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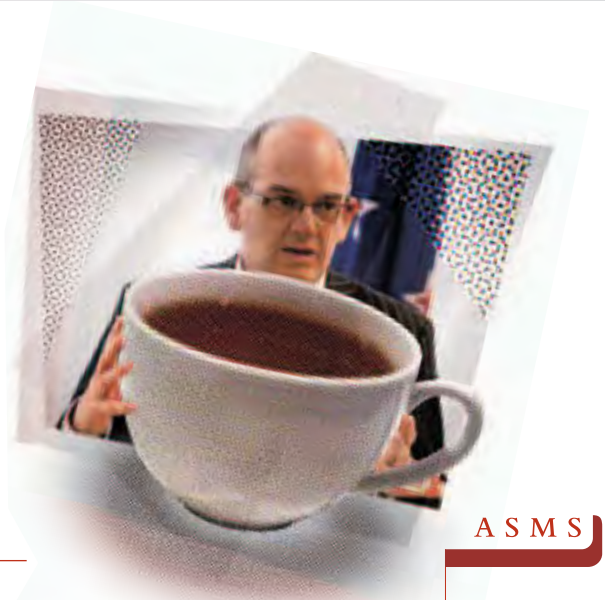
The Specialist

The newsletter of the Association of Salaried Medical Specialists

MECA cup getting closer to political lips



The expression about the gap between cup and lips is often used and has its relevance to our MECA (multi-employer collective agreement) negotiations with the 20 DHBs, and to the joint business case in particular. Respecting New Zealand's well deserved internationally recognised café culture, let's call the business case a well made flat white (cappuccino conjures up an image of too much froth).

This flat white is getting closer to the lips with the forwarding of the joint business case by the ASMS and the DHBs to the Minister of Health Hon Tony Ryall.

At the time of writing this article the business case has been referred to Mr Ryall who in turn will refer it to the cabinet social services sub-committee. In considering the business case's recommendation Mr Ryall will be mindful of his considered and perceptive statement when interviewed on TVNZ's Q&A programme (3 October 2010):

We have a workforce crisis in New Zealand because we need to maintain more of our hospital specialists, I say yes we do, it's our number one priority.

The flat white

The business case was the key feature of the previously reported 'variation' to the current (expired) MECA. In reference to the business case the 'varied' MECA states:

The parties also agree to jointly develop a business case that will address the senior medical & dental officer workforce challenges facing District Health Boards. Acting in good faith and by using their best endeavours the parties shall develop the business case by no later than 31 October 2010. It is intended that the business case should inform consideration by the parties and the government of any likely changes in remuneration to this Agreement in the 2011/12 and subsequent years.

Since late September the joint ASMS-DHBs steering group worked hard with candles burning late. The DHBs representatives on the steering group were Ron Dunham (Counties Manukau chief operating officer), Fiona McMorran (DHBNZ advocate), Phil Cammish (Bay of Plenty chief executive), Jenny Martelli (Lakes senior manager), and Tony Hickmott (Counties Manukau financial analyst).

The ASMS's representatives were Ian Powell (Executive Director), Angela Belich (Assistant Executive Director), Jeff Brown (National President), David Jones (Vice President), Brian Craig (National Secretary), and Derek Snelling (Wellington based anaesthetist and member of ASMS negotiating team). The conduct of the steering group was characterised by professionalism, collaboration and teamwork, a novel but heartening experience.

The business case is necessarily a confidential document. Its contents can't be disclosed for the moment.

Unanimous ASMS resolutions on joint MECA business case

National Executive, 17 November:

That the National Executive endorses the business case, *Securing a Sustainable Senior Medical and Dental Officer Workforce in New Zealand: the Business Case.*

Annual Conference, 19 December:

That Annual Conference endorses the National Executive's actions in the national DHB MECA negotiations including development, jointly with the DHBs, of a business case for investment in the retention and recruitment of the senior medical and dental workforce.

ASMS

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For clarity it should be noted, however, that it does not recommend specific terms of employment such as salaries or superannuation but instead seeks approval for the phased expenditure of a quantum of money.

We have a workforce crisis in New Zealand because we need to maintain more of our hospital specialists, I say yes we do, it's our number one priority.

Hon Tony Ryall, Minister of Finance

The ASMS National Executive has unanimously endorsed the business case (and the National Executive's approach to it was unanimously endorsed by the ASMS Annual Conference last month). It is now with the 20 DHBs' chief executives before referral to the Minister of Health for political approval.

Condensing the crisis

The workforce crisis recognised by the Minister can be described as follows:

- DHBs have an unsustainable senior medical staff workforce crisis.
- New Zealand has the lowest rate of specialists per capital and highest rate of international medical graduates (IMGs) in the OECD.
- The achievement of important government objectives is threatened by this crisis.
- Among these government objectives are the recommendations of the RMO Commission (2008).
- DHBs suffer from poor retention, high IMG turnover, and excessive dependence on locums.
- This status quo generates waste (including financial) and inefficiency.

The outcome of the business case will shape the future direction of the MECA negotiations which formally resume on 9 February (and when the National Executive meets the following day). The outcome rests with the chief executives in the first instance and then government.

Whither the business case

The business case recognises that to overcome this crisis the solution rests in looking through a quality lens. In sum, improving retention and recruitment leads to improved quality improvement and improved quality leads to improved cost effectiveness and financial savings.

At the ASMS's social function immediately preceding our Annual Conference last month a member of the Employment Relations Authority observed to me that one probably has to go back to the 1970s in New Zealand's industrial relations to see something that resembles our business case approach. If the grammatically correct readers will forgive me this business case not just unique, it is 'very unique'. Let's hope that the work of the baristas who made the quality based flat white don't experience spillage between cup and lips.

Ian Powell
Executive Director

23rd Annual Conference
17–18 November 2011

PRESIDENT'S COLUMN

Presidential Address to ASMS Conference

Below is Dr Jeff Brown's Presidential Address to the 22nd ASMS Annual Conference at Te Papa on 18 November.

Best

The best health care system in the world.

The best health professionals in the world.

The best doctors in the world.

Ideals plucked from sleep-deprivation fantasies? Unrealistic and unaffordable ravings? Emetic eternal optimism?

But what do our patients expect when their lives and ours intersect? Do they expect mediocre care? Do they expect us to achieve wide variances in diagnostic accuracy? Do they expect us to have 275,000 adverse drug events per year in New Zealand? Do they expect patient identification errors 900 times each year, harming 320 patients? Do they expect potentially preventable events to be costing our health system $590 million per year?

My experience, and yours, and that of the Health & Disability Commissioner, is surely that patients expect the best care. That they will see the best doctor to help them with their undifferentiated problem or problems. That they will see the best doctor to help them with diagnostically or technologically challenging conditions. That they will navigate a joined up system of best care that eases their journey rather than raising barriers or laying 'heffalump' traps at every turn.

They expect our best efforts, singly, and together. To put their best interests at the centre of our attention.

They expect best care, not second best. Not third best. Not barely good enough.

Tomorrow we will hear about the newly formed Quality and Safety Commission. About what projects we can expect to participate in, what shared learning we can quickly disseminate.

We will be challenged to think outside our silos. To look beyond variation. To consider the notion that the most dramatic advances in healthcare are not in extremely high cost pharmaceuticals or whiz bang technology, but in applying what we now know more equitably.

As Richard Bohmer elegantly outlines, modern health care organisations must be capable of simultaneously optimising the execution of standardised processes for addressing the known, and learning how to address the unknown. Health care providers need to excel at performing three discrete tasks simultaneously:

(i) vigorously applying scientifically established best practices for diagnosing and treating diseases that are well understood,

(ii) using a trial-and-error process to deal with conditions that are complicated or poorly understood, and (iii) capturing and applying the knowledge generated by day-to-day care.

We cannot excel at this as lone heroes, as individual autonomous doctors, as competing craft groups, or as adversarial organisations. Our collective intelligence has more chance when we take a stance for national services, for national clinical networks, for regional solutions. Provided we are always vigilantes for the complexity of patient care in which predictability and ambiguity exist side by side.

We will contemplate integration of primary and secondary care models tomorrow, of joining up partitions of care. Of joining up the leadership of organisations advocating for their portion of the pie. There is evidence out there, in New Zealand, that we can do so much better, while celebrating that we currently have one of the cheapest, most efficient, best outcome health systems in the world.

Yet even in New Zealand, if all hospitals were to meet the current average length of stay, we could save 382 beds, effectively the costs of building and running an entire new hospital. And the ongoing capital charges and depreciation.

Just by doing what others are doing best.

if all hospitals were to meet the current average length of stay, we could save 382 beds, effectively the costs of building and running an entire new hospital

But many claim that doctors are not natural team players, that stories of heroism reinforce autonomy at the expense of patient outcomes. Mounting evidence suggests that individual clinicians, and even hospitals, have only limited control over the fate of their patients. It all depends on complex adaptive chaotic systems, on small interventions with butterfly wing effects. And is totally dependent on a profession that attracts idealistic people who want to do good, and selects out the smartest, hardest-working and most competitive people in society. Is it any surprise that it is hobbled by their fierce autonomy? That medicine's altruistic core values actually reinforce practitioners' resistance to change? That doctors see themselves as their patient's sole advocates, with the rest of the world divided into those who are helping and those who are in the way?

Medicine used to be a cottage industry of autonomous artisans. That is how our beliefs and morals were forged. That is what formed the framework for those who trained us. And when we are challenged to change we argue from what we know. And we all know best.

On the few occasions we do not confidently know, we ask for or acquiesce to a second opinion. Yet, says Atul Gawande, the second opinion is a tremendously flawed institution. You do not get to

pick the best outcome, just to pick from two different options. What you really want is for those two doctors to talk to each other.

When they talk to each other the patient really wants the best from both. That doctors respect each other's expertise, whether in the minutiae or in the global aspects of the individual, their family, and their community. That they are not tired, not grumpy, not juggling duties and dropping balls, especially if those balls are theirs. That they know what other doctors have asked, have considered, have eliminated, and have treated. That one part of the individual's journey is joined up to the next step they take, supported by our care.

the second opinion is a tremendously flawed institution

Integrating primary and secondary care, and leadership of that care, is an increasingly important and challenging theme for hospital based specialists. Our DHB boundary riding, or primary vs secondary vs tertiary territorialism, has made innovation as vulnerable as island species, suspended in webs of significance we ourselves have spun. We continue to reinvent the wheel, instead of accepting the fundamental design as pretty good, and investing our energies into retreading the tyres for local roads.

Our performance variation should prompt us to work more as teams. To change from the fables of heroism of infallible lone healers to tales of great organisations and brilliant teamwork that make for great care. While we are the determinants of the most expensive spending in all health, we are also the levers for the greatest changes in the way we spend each health dollar.

What determines the inventiveness and rate of cultural change of any group is the amount of interaction between individuals. Some claim natural selection applies to shared ideas and discoveries. And we know we are sharing and telling our stories in the modern medical age at an unprecedented rate. We hold out hope that we will prosper mightily in the years ahead because our ideas are having sex with each other as never before.

But a caution as we rush headlong into innovation. Social psychologist Jonathan Haidt says, although we like to think of ourselves as judges, reasoning through cases according to deeply held principles, in reality we are more like lawyers, making arguments for positions that have already been established.

We all know that our provincial and rural hospitals are under threat. That we are reliant on locums and imported expertise to keep our communities afloat. That we are asking a diminishing pool of full-time hospital specialists to lead us through the exigencies of modern clinical life. With little or no formal training in leadership. Today we will hear the results of our survey into clinical leadership. Into how SMOs perceive the implementation of *In Good Hands*.

We will give you the opportunity in workshops to discuss how clinical leadership is working in your world. To identify the barriers, and how you have overcome them. To share how you deal with colleagues who illustrate the traits of high certainty and low agreement. And to explore how we can strengthen branch activities to best promote distributed leadership throughout our workplaces. To work out how we can tell the best stories of new heroes who use checklists, who tell stories of great organisations and brilliant teamwork that make for best care, who drive national and regional solutions. Vigilantes who enable ideas to be a whole lot more promiscuous.

Beyond the rhetoric, where does the rubber, even of retreaded tyres, hit the road? Where does the best solution for our troubles lie? In our workforce. Without one we cannot exist, beyond the dodgy and deranged who linger with nowhere to go. Our patients expect their doctors to be the best, not second best, or worse.

Your Executive and negotiating team have explored innovation and collaboration with DHBs to develop both a holding pattern improvement in conditions, in line with other health workers, alongside a business case for significant investment in the senior medical workforce to retain our best minds and minders, and recruit the best intended imports. Anticipated result – the best medical workforce for New Zealand. We have tried our very best, and are confident that whatever the outcome of political deliberation, our shared vision with DHBs is unarguably the best view of the future for our country's health system.

Our patients expect their doctors to be the best, not second best, or worse.

In these negotiations we have adopted the forensic pathologist approach to adversarial systems. They describe a "hot tub" process whereby proponents of arguments meet together, and over a meal, or more, develop a shared understanding, shared way through or over barriers, and shared vision of the future. I am reminded of the frog experiment where gradually raising the temperature of the hot water evoked no response from the frogs, other than acceptance of cooking to death. I hope that our organisation of mature health professionals, led by passionate exponents of a world class health system, are the best thermostats of our hot tubs. And that you as delegates to this Conference will support them as they explore beyond backyard pools, into communities of care, into regions of shared services, and into national networks and nationally funded services.

And support a case for investment in the best SMO workforce possible. To provide the best care for our population, the best care for our groups of patients, the best care for the individuals we share critical moments with.

To make them better we must be our best.

Kia kaha.

Jeff Brown
President

EXECUTIVE DIRECTOR'S COLUMN

Be careful what you ask for! You might get it!

The public statement released by the chief medical advisers of the 20 DHBs on the impact on patient care of the over 700 partial strikes by medical radiation technologists (mainly) and laboratory workers had much to commend it. The slightly odd literary style – somewhat patrician and revealing an obsession for capitals – did not detract from the message that patient safety was at risk and the situation potentially dangerous.

The chief medical advisers were not commenting in pristine isolation. Most at least have robust connections with their fellow senior medical staff colleagues and the thrust of what they said has origins in these interactions. They are well informed on patient safety. The threat is not from strike action in principle but a particular form and very high volume which make it difficult to cope (including rescheduling).

But this powerful message was diluted by a second message – that the government change the law to ban strikes in the health sector replacing them with compulsory arbitration. It is clear that the chief medical advisers had not done their industrial relations homework and not taken good expert advice.

...this powerful message was diluted by a second message

If one puts to one side the fact that the government has no interest in a law change of this nature (at least this is what it has indicated), there are still problems. First, compulsory arbitration can't be isolated from the type of industrial relations system that it operates within. Compulsory arbitration from the mid-1890s to the mid-1980s dominated New Zealand's industrial relations system. But, in the state sector at least, it was based on sophisticated relativity criteria (including horizontal and vertical) designed to determine a fair 'rate for the job'. That underpinning criteria (along with compulsory arbitration) was replaced by a system that placed more emphasis on negotiations. If we returned to arbitration we would have to return to some form of relativity criteria if it was to be a flexible and fair system. To devise such a system would require both political will (not present) and time, in order to work through the complexities.

But what about the police some might say. Certainly they are in a unique position with a system of compulsory arbitration called 'final offer' in the Police Act. It does have criteria but they are restrictive, particularly when one party or the other has to win on all of them. They are not based on the principle of establishing a 'rate for the job'.

The Police Association did win a case last year through final offer arbitration but that was on a very narrow issue (should the salary increase be 1% or 2%). It is not a sufficiently flexible system to address broader issues or those that are further away from the status quo.

It is difficult to see how it would have delivered on the introduction of job sizing which was a radical new concept when first introduced in the early to mid-1990s. Similarly the gains the ASMS made in the mid to late 1990s on subsidised superannuation and a premium for hours worked on after-hours call rosters at a time when the trend in the economy was going in the opposite direction would have been inconceivable under the police arbitration system.

The chief medical advisers have also missed a very basic point. The Employment Relations Act actually provides for a form of non-binding arbitration called facilitation. It is not binding but is compulsory if the Employment Relations Authority accepts an application from either the relevant employer(s) or union. Although not binding the Authority's decision has influence especially as it can be made public. The threshold for acceptance has been well exceeded in both the MRT and laboratory workers disputes. But neither party (union or the DHBs) has applied to the Authority. This leaves a bit sick a call for a law change for compulsory arbitration when an existing process for non-binding but influential arbitration is ignored.

Chief medical advisers should stick to their knitting (which itself is a broad scope) and focus on professional related matters including patient safety where they know what they are talking about rather than matters which they don't. There is an old maxim that there is a risk of bad policy arising out of bad experiences. It is disappointing that such an intelligent and impressive group of people fell into this trap even given how bad the experience has been.

Ian Powell
Executive Director

ASSISTANT EXECUTIVE DIRECTOR'S COLUMN

Surveying the implementation of *'In Good Hands'*

The *In Good Hands* statement was developed by a group of health professionals appointed by the Minister of Health, including ASMS President Dr Jeff Brown in early 2009. The Minister of Health has adopted it as policy and asked all DHBs to implement it although commitment and progress has been variable ranging from slow to non-existent.

In Good Hands requires:

- DHB Boards to establish governance structures ensuring partnership of clinical and corporate management
- The DHB chief executive to enable strong clinical leadership and decision making throughout the organisation
- The DHB at the governance level to promote and support clinical leadership and clinical governance at every level
- That clinical governance must cover the whole patient journey, with decisions devolved to appropriate levels
- That DHBs identify actual and potential clinical leaders and support their development

Reporting on implementation has fallen into a black hole with DHBs very unclear as to even when they are required to report on the implementation of the policy so when Associate Professor Robin Gauld of the Centre for Health Systems at the University of Otago approached ASMS asking whether we would help in surveying our membership on the implementation of *In Good Hands* we were very keen to help.

A survey (with 11 fixed response questions plus provision for comments) was sent to all DHB ASMS members in June this year. There were two follow up requests plus a follow up web based survey. The survey questions were directly related to the key policy directives. The survey achieved a 52% return rate out of the over 3,400 DHB employed members that the survey was sent to.

The ASMS Annual Conference last month heard a fascinating presentation by Dr Gauld on the results of the survey. Some of it was 'hot off the press' so to speak. He will be further analysing the results and also working on an article for publication in an international journal.

What is clinical governance and what is clinical leadership?

Dr Gauld, in his presentation talked about clinical governance as an indistinct concept which developed partly as a response to managerialism. He sees it as attached to ideas of quality improvement by health professionals and health professionals leading in service redesign and developing accountability mechanisms.

He referred to research which shows that hospitals with clinically trained leadership are more likely to have standardised processes in place and are more likely to have better patient outcomes. He also tied clinical leadership to concepts of greater productivity in the National Health Service in the United Kingdom and at the Geisinger group.

The Clinical Governance Development Index (CGDI)

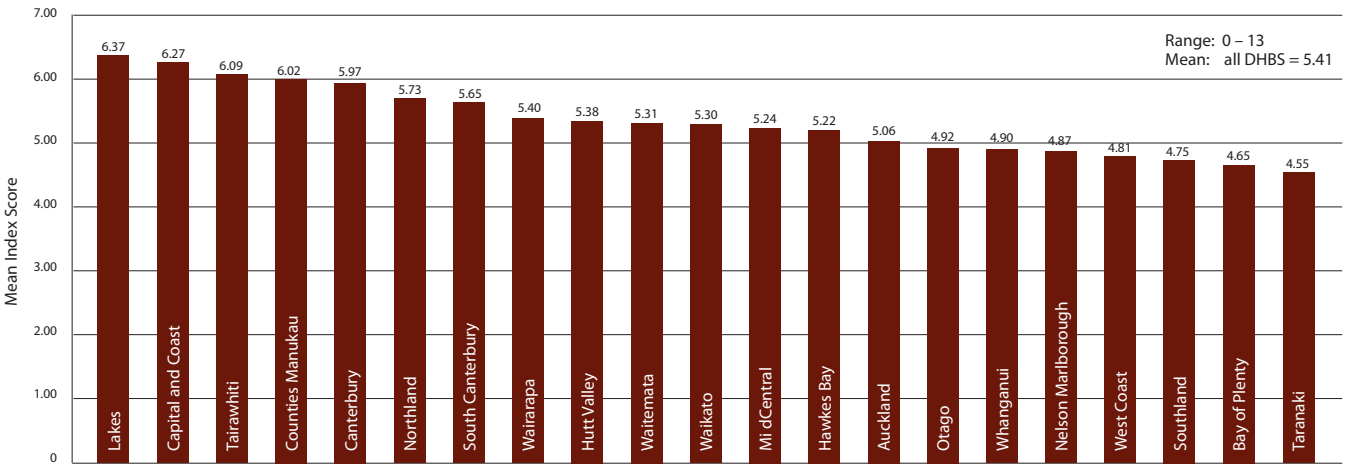
Dr Gauld has developed an index from the seven survey items representing aspects of clinical governance implementation. The extent to which a board and management fostered the development of clinical leadership were related to the CGDI score. This result was both independent and statistically significant.

The mean for all DHBs was 5.41. As you can see from the diagram below the worst performing DHBs over the range were Taranaki, Bay of Plenty, Southland, West Coast, Nelson Marlborough, Whanganui and Otago (Southland and Otago were treated as separate DHBs for the purpose of the survey given their recent merger). The best performing DHBs were Lakes, Tairawhiti and Capital & Coast.

Dr Gauld commented to the ASMS Conference that though there were clearly some DHBs who could be picked out as performing below the mean on implementing clinical leadership the mean itself was disappointingly low. This has implications for the quality, safety and efficiency of the system as international evidence shows that clinical leadership is the single most important ingredient for a high performing health system.

Angela Belich
Assistant Executive Director

The Clinical Governance Development Index (p=0.000)



Conference Highlights

Left: Dr Jeff Brown
President
Right: Dr Brian Craig
Secretary

The ASMS Annual Conference (18-19 November) had a record attendance with over 120 delegates and three visitors from the Australian Salaried Medical Officers Federation. On the preceding evening the ASMS hosted a pre-Conference function which provided an excellent opportunity for delegates to mix and network with politicians, Health Ministry and DHB officials, employment and medico-legal lawyers, and unionists.

On the first morning Dr Jeff Brown gave his Presidential Address which attracted media coverage (particularly Radio NZ) and is published elsewhere in this issue. This was followed by two tributes to former National President John Hawke who passed away in April from Drs James Judson and David Crum (NZ Dental Association).

MECA, MECA everywhere

The national DHB MECA negotiations were the main issue discussed at Conference. Only 24 hours earlier the joint business case between the DHBs and ASMS had been completed. On the first day Executive Director Ian Powell gave an extensive presentation on the direction of negotiations to date and the thrust of the business case (Budget confidentiality precluded some matters being reported). This was followed by many questions and wider discussion.

On the second day there was an open forum on the negotiations with many contributions. It included a resolution from the floor (moved and seconded by a Northland and Auckland delegate respectively) endorsing the National Executive's actions in the negotiations including the business case. This was adopted unanimously.

Revitalisation of branches

On the first day Senior Industrial Officer Henry Stubbs addressed Conference on the need to revitalise the Association's branches and the rationale behind the National Executive's recommended constitutional amendments. While the ASMS has a number of active delegates throughout the country our formal branch structures have largely become redundant in part due to overlap and confusion with the role of the Joint Consultation Committees in the DHBs and the various senior medical staff bodies.

The constitutional amendments which were adopted by Conference on the second day seek to streamline arrangements, establish minimalist structures with two key positions of branch president and vice president, and remove unnecessary transaction and administration obligations. They will take effect from July 2011. Further information will be provided to members closer to July.

Key sessions

There were several quality sessions on a range of subjects. In particular:

- Associate Professor Robin Gauld addressed Conference on the findings of his survey of ASMS members on the application of *In Good Hands* which included his new 'clinical governance development index'. This was followed by questions from and discussion with delegates, and then delegates participated in small workshop groups. His presentation is reported briefly elsewhere in this issue and his findings are likely to be published in an international journal.
- The Hon Tony Ryall, Minister of Health addressed Conference. This was followed by questions from and discussion with delegates. It was an interactive session which the Minister got a positive buzz out of.
- Professor Alan Merry gave a well prepared and considered address (when does he ever do otherwise) on the role of the new Quality and Safety Commission. Professor Merry was nominated by the ASMS to be Chair of the Commission's Establishment Board and was appointed to this position by the Minister of Health.
- Margie Apa (Deputy Director-General of Health) and Dr Bev O'Keefe (Chair, General Practice New Zealand) addressed Conference on achieving clinical leadership in primary-secondary collaboration. After a number of questions delegates participated in small workshop groups.
- Martin Stokes (Chief Executive, Medical Assurance Society) gave an interesting presentation on the subject of looking after oneself and family in times of financial uncertainty. This was followed by questions from and discussion with delegates. On behalf of the Conference Dr Jeff Brown expressed the ASMS's appreciation for the excellent support provided by the Society for members affected by the Canterbury earthquake.

Other matters

1. The Annual Report provides a thorough coverage of the ASMS's activities over the past year. It was adopted by Conference. Members are encouraged to read it. It can be downloaded from our homepage at **www.asms.org.nz**
2. Conference agreed to increase the membership subscription by $20.00 to $740.00 (GST inclusive) for the 2011-2012 financial year
3. WHK Wellington was reappointed the ASMS's auditors for the 2010-2011 financial year.
4. The dates for next year's Annual Conference were confirmed as 17–18 November in Wellington. Members are encouraged to enter this date into their diaries and consider attending as a delegate.

2010

TWENTY-SECOND ANNUAL CONFERENCE

Margie Apa Deputy Director-General of Health, Dr Iwona Stolarek Hutt Valley DHB, Deborah Kent Ministry of Health and Professor Des Gorman Health Workforce NZ

Chris Hodson QC, Harbour Chambers, and Penelope Ryder-Lewis, Bartlett Partners

Dr Jeff Brown, ASMS National President

Dr Trevor Cook, Canterbury DHB, and Dr Peter Roberts, Capital & Coast DHB

Mike Chan, WHK Sherwin Chan & Walshe, and Dr Judy Bent, ASMS National Executive

Dr Richard Tyler, Medical Assurance Society

Dr Peter Freeman Lakes DHB, Dr John Bonning ASMS National Executive and Dr John Chambers Southern DHB

Dr Helen Moore Auckland DHB, Dr Heinrich Stander ASMS National Executive

Dr Ruth Large Waikato DHB

Dr Paul Wilson ASMS National Executive

Dr Brian Craig ASMS National Executive

Clinical Leadership workshop

Dr Martin Thomas Lakes DHB

Dr Robin Gauld, Associate Professor of Health Policy, University of Otago Medical School


Hon Tony Ryall, Minister of Health

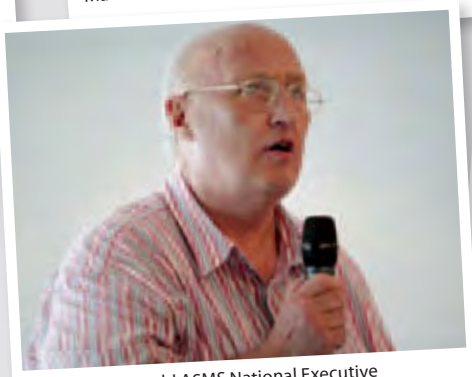

Professor Alan Merry, Chair of the Quality & Safety Commission Establishment Board


Margie Apa, Deputy Director-General of Health


Martin Stokes, Chief Executive, Medical Assurance Society


Dr Bev O'Keefe, Executive Chair, General Practice New Zealand


Jonathan Krebs, Barrister (Dinner Speaker)


Dr John MacDonald ASMS National Executive


Dr Chris Wisely Southern DHB


Dr Michael Jameson Waikato DHB


Dr David Grayson Hawkes Bay DHB


Dr John Chambers Southern DHB


Dr Martin Searle Canterbury DHB


Dr Denise Barnfather, Public Health Auckland

Dr John Chambers Southern DHB and
Dr Ian Shaw Southern DHB

DR ROBIN WHYMAN SPECIALIST IN PUBLIC HEALTH DENTISTRY

Senior Dentist Workforce – similar challenges, fewer responses

District Health Boards employ approximately 100 senior dentists as clinical leaders for the community dental services and as senior clinicians in hospital dental departments.

Community dental services primarily provide the traditional school dental service, and are currently transitioning to an upgraded community delivery model. The majority of the clinical delivery is by over 600 dental therapists, who work in a formal professional relationship with one or more dentists. Dentists employed with the community dental services have a range of skills, several are specialists in dental public health and all are experienced in public health and paediatric dentistry.

Hospital dental departments exist primarily to provide dental care for patients with medical conditions and disabilities that preclude their access to dental care in the community. The dentists working in these services cover a range of dental specialties and many are general dental practitioners with wide ranging experience in the delivery of dental care for people with special dental care needs.

The numbers

Dentists working in DHB oral health services are a small subset of the total practicing dentist population, but similar in size to the medical specialties of ENT and ophthalmology and about twice the size of the specialties of urology and radiation oncology.

In the past 30 years the New Zealand population has increased 34% from 3.2 million to 4.3 million, and the number of dentists 64% from 1100 to 1800. However, the population is aging with their own teeth. Virtually all adults under 65 years and over 70% of adults aged over 65 years now have some or all of their own teeth. This is a substantial change from 1976 when over 70% of the over 65 years group had lost all of their teeth. Demand for hospital dental services can reasonably be expected to increase, as a growing frail elderly population present with complex dental needs associated with their medical conditions and disabilities.

Despite these demographic changes New Zealand continues to train 54 dental students per year, a number that has not changed since the early 1980s when it was reduced from 60 per year. A far greater proportion of the graduate dentists are female and combined with the demands of increasingly technical dentistry, the full-time equivalent dentist to population ratio has begun to fall.

Overseas graduates currently comprise 26% of the dentist workforce, continuously increasing over the last 15 years from a previous relatively steady state of 5-7%. The proportion of overseas graduates is rising because, like medicine, we are failing to retain many of our own graduates. The cohort remainder rate for University of Otago dental graduates practising in New Zealand 3-10 years after graduation is only 48%. That is much lower than for New Zealand medical graduates where Medical Council data show that approximately 70% remain at an equivalent period of time post graduation. Medicine may be worried about losing well trained registrars and failing to build the specialist workforce. The problem for DHB dentistry is that the country isn't retaining many of the graduates long enough to attract them to the specialist training programmes needed by the DHBs.

What we do have in common with medicine is that for DHB dentists early in their career we are competing on salary with Australia, but we are also competing with the remuneration and career options of private dental practice.

The pathway

Unlike medicine, dental specialities require the acquisition of a three-year post-graduate university degree. These programmes are not supported by paid registrar positions and generally attract fees of over $20,000 per annum at all the Australasian universities. For some dental specialities with a strongly marketable private practice component (orthodontics and oral and maxillofacial surgery especially) the investment can make sense and still provide an opportunity to contribute to DHB dentistry.

However, DHB dentistry increasingly needs the skills of specialists in paediatric dentistry, special needs dentistry and dental public health to deliver effective community dental services and to manage the needs of the growing aged dentate and disabled population that require hospital dental services. These specialties don't have strong private practice options and so the decision to commit to training is difficult.

The need for policy response

In 2006 the NZ Dental Association published a report examining the dentist workforce and pointed out that the public sector dentist workforce was aging, that the workforce had remained steady at around 100 dentists, and that as a proportion of the total dentist workforce the public sector workforce was declining.

The main causes for the decline were attributed to salary differentials (especially with private practice) and a lack of career structure. The conclusions of the report appear as pertinent 4 years later, but little response has been forthcoming. Dentistry is not included in the voluntary bonding scheme or any other current initiatives aimed at improving the health workforce.

In May 2009 all of the oral health professions met in Nelson at a two-day sector meeting entitled *Right Type, Right Number, Right Education*. The group found common ground on a number of issues including the need to retain more of our own graduates in New Zealand and a need to increase undergraduate dentist trainee numbers by 6 places (11%).

The specialist workforce issues that concern medicine are equally as relevant in DHB dentistry. However, the wider dental workforce also needs attention from the policy makers. A good start would be including dentistry in the voluntary bonding scheme to assist graduate retention, addressing the number of New Zealand dental graduates, planning for the future public sector dentist workforce and a review of the pathway for postgraduate training in DHB dentistry.

Dr Robin Whyman
Specialist in Public Health Dentistry and Senior Dentist
Hutt Valley DHB

Health of the Health Professional Conference 2011

Surviving and Thriving in the Health Workforce

The Health of the Health Workforce – Major focus of 2011 Conference

Sustaining the health of health professionals is critical for maintaining the capacity of New Zealand's health workforce. These issues are being faced with an over-reliance on overseas trained health professionals, an ageing workforce, and the increasing complexity of health care roles.

Working in health has special rewards, obligations, and significant demands placed upon individuals and organisations. At times, the demands can seem to overwhelm the rewards. The interface between demands and rewards will be a focus of many of the presentations at this meeting.

Conference purpose and audiences

The Health of the Health Professional conference is the first international gathering for a large range of health professions, coming together to address the health of health professionals. This includes doctors, nurses, medical students, allied health professionals, health researchers, unions, employers, government and others.

Hosts

The conference will be co-hosted by The Goodfellow Unit at the School of Population Health, Faculty of Medicine and Health Sciences, University of Auckland in partnership with the Australasian Doctors' Health Network.

Vision

Peter Huggard, the Goodfellow Unit Director's vision is that: *'this meeting will be an opportunity to proactively work with colleagues and identify strategies and processes for managing the demands and maximizing the rewards for health professionals. An expected outcome will be a position statement with clear tactics for what must happen to support, and protect, those who work in the helping and caring professions.'*

Topics

A number of key presenters from New Zealand, Australia, and overseas have been invited to address issues such as organisation changes, the health economics relating to wellbeing, directions for policy change, and physical and psychological aspects of health professionals' health. In addition to combined sessions, there will be opportunities for profession-specific sessions.

Summary information

Theme: Surviving and thriving in the health workforce

Dates: Thursday 3 November – Saturday 5 November 2011

Venue: The Langham Hotel, Auckland

Website: www.hohp.org.nz

A family affair

Family input into a patient's treatment can be very useful, but what happens when a patient with mental health problems objects? MPS medicolegal consultant Dr Alan Doris looks at the options.

Assessment and treatment planning for any patient is usually most effective if information from family or care-givers can be taken into consideration. While most patients are happy for their families to be consulted, some are not.

Family involvement may be particularly important when the individual is suffering from a mental disorder. For a variety of reasons, it is not unusual for such patients to request that healthcare providers do not consult or share health information with their family. This can hinder assessment and may leave the family feeling excluded from important decisions.

Where a patient suffers an adverse outcome, an aggrieved family may seek explanation as to why they were not consulted or informed about their relative's healthcare. The adequacy of consultation and sharing of information with family and carers is often scrutinised in coroners' proceedings following the death of a mental health patient, or by the Health and Disability Commissioner.

In providing care to patients with mental health problems, relevant issues in this area can be divided into factors to consider when gathering information from others for the purpose of assessing a patient, and those to consider when disclosing the patient's information to others.

Gathering information from family

An initial consideration is whether the individual is being compulsorily assessed under the Mental Health (Compulsory Assessment and Treatment) Act 1992, as there are specific requirements to consult with family or whanau when carrying out an assessment under the Act.[1]

Section 7A of the Act requires the assessing doctor to consult with family unless it is not practicable, or not in the patient's best interests.

In deciding whether it is in the patient's best interests, the doctor must consult with the patient and consider their views. Refusal by a patient to give permission for the doctor to consult with family can be overridden if the doctor is of the view that such consultation is in the patient's best interests.

When consulting with family in this situation, it may be necessary to disclose some of the patient's health information. It is recommended that consultation with family of a patient subject to the Act happens whenever a major treatment decision is made: at each juncture of the compulsory assessment and treatment process, and when considering discharge from the Act.

When a patient is being voluntarily assessed, there is not a requirement for the doctor to consult with family, although it is good practice to do so.[2] It is important that the patient is aware of the reasons why consultation is requested and what information is sought, and if they refuse permission to disclose, that they are asked to reconsider their decision periodically.

Where an assessment is taking place and the patient refuses or is unable to supply important information, it may be reasonable to seek this information from other individuals. Rule 2 (2) (d) of the Health Information Privacy Code (HIPC) provides that an agency does not have to collect information directly from the individual concerned if it is not reasonably practicable in the circumstances.[3]

Similarly, Rule 2 (2) (c) permits non-compliance with the general rule that information must be collected from the individual concerned if compliance would prejudice the:

- Interests of the individual concerned
- Purposes of collection
- Safety of any individual.

Where there are serious concerns about a patient's risk of harm to themselves or others, failure to collect information from other people may prejudice the safety of the patient or others, if more extensive information is necessary for an adequate assessment.

Where a patient refuses consent for their family to be consulted, the family is still entitled to pass information to the healthcare providers as well as be offered general support and information. It may be difficult to point out this right to family members while trying to develop a trusting relationship with the patient, without appearing to disregard the wishes of the patient that the family are not involved. A way round this is to have general information about services available to family in the form of leaflets or notices in areas such as waiting rooms. General service information could include information indicating channels for information flow and the rules around this.

Case

A patient who was being assessed under the Mental Health Act complained to the Privacy Commissioner that his privacy had been breached after mental health staff consulted with his doctor, former employer and minister about him. The Commissioner ruled that there had not been a breach as the approach to these individuals was only after the patient had refused to talk to staff; they had all been in recent contact with him, and the information sought – which was the views of other people – could not be obtained from the patient himself.

It is important to note that the approach gave minimal or no information about the patient; it was information-gathering, not information-sharing.

Disclosing information to family

In the same way that there are requirements to gather information by consulting with family when the patient is being assessed under the

Mental Health Act, there is also a statutory requirement to provide a copy of assessment certificates to the "principal caregiver" at different stages of the process.[4]

Principal caregiver means the friend of the patient or the member of the patient's family group or whanau, who is most evidently and directly concerned with the oversight of the patient's care and welfare.

When a patient is released from compulsory status under the Mental Health Act, HIPC Rule 11 (1) (g) permits informing the patient's principal caregiver of this occurrence. If a patient refuses consent to disclose any other information to their family, the general rule is that their wishes must be respected.

However, for both compulsorily treated and informal patients there are situations where disclosure without the patient's consent is permitted, and in situations of clinical risk it is important to consider whether an exception to the general rule exists.

If there is a serious and imminent risk to the health or safety of the individual, or of the public, disclosure of information is permitted under HIPC Rule 11 (2) (d). This rule sets a high threshold for disclosure of information. It is important when considering disclosing a patient's information under this rule to be sure that such a disclosure will reduce the threat and that disclosure is necessary, ie, there is no other option. The information disclosed must only be to someone who can do something to reduce the threat and only to the extent necessary for the purpose. It is advisable to carefully document in the patient's records the process leading to a decision to disclose or not.

A case investigated by the Health and Disability Commissioner involving the suicide of a young man who had adamantly refused for the health providers to consult with his family discusses these issues.[5] In this case, the risk assessment carried out by the mental health service was deemed inadequate. It is suggested that if it had been adequate, then disclosure could have been justified under Rule 11 – to prevent serious and imminent harm to the patient and reducing the risk by enrolling family support.

This area of practice frequently presents difficult decisions to health practitioners and MPS encourages members to call for advice.

References

1. Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992, 1 April 2000
2. Involving Families; Guidance Notes, Ministry of Health (2000)
3. NZ Privacy Commissioner Case Note 7454 [1997] – Patient complains mental health unit questioned third parties
4. Sections 10 (4) (a) (iv), 12 (5) (d), 14A (2) (c), 29 (6) (b), 76 (7) (b) (iii) Mental Health (Compulsory Assessment and Treatment) Act 1992
5. A Report by the Health and Disability Commissioner – Case 08HDC08140.

This article was originally published in the Medical Protection Society's May issue of Casebook
www.medicalprotection.org/newzealand/casebook-may-2010/a-family-affair

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 3,000 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

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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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University of Otago, Wellington

Inaugural International Cancer Symposium

13–19 February 2011

The University of Otago is organising an Inaugural International Cancer Symposium at the Duxton Hotel, Wellington, from 13-19 February 2011.

The Symposium consists of five programmes and two special sessions. Each programme is distinct and stand-alone but the common thread of translating today's clinical excellence into tomorrow's cure runs strong in each presentation.

UNIVERSITY of OTAGO
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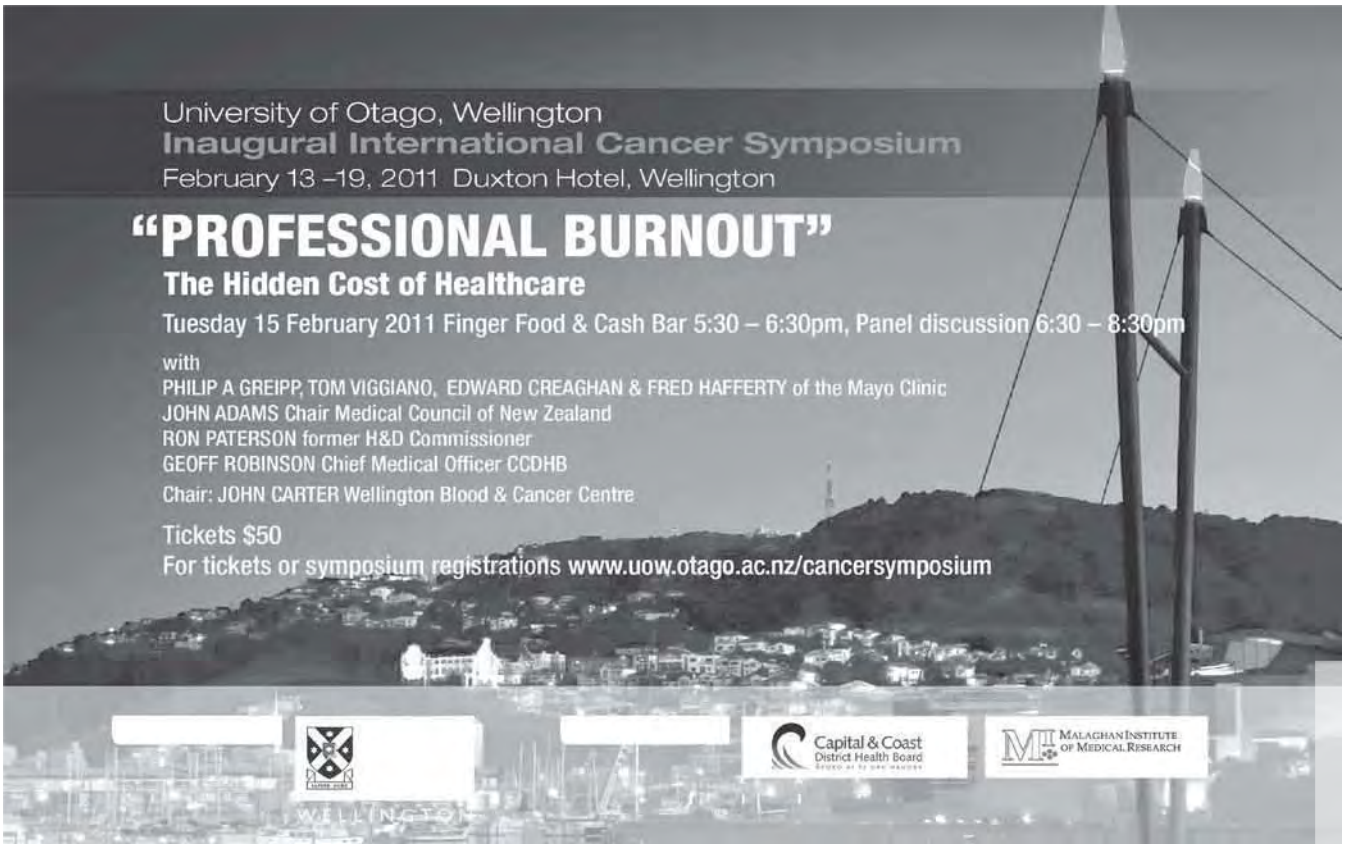
Further information is available at **www.uow.otago.ac.nz/cancersymposium.**

The five programmes will focus on:

- Haematological Malignancies and Benign Haematology
- Medical Oncology: lung, head and neck, gastrointestinal cancers and melanoma
- End of Life /Palliative Care
- Scientific Advances featuring the meeting topics
- The Role of Tobacco Control in Cancer Prevention and two special sessions will focus on: Progress and Innovation and Medical Burnout

Many overseas participants will be travelling from the Mayo Clinic in Minnesota and Arizona, the Dana-Farber in Boston, Royal Prince Alfred Sydney, Peter MacCullum Cancer Centre in Melbourne, and the University of Birmingham.

Part of the programme will include a session on "Professional Burnout: The Hidden Cost of Healthcare", on Tuesday evening 15 February.



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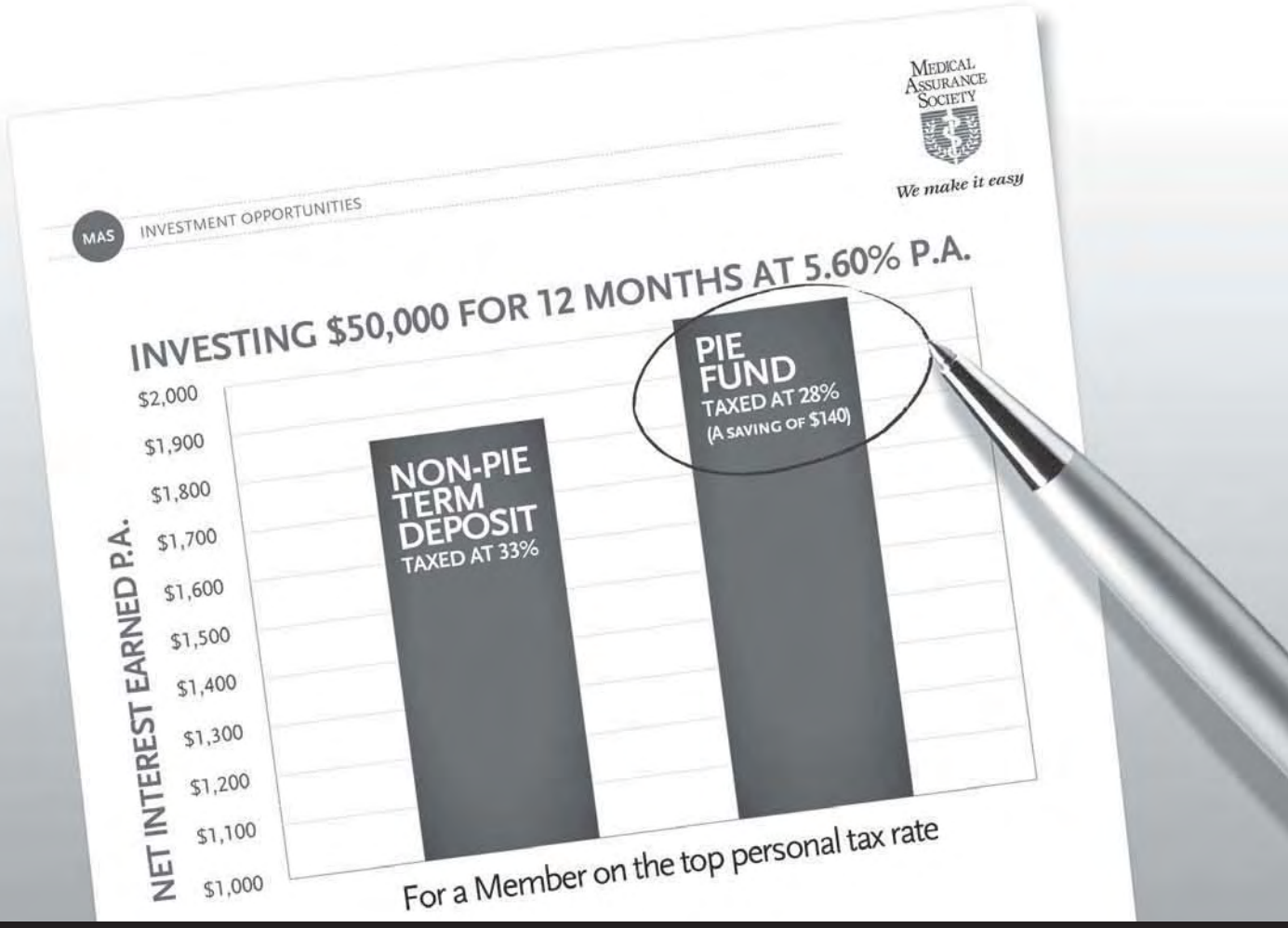

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Seasons Greetings

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

The national office will be closed from 25 December 2010 to 4 January 2011 inclusive.
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 with reduced staff.