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The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

'What it takes to stay'

The ASMS is conscious that although the settlement of the national DHB MECA would provide some stability and the independent commission into competitive terms and conditions of employment some hope for future recruitment and retention, there needed to be a sharper focus on encouraging senior doctors and dentists to remain employed in their DHBs. Consequently, immediately after ratifying the proposed MECA settlement on 8 May, the National Executive also adopted the following resolution:

That the Association focus its activities on the theme of 'what it takes to stay' in seeking to maintain and improve retention of senior medical and dental officers in district health boards during the period leading up to the renegotiation of the next national collective agreement. Further, the Association seeks as much as practical active engagement with district health boards over this objective.

Our current focus is largely on preparing for the independent commission, job sizing, enhancing clinical engagement and leadership, and the National Consultation Committee created by the MECA. The independent commission will be critical in terms of the longer term sustainability of the DHBs' medical workforce but the other factors are important in reducing or removing the 'push' factors that generate dissatisfaction and encourage members to look at other employment options.

Our work with the independent commission

At a national level the ASMS's relationship with DHBs has improved immensely since the MECA settlement. As an example of excellent collaboration between us joint recommendations on possible commissioners were made to the Director-General of Health. As a consequence he has made an excellent choice in his appointments. The commissioners are Len Cook (Chair of the Medical Training Board and former New Zealand and British Government Statistician), Ross Wilson (Chair of ACC, board member of Kiwi Rail and former President of the Council of Trade Unions) and Dwayne Crombie (former Chief Executive of Waitemata DHB). The ASMS has already had an initial productive meeting with the Commission.

In preparation the Association has engaged the services of an experienced health researcher who has been working on a substantial paper for presentation to the Commission. Meanwhile the ASMS Industrial Officers are undertaking job vacancy surveys in a number of DHBs. Our work will also include comparisons with Australian collective agreements and packages and, to the extent possible, the private sector.

Job Sizing

Job sizing is critical to the determination of remuneration for senior doctors and dentists employed by DHBs. Remuneration is linked to average hours of work (clinical, non-clinical, after-hours call duties, and other activities). Consequently, the ASMS has increased its work in supporting many members in job sizing reviews. The revision of the *ASMS Standpoint on Hours of Work and Job Sizing* to improve its practical focus for members' use has been part of this objective as has the time and efforts of our industrial staff who are out and about providing direct practical advice to members.

Job sizing is about addressing unfairness and inequity when average hours paid falls short of average hours worked. To put it in perspective, an hour worked that is unpaid is equivalent to a 2.5% increase on base salary when it is captured in job sizing and remuneration adjusted accordingly. In broad terms there are four general outcomes of a job sizing review:

1. Increased remuneration for members as hours paid are realigned with hours worked. The ASMS has been involved in several cases of remuneration increases ranging from moderate to significant arising out of job sizing reviews in a number of DHBs.
2. Recognition of the need to employ more senior doctors and dentists.
3. Reducing workload to be consistent with remuneration levels.
4. Increased secretarial and other support to free up the time of members.
5. Confirmation that the existing job size is about right.

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Enhancing clinical engagement and leadership

The ASMS is actively promoting the enhanced clinical engagement and leadership envisaged by both the MECA and the Time for Quality Agreement. The Time for Quality Agreement between the ASMS and DHBs was reported in some detail in the September issue of The Specialist. Its premise is that the health system requires quality to be its driver which requires health professional leadership, which requires sufficient time for health professionals to provide this leadership. There are key principles of engagement based on teamwork between health professionals and managers including certain lead roles for the former. Further, its engagement principles were without controversy included in the MECA with particular reference to senior medical staff. It also has a work plan involving a series of activities.

Responsibility for progressing Time for Quality currently resides with the National Consultation Committee (discussed below). The Ministry of Health has a resource responsibility for supporting the application of the Agreement and its senior officials attend part of the NCC meetings. This month the Ministry, DHBs and ASMS will meet informally to discuss how to give practical effect to the Agreement's work plan. The NCC will also receive Ministry advice on the number and range of clinical networks currently in place and clinical improvement initiatives currently linked to the Ministry.

The ASMS is also using the Joint Consultation Committees that we have in each of the DHBs to enhance clinical engagement and leadership in various forms and at various opportunities. This includes organising half-day workshops on enhancing clinical engagement and leadership in DHBs. These are held when no non-acute services are scheduled and are usually offsite. Two successful workshops have been held to date (Northland and Hawke's Bay) with more planned for February-March.

National Consultation Committee

The National Consultation Committee (NCC) is a creation of the new national DHB MECA. It is a joint DHBs-ASMS national committee comprising six representatives from each party. It is to meet at least quarterly. To date two meetings have been held so far.

Despite some scepticism over how useful it might be, we have been impressed with the potential opportunities the NCC provides for increased engagement and influence. There has been a significant improvement in the conduct of the DHBs towards the ASMS at a national level. To a limited extent this became evident following the change of advocates during the MECA negotiations (the public attacks and misrepresentations of our position ceased) but the improvement has accelerated since the settlement. It appears that nationally at least the DHBs have come to the collective conclusion that it is more useful to work with the ASMS in a collaborative framework on national issues of importance to the health system.

At the first NCC meeting the ASMS was asked by the DHBs to identify at least three subjects that we considered the NCC should work on (outside matters which fall under the ambit of the Time for Quality Agreement). Subsequently, the National Executive identified:

1. Recruitment and retention strategies to facilitate permanent SMO employment and reduce undue reliance on locums.
2. The primary-secondary interface including 'seeing patients without seeing patients'.
3. Information technology standardisation.

The subsequent discussion at the NCC on information technology focussed on the potential effectiveness of a national patient management system and it was agreed that a joint letter would be sent outlining the importance and advantages and recommending that the Ministry of Health take a lead role in working with DHBs on it.

The discussion on the primary-secondary interface extended into the productivity debate. Many activities that improved effectiveness were not counted and therefore not recorded as productivity gains. It was agreed that the NCC would prepare a paper for distribution to a range of bodies such as Treasury, Ministry of Health, applicable inter-departmental committees, Health Sector Tripartite Forum, and media.

The NCC has also considered the viability of a single consent form for all DHBs which has also been considered by the DHBs' Chief Medical Advisers Group. It was agreed to follow it up with the latter group.

This initial progress is encouraging especially when compounded by the positive attitude taken by both parties. It also has the potential to consider a number of employment related matters, some of which arise out of discussions and developments in the individual DHB based Joint Consultation Committees.

Overall there is much to be gained by this focus on 'what it takes to stay' but none of this will come to full fruition until workforce stability is reinforced by competitive terms and conditions of employment.

Ian Powell
Executive Director

President's Column

Leadership – it's not all about power

Below is an edited adaptation of Dr Jeff Brown's Presidential Address on 20 November to the ASMS 20th Annual Conference. The full address is available on the ASMS website www.asms.org.nz.

In November 2008, with fellow ASMS Annual Conference delegates, I contemplated action both necessary and discomforting. And I commented on the lack of leadership in many quarters, in DHBs and political, that had brought us to the brink. At this year's Conference, 12 months later, we met at the end of perhaps the most momentous year since our founding. I reflect on our achievements, highlight some of our challenges ahead, and then develop the theme of leadership by doctors. It's not all about power.

Achievements

MECA

After protracted and often acrimonious months the MECA was settled. Following the last Annual Conference we conducted a ballot which produced a mandate for industrial action. Action we were prepared to use while hoping we would never have to. Ministerial intervention led to breaking through the impasse, including the all night sitting or lock-up.

What we achieved required leadership. Leadership by the then Health Minister David Cunliffe. Leadership by some DHB chairs and chief executives. Leadership by the ASMS National Executive. We owe them all a debt of gratitude.

We now have significantly improved conditions for members employed by DHBs. And we have achieved even more – the independent Commission, signing of a transformational Time for Quality Agreement, the defeat of efforts to claw back previously hard won rights, and abolition of toxic efforts to reimpose managerialism. The new MECA also meant new and increased membership.

Implementation of MECA

The local implementation and application of the MECA, the ballots on the bargaining fee, the Joint Consultation Committees, and other issues including recent engagement workshops, all involved the national industrial team. But in addition it required leadership by members in their DHBs.

Challenges Ahead

Medical Council and elected representation

This is an ongoing battle. Former Health Minister David Cunliffe was convinced of our arguments and supported a return to some elected members for the Council. But other dark forces seemed to have influence. Among them seem to be the Nursing Council who are staunchly opposed to elected representation. It does not bother us, as doctors, how nurses are governed. Why should it bother them how we are regulated and governed, unless they feel vulnerable in some way? Why should they be permitted to use the whole medical profession for nursing political ends?

It appears that lobbying allied with some Ministry interference culminated in cabals of corridor power games, in Cabinet interference despite Ministerial advocacy.

There is no other cause which has so united all doctors. If the profession, and the Minister, and lay members of the Council support it – whose right is it to interfere or intercede. This is a battle we will continue to fight.

Dr Brown's comments have been overtaken by events with the announcement the following day by new Health Minister Tony Ryall to accept our position and issue regulations providing for mandatory elected medical practitioner representation on the Medical Council.

Ministry officials and review of HPCA Act

When the Health Practitioners Competence Assurance Act was passed, it included an obligation for review. This review process started, then has been radically changed in the middle of the review, at the whim of internal machinations and not in any way transparently to those affected. Some officials changed their mind despite their promises and are now shortcutting the review and short-changing stakeholders, especially doctors.

This reminds me of a recent book on measurement which introduced 'The Principle of Repeated Bodges'. Namely: if one way is demanding but accurate, and the other easy but not so accurate, temptation and human behaviour is to go for the bodge. We expect and demand fewer bodges and more integrity from the Ministry.

Our work and challenge is also to produce effective representation to the Commission on what it takes to stay, to keep us here, as specialists.

Reflecting on these challenges it is hard not to see them as more examples of repeated efforts to knock doctors off an imagined pedestal. To bring us down from a supposed position of power. To replace us or strip us of influence.

The effects of this behaviour are obvious and observable all around. If you knock us down, isolate us in silos, you will inevitably get self-interest. Solitary confinement leads to reactionary behaviour. And to mopping up the messes of solo practice.

Those who seek to cajole and control us fail to realise – it's not all about power.

Those who crave power confuse it with making a difference. Think it necessary for improving outcomes. They confuse power with leadership. Leadership that creates and nurtures 'followship' does not seek to impose it or enforce it.

We witness a battle for power, versus innate demand for leadership. The one inevitably producing conflict, the other inevitably creating teams.

But power demanded is fragile, it needs constant defence. Whereas leadership acquired is durable, defined by deeds.

When it all turns to custard

When physiology is disrupted

When anatomy is disrupted

When the psyche is seriously disrupted

When team dynamics are falling apart

When the system lets them down; who does the patient, the parent, the partner, the family, the community, society turn to?

Us!

We're already grounded in teamwork and in the fixing of the complexities of wellness, illness, and all between. We are leaders.

Leadership

Anthropology speculates that the origins of human leadership were due to perceived increasing need for dispute resolution in increasingly densely-populated and increasingly complex societies. Note that the OED traces the word "leadership" in English only as far back as the 19th century. And Noam Chomsky has criticized the concept of leadership as involving people subordinating their needs to that of someone else.

However Greenleaf's servant leader is used by others to reach a goal, supposedly achieving slow results but with strong engagement. A more explicit path-goal model of Evans and House tasks the leader with clearing the path toward the goal(s) of the group by meeting the needs of the members. A variant on this theme is functional leadership that helps a group by encouraging functional behaviours and discouraging dysfunctional ones.

Are managers leaders? Bennis 20 years ago drew some harsh distinctions between managers and leaders; he claimed:

- Managers ask how and when, leaders ask what and why
- Managers do things right, leaders do the right things
- Managers rely on control, leaders inspire trust
- Managers have an eye on the bottom line, leaders have an eye on the horizon

Lynn argues that both management and leadership are necessary. He postulates leadership as optimising opportunity compared with management based on minimising risk. He argues that leadership without management yields steps forward, but as many if not more steps backwards. Management without leadership avoids any step backwards, but doesn't move forward.

Pitcher 15 years ago also challenged the division into leaders and managers. She described three types of leaders: Artists - imaginative, inspiring, visionary, entrepreneurial, intuitive, daring, and emotional; Craftsmen - well-balanced, steady, reasonable, sensible, predictable, and trustworthy; Technocrats - cerebral, detail-oriented, fastidious, uncompromising, and hard-headed. While admitting a balanced leader would exhibit all three sets of traits she claimed to find none in her study. I contend that senior doctors exhibit all three sets of traits, most of the time.

Another model of leadership was first described 30 years ago by Burns and has been further developed including assessment tools in the 90's. This model describes and contrasts transactional leadership and transformational leadership.

The transactional leader is given power to perform certain tasks and reward or punish the team's performance. The manager leads the group and the group agrees to follow this lead to accomplish a goal in exchange for reward. Power is given to the leader to evaluate, correct and train subordinates when productivity is not up to scratch and to reward effectiveness when outcomes are achieved. Transactional leadership claims to build power by doing whatever will get more followers.

The transformational leader motivates a team to be effective and efficient. Communication is the base for achieving goals, focusing the group on the final desired outcome. This leader is highly visible and uses chain of command to get the job done. Transformational leaders focus on the big picture, needing to be surrounded by people who take care of the details.

Health systems are complex beasts, however, often resembling informal organisations, despite efforts to

the contrary. You all know that many wards and clinics certainly are informal in their daily activities and organisation. The personal objectives and goals of the individual members may or may not coincide with those of such organisations.

Leaders emerge from within these informal organisations. Their personal qualities, the demands of the situation, or a combination of these and other factors attract followers who accept their leadership within one or several overlay structures. These leaders labour on the shop-floor or stand in the front-line of battle, leading by example. To be effective this leader has to somehow get a group of potentially diverse and talented people - many of whom have strong personalities - to work together toward a common goal.

So what makes a leader? Several have attempted to define traits of leadership, either innate (born leaders) or learned. Some claim that leadership is defined by motives - a high need for power, a low need for affiliation, and a high level of activity inhibition or self-control. Others prefer to describe situational leadership where a particular event or activity determines who leads best and is dependent on 'followship' – the match of leader and follower critical for success.

Any study of effective leadership ends up with a list of qualities which cumulatively form a leadership style. Examples of these qualities include: specific technical skills, charismatic inspiration, cooperation, optimism, a sense of purpose or mission, empathy, an ability to delegate and to nurture, and a dedication that consumes much of a leaders' life.

The leadership styles that emerge from these qualities have been described by House and Podsakoff as: having a vision that describes a better future to which the followers have an alleged moral right, engaging with passion in outstanding or extraordinary behaviour and making self-sacrifices in the interest of that vision and mission, displaying confidence, determination, and persistence, challenging and even offending those who have a stake in preserving the established order, expecting high performance from their followers allied with strong confidence in their followers' ability to meet such expectations, aligning individuals' different ideologies and frames of reference, and communicating all of these in an inspirational manner.

Are senior doctors and dentists transactional or transformational leaders? Do they seek power in exchange for rewarding or punishing, or do they seek big picture change by surrounding themselves with detail people?

Translational leadership

I submit we are neither. We are translational leaders. We translate, in every patient encounter, the complex science of physiology, pathology and psychology into understandable shared frames of reference. We translate bureaucracy and managerialism to negotiate pathways through tortuous red tape. We translate patient and family desires into what might be achievable within the realms of medical miracles and funding envelopes. We live with our patients while liaising with politicians.

It's about leadership, not about power.

On the occasion of our 20th Conference I acknowledge our whakapapa, our past Presidents - George Downward, Allen Fraser, John Hawke, Peter Roberts, and David Galler. I hope that I and those who follow me can uphold their strength of leadership qualities and styles.

I finish with some blunt messages that need no translation.

- To the past Minister – I thank him for his action and strong words.
- To the new Minister – I look forward to turning his words into action.

Because no matter what tax regime, no matter what economic ideology, we still need a strong public health system. For those who cannot pay for the alternatives and for those who can – but have problems the alternatives cannot look after.

I urge you and those you work alongside to demand to lead, to inspire, to challenge, and to communicate. To grab leadership, for the sake of our good health. Together we can translate the new Minister's mandate. We can translate the new Ministry's guidance. Into the reality of national and regional networks. Into the reality of boardroom and bedside manners. Through translational leadership.

Based on time - for quality.

Based not on power – but on trust.

Dr Jeff Brown
National President

At last– the right to election for the Medical Council

"Consistent with our commitment to work with the medical profession on the basis of mutual trust and respect, we will provide for direct election of your representatives to the New Zealand Medical Council"

Hon Tony Ryall Minister of Health address to the ASMS 20th Annual Conference at Wellington, 21 November 2008

With these words the new Minister of Health ended a seven year struggle by the medical profession to have the right to elect doctors to the Medical Council.

Historical background

The issue arose with discussions on the introduction of the Health Practitioners Competence Assurance Bill (HPCAB) in 2001. This Bill was originally intended to extend the provisions of the Medical Practitioners Act (the MPA) 1995 to the other health professions who were operating under outdated legislation. The MPA provided for the direct election of doctors to the Medical Council, as well as doctors and laypeople appointed by the Minister. One of the provisions in the HPCAB that the NZMA, the ASMS and indeed the whole medical profession (including also the Medical Council) opposed was the total Ministerial appointment of regulatory authorities. With the support of other professional groups (and in particular the NZ Nurses Organisation) we managed to obtain a concession in that s120 (4) of the eventual Health Practitioners Competence Assurance Act 2003 (HPCAA) allowed for the Minister to pass regulations to allow for elections to a regulatory authority such as the Medical Council.

Immediately the Bill became the Act the profession began to lobby the then Minister of Health, Annette King to pass the regulations allowing for elections. She refused on the grounds that if she passed regulations for doctors there was no reason not to do so for the other professions. When Pete Hodgson took over as Minister of Health, it was one of the first issues that was raised with him by the ASMS and a formal letter was sent to him from the newly formed Pan Professional Medical Forum (Council of Medical Colleges, NZMA, Resident Doctors' Association and ASMS) under then convenor Phil Bagshaw.

Political threat and reaction

As an interim measure the Medical Council ran an election and then presented the results to the Minister for appointment. Almost as if in illustration of the point the profession was trying to make the Minister failed to appoint one of the top four candidates causing a great deal of speculation as to why one of the candidates had offended the Minister and/or the Ministry and/or the Government and as to why the alternative appointee had pleased the Minister, Ministry and Government.

Whether as a result of this experience or not, Pete Hodgson indicated that he had been persuaded to begin consultation on regulations allowing for elections. Before this had begun a new Minister, David Cunliffe took office suggesting that the whole process of persuasion had to begin again. However, the new Minister quickly took on board the profession's arguments. He was particularly influenced by the ASMS's contribution to the achievement of the Time for Quality Agreement and the principles it embodied. He saw similarities between this Agreement and elected representation on the Medical Council. In May this year Mr Cunliffe wrote to the ASMS saying he had asked the Ministry to begin work on regulations. It was his express intention to have these in place by the end of 2008 so that they could be applied in 2009 when the next elections were due.

However, in September we were informed that while the Minister had made repeated representations to Cabinet for approval on proposed regulations, he was knocked back on both occasions. Instead the matter had been left to await the outcome of the wider review of the HPCAA Act, currently underway. There was also a suggestion that s120 (4) itself may have been under threat as members of the then Cabinet other than the Minister of Health did not support even the possibility of election of some practitioners to regulatory authorities.

Ultimately, this didn't matter as the election intervened but the ASMS appreciated the effort that David Cunliffe the previous Minister made on this issue, possibly in the face of the ire of his Cabinet colleagues.

The Case for Elections to the Medical Council

There are good reasons in public policy to ensure that the regulatory authorities for medical practitioners do not simply function as extensions of the government of the day. In New Zealand the government is the major funder of health services. There will always be pressure on governments to provide health services and there will be

continuing pressure to make sure that these are affordable. The most costly part of providing health services is the cost of professionals that provide these services.

The principal purpose of the HPCAA is to protect the health and safety of members of the public. The Medical Council's role, in this respect, is two-fold: first it must set standards (either directly or by ensuring that educational institutions conform to standards), and then ensure (by registering and re-registering doctors, dealing with information about competence and notifying of risk of harm) that doctors meet the standards on a continuous basis. The mechanisms that are available to them to do this are set out in section 118 of the Act. The Council can thus fail in its duty to protect the health and safety of the public in two ways: by a failure to set adequate standards as well as a failure to ensure that doctors meet those standards.

The "elephant in the room" when we discuss medical workforce issues is that issues of supply could be addressed by eroding standards. Poorly trained or less skilled doctors are less likely to be attractive in overseas markets. New Zealand could retain them if we dropped our standards of training and recruit them if we dropped our standards for registration. They would probably cost less than skilled doctors and may therefore present an attractive option to future governments hard pressed by acute shortages of doctors. Protecting the health and safety of the public requires that the Medical Council can resist such pressures.

A wholly politically appointed Council risks eroding that credibility. It would be easy to contend that cost pressures had led to an erosion of standards. At present the Council answers those questions with authority (though questions were raised in the media during the recent media examination of a Health & Disability Commissioner report into an overseas doctor at Whanganui DHB as to a difference between College and Council standards). With a wholly politically appointed Council this authority will erode over time.

Public confidence in the Council is enhanced when the public can be sure that Council members have the mana bestowed on them through the mandate of their peers. Public safety is considerably enhanced when the public has recourse to scientific medicine.

The health and safety of the public is best protected in these circumstances by a regulatory authority that includes elected medical practitioners with the confidence and mana of their peers and who because of this may be, and may be seen to be, independent of government or DHB pressure.

This is not intended to be a criticism of appointed medical practitioners or lay appointees. There will be other issues where the balance provided by lay members or appointed professional members may protect the regulatory authority from perceptions of patch protection, or provide confidence that the profession is sensitive to the concerns of sections of the community or patients. Success lies in striking the correct balance.

Confidence by medical practitioners in their regulatory authority (and its independence from manipulation by employers and by funders), is a prerequisite if we expect doctors to use the guidelines issued by regulatory authorities and internalise the standards set by the regulatory authorities. It is the day to day safe practice of individual doctors that protects the public. The ability of the Medical Council to affect this is dependent on their standing with the profession it regulates, not on penalties exacted when something goes wrong.

The Medical Council is funded by the payment of doctors of the annual practising certificate (including disciplinary levies). The principle of 'no taxation without representation' is one that resonates strongly with the medical profession.

Success

It is to the credit of the new Minister of Health, Tony Ryall, that one of his first actions after the election was to announce this news without even the need for additional lobbying on the issue (the lobbying had been done while he was in opposition). We thank and congratulate him for starting his relationship with the medical profession on such a positive note.

Those that have tirelessly lobbied for this outcome need also to be thanked. We need to note in particular the persistent lobbying efforts of the NZMA. The ASMS also did its bit. But of greatest impact was when the medical profession spoke as a single voice. The vehicle for this, the Pan Professional Medical Forum, and in this respect the PPMF's then convenor Professor Phil Bagshaw in his role as PPMF convenor during this struggle deserves special mention and the appreciation of the medical profession.

Angela Belich
Assistant Executive Director

Hon Tony Ryall delivers his first speech as Minister of Health

Failure to engage; taking DHBs to task

The ASMS has always been a proponent of constructive engagement with the various organisations that employ senior doctors and dentists. In the public sector these began with area health boards, were restructured in the 1900s into first crown health enterprises and then hospital and health services, and then, since 2000, our current 21 district health boards.

Key documents

Today this commitment is reflected in two key documents. One is the national DHB MECA negotiated by the ASMS. It includes formal 'consultation' obligations but more significantly goes beyond them to both 'engagement' with and 'empowerment' of senior medical staff which are much higher standards to achieve. The MECA includes the obligation for collective responses and negotiations between the ASMS and DHBs over workplace challenges and issues as an underlying principle of the MECA.

The second is the ground-breaking Time for Quality Agreement signed by the ASMS and the 21 DHBs, and extensively reported in the September issue of The Specialist. This has the potential to revolutionise decision-making in DHBs for the better and to make their decisions more robust and sustainable. Time for Quality's engagement principles include health professionals rather than managers playing the leadership role in service design, organisation and development.

Cultural change in DHBs required

Of course, the ASMS is sufficiently pragmatic not to expect the culture change required to give this direction overnight practical effect. However, while we do not expect the pace of change to be that of the hare, we do expect it to be faster than the tortoise (even making allowances for the fable). The ASMS is not prepared to let these key documents become noble statements of aspiration only. We have not fought as hard and for so long as we have to achieve them to see them become mere weasel words. We want tangible and practical cultural change in the way DHBs work and in their decision-making processes.

We are prepared to challenge DHBs where either their pace of change is tortoise-like or their behaviour goes in the opposite direction. We are already challenging two larger DHBs over their failure to respect these agreements in respect of proposed changes to clinical leadership and with one DHB for failing to respect them in the context of trying to restructure the clinical leadership of a particular department. The ASMS will also soon be writing to all DHBs outlining what we expect of them given the tenor, expectations and obligations of both the MECA and Time for Quality.

Reaching agreement over important foundation documents is not the end of a pathway but the beginning of a new one and the role of the ASMS as the union of senior doctors and dentists is to significantly progress the journey.

Ian Powell
Executive Director

The National Executive and staff of the Association wish all members health and happiness over the festive season.

Back row, left to right:
Gail Robinson - Waitemata DHB, Brian Craig - Canterbury DHB, David Jones - Capital & Coast DHB, Paul Wilson - Bay of Plenty DHB, John Bonning - Waikato DHB, Torben Iversen - Tairawhiti DHB.

Front row, left to right:
Iain Morle - Hawkes Bay DHB, Judy Bent - Auckland DHB, Jeff Brown - MidCentral DHB, John MacDonald - Canterbury DHB

Features of 20th ASMS Annual Conference

In addition to the address by new Health Minister Tony Ryall after only 50 hours in the job, the Presidential Address by Dr Jeff Brown, and the remit on DHB use of the private sector (all covered extensively elsewhere in this issue), there were many other features and decisions in the 20th ASMS Annual Conference. All presenters addresses are available under the publications section of our website www.asms.org.nz

Life Membership

A key feature was the awarding of life membership to the first and second ASMS National Presidents, Drs George Downward and Allen Fraser, who along with Dr James Judson (already a life member), were the 'founding fathers' of the ASMS (or as they appeared to like describing themselves, the 'floundering fathers'). Appropriately, the unanimously adopted resolution was proposed by Dr Judson. Dr Downward was also the keynote speaker at the Conference dinner.

Quality Theme

Quality was a major theme of the Conference with the following sessions:

- Wellington Coroner Garry Evans on the role of coroners in a safety culture.
- Dr Alan Merry, Professor of Anaesthesia at the University of Auckland, on moving towards a safety culture in New Zealand.
- Pat Snedden, Chair of the Quality Improvement Committee (also Auckland District Health Board Chair) on future trends for quality improvement.
- Dr David Galler, Principal Medical Adviser to Minister and Director-General of Health, on improving the sustainability and performance of the health system.

Other Sessions

- Peter Glensor, Lead Chair of the 21 DHBs (also Chair of Hutt Valley DHB and Chair of the Wellington Regional Council) and Dr John Bonning, National Executive member and Waikato emergency medicine physician were panellists commenting on the Presidential Address.
- Director-General of Health Stephen McKernan on the role of the Ministry of Health in the health system (including retention of senior doctors in New Zealand).
- Bruce Corkill QC, Chair of the Health Practitioners' Disciplinary Tribunal, on the role and trends of the Tribunal.

'What it takes to stay' and the Independent Commission

Executive Director Ian Powell and Assistant Executive Director Angela Belich gave brief presentations on some observations of the national MECA negotiations, the National Executive's theme of 'what it takes to stay', and the ASMS's work in preparing our case for the independent commission looking at competitive terms and conditions of employment. This was followed by delegate workshops and a further plenary discussion.

Better Recognition of On-Call duties

The following remit was debated and overwhelmingly adopted:

> *That existing policy and payment for standby call carries little recognition of the disruption to normal family life nor the interference in normal sleep patterns and leads to real fatigue. The view that standby is not considered work is wrong and should be abandoned.*

Financial and Organisational

- Delegates voted without dissent to increase the annual subscription by $20 to $690 for the 1 April 2009 –31 March 2010 financial year. The amendments from the floor to enhance the increase to $80 and $40 were defeated, the first decisively and the second closely.
- WHK Sherwin, Chan and Walshe were reappointed auditors for the financial year 1 April 2008–31 March 2009.
- The dates of the 2009 Annual Conference were set for 3–4 December.

Annual Report

The ASMS Annual Report which was discussed and adopted at the Annual Conference last month covers an extensive account of the ASMS's activities over the past 12 months. Members are encouraged to read it as it is full of important and useful information. It is accessible on our website

www.asms.org.nz

ASMS 20th Annual Conference 2008

Associate Health Minister Hon Dr Jonathan Coleman chats with delegates at the pre conference function

Robert Reid (NDU), Paul Tolich and Andrew Little (EPMU)

Hon Tony Ryall and ASMS National President Dr Jeff Brown

Dr John Macdonald (Ashburton) assumes the role of master of ceremonies for the conference dinner

Chairman Medical Assurance Society Dr Richard Tyler greets guests at the social function sponsored by the Society

....and a few pointed remarks were made

ASTE President Tangi Tipene and National Secretary Sharn Riggs

ASMS Vice President David Jones (Capital & Coast DHB), Vijay Vijayasenan (Hutt Valley DHB)

Life members George Downward (President 1989-1991) and Allen Fraser (President 1991 -1995)

Philip Pigou, Medical Council of New Zealand, Dr Ian Brown

Solicitor-General Dr David Collins QC chin-wagging with Ron Paterson Health and Disability Commissioner

Musicians Elena and Steffan entertain guests at the pre conference function

Top row, left to right: Pat Sneddon - Chair, Quality Improvement Committee and Auckland DHB; Brian Craig - ASMS National Secretary; Bruce Corkill QC - Chair, Health Practitioners' Disciplinary Tribunal; David Jones - ASMS Vice President.

Bottom row, left to right: Jeff Brown - ASMS National President; Stephen McKernan - Director-General of Health; Garry Evans - Coroner; George Downward - Past ASMS National President; David Galler - Principal Medical Adviser to Minister & Director General of Health; Tony Ryall - Minister of Health; Peter Glensor - Lead National Chair of DHBs & Chair, Hutt Valley DHB; Alan Merry - Professor of Anaesthesia, University of Auckland; Peter Roberts - Capital & Coast DHB

Dr George Downward and Dr Allen Fraser engage the new Minister of Health Hon Tony Ryall

Sheryl Cadman (NDU), Eileen Brown (CTU) and Annabel Snow (NDU)

New Health Minister's first public address: ASMS Annual Conference

The following is a slightly edited transcript of the Minister of Health, Hon Tony Ryall, on 21 November to the ASMS Annual Conference. The transcript includes questions from delegates. This was Mr Ryall's first public address as Minister given a mere 50 hours after being sworn into office. The ASMS is grateful to Radio New Zealand for providing us with the transcript.

I can see by the colour of the backdrop you had a view about the election result. But I am very pleased to be here otherwise. Maybe next year.

(The Minister mistakenly thought the colour of the backdrop was red. In fact, ASMS National President Jeff Brown pointed out to him that it was maroon, ironically a mix of blue and red)

Thank you for the opportunity to speak to you this afternoon. The new Government was sworn in less than 50 hours ago and New Zealanders, I think, have been very impressed with how quickly the New Prime Minister has brought the government together. But also by the breadth of support John Key has secured across the political spectrum. I think New Zealanders voted very loudly on election day. You want to see improvements in public services like hospitals and schools and you want a government that focuses on the things that matter.

I am here today to say that I think it's time to put the wasted years behind us. We have had record spending on health but we suffer chronic shortages of doctors and nurses, growing waiting lists and wasteful bureaucracies. It's time to put behind us those wasted years of endless bureaucracy, endless strategies and total inaction on many of the things that actually matter.

Three years ago when I asked to become the opposition health spokesman I did so because I thought our country, a small country like New Zealand, could become a leader in responsive patient care, and now in government we want to remain even more committed to that goal. So, this afternoon I thought I'd update you on the work that we have been undertaking in those 50 hours and also to outline some of the approaches that we hope to bring to working with health professionals over the next few years.

Our starting point is that we represent the public, and therefore the patients, and what people are concerned about are waiting lists, emergency department delays, the cardiac crisis, the staffing shortages, endless bureaucracy and health care that depends more on your postcode than your illness. And it's these public priorities that inform the government's priorities. New Zealanders want better, sooner, more convenient healthcare and they want accountability for results - and that's our goal too.

Clinical leadership

But to be quite frank, we can't do any of that without you and the other health professionals in the New Zealand public health system. You, along with our other health professionals, are the hearts and brains of the hospital system. You continually innovate to improve diagnosis and treatment and I think its time that management in the health sector did the same. Our best health managers are already trying to do that.

Around the world clinical leadership is recognized as the fundamental driver for improved care. But here in New Zealand health professionals have an increasingly limited say on how health services are provided. And we think it is this failure to engage the people who have the expertise, the doctors and nurses who keep the pubic health system going that is eroding the health service's ability to provide patients with the care that they need. Doctors and nurses and other health professionals need to be able to make the most of their skills and commitment.

Recent research by McKinsey and Co. across 126 hospitals in Britain has found a very clear link between strong clinical leadership and hospital performance. The research has found that the best practices and approaches in hospitals reduced infection rates, improved productivity, readmission rates, patient satisfaction and value for money. And the key to this success was the level of involvement of clinicians in running their hospital services. Stronger and more direct involvement by doctors, nurses and other clinicians means better service and better quality. National wants to ensure that doctors and nurses and health professionals have more say in the New Zealand health service, how it's being developed and improved. We're going to do this by requiring DHBs to involve health professionals in decision making and we want to work with you to make sure that this happens.

This is not say that we want doctors and nurses to stop doing what you were educated to do and become managers. And we should acknowledge that many managers are also clinicians. But we do want to use the wealth of frontline experience you have accumulated to improve quality of care and rebuild confidence in the

public health system. Better clinical engagement will improve quality and job satisfaction and this will help the public health service retain skilled clinicians and attract new staff.

Clinical networks

Pivotal to this will be the further development of clinical networks. And there's growing international recognition that patient centered care is dependant on an infrastructure that supports clinical practice and fosters a culture of learning and teaching. We think New Zealand could learn from Australia where emerging frameworks are recognizing the pivotal role of formal coordinated care networks that are clinician led and patient centered. And frankly this is not some academic theory. In Australia and elsewhere there have been moves towards developing these formal care networks. I went to New South Wales to learn about such networks and the role of these networks is to provide advice and direction on where and how services should be delivered and their focus on clinical practice rather than upon institutions. Clinical networks bring together doctors, nurses and consumers across geographic provider and specialty boundaries and the emphasis is upon clinical management service improvement and partnerships.

And one example that you'll all be aware of is the New South Wales Stroke Services Network. Established in 2002 to develop a coordinated approach to care across the state, sharing available resources and promoting expertise, these new care pathways and programmes have doubled the recovery rate and proven real value for money. The lesson from there is, particularly from the early years, is the plans are not built around health service boundaries but around clinical networks that are appropriate to patients' health needs.

There are some new clinical networks in New Zealand. I think it would be fair to say that progress is uneven, they are often prompted by crises, particular shortages, caused for example by workforce shortages rather than being planned in a coordinated manner. Priority needs to be given to the development of such clinical networks in a number of areas like cardiac services. A recent clinician led report found woeful access to cardiac services in this country and I am sure that clinicians have the solutions to this.

We have asked the Ministry of Health to work with DHBs to identify such vulnerable services around the country. With a true and open picture of the crisis affecting our hospital services, we can then work together to improve services for New Zealanders. We want to work with your profession on solutions to these problems. If you have a solution to a problem then come to us and we will work on it.

The new Government set out its first 100 days priorities prior to the election and in health these are to instruct the Ministry of Health and DHBs to halt the growth in health bureaucracy, to open the books on the true state of hospital waiting lists and the crisis and services, to fast track funding for 24 hour plunket line, to instruct that a full 12-month course of herceptin be publicly available, begin implementing National's tackling hospital waiting list plan and to establish a voluntary bonding scheme offering student loan debt write-offs to graduate doctors, nurses and midwives agreeing to work in hard to staff communities or specialties. This is not an exhaustive list of National's policies, but a concise summary of the party's first priorities for immediate action.

Medical Council elections

Consistent with our commitment to work with the medical profession on the basis on mutual trust and respect, we will be providing for direct election of your representatives to the New Zealand Medical Council. We take this as our first demonstrable action to indicate to you that the tide is changing and there is now a much greater level of respect and determination to involve clinicians in the New Zealand public health system. (The Minister received spontaneous applause from delegates).

Value for money

Finally the new government, like every household in the country, will be focusing on better value for money. With the economic outlook weakening, the focus on getting most out of health investments becomes even more important. Quite simply money is going to be tight until the economy improves. And in health there are agreed funding allocations for increases in vote health, set indicatively two or three years in advance. The annual increase is currently, as you know, $750 million extra for each of the next three years. The first call on this future allocation is for increases to cover inflation and population changes. The remaining additional funding is available for new initiatives.

The three-year indicative budgets for the health system were quietly cut by $350 million in the weeks running up to the general election. National is committed to maintaining this updated future funding track. And because of the previous years and the world economic crisis, it will be difficult to get any extra money over that which has already been allocated. And that is why the health system has to move money out of bureaucracy and waste and on to the frontlines of patient care. Improvement in the health service is imperative to meet the needs of people of New Zealand.

And the task ahead is not going to be easy. There are huge problems existing in the health system that won't be easy to solve. But with your help I think we can solve them. There is no greater asset than your health, and we are determined to work with you to improve services for New Zealanders. Thank you for this opportunity to come and talk to you today and I wish you well with the rest of your Conference. Thank you.

Hon Tony Ryall fields delegates' questions, chaired br Dr Jeff Brown

Questions and Answers

Q: Public-private partnerships

I have been waiting to hear the words public-private partnership in your speech - is there any chance for that?

Ryall – Yes. Well we do think that there should be a smarter use of the public and private sector to help the New Zealand public health system. We particularly see, we have had outlined in our hospital, tackling hospital waiting lists plan, that there are opportunities to use longer term contracting arrangements with private hospitals, general practice, in order to provide more service for New Zealanders. But we do make it very clear that we remain strongly committed to the New Zealand public health system. It will be the place where most of the care in New Zealand continues to be provided, but we want to have a sensible relationship between public and private that benefits patients.

Q: Clinical governance

From what I've heard I would just like to ask the Minister if there's going to be a drive from the Ministry of Health to promulgate clinical governance from the top down as well as from the bottom up?

Ryall – I think the lesson that we can take from the Australian experience is that you're right, it's a combination of both that makes the difference. One is that you've got doctors, nurses, patients at the frontlines of health working together to make improvements. But we have also got a strong direction from the Minister and this is something that is important. I think we can't expect to improve the public health service if we don't facilitate more clinical governance and a greater leadership and opportunity for leadership from doctors, nurses and other health professionals. You know, as I travel around the country I find an incredible professionalism and determination from our health professionals and I think we have to harness that and work with those professionals to improve the health system. I think the idea that people sitting in Wellington and issuing edicts will improve the performance of the public health system has shown that that doesn't work. And where we're setting out as part of the new government, much clearer expectations of DHBs on how this happens and encouraging them to facilitate your role in leadership.

Q: Value for money

You mentioned value for money towards the end there and it's more statement than a question really. We are just very, very keen for you to use quality measures of outcome rather than just numbers frequently gathered from inefficient systems and disparate computer systems and so want you and the Ministry to work through looking at quality outcomes, not just numbers on lists and times gathered inefficiently.

Ryall – There's a lot of international experience that you'll be well aware of that indicates that when doctors, nurses and health professionals are given the opportunity to have greater leadership in the way services are run, planned etc, you get not only improved quality but improved value for money. And that's certainly the conclusion of that McKinsey study that I talked about in my brief comments.

Q: Quality improvement

We had some inspiring talks this morning about the Quality Improvement Committee and the work that has got underway there. I'm just interested in the Government's view about how that should progress into the future.

Ryall – Well we've got no view that we would have other than to continue with a commitment to quality. I think there may be some opportunities to enhance the role that the quality improvement committee plays in the public health service and particularly to connect it with any clinical networks that might emerge over the next while. But any changes that we'd make we'd want to be discussing with people in the sector before we made any firm announcements on any changes that might be made.

Q: Will doctors be in charge

Are you suggesting that after 30 years of the opposite we put the doctors back in charge?

Ryall – I don't know whether doctors want to be necessarily in that position that you know you might have had 30 years ago, but there's an opportunity for doctors, nurses, other health professionals to work much more constructively with management and the reason why I did want to take the opportunity to come here within the first 50 hours, new ministers don't normally speak for the first 50 weeks you might have noticed...

for the last two and a half years we have been talking about the importance of reengaging doctors, nurses and health professionals in the running of the health system. And I wanted to take this opportunity to tell you that the sea change is coming. That our Prime Minister, John Key, the National Party health team, has made it absolutely clear, we are determined to turn our commitment in opposition into action in government and that's why we are here today.

Q: Bureaucracy

I heard both John Key and yourself sort of mention a number of times cutting bureaucracy. In particular, do you have any ideas about a) how you'll do it, and b) what the final look will be in both the health sector widely, (and we are particularly interested in hospitals but it is not limited to hospitals), and in the Ministry of Health?

Ryall – Well we indicated clearly before the election that we wanted to cap the number of management administration staff across both the Ministry of Health and the DHBs and that will be our position. But coupled with that is the fact that bureaucracy is not just about people, its also about processes and the never ending generation of paperwork and endless reports that no one takes any notice of, and information that's collected where the only person who has asked for it in the last 15 years was the previous opposition spokesman on health. So there are, we are indicating and we will be through the formal processes that the Ministry have with DHBs, that this is an area where improvements need to be made and we will be outlining expectations of them with respect to that. Key to this is making sure that we can maintain good quality public services within that.

Q: RMO positions in Auckland

Fully over, almost a third of all the SMO's represented by this union work in Auckland. You might be aware that, probably from next month is public knowledge, that there will be about a 25% shortage of all RMO positions in Auckland, and yet the medical schools are bursting at the seams with applicants to get into medicine. Is your Government going to look urgently into what is going wrong and why RMOs are not available for working in New Zealand soon after they qualify?

Ryall – Well it worries me incredibly about the proportions of our young doctors who are leaving the country so quickly after graduation. We indicated before the election that we will be increasing the medical school intake by 200 over a period of time in order to increase the numbers who are available. But we also need I think a much stronger focus on retention of the people that we have at the moment and we do need to work with you to see what can be done to make sure that so many of these junior doctors who are leaving the country, or the Auckland region, have a greater sense of value and connection with the system.

I think more focus needs to go on to the retention side of the equation, not just recruitment. And in many ways that is one of the issues that we are going to have to be putting at the top of our agenda in dealing with your organization is how we engage senior doctors in helping us stem that retention problem. Which I must say is particularly bad in greater Auckland.

Q: Elected boards

I'm a relatively rare beast in that I'm a senior clinician and also an elected member of the DHB. In those two roles I have seen from below and from above, the functioning of management systems and I have studied these in some detail. And amongst other things I've found that the safety culture relates to good management. As a board member I also have seen that without the board intervening a year and three months ago that a crisis of management was taking us down the tubes at a great rate. The board was the catalyst in that people who actually had to move into action to change that. Without those elected people being there, without that process we would've been much further down the tubes. What are you going to do with the boards?

Ryall – Look, I have to say that a very clear message that I've received from the public health system is that the system does not need another round of massive structural change. I have been in Parliament 18 years and the one thing I can tell you is changing the letterhead doesn't fix the problem. So we've got no plans to change the composition of the elected versus appointed situation.

I think that the public likes having elected people on their DHBs. I think the turnout is incredibly low in the voting, but the public still likes to have their direct say on that and we are going to maintain that. We are not proposing a massive restructuring. I think that we can make a lot of the gains we want through much closer cooperation between DHBs, not only in the back office administrative function, but also in supporting the development of clinical networks. Because what this should be is not a question about what are you going to do about the boards but what are you going to do about improving the services and the cooperation that can come from that. And that really is my focus, we are less focused on structures as we are on service, and its getting those structures to support improved service through clinical leadership and greater involvement of the sector.

Q: What will happen to ACC

Firstly, fantastic that you are going to re-empower clinicians. But what I want to ask about is ACC. I realise it has a separate minister, but presumably you will have a big interest. Can you tell us what is likely to happen?

Ryall – Well I can tell you what the National Party policy was prior to the election, and that will be the Government's policy, and that is with respect to the workplace insurance, we want to have an investigation that if we can be satisfied that workplace safety can be improved and the premiums can reduce, then we would look at the possibility of introducing competition into that sector. But it is premised upon being assured about premiums being lower and workplace safety maintained.

The great concern that I meet in the health sector about that (rather than principle) is concern that people have about the huge administrative burden that some providers faced when we previously had competition. And I think one thing that was learned from that experience is the importance of having common forms and a clearing house to deal with the various claims that might be made. But the government's

position is that we are looking at an investigation. It's no way predetermined that there will be competition. We have to have an assurance that premiums will be lower and workplace safety will be improved.

Q: Pathology services

I'm a pathologist at Counties Manukau and I am going to bang the pathology drum here. Does the new Minister have any sort of over-arching plan for the development and perhaps coordination of the provision of community and public pathology services? I'm interested in what your impression is as to how it's working now and where do you think it can be changed?

Ryall – Well there are a number of issues behind that. I think that there's a weakness in what's happening at the moment in that there is no national overview of what is happening. And there is some real risk to the public health system in having quite a disjointed approach around the country. It is having considerable pressure on the workforce which is the key asset and must be protected at every opportunity. So we will be doing some work on that. We think that there's an opportunity to try and get more of a national view on what's happening. There's also a greater potential, I think, to have clinicians more involved in the discussions around that than they have been to date. As you're aware there's some legal action which restricts exactly what we are further able to comment on.

Q: Imaging

I'm one of the radiologists new to the country, working at Waikato. My interest is really in oncological imaging, in particular PAT imaging. It's an extremely effective tool, I am sure you will know about this, in the management of cancer worldwide. We are probably about seven to eight years behind the rest of the world I think in implementing this. What are your thoughts? Is there going to be a national implementation programme on this?

Ryall – I realise it's a priority, particularly in cancer. I am not able to give you a detailed answer on that today. But I do know there's a problem. It strikes me as being a great opportunity to look at getting a national approach to how this thing is dealt with, both from a capital and an operational point of view but I wouldn't want to speculate on what's happened.

Q: National coordination including information services

One of the things that is an impediment to any kind of national coordination, or even regional coordination, is the way over the last 20 years people keep on re-inventing the wheel in their own area. And I am thinking particularly of information services, electronic health records, and radiology imaging systems that are fantastic in your institution but can't talk and transmit to others. I realise this may be a bit early for you to have thought of anything detailed like this, but does your Government have any sort of view on coordination on a national level?

Ryall – Well I identify that's one area that does concern us about how long it takes to get any of this stuff done, and the different systems there are everywhere. You know I sort of have the starting point of, if you look at pandemic planning for example, I mean there are 21 different ways of dealing with bird flu across the country. And frankly I am the only person in parliament who read every 21 of them so I can tell you how different they are. And what, I would have thought the sensible approach there would have been to say to one DHB, look you do the template on this and we'll all make some local changes.

And I think there's an opportunity to have more of that in the public health service, where you ask certain groups of clinicians or DHBs to take a leadership role and other people leverage off that for their local conditions. And I wouldn't want to necessarily say that's what's going to happen in health IT but it is an area that we are doing some work on. We have some views and we will make sure that we engage with you on those.

Q: Ambulance service

I live in a rural community and one of the issues we have is with our ambulance service. With all the pressures that are on families nowadays, it seems the days that people have time to volunteer for these organisations seems to be, well, to be over or changing, and there is such a demand on the service. We are finding that every other day we ask for an ambulance to provide an inter-hospital transfer and we cannot get that service at all. My question is does the National party also have concerns about the volunteer service? Is it time now to decide to put some more money into the ambulance and make it a more professional organisation as perhaps it should be in a first world country?

Ryall – Parliament's health select committee has undertaken a review of ambulance services, and as you'll be aware also the government and ACC have a number of reports underway on this as well. I think I'd prefer to reserve my comments on that. I do think that St. Johns and the other ambulance providers do their level best to provide a professional service and I think the volunteer role is important and respected within the community, but I do take the point that you are making about lifestyle changes and peoples' ability to contribute to this, but that is something we'll have to consider over the coming while.

I have to say that the real pressure we will have is finding resources to make improvements in various parts of the health service. We are in quite a strapped financial circumstance as a country, and all priorities will have to be considered within that.

Conference Dinner

Dr Rod Harpin (NorthlandDHB), Dr Julian Fuller (Waitemata DHB)

Unanimous conference remit on the use of private sector by DHBs

At the 20th Annual Conference of the ASMS the following remit was adopted unanimously:

> *Maintaining and building the capacity of DHBs to provide health services should be the long-term strategy of government and DHBs. Use of the private sector as a short-term solution to capacity problems in the public health sector can be an effective occasional solution. However, in many DHBs use of the private sector has increased beyond occasional or temporary and now threatens the quality of patient care in the public system. This threat is from loss of skilled and experienced staff from DHBs, and the consequences, to those remaining, of dealing with only high acuity and emergency patients. ASMS calls on the government and DHBs to strengthen public health capacity to provide high quality care for elective as well as emergency patients.*

Since the turn of this century there has been a significant increase in the amount and proportion of DHB clinical work contracted out to the private sector under the outgoing government. This is particularly the case in the wider Auckland region although not confined to it. Further, in the general election campaign the parties making up the incoming government have promoted making greater use of contracting out to the private sector.

The remit deliberately differentiates between short-term needs on the one hand, and, on the other hand, the strategic direction of maintaining and building the capacity of DHBs to provide health services.

Further, while it might be argued that contracting out DHB-funded care to the private sector might supplement the income of members faced with perceived (or actual) inadequate DHB salaries, this is questionable. There are many members in specialities or geographical areas with very limited opportunities in the private sector. If salaries, other terms and conditions of employment, and working conditions in DHBs were sufficiently attractive to compete with Australia and opportunities in the private sector, then DHB work that is contracted out would not be a financial imperative for those who might see it this way.

It was important to not only say what the remit was but also what it was not. It was not an anti-private sector remit. Many Conference delegates themselves had private practice. Around 40% or so of ASMS members have private practice. The ASMS has over the years spent much time and resources defending rights of private practice including the protection provided in the national DHB MECA with the clause differentiating rights of private practice from conflict of interest. Nor is it against DHBs using the private sector where there are capacity difficulties that can't readily be overcome. Sometimes, however, political assertions overstate the practical benefits that use of the private sector can provide.

Instead it is about maintaining and enhancing the zcapacity of DHBs to provide a full range of accessible and quality comprehensive services and ensuring that any use of the private sector does not undermine this objective.

The ASMS will be using this Conference remit as the basis for discussions with the new government and with DHBs on this subject.

Dr Martin Orr (Waitemata DHB) and Dr Adrian Gilliland (Te Rununga o Toa Rangatira)

ASMS Industrial Officer, Lyn Hughes chatting with Dr Peter Dzendrowskij (Counties Manukau DHB)

Lost in translation

MEDICAL PROTECTION SOCIETY

The article below has been kindly provided by the Medical Protection Society for interest and benefit of members. Overwhelmingly ASMS members are also MPS members.

Hospital doctors are faced with a more diverse patient population, in terms of language and culture, than ever before. And, of course, it is not just the population of patients that is changing. Over 40% of doctors working in New Zealand are International Medical Graduates, many of whom work in hospitals throughout the country.

These changes to the population bring real challenges for healthcare professionals. There are an increasing number of studies that show that a breakdown in communication can be the trigger of a complaint or claim, sometimes even if there has been no fault in the care the patient has received. These dangers are magnified where one participant in a consultation is (literally) talking a different language.

Of course, it is about more than language. There are many other cultural factors that come into play, such as the use of particular gestures, body language and wider issues such as the role of women and the family.

Consultations can be a mess of misunderstandings.[1] In hospital practice this is a potential, and growing, risk.

Sometimes family members, friends or children are used as interpreters. This situation is not ideal. Using children to translate, for example, may prevent family members from getting vital, but embarrassing, information. Other members of the family may have an interest in controlling the information that is passed to and from the patient.

Care should also be taken when using dual-role translators (individuals who have another job in the hospital). While these can provide a convenient and effective service, it is important that their skills are up to the task.

In a perfectly resourced world, a professional interpreter is the preferred answer. Hospitals in New Zealand are required to have interpreter services available. The difficult question sometimes is when should an interpreter be used. Studies have shown that the use of professional interpreters improves care for patients with limited English proficiency.[2] Patients who rate their translator highly are more likely to rate their healthcare highly.[3]

Practical implications

So what are the main risks for hospitals and hospital doctors? Right 5 of the Code of Patient's Rights states that patients have the right 'to be given information that you can understand in a way that helps you communicate with the person providing the service.' The Health & Disability Commissioner has commented on language difficulties in a number of his reports and opinions and has criticised doctors for not using interpreters. The Commissioner has stated 'it may be appropriate to use an interpreter even when it appears that the patient's understanding of English is very good.'[4]

District Health Board (DHB) websites and information leaflets should include information on their interpreter services for patients. However, some may charge a nominal fee for interpreter services, and this would need to be discussed with the patient prior to engaging the interpreter. Where cost might potentially prevent the use of an interpreter this should be addressed so that the patient and doctor are not disadvantaged. Some DHBs also prefer for an interpreter to be booked up to a week in advance which is obviously of little help in an acute presentation.

Among the practical tips for using an interpreter are:

- Try to look at your patient and not at the interpreter when you are speaking, even if the patient cannot understand you. This can reduce certain anxieties from your patient. It also allows you to monitor body language.
- Remember that the interpretation process takes time, and ensure that background noise is at a minimum.
- Some people who most need information in their own language may not be able to read or write in any language.
- Be aware that non-medical staff are usually the first people that service users and patients encounter. Communication problems with a busy receptionist can cause distress or discomfort for a range of patients who have specific communication requirements.
- Remember that some languages do not have a written form, so audio material may be preferable.
- While good communication is important in any patient consultation, there are particular situations where patients are more at risk, such as:

Consent

Particularly where consent to treatment is complicated, it is important to check the patient's understanding of the risks and benefits.

Older people and those lacking capacity

The difficulty of establishing the needs and wishes of those with limited capacity will prove more difficult when their English is poor. This may be exacerbated if it is difficult to separate the interests of the carer, acting as translator, from those of the patient.

Dual residence

Patients living in two different countries may be seeing different health professionals. Matching treatment and prescribing options can be difficult.

Communication with patients where different languages are involved raises significant potential for misunderstandings. This can lead not only to clinical difficulties, but also to an increased likelihood of complaints. Interpreter services are available in hospitals, and although using an interpreter may take a little longer, the outcome for both patient and doctor may well be improved.

Dr Tim Cookson
Medico-legal consultant, MPS

1 Moss B, Roberts, C, Explanations, Explanations, Explanations: How do Patients with Limited English Construct Narrative Accounts in Multi-lingual, Multi-ethnic settings, and how can GPs Interpret them? Family Practice 22(4) 412-8 (2005)

2 Karliner LS et al, Do Professional Interpreters Improve Clinical Care for Patients with Limited English Proficiency? A Systematic Review of the Literature, Health Serv Res, 42(2) 727-54 (2007)

3 6. Green AR et al, Interpreter Services, Language Concordance, and Health Care Quality. Experiences of Asian Americans with Limited English Proficiency, J Gen Intern Med, 20(11):1050-6 (2005)

4 www.hdc.org.nz/files/hdc/opinions/01hdc01057.pdf

ASMS Office Hours

The national office will be closed from Wednesday afternoon 24 December through to Monday 5 January 2009. During this period messages of urgency can be left on the office answerphone which will be cleared regularly. Throughout much of January we will be operating on reduced staff.

ASMS services to members

As a professional association we promote:

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

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for around 3000 doctors and dentists, over 90% of this workforce.
- advise and represent members when necessary
- support workplace empowerment and clinical leadership

Other services

www.asms.org.nz

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

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

ASMS Job Vacancies Online

www.asms.org.nz/system/jobs/job_list.asp

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

Substantial discounts are offered for bulk and continued advertising.

ASMS email Broadcast

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

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

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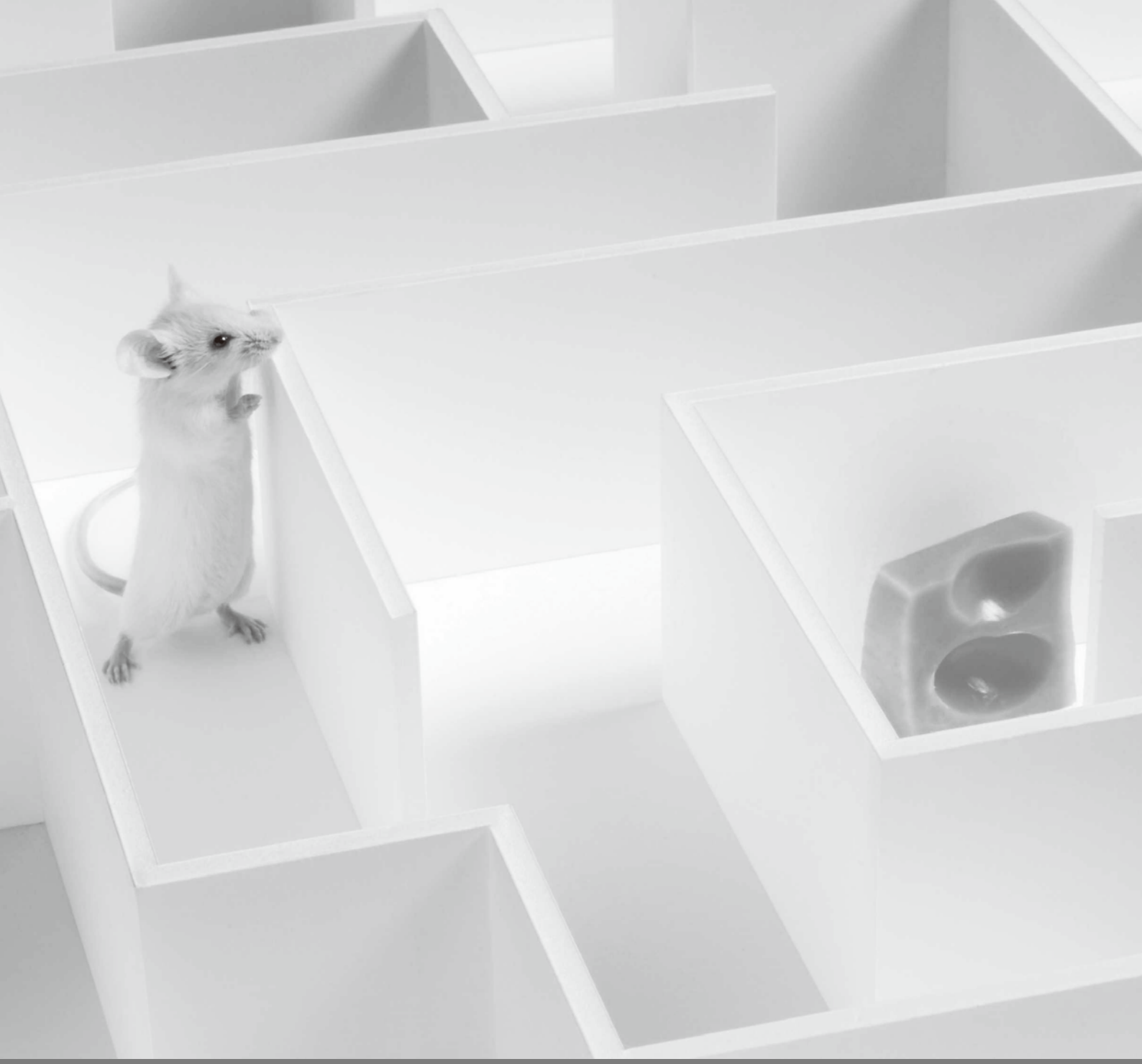
Street Address	Level 11 The Bayleys Building Cnr Brandon St & Lambton Quay Wellington



MEDICAL ASSURANCE SOCIETY

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