ISSN 1174-9261 ISSUE 76 | SEPTEMBER 2008

The Specialist

THE NEWSLETTER OF THE ASSOCIATION OF SALARIED MEDICAL SPECIALISTS

A journey done, a journey just begun

Lead National Chair of the 21 DHBs, Dennis Cairns; Minister of Health, David Cunliffe and ASMS National President, Dr Jeff Brown signing the Time for Quality Agreement

Once upon a time not so long ago hospitals were enjoined to unjoin: to compete against each other for points determined by obscure officials'; to hide their own triumphs and hinder their neighbour's efforts', to alienate their medical magnificence in the name of competitive corporatisation.

The purse string purveyors set out to measure anything that was easy to count and to ignore anything that counted but was too hard to measure. Immense effort was spent tallying assets so that balance sheets could discount depreciation. Capital investment flirted with private borrowing. Public financing demanded return on investment to shareholders (two Crown ministers) the same as if the health dollar had been parked in a bank account.

Doctors were moved out of managing the hospitals and out of the decisions about which parts of which services needed investment. Doctors were instructed not to share innovation and not to network. Agendas (whether hidden or not) included pedestal lowering, disempowering, and control theories. This was all in the name of market efficiency and bonus driven productivity. Sicknesses were ranked by return on investment. While not necessarily a conspiracy, the movement nevertheless conspired to fragment and marginalise many medics.

One has only to observe the variety of organisations that grew out of the divisiveness to represent factions of the medical community to measure the success of this disempowering.

Concurrently, consumerism joined forces with exposure of experiments to multiply the avenues of redress for wrongdoings, real or perceived. Multiple, not just double, jeopardy became the threat and the reality.

Once were victims

The theme at repeated ASMS Annual Conferences echoed a victim mentality. Invited speakers and delegate debates bemoaned the many airing rooms in which specialists found their foibles washed, hung out, starched, and soiled. Adversarial attitudes were inevitable: towards management; towards some colleagues; towards even a few patients (or at least their advocates).

Victims fight to survive but not always in healthy ways either for themselves, or for those they live and work with. It seemed that as groups - locally, regionally and nationally - we were forced into reactive and reactionary roles. On many fronts we were backed into fights with those we most needed to associate with for the delivery of health care.

Is it any wonder that shared perceptions of each other became entrenched distrust in many arenas and played out in the politics of employment relations? It was more than perception that those specialists intent on preserving networks and the future viability of clinical services were tolerated at best. We were unit costs and spreadsheet liabilities, expensive and, hopefully, replaceable drivers of expensive services. We were selfish empire builders' intent on self-preservation and dogged in defence of an outdated paradigm. We were unbudging clingers to the vestiges of an old order.

But islands of sanity shone out amidst the storms: managers who knew that micromanagement strangled innovation and investment; that focussing on the cents cost dollars to account; that marginalising medic's cast leadership to the wolves.

The tragedy – in the classical sense – of this posturing was the separation, by more than corridors, of the intelligent intense individuals who laboured apart.

Continued next page

ASMS

Executive Director
Ian Powell

Assistant Executive Director
Angela Belich

Senior Industrial Officer
Henry Stubbs

Industrial Officer
Lyn Hughes

Industrial Officer
Sue Shone

Executive Officer
Yvonne Desmond

Admin Officer
Leigh Parish

Admin Assistant
Ebony Lamb

Membership Support Officer
Kathy Eaden

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

Ph 04 499-1271

www.asms.org.nz

Heroes once more

I joined others in trying to turn the tide. Exhortations to ASMS Annual Conference for senior doctors to seize power, to grab hold of leadership with all its nettles, gained publicity if not traction, and still we saw the vestiges of managerialism erupt amid militaristic mendacity. As if a passion play was unfolding we saw marginalised opinions over performance based pay pitted against the oft-repeated persistence of principled practitioners. At the risk of strangling Ministerial procrastination we steadfastly advised and sought every avenue for engagement. We made events out of each difficult collective decision along the road to MECA. We used the leverage from these events to try and avoid each unpalatable challenge to professional probity.

We uncovered heroes in our midst. Local leaders who became touchstones for their colleagues, and cherished advisers to their managers. The not so rare breed of senior doctor who could walk the clinical walk, and talk the management talk. That is what they have learned on the job in order to innovate, improve, evaluate, redesign, change, network, regionalise, ration, champion, and lead the teams, departments, hospitals and health systems to which they dedicate the decades of their professional lives.

We learned to seize the moment when medicine is most likely to be effective. To grasp the offer of conciliation from a contributor to our 2007 Annual Conference who earnestly sought to rebuild respect, and to earnestly explore the offer of a new Health Minister (David Cunliffe) to broker resolution of an impasse in negotiations. The latter led to the signing of a new MECA. The former to an even more far-reaching and revolutionary resolve.

Director-General of Health, Stephen McKeran and ASMS National President, Dr Jeff Brown

Time for quality

Time for Quality is the new journey to a terrific future where medical and dental practitioners are installed once more in the leadership of hospitals and DHBS (note the emphasis). The very public signing of this "new way" by the ASMS and DHBs was formally witnessed by the Health Minister in the company of the Director-General and other leaders of the health system. 'Time for Quality' recognises 'disconnects' in sections of the system. It acknowledges collective responsibility to improve the quality of healthcare delivery and a commitment to transform it along a path to become a system of excellence.

The words bear scrutiny for they are the result of intense introspection and honest appraisal by CEOs, GMs, HR heads and SMOs. They are the result of intelligent, wise and passionate persons gathered together. They are the result of time taken away from our doctor jobs and our desk jobs away from our patients and our policies. They admit that underperformance in the sector can be attributed to under-utilisation of the experience and expertise of health professionals and to the often poor state of relationships between health professionals and management.

The words also proclaim that we are not currently working to best effect that from henceforth it is essential we work together to transform the system to one of excellence. We are fundamentally agreed that the community we serve has a legitimate expectation that we have the expertise, resource and will to do better.

Time for Quality is central to our collective responsibility that the patient and citizen receives care of optimal quality, and has trust and confidence in the health system now, and into the future. It is an explicit commitment to a partnership.

Terrific future

The terrific future may be terrifying to some entrenched managers but the enlightened ones know that an ideology of simplism produces the lie of simplifying. They know that complex systems require trust and teamwork to ride out the chaotic swings of fortune and natural "attractors" and that the precautionary principle of the "one percent doctrine" is necessary when dealing with individual lives but chokingly constraining when planning population sickness services, let alone health.

I worry even more that specialists and other doctors will be either dismissive or terrified of 'Time for Quality'. The burnt out and more than twice-burned will bury their clinical minds and dismiss this as platitudes or a sop to fashionable nest-feathering, and will look to every HR hiccough as evidence of hubris. Every management mis-

step will appear as malign manoeuvring. The wary and worn-out may be unwilling to take on extra efforts on top of their clinical load, to take on the risk of frustration at bureaucratic inertia and the reward of the ridicule of their colleagues.

Let us not be terrified. Let us embrace the terrific.

Quality leadership

I personally challenge each and every member to seek leadership; to take up the reins of control of their destiny, not by isolation and insularity, but by involvement and inclusion; to read the words, talk the talk, and walk the walk; to lead, with management backing at every step, the path to the future to change the culture of our workplace rather than leave for greener pastures; to demand devotion to the new partnerships based on teamwork and respect.

The test will be the embedding of quality improvement and service delivery in the weekly schedules of all doctors – in training, in specialisation, in supervision, in leadership. How resolute will be this translation into the daily life of our DHBs? The corridor conversations, the bedside decisions, the back office behaviour and front office favour? ASMS has achieved, with the wholehearted backing of DHB chiefs, and the explicit support of the Minister, potentially the most significant transformation in health leadership in decades.

Quality is critical for the health system to succeed. Senior doctors and dentists are critical for ensuring quality. Their most valuable resource is time. DHBs are responsible for providing this time and specialists are responsible for embedding this time in their work.

Join with me in a transformation in the wards, clinics, departments, theatres, and corridors of power. The new journey is just beginning.

Jeff Brown
National President

Lead National Chair of the 21 DHBs, Dennis Cairns with David Cunliffe and Dr Jeff Brown

ASMS services to members

As a professional association we promote:

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

As a union of professionals we:

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

Other services

www.asms.org.nz

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

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

ASMS Job Vacancies Online

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

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

Substantial discounts are offered for bulk and continued advertising.

ASMS email Broadcast

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

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

How to contact the ASMS

Telephone	04 499-1271
Facsimile	04 499-4500
Email	asms@asms.org.nz
Website	www.asms.org.nz
Postal Address	PO Box 10763, Wellington
Street Address	Level 11 The Bayleys Building Cnr Brandon St & Lambton Quay Wellington

The Time for Quality Agreement

This agreement was developed between the Association of Salaried Medical Specialists (ASMS) and the 21 District Health Boards (DHBs) with the support of the Minister of Health.

Time for Quality sits within the Tripartite Process involving the Government, the District Health Boards and the Council of Trade Union affiliated health sector unions.

Reports of the Commonwealth Fund and OECD indicate that the New Zealand health system is in relatively good shape and compares well internationally. Other indicators highlight problems, including systemic failures, and disconnect in sections of the system.

We recognise we have a collective responsibility to improve the quality of healthcare delivery. We are committed to building on the current system, to transform it along a path to become a system of excellence.

We acknowledge that, central to our collective responsibility, the patient and citizen receives care of optimal quality, that is financially sustainable, and that encourages and supports trust and confidence in the health system, now and into the future.

We recognise that in some cases, a contributor to areas of underperformance in the sector is under-utilisation of the experience and expertise of health professionals which is, in part, due to the poor state of relationships between health professionals and management. This means we are not working to best effect and is something we need to work together to transform. It is essential if we are to achieve a health system of excellence. The community we serve has a legitimate expectation that we have the expertise, resource and will to do better.

We will jointly seek to achieve this transformation by making an explicit commitment to a health professional partnership founded on:

1. Recognition and acknowledgement of the problem
2. Legitimation of a new view through principles of engagement
3. A work plan of active steps

Principles of Engagement

Health professional–management partnerships are founded on teamwork and respect

- Managers will support health professionals to provide leadership in service design, configuration and best practice service delivery
- Managers will support health professionals to ensure recognised competency and credentialing standards are met
- Managers and health professionals affirm that quality care drives the system to optimise patient outcomes
- Managers and health professionals will collaborate to meet both the "patient test" and the "whanau test", which means the patient experience is optimised for the patient and in a culturally appropriate way
- Managers and health professionals explicitly agree that decision-making and responsibility will be devolved to the appropriate level
- Managers and health professionals accept that there will be some services that can more appropriately be delivered regionally or nationally to effectively meet patient needs
- Health professionals will support managers to operate services within the resources available

Work Plan of Active Steps

- Acknowledge that participation of health professionals in quality development and service improvement is a core aspect of their roles
- Facilitate participation of health professionals and managers in conversations nationwide, within existing DHB budgets, as a symbol of commitment
- Use the Ministry of Health Sector Capability and Innovation Directorate to host these conversations on behalf of the sector
- Through these conversations, identify and animate projects for nationwide improvement, with an initial focus on five areas
- These five projects will be a combination of high risk and high gain areas (examples may include national Cystic Fibrosis services, national Paediatric services, national Intensive Care networks)
- Give life to the partnership so it becomes 'business as usual', through the spreading and sharing of progress made across the system

Signed by:
Jeff Brown, President ASMS
Dennis Cairns, Chair on behalf of 21 District Health Boards

Witnessed by:
Hon David Cunliffe, Minister of Health

Health Minister on the 'Time for Quality' agreement

Below is the official speech by the Hon David Cunliffe, Minister of Health, at the launch of the 'Time for Quality' agreement on 7 August. The Agreement was signed by Dr Jeff Brown, ASMS National President, and Dennis Cairns, lead national chair of the 21 DHBs. The Minister also signed as an official witness.

Tena koutou katoa, and warm Pacific greetings to you all.

I am pleased to celebrate the signing of the "Time for Quality" agreement between the Association of Salaried Medical Specialists (ASMS) and District Health Boards with my support through the Ministry of Health.

This forms an important part of the broader Health Sector Tripartite Relationship Agreement between the Council of Trade Unions, DHBs and the Government.

I have continued the work of my previous colleagues in driving a stronger focus and leadership for quality and the work that will form part of this agreement will be critical to that agenda.

Over the past week I have been championing a shift in direction among my colleagues that will sharpen a focus on collaboration across the health system.

When people enter the health system for care and support, they rightly expect "quality". Quality means, among other things, a safe environment, and professional and qualified staff.

There is a trust and confidence in our system that we must continue to preserve. That trust and confidence relies on us – funders, providers and health professionals – to work together collectively.

We need to model the way we expect people to work together on the shop floor – that is as a team - because patients do not make a distinction between us when they consider whether their experience in our system was a good one or not.

I congratulate and want to encourage the work that falls out of the Time for Quality agreement.

Health professional leadership is a critical component of successfully driving improvement and I will watch closely the priority areas that you agree on. The initial focus will be on five projects. These may include the national cystic fibrosis services, the national paediatric services and the national Intensive Care Network.

The Minister of Health, David Cunliffe speaking at the launch of the Time for Quality Agreement

Although the process of engagement is an important investment of your time, we must also be action orientated – the public and patients must see and touch the benefits of collectively supported service improvement soon.

I also look forward to the signing of the wider Health Sector Tripartite Relationship Agreement of which this is a part. Building our relationships will take time and we need to make this an important priority.

Our expectations of what we want the health system to deliver rests on the quality of the relationship between health professionals, their employers and the operational settings we create for the sector.

It is important to me that we set a strategic pathway for more constructive engagement between us all. The quality of care and support that our community receives relies on us to move forward collectively. I look forward to supporting you in your work.

Thank you.

Banning strikes? Compulsory arbitration?

Using patients as industrial weapons by 'bargaining agent' behaviour has led to the unhelpful call for an end to strikes by health professionals. This follows the recent Health & Disability Commissioner decisions involving neurology at Dunedin Hospital.

The only system of arbitration available in legislation ('final offer' in the Police Act) is arguably the most conservative known. It was proposed by the DHBs during the ASMS's national stopwork meetings in July-August last year because it would favour their conservative position. It is based on an arbitrary inflexible 'winner takes all' approach based on winning on all the disconnected criteria. It is guaranteed to leave an aggrieved party. It is not designed to address major problems such as recruitment and retention difficulties. Whether or not it is suitable for the police, given the nature of their work, is not for me to comment. But it is too rigid for a complexity based sector which includes a range of highly specialised and stratified occupational professional and other groups.

The most effective way to provide an arbitration system in the health sector at least would be to return to a detailed relativity based system somewhat similar to the 'rate for the job' legislative structure New Zealand had up until the late 1980s except that in today's economy it would have to be further adapted for international relativities. The political prospects of this are remote and we should not be rejecting what we have until we know where we are going to.

But three important considerations need to be taken into account in considering this call from him and others. First, some times these patient safety intrusive strikes are not the only factor that impact on the stress on clinicians and the safety of patients. The effect of workforce shortages (not just senior and junior doctors but also nurses, allied health professionals) is another. Second, there is not an alternative system of arbitration available and suitable for the health system. Third, removing the right to strike is even more likely to threaten patient safety because of the considerable strengthening of DHBs' bargaining position that would consequentially occur and their more often than not state of denial over the severity and precariousness of the workforce situation in DHBs.

Ian Powell
Executive Director

New ASMS website up in October

New technology and the desire to make our website a little more immediate have prompted a redesign.

Now you'll find hot topics, the latest publications and job vacancies right up front. For more information go to www.asms.org.nz

Sue Shone, Industrial Officer

Hospice Settlement

Hospices have now been operating in New Zealand since 1986. It was not until 2006 that the first multi employer collective agreement (MECA) for doctors working in hospices was settled. This agreement ran for one year. Recently a second MECA – for the period from 2007 until 2010 - was ratified and endorsed in a membership ballot.

To date ten hospices are parties to the new ASMS-Hospice MECA. These are North Shore Hospice Trust, Mercy Hospice Auckland, South Auckland Hospice Charitable Trust, Waipuna Hospice, Presbyterian Support East Coast (Cranford Hospice) Arohanui Hospice Service Trust, Te Omanga Hospice, Mary Potter Hospice, Nurse Maude and Hospice Taranaki.

The hospice MECA represents ASMS's second biggest MECA and early in the document there is acknowledgement that hospices in New Zealand are linked with the public health system and that where possible the parties "shall endeavour to ensure that conditions of employment are fair and comparable to their peers working in public hospitals."

Salaries are now aligned with those in the ASMS -DHB MECA, and nine of the ten hospices will now have six weeks' leave. Enhanced CME provision was agreed to, which in summary is the reimbursement of actual and reasonable expenses of up to $7,000 per annum from 1 July 2007, increasing to $8000 per annum from 1 July 2008, and further increasing to $9000 from 1 July 2009. These expenses are pro rata for part-time employees below 0.5FTE.

Changes to the after hours on-call rates were agreed along with amended definitions of a weekend (to be 8am Saturday until 8am Monday) and of a weekday night (to be Monday to Friday inclusive between 5pm and 8am). Thus any doctor who works on both Friday night and the weekend will receive $1400.

While there will be some disappointment that superannuation was not achieved in negotiations, we are aware that a number of hospice doctors have already joined a KiwiSaver scheme. Under Kiwisaver there is a statutory requirement for increasing employer contributions and the employer must pay 4% by 2011.

New provisions include additional leave and paid clinical supervision. The former is approved paid leave for employees to meet professional obligations and occasional teaching or examination requests, and to attend meetings convened by other government departments and statutory bodies where the employee has been invited to attend or is doing so in their professional capacity. The latter is a new sub-clause providing for the inclusion of clinical supervision in agreed hours of work and job description. This aims to make clear that clinical supervision and oversight are within paid time and expenses are paid by the employer.

The matter of rates for locums was vigorously debated and although there are schedules applying in two hospices, most hospices will now include a locum rate (subject to certain conditions) of no less than time and a half of the employee's current daily rate.

While the aim was to have standard conditions across all ten hospices, settlement ultimately depended on the development of schedules – in respect of Cranford, Mercy Hospice Auckland, Mary Potter, Te Omanga and Arohanui hospices.

Still to be conducted, in each hospice which is party to the new MECA, is a bargaining fee ballot. This bargaining fee is intended to ensure that all doctors who benefit from the Hospice MECA shoulder their share of the costs of the bargaining.

It was at the 2005 ASMS conference that members voted to seek a bargaining fee clause in the MECA, because for many years ASMS members had been concerned that non-members had the terms and conditions of employment negotiated by ASMS passed on to them by the employers, without having to bear any of the cost of negotiating those terms and conditions.

The Department of Labour summarises the concept of a bargaining fee thus:

"A bargaining fee arrangement is an arrangement where employees who are not members of a union can be employed on the same terms and conditions as those in a collective agreement if they pay a bargaining fee to the union that negotiated the collective agreement. The bargaining fee recognises the work done by the union in bargaining for these terms and conditions."

Arrangements for conducting the bargaining fee ballot are still being finalised with the employer party but it is expected that the process will be completed before the end of October 2008.

Sue Shone
Industrial Officer

The Human Touch

MEDICAL PROTECTION SOCIETY

Intuitively we know that developing good interpersonal and communication skills improves our clinical effectiveness and reduces our medico-legal risk, leaving us with a satisfied patient and a considerably less stressful, and actually enjoyable, consultation.

This can be easier said than done, particularly when we are busy, stressed and doing our best to cope with the multiple demands of current clinical practice. At times like that we are all likely to find effective communication a challenge.

You will be unsurprised to hear that studies have shown that the quality of medical care is not the only thing that determines whether a patient will make a complaint or seek compensation.

Great expectations

Patients expect us to be competent and skilled, but how can they tell if we are? Many will judge the quality of clinical competence by their experience of personal interactions with a doctor. While patients want doctors to have good clinical and technical skills, they often rate interpersonal skills as more important.[1]

Communication problems may lead a patient to complain and the reasons why they do can be separated into two distinct categories: predisposing factors and precipitating factors.

The former includes rudeness, inattentiveness and apathy, while the latter includes the actual adverse outcomes, mistakes and failures to provide adequate care. What is important is that precipitating factors are unlikely to lead to medicolegal problems in the absence of predisposing factors.[2]

Body talk

Eliciting patient expectations can make a vital difference to whether a consultation is successful. The actual words we use are often of less importance than our tone of voice, or body language.

Whilst patients will be dissatisfied if their expectations have not been met, many expectations may be unrealistic – that you have unlimited time and availability, will solve all the issues at once and all treatments will be 100% effective and risk free.

Letting patients tell their full story allows you to gauge their understanding and concerns; and, as patients do not present problems in order of clinical importance, the longer you delay interrupting, the more likely you are to discover the full spread of concerns the patient wants to discuss.

Eye contact is critical in demonstrating interest and understanding. So turning away from the computer to offer your full attention, and summarising what you have heard to check your understanding, helps the patient feel understood and appreciated.

A margin for error

Despite the best of intentions, there will be occasions when patients or their relatives will be dissatisfied with the care you have provided, or with the outcome they have experienced.

Complaints can feel personal, hurtful and sometimes unfair. So initially discussing the situation with an experienced colleague or your MPS adviser will be very helpful.

The senior doctor responsible for the care of the patient should be the person who speaks with the patient or relatives to:

- acknowledge what has occurred
- find out the facts and discuss them as they become known
- provide an explanation
- apologise
- identify what can be done to prevent similar issues arising
- adopt those lessons into future practice
- discuss whether an Accident Compensation Corporation (ACC) claim for treatment injury should be made.

There should also be a decision made on whether an incident report should be filed and if there should be a sentinel event review.

The Medical Council has published Good Medical Practice: A Guide for Doctors, which sets out its views on good practice. Cole's Medical Practice in New Zealand 2008, also available from the Medical Council, provides a useful guide on communication.

Continued bottom right ▶

Angela Belich, Assistant Executive Director

Progress on collective agreement negotiations outside District Health Boards

This is an update on collective bargaining with Non-District Health Board employers.

Salaried General Practice

Ngati Porou Hauora (Gisborne)
The agreement expired in January this year. Vocationally registered GP rates have been tied to the MECA. A claim has been lodged and two negotiating sessions held.

Ngati Whatua O Orakei Community Health Services
The Collective Agreement expired on 31 May 2008. A claim is being developed.

Te Oranganui (Wanganui)
The new collective agreement with a term from 1 January 2008 to 31 December 2009 has been signed and distributed with an increase of 4.5% in year one 4.5% in year two, CME leave of 20 days with expenses set at 5% of salary. Annual leave is still only 5 weeks.

Wellington Primary Health Care Service Multi Union Collective Agreement
The agreement has now been resolved with a term going from to 2008 to 2010. Increases for doctors range from 4 % per year upwards.

Christchurch Union and Community Health Service
The Collective Agreement expired on 30 June 2008. A new collective Agreement was agreed in July, with salary increases over two years of 6% and 4%. In addition there were increases in annual leave and CME expenses. An indicative ballot is currently being conducted.

New Zealand Blood Service

The Blood Service was cited as a party to the DHB MECA but had indicated that it didn't want to be a party. An agreement has been reached exactly mirroring the MECA as to leave, salaries, retention payment and CME. Many of the other lacunae in the agreement have also been addressed. We have agreed to have a separate negotiation on the availability allowance. The agreement is being prepared for signing.

Wellington Independent Practice Association (WIPA) Sexual Health Services

The collective agreement expired on 30 June 2008. A claim has been presented and negotiations are underway. The principal area of disagreement is provision of superannuation. It is hoped that agreement will be reached by the end of September 2008

Community Hospitals

Hokianga Health Service The Collective expired on 30 June. A claim has been lodged with the employer who has responded, rejecting all claims and offering a 2.7% increase.

Central Otago Health Services (COHSL) At the employers suggestion we have agreed to a variation to the previous collective to address issues pertaining to the back dated MECA salary retention payment and CME leave. This leaves a new agreement from 1 July 2008 partially negotiated.

Waitaki Health Services A claim was lodged with the employer last April; we are still awaiting a response.

One step beyond

As doctors we enter a world of patient interactions with heads full of clinical information, and through hard work, experience and application strive to bring to bear our expertise, knowledge and technical competence. Yet there are times when we find that, as vital as our clinical skills and knowledge are, they are not in themselves sufficient to avoid complaints and medicolegal problems.

The other vital ingredient is good communication and this, like all skills, has to be acquired. Taking the time to talk and to listen to patients, while juggling the demands of work, is not time wasted and proves, ultimately, to be highly rewarding for all involved.

Gareth Gillespie
Medical Protection Society, United Kingdom

Dr Peter Robinson
MPS medico-legal consultant, New Zealand

1. MORI, July 2005; www.mori.com/polls/2005/pdf/doh.pdf

2. Bunting R F et al. Practical Risk Management for Physicians. *Journal of Health Risk Management* 1998 Fall;18 (4):29-53

Importance of the right to strike

There are compelling reasons for considering the right to strike as inalienable. Negotiating with one's employers is not a level playing field. A central aspiration of negotiations is getting employers to part with money to their employees gain and possibly increasing employee influence at the workplace. In the absence of any other leverage employers can often simply say "no". Without the right to additional leverage employees are in the weaker position and often employers are prone to take advantage of this. This is especially the case in the health system where DHBs have been prepared to take advantage of professional commitment to patients.

In the case of senior doctors and dentists they have exploited the premise that this workforce would never take strike action, notwithstanding a successful localised strike in South Canterbury five years ago. The outcome of our strike ballot late last year changed all this. As well as a surprise for the ASMS it was a powerful wake-up call for both DHBs and the government.

Had the ASMS not received such a strong membership mandate for limited industrial action late last year, we would not have achieved the settlement we did, including the independent commission and the 'Time for Quality' engagement principles. It is not whether one takes strike action that is of critical importance but that the right exists and there is preparedness as a last resort to exercise it. Without this right our, and other settlements, including nurses, would have been worse.

However, with every right there is a responsibility. Our best supporters are patients and the wider public. One does not treat and respect patients as an ally when they are used as a weapon. This is the context in which recent Health & Disability Commissioner's reports concerning neurosurgery in Dunedin Hospital, along with a case considered by the Employment Relations Authority (ERA) in 2007, all involving strikes by medical radiation technologists represented by the APEX union, should be considered. They do not challenge the right to strike but raise important issues over the application of this right.

Contrasting unionism with bargaining agents

In our MECA dispute the ASMS came very close to taking strike action to the point of having determined the dates. Draft notification letters to the DHBs were ready to go. But we were insistent that, in the event of proceeding, with the strike patient safety would not be compromised. First, rather than the statutory minimum of two weeks, we would have given at least eight weeks notice to DHBs of the strike dates and other details. This would have meant that patient activities such as clinics and lists would not have to be cancelled because they would not have been scheduled in the first place. Second, cases that should not, on clinical advice, be deferred (primarily acutes and emergencies) would be excluded from the action. While, by statute, there would have to be life preserving services plans, these would have been notional at most.

In contrast the type of behaviours experienced in the APEX strikes has origins in the environment created and encouraged by the now repealed Employment Contracts Act in the 1990s. That essentially anti-union legislation encouraged advocates for employees to see themselves as bargaining agents. The essential difference between bargaining agents and broader based unionism is that the former focuses on what it can scratch out of the system while the latter focuses on what it can put into it (this in no way means ceding the importance of negotiating enhanced terms and conditions of employment). Not to put a fine point on it, those who embark upon strike action that drives into the core of non-deferrable patient care are more like bargaining agents than unions.

So much stems from whether, intentionally or otherwise, explicitly or implicitly, one sees patients as allies or weapons in an industrial dispute. Either approach is generated by quite different values and sets off quite different sets of behaviours. Regardless of motivation, seeing patients as weapons is an inevitable consequence of a bargaining agent approach whereas the broader unionism approach sees them as natural allies. It is important to appreciate that the bargaining agent approach is not necessarily any more assertive and strident than broader unionism. In the right circumstances assertiveness and stridency can be justified; it is their form that is the issue. Quite aside from professional ethos and values, strikes that risk compromising patient safety do not advance the particular employees' cause. Intended and actual strikes that don't compromise safety can.

If strikes go too far and push the parameters unduly in the realm of non-deferrable patient care and if they become ritualistic, inevitably DHBs will react. DHBs might be led by people who do foolish things but these people are not fools. DHBs have not learnt that much on how to settle difficult negotiations but they have learnt that they can survive strikes that push the safety parameters. They know that the five day strike in 2006 by RMOs largely collapsed towards the end even though the DHBs were at the time pushing an aggressive control agenda. They now

know that even two day strikes are difficult to sustain given the relatively high and increasing number of RMOs who worked in the April and May strikes.

Defending the right to strike from all comers

Without excusing at all the DHBs' performance in industrial relations over the past couple of years, the inalienable right to strike is being undermined by bargaining agent type behaviour.

We should not allow this right to be undermined. The right to strike is critical to achieve workforce stability and confidence within DHBs. Settlements important for pursuing an objective of recruitment and retention would not have been achieved without it even when not actually exercised. The stark reality is that in the medium to longer term (arguably even the short-term) the absence of fair and competitive terms and conditions across the DHB workforce risks a recruitment and retention crisis that will do much more harm to patient safety than punitive strikes.

We need to treat the Health & Disability Commissioner's decision as a wise wake-up call. It is not an attack on the right to strike. Rather it is an attack on the use of patients as a weapon in the exercise of that right. It is possible to have effective strikes that affect volumes but don't involve patients as weapons. Some patient inconvenience may be unavoidable but this need not threaten patient safety.

The right to strike must be defended against all those who undermine it, including those who use it in such a counter-productive manner. It is the DHB workforce that is harmed the most by undermining the right to strike. The paradigm of bargaining agents is too narrow to appreciate this point.

Ian Powell
Executive Director

ASMS 20th Annual Conference at Te Papa

Thursday 20 – Friday 21 November 2008

Delegates required

The ASMS makes all travel and accommodation arrangements for ASMS members to attend its 20th Annual Conference as delegates.

Leave

Clause 29.1 of the MECA includes provision for members to attend Association meetings and conferences on full pay. Members are advised to start planning now and encouraged to make leave arrangements and register by 30 September 2008.

Dinner and Pre-Conference Function

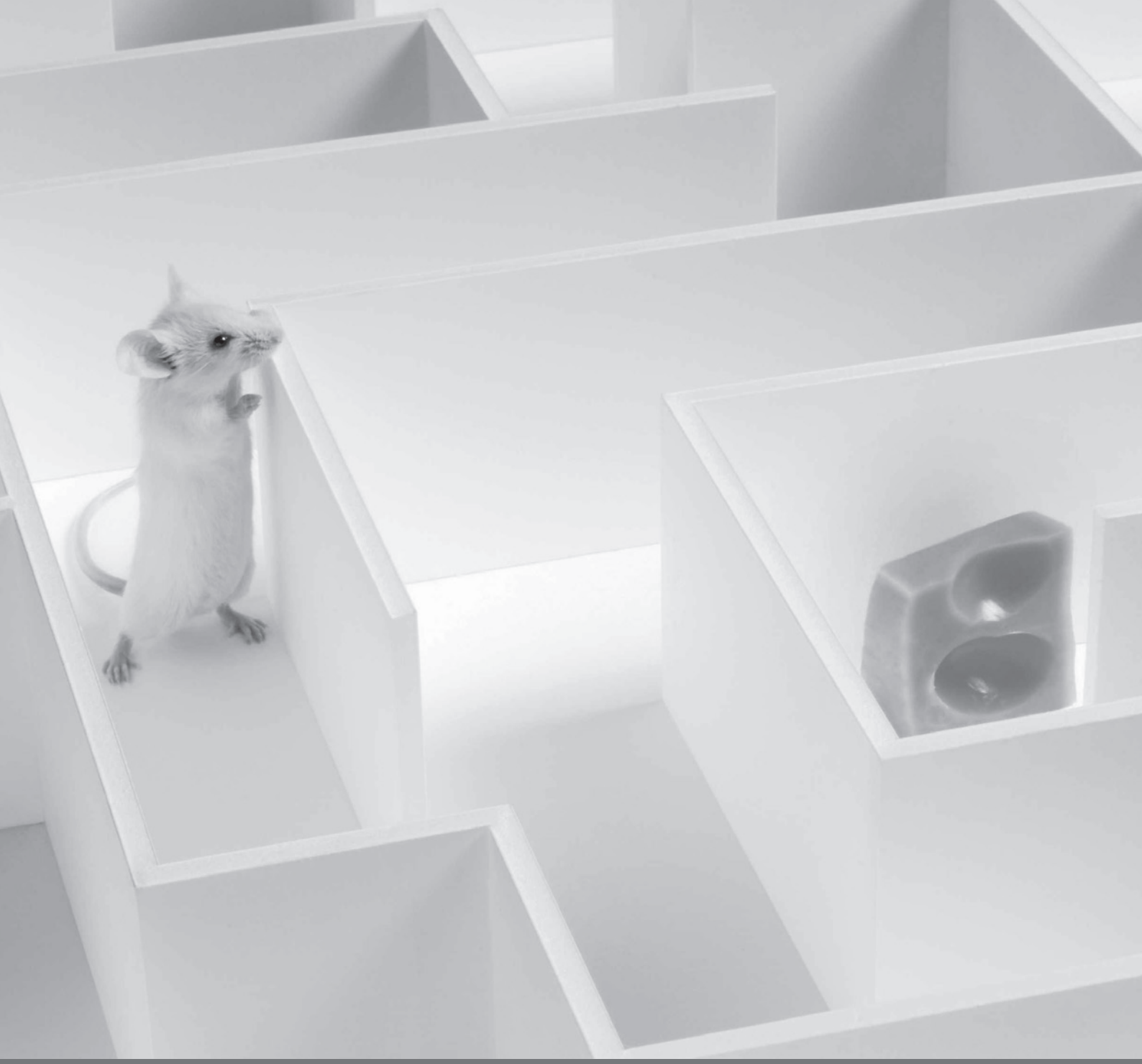
A Conference dinner will be held on Thursday 20 November. Delegates are also invited to attend an informal cocktail function on the evening of Wednesday 19 November.

Registration of Interest

Please help us plan for another great Conference. To assist with travel and accommodation reservation, email our Membership Support Officer, Kathy Eaden, at **ke@asms.org.nz.**

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

Register your interest today
ke@asms.org.nz.



MEDICAL ASSURANCE SOCIETY

We make it easy

It's much easier to find the right loan.

It's amazing – it's as easy as picking up the telephone and talking to us today. Our Members tell us how busy they are, so when they need a loan they need it quickly. Whether you're after a new vehicle, something for the house, practice equipment or just covering unexpected bills, it's now as easy as picking up the phone. In most cases, we can approve the loan on the spot. *It's that easy.*

PHONE 0800 800 MAS (627) **EMAIL** society@medicals.co.nz

Our friendly staff are standing by for your call.

Medical Securities Limited's normal lending criteria apply for all credit and loans, and your application is subject to acceptance by Medical Securities Limited.