ISSN 1174-9261

MARCH 2011 | ISSUE 86

The Specialist

The newsletter of the Association of Salaried Medical Specialists

MECA negotiations on a cusp: but of what?

'Cusp' is an interesting word. It has particular usages in astrology, astronomy and anatomy, for example. In plain language it is a point that marks the beginning of a change; hence the expression, 'on the cusp of a new era'. This is a reasonable description of the current stage of our national DHBs multi-employer collective agreement (MECA).

We are on the cusp of something but what? It could involve a significant paradigm shift in the ability of DHBs to enhance effectiveness and efficiency and achieve laudable government objectives. This would be through providing a sustainable pathway to terms of employment that enables DHBs to markedly improve recruitment and retention in order to generate sufficient senior medical and dental staff capacity to deliver. This would be a great cusp to advance from.

Alternatively, through lack of DHB and government will and leadership, we could miss out on this opportunity and the workforce brittleness that undermines achieving the health system's potential could further deteriorate with the consequential negative repercussions that would inevitably follow.

Time and workforce capacity

Late last year Associate Professor Robin Gauld (Otago University Medical School) conducted a survey of DHB-employed ASMS members on the implementation of the government's policy statement on clinical leadership, *In Good Hands*. The government has correctly recognised that if it its health policy objectives are to be achieved effective comprehensive clinical leadership will be required in DHBs.

But Dr Gauld's survey results deliver a sobering message with ASMS members' assessment of DHBs' performance ranging from poor to mediocre. He constructed a 13-point clinical governance scale but not one single DHB achieved at least a 50% pass.

Dr Gauld's survey results deliver a sobering message with ASMS members' assessment of DHBs' performance ranging from poor to mediocre.

The most revealing factor was lack of time. Respondents reported that only 20% of them had sufficient time to participate in clinical leadership or development activities. Lack of time is the immediate consequence of specialist shortages in our public hospitals.

'Business Case' path

The 'business case' jointly developed between the ASMS and the 20 DHBs last December focused on addressing this issue and on the significant quality improvement and cost effectiveness gains that could be achieved through clinical leadership. The intention had been to forward the agreed document to government before Christmas. However, for tactical reasons, the DHB chief executives concluded that the timing was not right and that there needed to be an accompanying 'operational' document (which would have to be agreed with the ASMS).

On the one hand, this was a surprise change of tack. On the other hand, it was still consistent with our broad direction. Further, both the ASMS and DHBs had envisaged this sort of thing being in the 'business case' itself but ran out of time in respect of the deadline we were then working to. This 'operational document' might aptly be described as the missing chapter of the 'business case'.

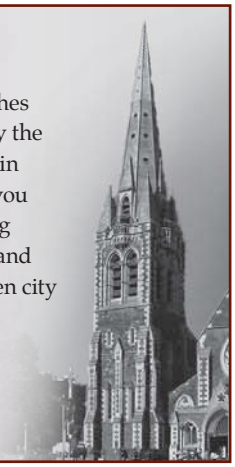
Resumption of negotiations; ups, downs and ups

Negotiations resumed this year on 9 February and continued on 15 March. The post-'business case' focus has been on costing various scenarios on remuneration in order to achieve an outcome consistent with the parameters of the 'business case'. Unfortunately, on the 15th the DHBs' negotiating team found itself in the

CHRISTCHURCH AND JAPAN

The Association extends our sympathies and best wishes for members and their families and friends affected by the devastating earthquakes and their consequences first in Christchurch and then Japan. Our thoughts are with you all. We also express our admiration and overwhelming appreciation for those involved in providing medical and other care, both in Christchurch and outside the garden city for the victims of the Christchurch tragedy.

Please make sure you read the moving column from ASMS National President Dr Jeff Brown who was in Christchurch at the time (see Page 3).



ASMS

Executive Director
Ian Powell

Assistant Executive Director
Angela Belich

Senior Industrial Officer
Henry Stubbs

Industrial Officer
Lyn Hughes

Industrial Officer
Lloyd Woods

Executive Officer
Yvonne Desmond

Membership Support Officer
Kathy Eaden

Admin Officer
Terry Creighton

Admin Assistant
Ebony Lamb

Level 11
Bayleys Building
Cnr Brandon St &
Lambton Quay
PO Box 10763
Wellington
New Zealand

Ph 04 499 1271

www.asms.org.nz

position of not having a mandate (or being very uncertain over their mandate) in order to continue this process. The ASMS negotiating team started to doubt the commitment of the DHBs to the full 'business case'.

As a result it was agreed to cancel the next date of negotiations on 23 March and instead use that day to hold a 'crisis' meeting with key DHB representatives further up the pecking order and the ASMS. The purpose was to get an understanding of what the road-blocks were and whether we could progress through the impasse that had emerged.

The 'crisis' meeting proved to be useful in getting negotiations back on track. The DHBs representatives included Northland Chief Executive Karen Roach (who chairs the DHBs Employment Relations Strategy Group which oversees all negotiations) and Hutt Valley Chief Executive Graham Dyer (who is her deputy on the ERSG). Discussion was both frank and constructive as the parties discussed their respective frustrations.

They [DHBs] seem to be akin to possums caught in headlights (at risk of morphing into cornered rats)…

My reading of the DHBs representatives is that they are struggling to cope with the combined pressures of the Minister of Health (on the one hand, saying that the senior doctor workforce in DHBs is the government's top investment priority and, on the other hand, saying repetitively there is no more money) and the negative attitudes of some chief executives. They seem to be akin to possums caught in headlights (at risk of morphing into cornered rats) which appears to have affected the clarity of communication between their Employment Relations Strategy Group and negotiating team.

Reaffirmed path forward

Arising out of this discussion the DHBs and ASMS reaffirmed a commitment to resolve the 'operational document' (within the framework of the 'business case'); resolve the relationship between this document and the MECA; and to endeavour to settle the terms of the MECA itself (largely now down to remuneration) by the end of April (subject to ratification by the DHBs' chief executives and the ASMS National Executive following an indicative ballot of members as well as the go-ahead from government).

Consequently it was agreed that the ASMS and DHBs would meet on 31 March to finalise the 'operational document' (and its relationship with the MECA) and resume formal negotiations for hopefully only two further days (18 April and 29 April). Meanwhile the DHBs would continue to keep government informed of progress.

If the ASMS's current national collective agreement negotiations with the DHBs don't achieve terms of employment that enable us to retain those we train, retain those we currently employ, and recruit effectively in an internationally competitive medical labour market, senior doctors will not have the time necessary to ensure that DHBs achieve the government's objectives. And this would be on the cusp of something very bad.

Ian Powell *Executive Director*

TIMELINE

RECENT

December ASMS and DHBs complete 'business case'; DHBs decide to develop supplementary operational document for discussion and agreement with ASMS

9 February Formal negotiations resume (including discussion on salary scale scenarios)

15 March Impasse in formal negotiations; agreement to cancel negotiations on 23 March and hold 'crisis' meeting

23 March 'Crisis' meeting between DHBs and ASMS; agreement on path forward.

NEXT STEPS

31 March DHBs and ASMS meet to finalise 'business case' operational document

5 April DHBs brief Government and Health Ministry (part of regular scheduled meeting)

18 April Formal negotiations resume

29 April Further negotiations (best endeavours to reach settlement subject to ratification by both parties and acceptance by government).

Tribute to David Jones

After serving 16 years on the ASMS National Executive, David Jones did not stand for re-election; his term ends on 31 March 2011.

1993-97 Region 3 Representative

1997-2001 Vice President under Peter Roberts

2003-2011 Vice President under Jeff Brown

The following tribute is from Jeff Brown.

David first joined the Executive of ASMS eighteen years ago as Region 3 representative. When I joined the Executive in the late 90's he was already recognised as a wise head who demonstrated a balance of analytical thinking and resolve. He has seen ASMS grow in membership, evolve into national MECA negotiations, and helped chart a course through the many reforms and revisions of the health system. He supported Peter Roberts as Vice President and over the last eight years, myself. He has never sought the limelight but has provided unfailing help, wise counsel, and sound leadership behind the scenes. His pithy contributions will be missed at the Executive table and his pertinent observations at other gatherings. His clarity of thought and corporate knowledge will be a challenge to his successors to emulate. Thank you David for all your hard work. New Zealand has a better health system because of you. Even though you are now outside the caucus, I have no doubt you will continue to steer us in your inimitable way.

Jeff Brown *National President*

Ode to Heroes 12:51 Tuesday 22 February 2011

I heard thunder on the 14th floor
I knew before I knew it would not be good
I felt hurling violence as I hurtled to the door
I bounced and tossed between the jambs
I saw ceilings drop and walls crumble
I heard windows shatter and eerie crunching
I saw an evil crack split the floor asunder
I felt the building sag away and down
I breathed the plaster dust that could be smoke
I heard the wail of fire alarms
I paused in the stillness of rattle and awe
I wondered if our team was intact
I wondered at the alertness of hotel staff
I watched doors bashed by shoulders
I praised engineers who stitched a fire escape outside our floor
I enjoyed egress with accumulating anxiety
I traversed multistorey car park and tunnel to the street
I emerged into bedlam only Bruegel could paint
I tasted dust and fear and betrayal
I had to know if we were all out in the rubble and glass
I think I heard directions for us to move
I hated collapsed buildings crushing randomly
I hesitated forlorn and helpless to help
I turned one way to see if anyone could be useful
I sent a couple to be so and hoped they would be resilient
I heard directions to Latimer Square
I passed smoking CTV with bodies and bits of bodies
I dreamed I saw heroes leaping into the ruins
I feared they would join the bits and bodies
I found myself among many in the Square
I saw bleeding and crushed carried and limping
I knew no-one could fathom the catastrophe unfolding
I floated into tiny increments of action
I followed the lead of others to act
I felt the desire of these great folk to do anything
I knew their drive to pitch in with intent
I helped them to organise their passion
I steered their skills under the oaks
I saw courage and compassion
I felt strength and togetherness
I saw miracles of care with just hands and voice
I became aware of some first aid kits appearing
I encountered paramedics with backpacks
I asked them for their supplies and their skills
I heard ambulances and scooped up cries
I knew nothing of the rest of the city
I had no idea if we were all there was
I met Craig from St Johns who had no Comms
I heard him say we were there for the East
I touched his arm and asked for help
I rounded our charges asking for status
I tried to encourage our limited efforts
I searched for some futures beyond merely doing
I wanted some definition and boundaries to our calling
I waited for calm beyond calamity's ken
I knew it unlikely to come anytime soon
I watched mini-teams form and unfold
I saw scared people give the coats off their backs
I was told of splints from the pages of APLS manuals
I rejoiced when the first lady left in an ambulance
I saw her replaced with another extracted citizen
I became a little numb to the details
I focused on the scary big picture
I squeezed what heroism I could out of others
I asked more of them than I humanely should
I heard them weep as they tested themselves
I saw them shudder with the enormity
I helped them let death creep up slowly
I was humbled by their calmness in the clamour
I laughed with them when the ridiculous reared
I hugged them for mutual support
I smelled the night creep on
I encountered fewer rescues and more opportunistic wanderers
I gave a shoulder to desperate husbands
I fielded offers from US Air Force and local students
I met materialising medics of all persuasions
I interlaced with amazing army and police
I watched the media appear with occasional dignitaries
I shared stories with newly intimate companions
I may never meet again
I stood through the night which stretched my beliefs
I was befriended by angels whose names I do not know
I was a tiny part of a special team
I was privileged to join for a different purpose
I am eternally proud of their heroic actions
I know pale in the face of more deserving heroes
I saw put their lives in incredible danger
I wondered if I could ever emulate
I am grateful for my survival
I know that my part was small and short
I know that I helped in the only way I could
I hurt at the ongoing misery and destruction
I weep without warning and wake drenched with sweat
I have recalibrated my importances
I try to re-engage with my world
I accept forever is changed
I revisit sights sounds and smells
I recall horrors and miracles
I lived beyond Homer and Hollywood
I felt all my life culminate in the moment
I worked alongside heroes
I felt his fear under his marvellous calm

Jeff Brown *National President*

EXECUTIVE DIRECTOR'S COLUMN

Lessons to be learnt

The controversy over the awarding of the community testing laboratory contract by the three Auckland DHBs (Waitemata, Auckland and Counties Manukau) offers important lessons for DHBs and senior medical staff.

In summary, the three DHBs had unsuccessfully approached their then (longstanding) sole provider (Diagnostic MedLab – DML) of GP referral community laboratory tests to reduce annual expenditure which was forecast to increase by 5% per annum. Their next step was to conduct a tender process for a new contract which included the introduction of capped funding and other cost saving measures.

The result was that DML lost the contract to a competing provider, Labtests Auckland (LTA). Both DML and LTA are owned by aggressive and antagonist companies competing for market share in Australia, and now in the much smaller New Zealand market. Increasingly it seems inevitable that one of them will fail here.

The DHBs' decision led to lengthy litigation. DML succeeded in overturning the decision in the High Court but LTA took a successful case to the Court of Appeal which was upheld by the Supreme Court.

The ASMS was not involved in this because it did not directly involve hospital laboratories. Unlike some DHBs, the three Auckland DHBs wisely did not also put up their hospital laboratories for tender as well, which would have increased their vulnerability. The implementation and transition phases were then prone to considerable controversy and acrimony including serious concerns over patient safety. This led Health Minister Tony Ryall to set up a review of the transition by Graeme Milne and Jens Mueller. Their report, Auckland Region Laboratory Transition Review (September 2010), is a fascinating read which draws on academia (unusual in health system reviews) with many lessons to be learnt.

It notes that the DHBs failed to communicate that there was a sense of urgency. Instead the message was expressed as a desire to create significant laboratory services savings which could be used to improve health services in other areas. Unsurprisingly, because it was couched in this way by the DHBs, it meant that this sense of urgency would not be shared by all parties (not just DML). While the report accepts there was a genuine sense of urgency it notes that the critical group, GPs, were not adequately informed about the mechanics of the change. The DHBs failed to link this tender process into a long-term strategic direction and consequently failed to achieve stakeholder 'buy-in'.

The report, however, is not uncritical of some key stakeholders, particularly opponents of the DHBs process, who complained that they had not been invited to participate and help in the transition phase. The authors believe the DHBs ensured there was sufficient leadership involvement to signal to all stakeholders the importance of proceeding to improve laboratory performance.

But it does acknowledge that more effort could have been made by the DHBs to involve stakeholders more in the specific planning issues of the transition once the final court order had been made. Instead DHBs were preoccupied in dealing with the mechanics of the transition and a hostile outgoing provider (DML).

The report sharply criticises the DHBs for lack of laboratory expertise (describing it as "thin at best"). This is significant for the writers because they refer to the lack of specifications in the tender document as the "root cause" for many of the transition problems that followed. The DHBs were unaware, for example, of the myriad of services provided by DML that were not specified in the previous contract which then threw LTA into confusion when it picked up the new contract. There should have been stronger medical specialist involvement in the process. The potential conflict of interest in some cases is acknowledged but this is not accepted as an excuse.

But DML is not let off the hook. The report refers to what is called a "venomous" media campaign. It accused DML, as part of its strategy, of not being transparent about factors that might aid a competitor to better understand the market." This is understandable business behaviour but a bit rough when standards of patient care are at stake. Nevertheless, given the financial stakes and emotional investment of DML in opposing the change, its lack of cooperation in the transition should have been anticipated by the DHBs. LTA also gets a biff from the report. Their representations that they were ready to perform in the start-up were "at best overly enthusiastic and at worst misleading."

In summary, the reviewers conclude that the transition was initiated by "well-intentioned people who used a narrow platform of short-term/mid-term financial considerations to embark on a complex change of relationships." As a result damage was done to clinical relationships and public perception of the DHBs. On the other hand, although reduced by the problems with the transition, the DHBs have achieved expected savings of around $10-11 million per annum for the life of the contract. Further, they also conclude that the service is now "considered by most to be efficient and reliable and by some to be superior."

One final observation which was not in the report deserves mention. For all the legitimate criticisms that can be made of the three Auckland DHBs in this most difficult experience, in contrast with some other DHBs, at least they did not put their hospital laboratories directly at greater risk by also subjecting them to the same tender process. In a country like New Zealand the private sector has a role to play but it can't be the overall driver of laboratory services, especially hospital testing.

Ian Powell
Executive Director

ASSISTANT EXECUTIVE DIRECTOR'S COLUMN

Changes to the Employment Relations Act: what they mean in the workplace for Senior Doctors

On 26 November 2010 the Employment Relations Amendment Act 2010 and the Holidays Amendment Act 2010 became law. Most of the changes come into force on 1 April 2011. State employers, such as District Health Boards have been instructed by the government not to contract out of the application of these law changes so our opportunity to negotiate to restrict some of the conditions collectively in DHBs may be limited.

The situation for our members working for community employers may be better, in the sense that we can negotiate protections from some of these provisions into collective agreements and worse, in the sense that some of these small employers are sometimes less measured in their industrial relations practices and may wish to use these provisions at their employees expense.

Union access

Under the previous provision, a union representative did not require prior permission from an employer before entering the workplace to conduct union business. The law included largely uncontroversial conditions relating to access at reasonable times, health & safety and the normal business operations of the employer.

The new provision requires a union representative to obtain the employer's prior permission before entering the workplace. Neither the request nor the permission needs to be in writing and the consent must not be unreasonably withheld. The employer must advise the representative of the union of its decision no later than the next working day. If the request is denied, the employer must give its reasons in writing no later than the working day after it makes its decision.

We have rarely had problems gaining access to workplaces. However when relationships with DHBs were at their nadir (during the stopwork meetings in 2007) some DHB Human Resources people were heard to mutter about denying access to union officials

The ASMS has submitted a late MECA claim (which the DHBs have been warned to expect some time ago) that would give us access consistent with the previous provisions of the Employment Relations Act. We will also be submitting similar claims in our other collective agreements as they are renegotiated

The extension of 90 day trial periods to all employers

Under the previous provision, any employer of 20 employees or less *might* agree with a new employee to include a 90-day trial period in their employment agreement, during which the employee might be dismissed without the right to bring a personal grievance. The new provision would allow *any* employer to seek to include such a trial period for any new employee. A trial period must be agreed between the employer and the employee and is not something that an employer may unilaterally insert within an employment agreement.

Under the MECA and a number of our other collective agreements our employers are required to give three months' notice of termination. Three months' notice would usually be more than 90 days and unless the employee agreed to a lesser period of notice than three months, our employers will not be able to use the 90-day trial period, even if they wished to and were able to obtain the agreement of a new employee. This is because, under the law, the employer must offer the MECA in full (including the three months' notice period) for at least the first 30 days of employment.

The exception is an employee who is employed at a time where three months includes February.

The ASMS has put a late MECA claim to DHBs which would protect employees who come within the coverage of the MECA and we will also be making similar claims in other agreements when they are renegotiated.

We will also be putting advice on the website alerting prospective appointees to the issue and urging them to seek our advice on any offer of employment they might receive particularly one that includes a trial period. Senior doctors looking at employment in New Zealand from overseas will understandably be reluctant to uproot themselves and their families to take up a new position from which they may be arbitrarily fired.

Changes relating to personal grievances

The previous test for justification of an employer's actions, including dismissal, has been revised to "whether the employer's actions, and how the employer acted, were what a fair and reasonable employer *could* have done (as opposed to *would* have done) in all the circumstances at the time the dismissal or action occurred".

The new legislation also introduces statutory minimum requirements for a fair and reasonable process, and reduces the importance of procedure in dismissal and disciplinary situations so that an action or dismissal would not be found to be unjustified if there had been "minor" procedural defects which "did not result in the employee being treated unfairly". However it also requires the employer to "genuinely consider" the employee's explanation and having regard to the resources available to the employer, did the employer, "sufficiently investigate" the allegations? There will still be a heavy obligation on well-resourced DHBs to investigate thoroughly. The standard among smaller employers may not be as high and we may need to look at grievance procedures for members employed by these employersw when collective agreements are renegotiated.

Reinstatement is no longer the "primary remedy" where a dismissal is found to be unjustified, but is retained simply as *one* of the remedies available "if it is practicable and reasonable to do so". Nevertheless, decisions of the Courts have made it clear that they will not "license" unjustified dismissals by enabling employers with the financial means to do so, to simply pay out an employee who genuinely sought reinstatement to their former position. This will very occasionally be important to a very few of our members who find themselves unjustifiably dismissed but with almost no employment options at the same location other than the hospital from which they were dismissed.

Holidays Act changes

There are a number of technical changes in the Holidays Act. However the change which allows workers on the statutory minimum of four weeks annual leave to 'cash up' one weeks annual leave may have the unintended consequence of limiting ASMS members with leave greater than the statutory minimum from cashing up more than one week in any given year .

Angela Belich
Assistant Executive Director

Support service for doctors

The Medical Assurance Society and Medical Protection Society have joined forces to bring their members an important support service.

The support service provides access to a free professional counselling service. Doctors seeking help can call **0800 225 5677 (0800 Call MPS)**. The call will be answered by the Medico-Legal Adviser on duty who will then arrange counselling or support.

The service is completely confidential.

MPS

MEDICAL ASSURANCE SOCIETY

We make it easy

HOHP **Health** of the **Health Professional Conference** 2011

Surviving and Thriving in the Health Workforce

Call for abstracts now open

This major international event, being held in Auckland on 3-5 November, focuses on bringing together employers, staff and unions across the health and caring professions to raise awareness and advance the state of knowledge about issues that affect the health of health workers.

The conference is being coordinated by a team of senior health sector experts led by Dr Peter Huggard, Director of The Goodfellow Unit and Dr Patrick Alley Director of Clinical Training at Waitemata DHB. The conference is being jointly hosted by the Goodfellow Unit at The University of Auckland, and the Australasian Doctors' Health Network.

Who should participate

We invite participation from doctors, specialists, nurses, medical students, allied health professionals, researchers, health sector employers, unions and government officials.

The three day programme will include professional streams with plenty of opportunities for networking and shared insights. More information is available at **www.hohp.org.nz.**

Keynote speakers include:

Prof Neill Piland – The Economic Impact of Ill Health in the Healthcare Workforce;
Dr Lester Levy – Dysfunctional workplaces;
Prof Erica Franks – Why should we be healthy?

Conference themes include:

Building resilience, coping strategies, re-energising using holistic approaches; caring for your colleagues; practical advice on career transitions and flexible ways of working.

Call for abstracts now open

For more information about abstract submission please refer to **www.hohp.org.nz/call-for-abstracts**

Key dates:

1 May online registrations open
31 May abstract submissions close
1 Sept early bird registrations close.

Poor to mediocre performance by DHBs in clinical governance and leadership

Last year with the active support of the ASMS, Dr Robin Gauld (Associate Professor of Health Policy & Director, Centre for Health Systems, Dunedin School of Medicine, University of Otago) conducted a survey of ASMS members employed by DHBs on the application of the government's policy statement on clinical leadership in DHBs known as *'In Good Hands'*. The response rate was 52% of the 3,402 potential respondents. In the article below Executive Director Ian Powell offers his observations and conclusions also drawing upon his own insights of the DHBs.

In Good Hands contains specific requirements for DHBs; in particular:

- establish governance structures ensuring partnership of clinical and corporate management;
- chief executives to enable strong clinical leadership and decision-making throughout their DHB;
- promotion of and support for clinical leadership and governance at every level; clinical governance to cover the whole patient journey with decisions devolved to the appropriate levels; and
- identification of actual and potential clinical leaders and support their development.

Findings: Insufficient Time

Dr Gauld presented his findings to the ASMS Annual Conference last November. This included the construction of a 13-point 'clinical governance development index' (CGDI). This index is work in progress as Dr Gauld and his colleagues continue to revise it, possibly to a lower number of points. But the first results still provide valuable information and food for thought. Overall it reveals disappointing performance with a national mean of 5.41 out of 13. No DHB gets a 50% pass. If this was graded A to E the range would be C- to E.

The most significant factor is lack of time for ASMS members to participate in leadership and engagement beyond their immediate clinical practice. To some extent (but not completely) this involves factors behind the DHBs control. In particular, the effects of the senior doctor recruitment and retention crisis severely constrain the amount of time available for involvement outside clinical practice.

A mere 20% of ASMS members believe they have enough time to engage in clinical leadership activities or development programmes. This is significant further evidence of the effects of the crisis and also means that key government objectives in health policy that depend on clinical leadership will not be achieved until the crisis is resolved.

No DHB gets a 50% pass. If this was graded A to E the range would be C– to E.

It should be noted, reinforcing this assessment, that the differences in ranking points between the highest and lowest performer is only 1.82 out of 13; all the 21 DHBs surveyed were bunched within this small number. **There is no continuum from good to average to poor; only barely average to poor.**

Another factor, even more beyond their control, is the fiscal pressures on DHBs from government of the severe reductions in the level of funding increases which make the benefits of clinical leadership more difficult to achieve. When the level of funding increases is halved DHBs find themselves in a potential siege-like environment not conducive to quality improvement. What is under their control is how they respond to it – some wisely take a longer-term approach through a quality and continuous improvement lens; others unwisely resort to short-term approaches without sufficient regard to longer-term consequences and then dump the problem on their staff like World War I Generals.

But there is no escaping the fact DHBs own conduct contributes as well.

We don't have the comprehensive attitudinal clinical governance culture in DHBs to enable more effective clinical leadership.

While constrained by the above factors, there are five key positions that help shape an effective culture of clinical leadership in DHBs. These are the attitude and effectiveness of the:

1 Chief Executive.
2 Chief Operating Officer (or general manager of the largest hospital or biggest service grouping in each DHB).
3 Chief Medical Adviser/Officer (Medical Director in some DHBs).
4 Funding & Planning leadership.
5 Human resources/employment relations leadership (generally less important relative to the above roles).

The survey results rebut the perception that the smaller the DHB the better the clinical leadership. Of the top five, three are larger DHBs (Capital & Coast, Counties Manukau and Canterbury), one (Lakes) is medium sized, and only one is small (Tairawhiti).

Following is an assessment of the individual DHBs (Otago and Southland are treated separately even though they are now one DHB, Southern) based on their ranking:

We don't have the comprehensive attitudinal clinical governance culture in DHBs to enable more effective clinical leadership.

continued overleaf

How they ranked

1… Lakes (6.37)

It comes as no surprise that Lakes, covering the Rotorua-Taupo area, is the best performer even though scoring just under 50% (at best a C- bordering on C). The lack of surprise is largely due to the **visible genuine commitment to clinical leadership by its Chief Executive, Chief Operating Officer and Chief Medical Adviser** (the contribution of the outgoing Board chair should also be noted).

Lakes scored the highest positive response (over 70%) from members when asked whether their DHB had established a governance structure which ensures partnership between health professionals and management. The next highest score was Capital & Coast (over 60%).

It was also the second highest positive response to the combination of 'a great extent' and 'to some extent' to the question about the extent to which the chief executive has worked to enable strong clinical leadership (nearly 90% closely followed by Northland and South Canterbury; Wairarapa was the highest at 90%) although less so for the 'great extent' part (about 10% with six higher; Tairawhiti the highest at over 30%).

Lakes does relatively well also in clinician-management partnerships (third on a combination of some to a great extent; headed off by Capital & Coast and Tairawhiti). It is second highest in identifying clinical leaders (nearly 90% headed off by South Canterbury) and tops in fostering clinical leadership (over 90% to some or a great extent). One qualification, at least in respect of the comparatively better performers, is the relatively lower response rate (47%).

2… Capital & Coast (6.27)

This is a surprise. It is not that long ago that this Wellington based DHB was rightly regarded as a basket case in terms of staff morale. An ASMS survey in 2007 of clinical leaders revealed depressingly low morale. But, three years later a radically improved environment is evident.

Capital & Coast performed consistently high relative to other DHBs on several of the questions but was highest among the larger DHBs on establishing a 'governance structure which ensures partnership between health professionals and management'; the 'extent to which the chief executive has worked to enable strong clinical leadership' (5th behind the smaller Lakes, Northland, South Canterbury and Wairarapa DHBs); the 'extent that health professionals involved as active participants in decision-making processes'; and the 'extent health professionals are in partnership with management with shared decision-making, responsibilities and accountability'. In fact, it is the highest ranked of all the DHBs in management partnerships (over 80% either to a great or some extent).

The major explanation seems to be the performance of **Chief Executive Ken Whelan (unfortunately recently departed).** Much of management below him has been uneven but he **certainly made a difference and inspired confidence** assisted by a well respected chief medical adviser.

It has to be said, however, that Capital & Coast's ranking above Hutt Valley does not make much sense given what the ASMS knows of both DHBs but may be explained by the subjective perception of the quick impact of an effective chief executive on a low base.

One factor, along with Otago, is that nearly 30% of senior doctors at Capital & Coast feel they have enough time to engage in clinical leadership activities or development programmes. This is hardly impressive but does compare favourably with the 20% national average (Hutt Valley is consistent with the national average).

3… Tairawhiti (6.09)

Tairawhiti (Gisborne and East Coast) has performed relatively well, especially given the wariness that many senior doctors have towards the human resources and funding & planning divisions. However, the chief executive is generally well respected and has been proactive in encouraging the development of a clinical leadership structure. One qualification has to be that in a small DHB the response rate (43%) was among the three lowest.

Relative to other DHBs it has scored consistently well on most questions. **Tairawhiti's chief executive rates the highest in terms of working to enable strong leadership to 'a great extent'** (albeit only a little over 30%) although he falls behind somewhat when the 'to some extent' category is added.

Tairawhiti also scores highest of all DHBs in achieving management partnerships to a 'great extent' (but still only less than 20%) and in the top three when the 'to some extent' category is added.

4… Counties Manukau (6.02)

Fourth ranking for Counties Manukau is a surprise in that it is inconsistent with the persistent messages of frustration from many members, including delegates at the Joint Consultation Committee, over issues such as the accessibility of the chief executive, the continuing failure to address serious car parking concerns, and a debacle over an annual leave audit.

Dr Robin Gauld presents the results of his survey on the implementation of *"In Good Hands"*

On the other hand, **in the mid-1990s Counties Manukau became a leader in clinical engagement and there is a well established culture of devolved engagement and leadership closer to the clinical 'coalface' and a strong well established focus on continuous and quality improvement.** This is reflected in its very good ranking on the question about the extent to which the DHB sought to delegate responsibility for clinical service decision-making. Further, management (including the chief executive) responded very positively in ensuring resources were put in place to support senior medical staff achieve the six hour target in the emergency department (an impressive achievement in such a busy acute hospital as Middlemore).

Compared with the larger DHBs Counties Manukau scored poorly over familiarity with *In Good Hands* although did better on familiarity with the concept of clinical leadership as an 'obligation to step up, work with other leaders, and change the system where it will benefit patients'. Senior doctors scored the chief executive low compared with other DHBs over the extent to which he had worked to enable strong clinical leadership (particularly in the 'to a great extent' category).

Generally, however, Counties Manukau compared well on more systems questions such as the extent to which safety and quality is a goal of every clinical initiative and management partnerships. Again the relatively lower response rate (46%) has to be factored in.

5… Canterbury (5.97)

Although much less dramatic than Capital & Coast, Canterbury's ranking is impressive in the context of the legacy of low morale and disengagement in the 1990s brought to the fore by the Health & Disability Commissioner's 'patients are dying' report. In the subsequent decade much hard work was put in to improve engagement and relationships, including innovation and primary-secondary collaboration, accelerating during the three years Gordon Davies was chief executive and continued by his successor.

Canterbury consistently scores relatively well in the various questions; better in the extent to which the chief executive has worked to enable strong clinical leadership, the extent that safety and quality is the goal of every clinical and administrative initiative, involvement of health professionals in partnership with management, and the extent to which clinical leadership is supported at the hospital management level.

One area of significant improvement in recent years has been the transformation of its funding & planning division to be much more integrated with the rest of the DHB in contrast with earlier artificial barriers (then similar to several other DHBs). However, there is still room for improvement including in the role of the chief medical adviser and longstanding concerns about the performance of human resources.

6… Northland (5.73)

Like Capital & Coast but less dramatically the appointment of a new chief executive four years ago has made a significant difference for the better. **Northland is especially strong relative to other DHBs in the extent to which the chief executive has worked to enable strong clinical leadership.** It is also relatively strong in familiarity with the concept of clinical leadership; establishing a governance structure which ensures partnership between health professionals and management; and management partnerships.

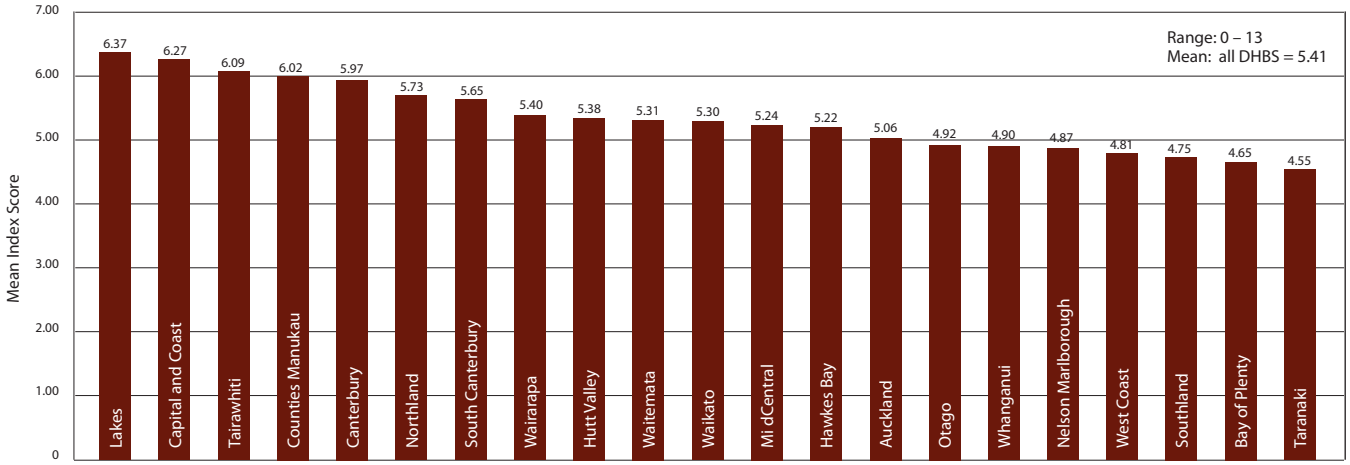
Where Northland falls down relative to a number of other DHBs is in the fostering and supporting of clinical leadership by hospital management below the chief executive. On the other hand, the DHB has a good recent tradition of chief medical adviser appointments and its human resources division stands out as being supportive of senior medical staff.

7… South Canterbury (5.65)

South Canterbury is another surprise and also the last DHB to score above the national mean. The surprise is that the only senior doctors strike in New Zealand's public health system was in this DHB back in 2002 and the occasional tetchiness in the relationship between senior management and senior medical staff. Nevertheless there is also a climate of goodwill that has gone someway to help overcome this. A successful SMO engagement workshop in 2009 served as a catalyst for a turn-around as did the Chief Executive's decision to bring in the well regarded Cognitive Institute for work on clinical leadership.

South Canterbury has scored relatively well in establishing a clinical governance structure which ensures partnership between health professionals and management while the chief executive has also performed well in working to enable

The Clinical Governance Development Index (p=0.000)



strong clinical leadership (despite some tetchiness in the relationship). **Its best performance, however, is topping all DHBs in identifying clinical leaders** (over 90%).

8… Wairarapa (5.40)

Wairarapa is the highest performing of the 14 DHBs which are below the national mean. However, caution is required because of the low response rate (43%) in one of the smallest DHBs. **Its strongest area has been the extent to which the chief executive has worked to enable strong clinical leadership;** an impressive achievement given that she is a relatively recent appointment. There are also recent signs, subsequent to the survey, of improved relations between senior medical staff and hospital management below the chief executive level.

9… Hutt Valley (5.38)

My expectation had been that Hutt Valley would have ranked higher than this even though it is still in the top half. Notwithstanding the impressive improvement in Capital & Coast, many would still rank Hutt Valley higher. For example, **there has been impressive collaboration between management and senior medical staff in recruiting registrars trained in Hutt Valley to take up specialist positions.** But whereas the larger DHB was a significant improvement on a low base level, the latter has over the years been at a higher base. One qualification is that Hutt Valley's response rate (46%) was lower than its larger neighbour.

It is interesting that Hutt Valley senior doctors have a relativity lower familiarity with *In Good Hands* (compared with Capital & Coast and other DHBs) but have a greater familiarity with the concept of clinical leadership including the 'obligation to step up'.

What does drag Hutt Valley down is a poor ranking on whether it has established a governance structure which ensures partnership between health professionals and management (it is timely that the DHB is currently revising its governance structure). It is also down the ranking ladder on the fostering of clinical leadership by hospital management below chief executive level (I suspect this is below the chief operating officer level). On the other hand, chief executive commitment to enabling strong clinical leadership compares very favourably with other DHBs.

10… Waitemata (5.31)

One immediate qualification to interpreting Waitemata's performance is the fact that it had the lowest response rate (39%). The responses to the various questions are broadly consistent with the average among all the DHBs. The chief executive rates poorly over whether he has worked to 'a great extent' to enable clinical leadership (in the bottom seven chief executives and less than 5%) although the ranking improves when the to 'some extent' category is added (in the top 11 and over 70%). Waitemata does perform relatively better on decision-making partnerships between health professionals and management and in the identification of clinical leaders.

Further, Waitemata is a little above the national average in providing sufficient time for clinical leadership or development programmes (in the context, however, of a very poor national average).

Two factors that may have also contributed to Waitemata's difficulties are longstanding dissatisfaction among many senior doctors over the chief medical adviser role (there is now a recently appointed new incumbent) and frustration with management over excessive time to conclude issues such as job sizing reviews (which continues).

It is worth noting that the Board chair (appointed over a year ago) has given a strong message on his expectation of achieving clinical leadership (it takes time for this to filter through). Consistent with this **the Board has recently determined that it will not approve any recommendation relevant to clinical matters and service provision that the relevant clinicians do not support.**

11… Waikato (5.30)

As with Waitemata, **Waikato is middling in terms of many of the responses from its senior doctors.** On the positive side the chief executive compares favourably on the extent to which he has worked to enable strong clinical leadership when the 'great' and 'some' extent categories are combined (7th) as does the DHB as a whole on the extent that safety and quality is a goal of every clinical initiative. Not helping Waikato's performance is the assessment that senior medical staff do not have enough time to engage in clinical leadership activities or development programmes, this is below the very low national average.

12… MidCentral (5.24)

MidCentral's ranking is lower than some might have anticipated. Most of its scores are around the DHB national average. However, it does rank very high on extent of familiarity with *In Good Hands*, which should not be too surprising given that the group that wrote this policy statement was chaired by local paediatrician (and ASMS National President) Dr Jeff Brown, and also familiarity with the concept of clinical leadership. Further, **MidCentral's chief medical adviser has high mana among clinical colleagues within and beyond this DHB.**

What is significant is the very low ranking of the chief executive on whether he has worked to 'a great extent' to enable strong clinical leadership. It is less than 5% along

SUMMARY

Surprises

Counties Manukau (high ranking)

Capital & Coast (high ranking)

Taranaki (low ranking; may be skewed)

MidCentral (low ranking of chief executive; possibly influenced by circumstances at the time)

Hutt Valley (lower rank than Capital & Coast)

DHBs with top ranked Chief Executives

Northland

Lakes

Wairarapa

Capital & Coast (now departed)

DHBs with low ranked Chief Executives

Waitemata

Hawke's Bay

Mid-Central

Southern (twice – Otago and Southland)

with Waitemata, Hawke's Bay, Whanganui, Otago and Southland. However, when the 'to some extent' category is added the ranking is much improved albeit to around the middle. But the low ranking can't be ignored especially as it is a surprise given the highly personable and likeable style of the chief executive. On the positive side, however, he actively participated in a local largely specialist-GP focused workshop on clinical leadership in primary-secondary collaboration including break-out groups.

The result is similar to the question on the extent to which hospital management has fostered clinical leadership. It also compares poorly on whether it has achieved 'to a great extent' partnerships between health professionals and management (but much better when the 'to some extent' category is added).

One possible explanation for MidCentral's situation is that there is a considerable gap between the DHB's funding & planning division and senior medical staff with the former playing a lead role in a difficult financial review of clinical services in response to the DHB's deficit last year. Many senior doctors found this a brutalising experience and it also attracted negative media publicity. Another factor is that the DHB no longer has the equivalent of a chief operating officer position which pushes much of this important work in the direction of an already busy chief executive.

13… Hawke's Bay (5.22)

Hawke's Bay has had a troubled recent history including strong tensions between the former board and senior management (particularly the former chief executive and chief operating officer), an independent report highly critical of the management of conflict of interest by the former board, the sacking of the former board and appointment of a commissioner (subsequently replaced by an elected board largely comprising the former dismissed board members), and the abrupt departure of the former chief executive. It now has a new chief executive recruited from the English NHS.

The net result has been an unsettling environment for senior medical and other staff. This may all have contributed in the background to Hawke's Bay's unimpressive performance relative to other DHBs. **It certainly has not provided an environment conducive to flourishing clinical leadership.**

Consistent with its overall score, Hawke's Bay is average for many of the questions. But, as with Waitemata, Whanganui, MidCentral, Otago and Southland, the chief executive scores very low on whether he has worked to 'a great extent' to enable strong clinical leadership (his ranking improves when the 'to some extent' category is added). It is difficult to assess whether this is due to the incumbent. On the one hand, he is relatively new in the role and has inherited difficult circumstances. On the other hand, the approach to clinical governance in England is seen as much more top down compared with New Zealand and this approach will not go down well here. It is too early to make a call on what the explanation might be.

While the performance of the chief executive is not ranked high, the performance of hospital management below him does rank very well in fostering clinical partnership. It is a relatively impressive second behind Lakes and is largely due to the highly respected chief operating officer (who also made a significant contribution to Hutt Valley earlier in his career).

14… Auckland (5.06)

Relative to the other DHBs there is only an average (over 40%) extent of familiarity by Auckland ASMS members with *In Good Hands* and with the concept of clinical leadership which goes some way to explain the DHB's overall low ranking. Auckland also scores low on the establishment of a clinical governance structure which ensures partnership between health professionals and management. Further, it falls down on the extent to which it has employed clinical leaders.

The chief executive's performance in the extent to which he has worked to enable strong clinical leadership is about average, relative to other DHBs, while Auckland is ranked as high as 8th on the extent to which health professionals are involved as participants in decision-making processes and in partnership with management.

But where Auckland performs particularly poorly is the extent to which clinical leadership is fostered and supported by hospital management (below chief executive). It is one of five DHBs where senior management is ranked less than 5% in fostering to a 'great extent' and is barely 50% when the 'to some extent' category is added (one of the four lowest). This is consistent with the very low number of senior doctors who believe they have enough time to engage in clinical leadership activities or developmental programmes (10% compared with the national average of 20%).

What should one make of this poor performance in New Zealand's largest tertiary DHB? The chief executive has a genuine commitment to enhancing clinical leadership and is generally liked by those who engage with him but, at least until recently, has assumed that changing structures which he did a few years ago would lead to effective devolved decision-making. It hasn't, at least to the extent that would have been hoped. The level of devolved decision-making, clinical leadership and an engagement culture has yet to emerge although overall the situation has improved since he commenced his chief executive appointment.

The survey suggests that the problem in delivering this aspiration rests largely with the layers of senior management below him. It has not been helped by the perception among ASMS members that until recently the chief medical adviser is essentially a management position. Reinforcing all of this has been the failure to sufficiently address time for non-clinical duties as part of job sizing. An important factor underpinning

DHBs with poorly ranked Chief Executives

Bay of Plenty

Whanganui

Other interesting outcomes

Effect of long established culture of devolved engagement and leadership closer to clinical 'coal-face' in Counties Manukau

High ranking of Hawke's Bay hospital management

Low ranking of Auckland and Southland hospital management

this is uneven behaviour and performance within the human resources department from sensible and constructive to the opposite. Further contributing to senior medical staff frustration has been a poorly executed across-the-board job sizing review which has been plagued by avoidable delays.

15… Otago (4.92)

Last year Otago and Southland merged to form the new Southern DHB. But because this was so recent the survey conducted soon after the merger treated them as separate DHBs. Since late 2007 they have shared the same chief executive. However, they have had separate chief operating officers.

Otago SMOs ranked their DHB very low for establishing a governance structure which ensures partnership between health professionals and management (second lowest just above Bay of Plenty) **and similarly their chief executive for working to enable strong clinical leadership.** Unfortunately the chief executive, while hardworking, has a propensity to get fixations on particular issues which makes achieving effective clinical leadership difficult.

Otago is above the 20% national average for having enough time to engage in clinical leadership activities or development programmes, one of the highest in fact but still under 30%.

16… Whanganui (4.90)

The biggest factor contributing to Whanganui was the poor ranking by SMOs of their chief executive with no-one surveyed considering that she has worked "to a great extent" to enable strong clinical leadership, the lowest ranking of all the chief executives sharing this with Bay of Plenty (the response rate at 48% was a little lower than the national average). **The management style in this DHB is generally seen by SMOs as very top-down.**

17… Nelson Marlborough (4.87)

It is difficult to identify one or two particular reasons for this poor overall ranking; the specific performances are broadly consistent with each other. If there is one thing that stands out a little compared with others, it is that it is one of the four worst performers on whether it has achieved "to a great extent" health professional-management partnerships with shared decision-making, responsibility and accountability (falling to the bottom three when the "some extent" category is added.

The management leadership culture at Nelson Marlborough could best be described as benign and patrician. **While there is not much conflict there is also limited effective engagement.** Since the survey was conducted a new leadership structure has been established which, on paper at least, has significant senior doctor involvement. Hopefully this will lead to improvement but the lessons of Bay of Plenty (and Auckland) should be kept in mind; **cultural change is more decisive than structural change.**

18… West Coast (4.81)

This DHB should have done much better, up there with Wairarapa, for example, given its small size. But its response rate was the highest (70%). **A feature of the West Coast is that a sizable proportion of its senior medical staff are salaried GPs in Westport, Greymouth and South Westland.**

It is interesting that while the then chief executive ranked about average over whether he had to a 'great extent' worked to enable strong leadership, the ranking dropped dramatically to among the lowest when the 'to some extent' responses are added. West Coast's ranking is particularly low (bottom) on the extent to which it has sought to identify clinical leaders.

19… Southland (4.75)

As discussed above, Southland shared the same chief executive as Otago prior to their merger into Southern. For similar reasons it compares poorly (but more so) with DHBs although it does rate better than Otago on the establishment of a clinical governance structure which ensures partnership between health professionals and management (but still below the 48% national average) and management-health professionals (but again low compared with other DHBs).

The extent to which the chief executive has worked to enable strong clinical leadership is ranked very low. A very low ranking is also given to the extent to which clinical leadership is fostered and supported by hospital management (including lower than Otago). These appear to be the main factors that separate Southland from most other DHBs and are consistent with the ASMS's own observations and membership feed-back.

20… Bay of Plenty (4.65)

There was a time, admittedly several years ago, when Tauranga was perceived as the happiest place in New Zealand for senior medical staff (less so Whakatane as the second centre of the Bay of Plenty DHB). Pasts are often exaggerated and halcyons are usually better in perception rather than reality. Nevertheless there has been a sea change. Part of the source of this low ranking probably predates the current chief executive. In particular, **senior medical staff were severely and destructively disengaged over the redesign of Tauranga Hospital while their colleagues in Whakatane have often been uncertain over their hospital's future.**

But the current senior management has had a focus on structural rather than cultural change. On paper the structure looks good but there is not the underpinning culture to make it work. It is interesting that despite the poor result ASMS members have a comparatively good familiarity with the *In Good Hands* policy statement and with the concept of clinical leadership as 'an obligation to step up, work with other leaders, change the system where it will benefit patients'. The DHB does perform comparatively better on the extent to which it is prepared to identify clinical leaders.

But there is much slippage on the performance or culture/relationship side of the equation. It is the lowest ranked of the 21 DHBs of those who believe that the DHB has established a governance structure which 'ensures partnership between health professionals and management'. Also of note was the poor ranking by members of their chief executive with no-one surveyed considering that he has worked "to a great extent" to enable strong clinical leadership, sharing this ignominy with Whanganui (the lowest when the to "some extent" category is added). Hospital management's fostering and supporting of clinical leadership is also unimpressive.

Bay of Plenty also performs badly on the question of the extent to which safety and quality is the 'goal of every administrative initiative', the extent that health professionals are involved as 'active participants' in decision-making processes', and the extent to which health professionals are in partnership with management with shared decision-making, responsibility and accountability.

21…Taranaki (4.55)

Taranaki was the big surprise. My anticipation was that Taranaki would rank somewhere in the upper grouping, not last.

In many respects it shares similar features to top ranked Lakes. There are strong similarities in approach and style of the key positions of chief executive, chief operating officer (now departed), and chief medical adviser. If anything Funding & Planning at Taranaki has a closer and more integrated relationship with DHB health professionals than in Lakes. It is worth adding that the chief executive has responded quickly and positively to the news of this survey by initiating discussion with senior medical staff on why this result occurred and how can it be improved, including at a very recent SMO engagement workshop.

There are two factors to note over this surprise. First the margin between first and last is small (1.82 out of 13). Second, in the late 1990s in a privatisation binge some Taranaki services were contracted out thereby reducing the number of SMOs able to be covered by this survey. The result in a comparatively smaller DHB employed workforce for a DHB of its size may have been skewed by negative views of management within one larger service.

Despite its low ranking Taranaki ranks about average on establishing a governance structure which ensures partnership between health professionals and management as does the extent to which the chief executive has worked to enable strong clinical leadership.

Where Taranaki appears to fall down is the extent of its commitment to health professional-management partnerships and hospital management's fostering and supporting of clinical leadership (this may be explained, in part at least, by my belief that this result may be skewed).

Ian Powell
Executive Director

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

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

Substantial discounts are offered for bulk and continued advertising.

ASMS 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***

How to contact the ASMS

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

Telephone	04 499-1271
Facsimile	04 499-4500
Email	asms@asms.org.nz
Website	www.asms.org.nz
Post	PO Box 10763, Wellington 6143

ROSS WILSON FORMER CTU PRESIDENT / CURRENT EXECUTIVE CHAIR OF UNIONAID

UnionAID: supporting real change

2011 is going to be the year when UnionAID really takes off. UnionAID (Unions Aotearoa International Development Trust) was established by the Council of Trade Unions in 2009 to assist struggling workers and their families in developing countries.

A registered charity, it supports workers' rights to fair rewards and conditions by funding special programmes enabling them to help themselves. The CTU had already developed several projects and UnionAID was formed to professionalise our work.

UnionAID has now undertaken very successful projects in South India, Sri Lanka, and the Thai –Burma border, as well as establishing and managing a programme which brings six young Burmese community leaders to Wellington for a six month programme in English language andwelopment studies.

Skills training in Mae Sot

We have just completed the first classroom-workshop for our new occupational skills training centre in Mae Sot. This is being established to address an urgent need for skills training as young Burmese women continue to stream across the border into this Thai border town.

Skills training in Mae Sot

Our Project Leader Min Lwin is concerned that, unless these young women get the skills for employment in local factories, their desperate situation can lead them into prostitution or being trafficked to other Asian cities.By mid-year the project buildings will include two classroom/ workshops, an office, and accommodation for both staff and trainees. With total funding of $NZ56,000 our project partner, the Federation of Trade Unions of Burma (FTUB) will build the complex of buildings, pay three staff, and provide food and accommodation for the staff and trainees for a full year.

350 young Burmese migrant women a year will be trained on industrial knitting and sewing machines and will move on to employment in the hundreds of clothing factories which have been established in the border areas of Burma and Thailand to take advantage of the cheap labour.

While many of these factories are sweatshops the FTUB see this employment as a far better option than being forced by poverty into prostitution in Bangkok or trafficked off to other Asian cities.

The other part of the UnionAID – FTUB project is organizing to improve working conditions in the factories.

Dalit and tribal workers in Tamil Nadu

Through our UnionAID project in Tamil Nadu more than 30,000 Dalit (untouchable) and tribal workers have formed local unions over the past 4 years. 164 local unions work together under the leadership of our project partner, the Tamil Nadu Labour Union. 10,600 of the members are women. This is a tremendous achievement by workers who have historically been oppressed, abused and exploited by upper castes.

The huge list of achievements for the project have been reported in our UnionAID "Solidarity" newsletters (refer www.unionaid.org.nz), but probably the most impressive is the sense of pride and confidence which their collective work has given them.

A strong focus for future project work will be encouraging economic development and the independence of workers through co-operatives which is already an important strategy for the Tamil Nadu Labour Union.

Guiding principles

International research has shown that development projects are effective when they are owned and driven by the recipients to achieve their own priorities for action, promote a sense of dignity and worth and are empowering, and involve and benefit the whole community.

These have been the guiding principles for UnionAID projects which are led by carefully selected local partners and have a strong focus on building collective capacity as unions and cooperatives.

How you can help

Although we get some project funding from government aid programmes such as the new Sustainable Development Fund, we are reliant for core funding from unions and union members.

UnionAID is unique in having a focus on worker rights and development, and ensuring that every cent of the donor dollar is spent on our projects.

We invite all ASMS members to become Kiwi Solidarity Members of UnionAID by committing to a small monthly donation by direct debit.

For further information please email **unionaid@nzctu.org.nz**

Investigations into clinical practice

Dr Alan Doris of the Medical Protection Society, outlines what could happen if your practice is called into question.

When there are concerns about the ability of a hospital doctor to practice safely, whether due to competence issues or impaired health, both the Medical Council (MCNZ) and the employing District Health Board (DHB) may become involved in investigating the doctor's practice. Both have standard processes which they must follow when investigating concerns about a doctor's competence. It is important that such a process of investigation is fair; that the doctor is adequately supported, and if necessary represented. MPS and the ASMS are both of assistance in such circumstances with a synergistic involvement often being most helpful for the member.

Concerns about a doctor's competence may be brought to the MCNZ from many sources. Medical Council processes are determined by Part 3 of the Health Practitioners Competence Assurance Act 2003 (HPCAA) and are to ensure that "the health practitioner's practice of the profession meets the required standard of competence" (section 36(5) HPCAA). Though the form of a competence review by the MCNZ is at its discretion, the usual process is to decide on terms of reference for the review and appoint a three person performance assessment committee (PAC)[1]. Two members of the PAC are doctors from the same clinical discipline, the third being a lay person. The stated purpose of a review such as this is to assess competence and educate the doctor, rather than discipline. The composition of the PAC and the terms of reference may be challenged by the doctor. The performance assessment may cover a range of matters and involve a visit to the doctor's clinical area. At conclusion, a report is provided by the PAC to the MCNZ. After receipt of the report by the MCNZ it is passed to the doctor so that further comment, representations or information can be provided to the Council before a decision is made.

If after a review the Council believes that the doctor does not meet the required standard of competence then it can require the doctor to undertake a competence programme or sit an exam, receive counselling or assistance, or have conditions placed on their practice. The whole process of a competence investigation usually takes several months.

Clause 42 of The National DHB Collective Agreement (MECA) requires employers to follow a strict process when investigating concerns about a doctor's clinical practice. The process follows principles of natural justice and aims to prevent the unreasonable use of suspension or unnecessarily drawn out processes. After seeking initial comment from the doctor about a competence concern the DHB may decide to pass the matter on directly to the MCNZ. If the DHB chooses to carry out an investigation itself the process is similar to that described above with the setting of terms of reference and selection of an investigator or investigators. As the outcome of such an investigation may affect a doctor's employment it is important to be represented and advised throughout this process.

A Memorandum of Understanding was signed in August 2010 which details a partnership between the MCNZ and DHBs, including how communication will occur when there are competency concerns about a doctor[2]. The memorandum states that DHBs must take steps to ensure patient safety while any competence or health concerns are being investigated, and to have a system enabling DHBs to exchange information about competence concerns to other hospitals which may employ the doctor.

In addition to this, Section 34 (3) of HPCAA places a statutory duty on the employer of a doctor who is dismissed or resigns from employment for reasons relating to competence to inform the Registrar of the MCNZ.

For a doctor undergoing a competence review process either by the MCNZ or an employing DHB the stakes are very high. The possibility of suspension or termination of employment is a serious threat to a doctor's livelihood and career, as are conditions being placed on clinical practice. There is also the possibility of loss of the ability to obtain a Certificate of Good Standing from the MCNZ should the doctor wish to seek registration overseas.

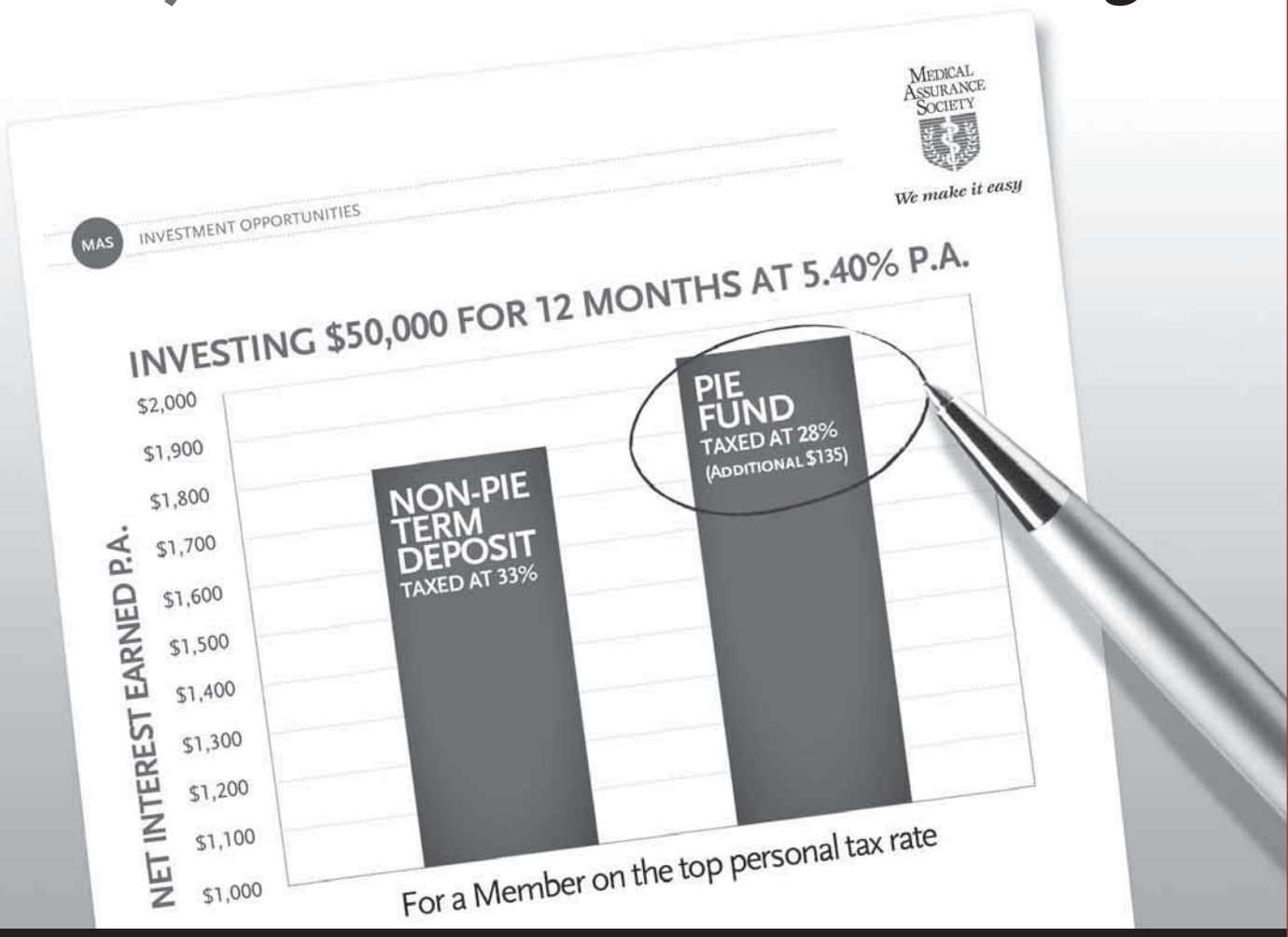
MPS assists members with all MCNZ procedures and related professional matters, and where appropriate in DHB processes. As a union of health professionals ASMS is best placed to advise members of their employment rights and assist in resolving employment relations difficulties. As professional matters and processes are often entwined with those of the employer it is important for the member doctor to make use of the organisation (MPS or ASMS) with the best skill set for the particular process and stage, and for this to be co-ordinated. ASMS and MPS work jointly to ensure that members have effective representation when faced with competency investigations whether by the MCNZ or DHB. Members are encouraged to consider a co-ordinated approach in the common situation of professional and employment processes occurring concurrently or consecutively.

References

1. Performance Assessment: A guide for doctors being assessed. Medical Council of New Zealand 2005

2. http://www.mcnz.org.nz/portals/0/publications/MCNZ%20%28MOU%29%202010.pdf

You may find this investment **less taxing.**



Lower tax means a higher return

The Medical Securities Limited (MSL) PIE Fund could enable you to earn a superior return on your investment. That's because a PIE (Portfolio Investment Entity) investment is taxed at a maximum of 28% p.a. If your personal tax rate is higher, you'll pay less tax in a PIE than on a traditional savings account or term deposit, with no further tax to pay.

For Members on the top personal tax rate with a MSL 12 month Term PIE at 5.40% p.a.*, the tax savings bring the **effective** return up to 5.80% p.a.*, well ahead of most non-PIE term deposits for the same term.

The MSL PIE Fund is **flexible** and **easy,** with both term and on-call options.

Call us today to find out how we can help make tax work in your favour.

Call us today

0800 800 MAS (627)

Visit us online at **medicals.co.nz**

* Interest rates are subject to change. Minimum investment of $500.

Investments in the Medical Securities Limited PIE Fund are not guaranteed. For a copy of the latest prospectus and investment statement, please visit www.medicals.co.nz or call us on 0800 800 MAS (627). The MSL PIE Fund invests only in debenture stock issued by MSL. MSL is rated A-/Stable by Standard & Poor's. Further information is available by visiting www.medicals.co.nz.

MEDICAL ASSURANCE SOCIETY

We make it easy

MAS1491 1Specialist