provider superannuation contributions such as to Kiwisaver, previously paid for by the State Services Commission. Source: Ministry of Health, Vote Health Four-year Budget Plan, 8 February 2011. From 2015/16 provisions for DHB deficits were transferred from operational funding to capital funding. In 2015/16 this was $55 million, which has been included as operating funding in this table for comparability with earlier years.

2. *Budget Economic and Fiscal Update 2015*. Figures for the years 2013/15 and 2015/16 are forecasts.

For primary care specialists, New Zealand ranked 20th. Physician numbers alone do not necessarily determine access to services – there are a range of factors – but it is reasonable to assume it is a key measure.

It is well recognised in the sector that there is hidden unmet need across a range of health care services, such as primary health care, dental health, mental health, sexual health, disability support and primary services for disadvantaged communities, as well as medical and surgical specialties.

Even in the Government's high priority services such as elective surgery, there have been reports from around the country of increasing barriers to accessing treatment. It appears patients have to be in more pain to access elective surgery now than ever before. As the New Zealand Medical Association has put it, the gap between the patients who meet the clinical threshold for surgery, but fall short of our hospitals' financial threshold, is widening.[1]

So while it must be acknowledged that the numbers of operations have been steadily increasing, New Zealand's access to elective surgery, as the Commonwealth Fund report shows, still lags behind many other comparable countries. This is reinforced by OECD figures. In a comparison of the number of 11 common surgical procedures performed per head of population in New Zealand, Australia, the UK and Canada, New Zealand ranks last in all but two, where we come third.

It is fair to assume most New Zealanders would expect our health system to be at least on a par with Australia's, but if you need a hip replacement, heart bypass, hernia repair, cataract surgery... you name it, you are far more likely to get it done if you lived across the Tasman. The Commonwealth Fund report also shows New Zealanders have a 39% greater chance of dying from a condition amenable to health care than Australians - 79 per 100,000 population under the age of 75 in New Zealand compared with 57/100,000 in Australia. If New Zealand had the same rate of mortality amenable to health care as Australia, more than 900 lives would be saved each year.

> *While government health funding is falling in real terms, it is difficult to see New Zealand's health system providing the same level of services as those countries we like to compare ourselves with.*

The Government's approach has been to focus on doing things smarter. There are certainly areas with significant potential for achieving greater efficiency. Distributive clinical leadership has been shown internationally to achieve greater cost-effectiveness. This was at the heart of the joint ASMS-DHBs Business Case for securing a sustainable specialist workforce, produced in 2010. But in order to develop comprehensive clinical leadership, DHBs must first invest in building the capacity of the specialist workforce to enable specialists to find the time to engage in process improvements initiatives. This requires more funding.

There is also mounting anecdotal evidence of a lack of investment in information technology, which is hindering effective and timely health care. Too often clinicians have to deal with unreliable systems and outdated software, which not only wastes time and money but compromises patient care.

> *Can the country afford higher health spending? There is no doubt about it.*

Vote Health's Budget day operational funding has fallen from 6.46% of GDP in 2009/10 to an estimated 5.91% in this year's Vote. If the proportion of health funding to GDP had remained constant from 2009/10, Vote Health's operating funding in this year's Budget would have seen an additional $1.4 billion (see table). This is consistent with Infometrics' analysis of core health spending, and the CTU-ASMS analysis of Vote Health operational funding based on cost and population growth.

The Government's overall priority of reducing expenditure and policies such as the planned tax cuts are in effect being paid for in New Zealanders' health services and other public services.

REFERENCES

1. O Carville. *"Unmet need 'a national disgrace'"*, The Press, 31 May 2014.

ANJA WERNO IS A MICROBIOLOGIST AT CANTERBURY HEALTH LABORATORIES, AND IS ALSO PRESIDENT OF THE ASMS CANTERBURY BRANCH.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

I don't recall anyone in particular inspiring me to take up medicine while I was growing up in Germany, and I don't come from a family with a medical background. What I do remember, though, is that I always wanted to be a doctor, right from when I was a small child. It really appealed to my desire to do something worthwhile. Surprisingly, when I finally got into medical school, for the first time ever I doubted my decision. I think I was quite taken aback by the difference from being a kid at school to finding myself in a hugely competitive medical school, along with 400 other students. The main focus then was passing exams, the patient didn't seem to feature a lot, at least in the first couple of years of medical school. It was scary, but also had its fantastic moments.

I came to New Zealand in 1992 as a medical student and spent eight months at Grey Hospital on the West Coast doing my trainee internship. I fell in love with New Zealand and with the outdoors but at the time I couldn't see myself living in Greymouth or in fact moving away from Europe. So I went back to Germany to finish my training and then onto England to work as a house officer.

It was in 1996 that my partner at the time and I decided to move to New Zealand, rather than return to Germany. As a German medical graduate I had to study for the required USMLE and NZREX exams. Whilst preparing for these exams I set about looking for work and found myself a part-time job as a physiotherapy assistant and a teacher's aide in Auckland's Mt Roskill Primary School - special education class for disabled children. I really enjoyed the experience and learnt a lot, including communication through New Zealand sign language at a basic level. In 1997 I enrolled for a post-graduate diploma in teaching: health science and biology for secondary schools. I graduated at the end of that year just after giving birth to our first child. By 1998 I had finished all of my medical exams and had to choose between a career in teaching or re-entering the medical work-force. I enjoyed them both so it wasn't an easy decision but in the end I chose medicine. In 1998 I started my specialist training in microbiology in the virology department at Auckland Hospital. I moved to Christchurch to work at Canterbury's laboratories in January 2000, and that's where I've been ever since. It's a good place to live – I like the outdoors, tramping, running and biking. Christchurch as a city, despite its post-earthquake damages, has the pre-requisites for achieving a healthy work-life balance.

A year ago I started an MBA at Canterbury University. I have so far particularly enjoyed the leadership papers as they assist me to look more critically at how we operate in the healthcare service.

WHAT DO YOU LOVE ABOUT YOUR JOB?

I'm quite an idealistic person. I think it has always been a big driving force for me wanting to improve the status quo and change environments for the better. Working in medicine fits very well with that, and it's been a highly motivational and inspirational journey.

I love the fact that medicine offers much variety. Microbiology is particularly intriguing because it can be very unpredictable. Novel infectious pathogens, like SARS or MERS, emerge and antimicrobial resistance is spreading worldwide. The impact of these microbiological changes on human health and health economy is phenomenal. I find it inspiring to work on issues like these, trying to make a difference.

WHAT IS THE MOST CHALLENGING ASPECT OF PRACTISING MEDICINE?

Probably the politics of health is the hardest part. The structure of laboratory services in New Zealand has developed in interesting ways over the last 10 years. The current trend is towards having the majority of the laboratory work across New Zealand sitting with private providers. This trend is not necessarily unique, other parts of the world operate under this model. It is not, however, necessarily supported by all pathologists or clinicians.

Closer to home, there are always issues to do with working in a laboratory and not having direct patient contact. I do miss the interactions with patients and their families. As microbiologists we get involved in patient care and the patient experience in a more indirect fashion. In Canterbury the localisation of the laboratory outside the main hospital has at times negatively impacted on the immediacy when dealing with my clinical colleagues. However, it has also created a shift in the way I operate in that I readily try and take up invitations from the hospital side to discuss clinical cases and develop those collegial relationships.

WHY DID YOU DECIDE TO BECOME A BRANCH OFFICER FOR THE ASMS?

I became involved when Seton Henderson joined the ASMS National Executive, after having been a Canterbury branch officer for some time. I was talking to him in a corridor and he said: "Do you want to be a branch officer? It'll be fun, you'll like it." I asked if I could think about it, and the next thing I knew I had been nominated. Now I'm into my second term as branch president and haven't looked back.

And he was right – it is fun! Improving things is at the heart of any movement, including unions, and I'm very passionate about it. You want people to be treated fairly and reasonably. Being involved with the ASMS has enabled me to meet and form relationships with people I wouldn't ordinarily have much to do with. I've also been able to look at the broader context for health and have developed a genuine interest in health care strategy.

WHAT HAVE YOU LEARNT FROM THIS EXPERIENCE SO FAR?

There are a lot of emerging issues that need to be looked at, and I think ASMS is doing a very good job of picking up on these. I have a German exchange student staying with me at the moment, her father is a GP in Germany and it's been very interesting to hear about the current German health care system and its challenges. Interestingly, over there as much as here, we are seeing a new generation of doctors coming through. Younger doctors appear to have different expectations about what work should be and what constitutes a good work-life balance. Generation XYZ – whatever – do not want to work 80 hours a week. They want to balance work with their other commitments, their families or children or study. They don't define themselves through their work quite as much as the baby boomer generation, and they don't want to work more than 50 or 60 hours a week. In some parts of Germany they're apparently struggling to recruit enough doctors, because these societal changes and shifts in expectations mean that more people are needed. It'll be interesting to see what these trends mean in New Zealand, with its smaller population.

HISTORIC MOMENTS

EACH ISSUE OF *THE SPECIALIST* WILL FEATURE A PHOTOGRAPH OR DOCUMENT FROM ASMS HISTORY. YOU CAN FIND MORE SLICES OF HISTORY ON THE ASMS WEBSITE (WWW.ASMS.NZ) UNDER 'ABOUT US'.

THIS ISSUE: A PHOTOGRAPH OF THE FIRST ASMS NATIONAL EXECUTIVE, 1989 - 1991.

DID YOU KNOW

MECA clauses that you may not be familiar with are highlighted in each issue of ASMS Direct sent regularly to ASMS members. These clauses are also promoted on the ASMS website (www.asms.nz) and are reprinted here for your information.

...ABOUT REPRESENTATION?

The ASMS cannot represent non-members or people who join ASMS after an incident has occurred, hoping to get advice and support. Our constitution makes this very clear. This is one of many reasons why it's important to encourage newly appointed colleagues to join ASMS.

"The Association reserves the right to refuse to advise, represent or otherwise assist a member: (a) Who joins the Association after the particular matter on which they have sought advice or assistance arose."

You can read more in the ASMS Constitution: http://www.asms.org.nz/wp-content/uploads/2015/04/ASMS-Constitution-2014-amendments_162343.2.pdf

...ABOUT FLEXIBLE WORK?

As employers, all DHBs are required to consider an employee's request for more flexible working arrangements. This includes a request to change hours of work, days of work, and/or place of work.

The employer must respond to your written request within one month and can only reject it for operational reasons such as an inability to reassign duties or recruit additional staff. A full list of permitted reasons can be found at http://www.legislation.govt.nz/act/public/2000/0024/latest/DLM1398217.html

You can find out more about flexible working arrangements here: http://employment.govt.nz/er/bestpractice/worklife/flexibleworkguide/index.asp

...ABOUT THE EMPLOYER SUBSIDY FOR YOUR SUPERANNUATION?

Clause 17.1 of the DHB MECA specifies that your employer will make the required employer contribution in respect of any of the superannuation schemes operated by the National Provident Fund or the Government Superannuation Fund to which you belong. If you do not belong to one of these, then Clause 17.2 of the MECA entitles you to a 6% employer subsidy matching your contribution to an approved superannuation scheme, and ASMS encourages members to take advantage of this.

More information is available at http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-17/

...ABOUT RELOCATION EXPENSES?

These are not fixed, but a newly appointed SMO must negotiate with the DHB about what costs the employer will cover. It is really important that these are agreed before the appointment is finalised; it is not a good idea to tackle this retrospectively.

A good way to begin this discussion is to provide quotes for the costs of economy travel for you and your family, and for transport of your household effects.

If you are part of an appointments committee or have a clinical leadership role, it's helpful to be aware of this clause so you can offer support to newly appointed SMOs.

You can read more about relocation expenses in Clause 22 of the MECA: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-two/clause-22/

...ABOUT OVERNIGHT ACCOMMODATION?

If you need to stay overnight at the hospital due to your work duties, you must be provided with "good quality accommodation". This means it must be at or near the hospital, and include reasonable sleeping, study, relaxation and bathroom facilities. These are described in MECA clauses 53.2 and 53.3: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-six/clause-53/

...ABOUT FULL PAY ANNUAL LEAVE ENTITLEMENTS FOLLOWING RETURN FROM PARENTAL LEAVE?

Unlike most employees who only get paid a proportion of normal pay for annual leave in the year after parental leave, if you are employed on the ASMS DHB MECA you're entitled to annual leave on full pay after you return from parental leave.

Clause 23 of the DHB MECA provides for annual leave on full pay – not the averaging formula used in the Holidays Act: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-23/

This carries over to Clause 28 of the MECA that also entitles you, after parental leave, to return to the same or a similar position you held prior to the leave: http://www.asms.org.nz/employment-advice/agreement-info/nz-dhb-senior-medical-and-dental-officers-collective-agreement/part-three/clause-28/

WHAT HAPPENS IF YOU RECEIVE AN MCNZ COMPLAINT?

ALTHOUGH ALL DOCTORS HAVE CONTACT WITH THE MEDICAL COUNCIL OF NEW ZEALAND (MCNZ) ON AN ANNUAL BASIS WHEN RENEWING THEIR PRACTISING CERTIFICATES, MANY DOCTORS ARE UNAWARE OF HOW OR WHY THEY COULD BE INVESTIGATED BY THE COUNCIL.

DR LUCY GIBBERD | MEDICAL PROTECTION MEDICAL ADVISOR

COMPLAINTS BEFORE THE MEDICAL COUNCIL OF NEW ZEALAND (MCNZ)

The fundamental purpose of the MCNZ is to ensure that all doctors are fit to practise medicine, and to investigate concerns regarding professionalism and clinical competence.

In most cases, MCNZ investigations are prompted by a complaint or concern that is raised by a doctor or health professional regarding another doctor's competence or professionalism. While there is no legal obligation on health professionals to contact the MCNZ if they have concerns about a colleague's competence, there may be an ethical duty if the doctor believes there could be a risk to patient safety.

Complaints to the MCNZ should not be confused with patient complaints, which are usually handled by the Health and Disability Commission (HDC) and viewed from a patient/consumer perspective. However, the HDC may pass a doctor's complaint history onto the MCNZ for possible investigation if a doctor has three or more 'low level' complaints about them within a five year period.

The MCNZ may also receive concerns which have been passed on from the Accident Compensation Corporation (ACC) following a treatment injury claim, or from employers, as they must advise the MCNZ Registrar if a doctor resigns or is dismissed for incompetence. Finally, the courts are required to inform the MCNZ if a doctor is convicted of a crime punishable by a sentence of three months or longer, and the police can also raise concerns.

THE PROCESS OF A COMPLAINT

When a complaint is received by the MCNZ, it will be assessed by the Complaints Triage Team, who will contact the doctor to let them know how they have decided to respond to the concern and, if necessary, who will conduct further investigations. For example, the Council's:

- Professional Conduct Committee (PCC), which investigates concerns regarding professionalism or personal conduct,
- Performance Assessment Committee (PAC), which looks into concerns around clinical competence, or
- Health Committee, which considers concerns around mental and physical conditions.

While awaiting the outcome of an inquiry, the MCNZ may seek a voluntary restriction of practice from the doctor to reduce any potential risks to the public if the concern proves to be correct.

PROFESSIONAL CONDUCT COMMITTEE

Membership of the PCC will vary from case to case, but will always consist of two doctors and one layperson, all of whom have received training for their roles. Doctors being investigated will be notified who will consider their case prior to it commencing and have the option to challenge this if they believe there could be a conflict of interest.

The PCC must apply the rules of natural justice and provide the doctor with details of the information which has been referred for investigation. Evidence may be heard in person or received in writing from several sources including the doctor, their employer, colleagues, clinical experts and the complainant (if applicable). The doctor under investigation will be given the chance to respond either in writing or in person.

Once the PCC has considered all the information available, it will compile a report and make recommendations on what, if any, action is to be taken.

This process can take several months, but a doctor should be kept informed about progress over that time.

The possible outcomes of an investigation are:

- No further action required and the case is closed
- Recommendation for a competence review
- Recommendation to review the doctor's scope of practice
- Recommendation to review the doctor's fitness to practise
- Decision to bring a charge against the doctor at the Health Practitioner's Disciplinary Tribunal
- Decision to refer the complaint to conciliation.

There is no appeal process to challenge the decisions of the PCC but if there were concerns that due process was not followed, a judicial review could be sought.

PERFORMANCE ASSESSMENT COMMITTEE

Like the PCC, membership of the PAC will vary depending on the case, but will always comprise of two doctors and one lay member, which the doctor being investigated can challenge if they believe there may be a conflict of interest.

The PAC will conduct a broad performance-based assessment of the doctor covering a number of areas of practice. For example, the committee may visit the doctor's practice over one to two days to review their notes, sit in on consultations, audit prescribing, and assess clinical skills, clinical knowledge, communication skills and practice systems. They may also interview staff and colleagues in the practice.

The PAC will then prepare a report on whether the doctor reached the required standard of competence for their scope of practice. This is shared with the doctor for feedback before being submitted to the MCNZ.

The performance assessment process is intended to be educational, not disciplinary. The outcome may be:

- the doctor is required to undertake a competence programme
- conditions may be imposed on the doctor's scope of practice
- the doctor is required to sit an examination or assessment
- the doctor must be assisted or counselled
- an interim suspension of the doctor's practising certificate may be imposed.

HEALTH COMMITTEE'S ROLE

According to the Health Practitioners Competence Assurance Act 2003, doctors, their colleagues and their employers must advise the MCNZ if they believe a health professional has a mental or physical condition that could affect their ability to practice safely – in which case the Health Committee will become involved.

The Health Committee consists of four doctors and one layperson and aims to allow doctors who have a treatable illness to continue practising while receiving treatment. The Committee may request reports from treating doctors or an independent specialist assessment, and potentially seek the doctor's voluntary withdrawal from practice while the case is being considered.

Following the assessment the doctor may be considered unfit to practise temporarily or permanently, or may be asked to participate in a monitoring programme or review process. Alternatively, they may be found fit to practise as normal.

FINAL DECISIONS

The PCC, PAC and the Health Committee are required to report to MCNZ meetings on a monthly basis, at which recommendations will be considered and final decisions regarding further action will be made. Doctors may have the opportunity to appear before the MCNZ to argue their case.

IT'S OK TO ASK FOR HELP

Receiving a complaint can be stressful and can knock your confidence, but it is important to remember that many doctors will receive a complaint at some stage in their career.

Doctors who receive a letter from the MCNZ informing them of concerns regarding their competence, professionalism or health - though easier said than done – should keep calm and try not to worry.

Once you understand what the complaint is and what is being asked of you by the MCNZ, contact your medical defence organisation as soon as possible for assistance formulating a response and general support.

ASMS 27TH ANNUAL CONFERENCE

THURSDAY 19 & FRIDAY 20 NOVEMBER 2015
TE ARO ROOM, MAC'S FUNCTION CENTRE, WELLINGTON

DINNER AND PRE-CONFERENCE FUNCTION

A conference dinner will be held on Thursday 19 November at Te Wharewaka on Wellington's waterfront.

A pre-conference function will be held at The Boatshed on the evening of Wednesday 18 November. This is a great opportunity to mingle, in a relaxed social atmosphere, with key decision-makers and players in the health sector.

LEAVE

Clause 29.1 of the MECA includes provision for members to attend Association meetings and conferences on full pay. Members are encouraged to make leave arrangements and register by 8 October 2015.

REGISTRATION OF INTEREST

Please help us plan for another great Annual Conference and assist us to organise travel and accommodation by emailing our Membership Support Officer, Kathy Eaden, at ke@asms.nz.

Your interest in registration will be noted and confirmed closer to the date with your local branch officers, as each branch is allocated a set number of delegates. Extra members are welcome to attend the conference as observers.

DELEGATES REQUIRED

The ASMS makes all travel and accommodation arrangements for ASMS delegates to attend its 27th Annual Conference.

Register your interest today to **ke@asms.nz.**

ASMS
TOI MATA HAUORA
www.asms.nz

ASMS SERVICES TO MEMBERS

As a professional association we promote:

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

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

OTHER SERVICES

www.asms.nz

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

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

ASMS job vacancies online
www.jobs.asms.nz

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

Substantial discounts are offered for bulk and continued advertising.

ASMS Direct

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

If you wish to receive it please advise our Membership Support Officer, Kathy Eaden, at ***ke@asms.nz.***

How to contact the ASMS

Association of Salaried Medical Specialists
Level 11, The Bayleys Building,
36 Brandon St, Wellington

Postal address: PO Box 10763, The Terrace, Wellington 6143

P 04 499 1271
F 04 499 4500
E asms@asms.nz
W www.asms.nz
www.facebook.com/asms.nz

Have you changed address or phone number recently?

Please email any changes to your contact details to: **asms@asms.nz.**

MAS MEMBERSHIP SEMINARS

The MAS has been holding a series of seminars on a range of interesting topics for MAS members. The seminars involve experts presenting an idea with a view to stimulating conversation, thought and healthy debate.

The topics include rethinking what we know of nutrition, the future of finance, and privacy and security.

There are still a couple of seminars available in the series, and details are available from **http://www.asms.org.nz/wp-content/uploads/2015/08/MAS-Talks-2015.pdf.**

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