



NHS has first Trust failure

Our guest speakers from the UK have regularly been predicting the likely demise of an NHS Trust. Now it has happened. Not that anyone south of Hadrian's Wall would notice. Type Argyll and Clyde Health Board into Google and you get no indication that all was not well. Yet the ripple spreading out from the axing of this Trust continues to grow. As we seem to mirror UK policy, structures and experiences in so many ways, a more detailed look is indicated

The Scotsman of May 20th led with this story:

A HEALTH board facing debts of up to £100 million is to be scrapped, health minister Andy Kerr announced yesterday. The responsibilities of NHS Argyll and Clyde will be divided between NHS Greater Glasgow and NHS Highlands. The board's massive existing debt will be paid off with £80 million from the public purse. NHS Argyll and Clyde had finally succumbed to unworkable geography and financial mismanagement.

Scottish Parliament Opposition MPs called the move a damning indictment of the Executive and demanded "heads should now roll". Unions said the proposal was "distracting, divisive and demoralising" for staff. And while campaigners welcomed the decision, they expressed concern for the 430,000 users of the board.

NHS Argyll and Clyde, which has a budget of around £520 million for this year, was dogged by the problems of handling a vast geographical area (in Scottish terms) stretching from Paisley to Campbeltown and including dozens of west coast islands. Spanning the River Clyde from Greenock north to Oban, services had to cater for the demands of 26 islands as well as urban Clydebank and Paisley. From 2001 debts rose from 0.3 per cent of the overall budget to 11 per cent today.

In 2002 then health minister Malcolm Chisholm ordered an inquiry into the spiralling debt. It found a catalogue of failings and bad planning within the organisation culminating in deficits of £30 million. Doctors were concerned that management were incapable of making decisions amid a culture of mistrust and blame instead of teamwork. Board chief executive Neil McConachie and the former trust chief executives David Sillito, Michael Bews and George Buchanan were forced to resign. Despite the anger of patient groups, Neil McConachie, was reportedly given a record £450,000 pay-off.

Mr Chisholm looked forward to re-establishing patient confidence. But by 2004 the new management team were facing familiar problems and NHS Argyll and Clyde was £36 million in the red. After Scotland's Auditor General Robert Black warned that NHS Argyll and Clyde could fall £100 million into the red by 2008, the Executive ordered an inquiry. Mr Kerr said the results of this gave him no other option than to scrap the board.

He said: "Whilst recognising progress, I do not think that the Executive could justify allowing a publicly funded body to spend so much more than its income. To this end, we have concluded that a fresh start is required." But Mr Kerr insisted services to patients would be maintained and they would be consulted on boundaries.

John Mullin, current chairman of the board, wanted longer to try to bring the board back from deficit. But Mr Kerr said the Executive could no longer justify a public body being in such

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debt. "I am in no doubt it has become necessary to dissolve the board and move on, free from the millstone of the recent past," he said. The health minister accepted that his department and the board had failed to agree a financial recovery plan. "I agree that this was unacceptable and want to acknowledge and accept the department's share of the responsibility in this matter," he said. But Mr Kerr declined to comment on what the shake-up would mean for the senior officials at the board.

He admitted the Executive had set the Argyll and Clyde management the "almost impossible" task of operating with a growing deficit and a strategy for acute services which had not been agreed, in a geographically difficult area.

Shona Robison, health spokeswoman for the SNP, said: "This is a damning indictment of the health department's failure to adequately monitor the financial plans of health boards," she said. "Perhaps heads should now roll in the health department, not just at Argyll and Clyde health board." And Ms Robison called for reassurance the board would not get "grotesque" pay-offs.

Tory Annabel Goldie said the massive deficits were built up by having a centralised NHS rather than smaller budgets controlled at local level. Jim Devine, Scottish health organiser for the union Unison, warned months of negotiations with staff could now affect services. "The announcement today could paralyse service change for nearly half a million Scottish people whilst they have to go through formal consultation ... and demoralise 10,000 staff," he said.

Greater Glasgow is thought likely to take control of services in Inverclyde, Renfrewshire, East Renfrewshire and parts of Dunbartonshire, the running of the Vale of Leven Hospital in Alexandria, Inverclyde Royal Hospital in Greenock and the Royal Alexandra Hospital, Paisley. NHS Highlands is likely to take over services in Argyll and Bute, running the Lorne and Islands Hospital in Oban.

NHS Grampian also in trouble

The bad news did not stop there.

NHS Grampian with a budget of £750 million is projected to spend £770 million for this financial year.

Managers in Aberdeen insist the £20 million overspend will be brought under control through a series of measures including putting various projects on hold, individual department savings, selling hospital buildings and bulk purchasing. However, opposition politicians and campaign groups voiced concern that this would impact on services, particularly cancer care. Accounts from the health board also show a "large overspend" of more than £200,000 on drugs at a cancer unit in the city.

NHS Grampian said "budget managers" have been asked to confirm that the "larger than normal" overspend at the unit at Aberdeen Royal Infirmary will be "smoothed out" during the rest of the year.

He admitted the Executive had set the Argyll and Clyde management the "almost impossible" task of operating with a growing deficit and a strategy for acute services which had not been agreed, in a geographically difficult area.

The government wants to axe all 15 of the country's health boards and replace them with three "super boards"

Richard Lochhead, the MSP for North-east Scotland, said that the cuts raised the "possibility of denying potentially life-saving drugs to patients, in order to keep costs down". Mike Rumbles, the MSP for Aberdeenshire, called for the £20 million potential debt to be written off. "This is an albatross round NHS Grampian's neck," he said. "The Executive has written off other debt. Why not here?"

But NHS Grampian pointed out that last year's financial targets had been met despite a projected overspend of £14 million. Allan Gall, finance director at NHS Grampian, said: "The £20 million will be managed through a series of measures, including budget managers reviewing the timing and extent of service developments, a continuous drive by everyone in the organisation to maximise cost efficiency and disposal of land and buildings excess to requirements." (Does all this sound familiar?)

The Executive insists all health boards have a statutory duty to remain within their budgets and is confident NHS Grampian will achieve this by 2007. Andy Kerr, the health minister, added: "It's a big budget, as it ever is in Scotland in terms of health. Therefore it is of concern to me. But I will ensure patients do not suffer."

Other health boards have also struggled to cut overspending. Health services in Glasgow are currently facing cuts as the city's health board tries to avoid a £10.4 million deficit. At the same time they have to absorb the Argyll and Clyde services.

NHS jobs blitz to hit thousands

Looking for a fix, the government wants to axe all 15 of the country's health boards and replace them with three "super boards" covering the north, east and west of Scotland. The move, which could follow the next Scottish Parliament elections in 2007, is designed to cut deep into the NHS's 28,000 administrative posts north of the Border, freeing up resources and medical staff.

But critics of the plan fear it will lead to the nationwide closure of small hospitals and clinics, meaning that many patients have further to travel and making health services less responsive to local needs. The plan is expected to form a key part of Labour's manifesto ahead of the next Scottish elections and will be put in place if the party is re-elected for a third term north of the Border.

First Minister Jack McConnell and health minister Andy Kerr are concerned about the rapidly rising running costs of health boards. Despite a record £5.4bn being ploughed into the boards last year, they used £218m set aside for health programmes to cover their running costs. Kerr is drawing up details of how the NHS would operate with three health boards. (Perhaps we can sell them our RHA model?)

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A senior source confirmed: "We are heading towards a major restructuring of the health service post-2007, with a reduction to three boards." Another source close to the health minister said: "Health boards have been told for some time to think beyond their current boundaries when they are making their plans for the future. "If there's a hospital just over the boundary then they should bear it in mind when thinking about future provision. This is part of the ongoing attempt to bring health boards closer together."

Officials claim cutting the number of health boards will reduce inefficient spending practices. In one example, all 15 health boards have bought separate and sometimes incompatible computer systems. The NHS in Scotland is believed to have spent four times as much on IT compared with England, where a single system was purchased for all board areas.

Having 15 boards for a country of just five million people also leads to job duplication, according to critics. Each board has a highly paid team of executives and support staff, many of whom would be shed under a simpler structure. In all, 27,700 people work in administrative and management roles, compared with 13,700 doctors.

The three-board structure is expected to fit with proposals put forward by Professor David Kerr in his 20-year vision for the NHS in Scotland, published earlier this month. But critics fear the restructuring plans will cause years of upheaval for patients and could also mean further centralisation of services as specialist units are concentrated in major city hospitals, leaving many patients with greater distances to travel for treatment.

A spokeswoman for the Patients Association welcomed moves to cut bureaucracy, saying: "Money should be going into frontline services, but it is too often spent on managers." But George Venters, from the Scottish Health Network Campaign, warned: "Money is going to be poured into the major cities while rural areas lose out. "They are ignoring the fundamental problems in the health service like staffing, recruitment and funding." §

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But natural selection does not favour the very vicious bugs when transmissions from sick hosts is difficult because the hosts literally become dead ends before the bug can leap to another. In such cases, milder strains tend to become the dominant ones in circulation.

This Ewaldian logic has major implications. It explains why water-borne diseases like cholera and typhoid tend to be deadlier in countries with easily contaminated water supplies. In the 1990s Ewald and his colleagues tracked a cholera outbreak in South America. Over seven years, strains of cholera bacterium in Chile, which has good public health water systems, evolved towards mildness. In Ecuador, which has less clean water, very virulent strains became the dominant ones.

Similarly, hospitals tend to become hotbeds for highly virulent germs because transmission is so easy via conduits such as staffers' hands and equipment. (Many hospital patients are also immune-suppressed, which also abets germ jumping). Data on staph infection among hospitalised babies, for instance, suggests that strains of the bacterium endemic to hospitals are five to ten times more likely to cause illness than strains whose virulence has not been honed by evolution inside the facilities.

Ewald posits that the unequalled deadliness of the 1918 flu pandemic reflects the same phenomenon. War weary populations, packed war time hospitals and the rapid transport of very ill troops spread flu more effectively than at any other time in history, causing extremely virulent strains of the virus to evolve. He believes such conditions are unlikely to be repeated (but perhaps overlooks everyday mass movement by air), making the odds of another 1918 pandemic (in the shape of avian flu) smaller than some people are predicting.

In his view, far more worrisome are the growing signs that sexual contact can transmit hepatitis C. This liver destroying virus mainly spreads via infected blood (often via addicts' shared needles). But some strains appear capable of spreading via sex. As they evolve, they could trigger a massive wave of hepatitis C and in coming decades, thousands of cases of liver cancer as a result.

And that's the rub. While evolutionary sciences can plot the past and point the way towards the future, their crystal balls are clouded with "coulds" and "maybes". §

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by electronically
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or e-mail the Editor for more information at admin@nzihm.org.nz

Is diarrhoea good for you?

What is diarrhoea good for? That is a question Paul Ewald, now a professor of biology at Amherst College, pondered some 30 years ago as he lay in bed with an intestinal bug. For the answer, read on.

His first thought was that it was a defence mechanism by the body to get rid of an infectious agent. Then he realised that it might be due to a microbe manipulating his body in order to spread itself. That is, diarrhoea might be a microbe survival strategy – a way for it to find fresh victims through the contamination of hands, objects and water supplies.

This musing led him to abandon his research into sparrows and help pioneer a branch of medicine that analyses disease from the (Darwinian) perspective of evolutionary biology. While the Darwinians have not gained a high profile, they offer perspectives on many medical riddles, such as why hospital acquired infections are so deadly. They have also chipped away at ingrained wisdoms — such as, when you're prescribed antibiotics it may not always pay to take them all; and popping pain killers for a sprained ankle could hurt you. Ewald also suggests we should probably be a lot more scared of hepatitis C than emerging killers like avian flu.

After recovering from his stomach bug Ewald spent the next three years pouring over studies on infectious microbes and arguing with himself over their meaning. In his 1980 landmark paper in *The Journal of Theoretical Biology* Ewald laid out a list of tricks that microbes have evolved to exploit their hosts, as well as host's counter-measures. It turns out that diarrhoea can be both a curse and good for you.

Ewald thought his paper would have a big effect. It didn't. Never the less, fellow Darwinians urged him on. Richard Dawkins, one of biology's biggest names, called Ewald a "master explainer" who produces "gems of insight". Ewald and other Darwinians soldiered on and in the 1990's evolutionary medicine hit the mass media with articles in *Newsweek*, the *Wall Street Journal* and other national publications in the United States. His books, *Evolution of Infectious Disease* and *Plague Time*, have gained wide attention.

While the term Social Darwinism has become widely used as a pejorative to attack almost any idea or policy the speaker dislikes, Darwinian Medicine seems to have escaped such censure. A quick Google search offers a wealth of material to explore.

Perhaps the fields most fertile idea is that modern lifestyles sometimes conflict with patterns hacked into our genes by evolution. This may seem patently obvious to those faced with yet more chocolate cake – our drive to gorge on sweet and fatty foods no doubt evolved to help our ancestors bulk up in order to survive lean times. But other clashes with the past inside us are not so evident.

Consider the common household remedy of taking aspirin

to lower a fever. It has long been known that the fever response evolved to help fight germs. But in the age of antibiotics doctors typically regard it as a bad thing. Ewald disagrees. Studies with rabbits has shown that raising body temperature reduces the risk of death from respiratory infections – many germs can not take the heat. Fever also cuts appetite, and reduced nutrient intake appears to make our infected cells more likely to die, wiping out the germs that have invaded them. And fever induced lethargy frees energy to fuel our immune system's attacks on germs.

In a study Ewald conducted with his students during the cough and snuffle season, those who took to bed as soon as they felt a cold coming on recovered within 24 hours.

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In a study Ewald conducted with his students during the cough and snuffle season, those who took to bed as soon as they felt a cold coming on recovered within 24 hours. A second group who stayed on the go when they first felt ill took on average ten days to recover.

"You are gambling if you do not let your body take care of itself as evolution designed it to

do," says Ewald. But not always, fever isn't always helpful because some germs have evolved ways to cope with it. For instance, the bug that causes malaria benefits from elevated temperatures in one of its insect hosts.

The pain of muscle strain is another response honed by evolution that we should heed. A sprained ankle's healing involves an exquisite sequence of events that can be ruined by putting the ankle back to work too soon – easy to do when on pain killers. The crippling injuries sportspeople often suffer by age 40 may largely result from the continual interruption of the healing of relatively minor hurts. Ewald does not advocate forgoing painkillers when hurt. We should just rest and act as if we had.

Ewald suggests an unorthodox tactic to lessen the spread of resistant bacteria. Administer antibiotics to infected people only long enough to allow their immune systems to kick in and knock out the culprits. After all, he reasons, it's much harder for bacteria to evolve resistance to our immune system, shaped by eons of evolution, than it is to antibiotics.

Unlike antibiotics, public health measures to block the spread of germs, such as installing water treatment plants, always make evolutionary sense because they push virulent microbes to evolve into milder forms. The more readily a germ can spread from host to host, the more likely it is to exist in a lethal form. That is because sure fire transmissibility favours strains that grow like wildfire in their hosts, killing them fast. Such killers out compete and displace slower growing milder strains. (Picture a gang of Headhunters shoving their way into the bodily banquet).

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Hamilton Naki: A surgical pioneer of another age

ON DECEMBER 3rd, 1967, the body of a young woman was brought to Hamilton Naki for dissection. She had been knocked down by a car as she went to buy a cake on a street in Cape Town, in South Africa. Her head injuries were so severe that she had been pronounced brain-dead at the hospital, but her heart, uninjured, had gone on furiously pumping.

Mr Naki was not meant to touch this body. The young woman, Denise Darvall, was white, and he was black. The rules of the hospital, and indeed the apartheid laws of the land, forbade him to enter a white operating theatre, cut white flesh, or have dealings with white blood. For Mr Naki, however, the Groote Schuur hospital had made a secret exception. This black man, with his steady, dexterous hands and razor-sharp mind, was simply too good at the delicate, bloody work of organ transplantation. The chief transplant surgeon, the young, handsome, famously temperamental Christiaan Barnard, had asked to have him on his team. So the hospital had agreed, saying, as Mr Naki remembered, "Look, we are allowing you to do this, but you must know that you are black and that's the blood of the white. Nobody must know what you are doing."

Nobody, indeed, knew. On that December day, in one part of the operating suite, Barnard in a blaze of publicity prepared Louis Washkansky, the world's first recipient of a transplanted human heart. Fifteen metres away, behind a glass panel, Mr Naki's skilled black hands plucked the white heart from the white corpse and, for hours, hosed every trace of blood from it, replacing it with Washkansky's. The heart, set pumping again with electrodes, was passed to the other side of the screen, and Mr Barnard became, overnight, the most celebrated doctor in the world.

In some of the post-operation photographs Mr Naki inadvertently appeared, smiling broadly in his white coat, at Barnard's side. He was a cleaner, the hospital explained, or a gardener.

In some of the post-operation photographs Mr Naki inadvertently appeared, smiling broadly in his white coat, at Barnard's side. He was a cleaner, the hospital explained, or a gardener. Hospital records listed him that way, though his pay, a few hundred dollars a month, was actually that of

a senior lab technician. It was the most they could give, officials later explained, to someone who had no diploma.

There had never been any question of diplomas. Mr Naki, born in the village of Ngcangane in the windswept Eastern Cape, had been pulled out of school at 14, when his family could no longer afford it. His life seemed likely to be cattle-herding, barefoot and in sheepskins, like many of his contemporaries. Instead, he hitch-hiked to Cape Town to find



work, and managed to land a job tending lawns and rolling tennis courts at the University of Cape Town Medical School.

A black—even one as clever as he was, and as immaculately dressed, in a clean shirt, tie and Homburg hat even to work in the gardens—could not expect to get much further. But a lucky break came when, in 1954, the head of the animal research lab at the Medical School asked him for help. Robert Goetz needed a strong young man to hold down a giraffe while he dissected its neck to see why giraffes did not faint when they drank. Mr Naki coped admirably, and was taken on: at first to clean cages, then to hold and anaesthetise the animals, then to operate on them.

Stealing with his eyes

The lab was busy, with constant transplant operations on pigs and dogs to train doctors, eventually, for work on humans. Mr Naki never learned the techniques formally; as he put it, "I stole with my eyes". But he became an expert at liver transplants, far trickier than heart transplants, and was soon teaching others. Over 40 years he instructed several thousand trainee surgeons, several of whom moved on to become heads of departments. Barnard admitted—though not until 2001, just before he died—that Mr Naki was probably technically better than he was, and certainly defter at stitching up afterwards.

Unsung, though not unappreciated, Mr Naki continued to work at the Medical School until 1991. When he retired, he drew a gardener's pension: 760 rand, or about \$275, a month. He exploited his medical contacts to raise funds for a rural school and a mobile clinic in the Eastern Cape, but never thought of money for himself. As a result, he could pay for only one of his five children to stay to the end of high school. Recognition, with an honorary degree in medicine from the University of Cape Town, came only a few years before his death, and long after South Africa's return to black rule.

He took it well. Bitterness was not in his nature, and he had had years of training to accept his life as apartheid had made

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it. On that December day in 1967, for example, as Barnard played host to the world's adoring press, Mr Naki, as usual, caught the bus home. In his carefully pressed suit, with his well-shined shoes—to his one-room shack in the township of Langa. Because he was sending most of his pay to his wife and family, left behind in Transkei, he could not afford electricity or running water. But he would always buy a

daily newspaper; and there, the next day, he could read in banner headlines of what he had done, secretly, with his black hands, with a white heart.

Hamilton Naki, an unrecognised surgical pioneer, died on May 29th, aged 78

A World Tour of Interpreter Ethics and Standards

Unlike previous waves of immigration to this country, who came with a good grasp of English, our current immigrant wave is linguistically highly diverse. As a result, workers in health and human services reveal a growing frustration with language barriers. Their patients and clients are fearful and sometimes angry at being unable to communicate or pressured to bring their own interpreters (friends and family members) while providers and administrators feel increasingly overwhelmed by the growing volume of limited English proficient clients and the diversity of languages they represent. There is a shortage of trained interpreters in health care and the quality of interpreting is uneven.

Around the world the need for trained interpreters in public service is acute. Yet the professionalism of interpreters is rough and uneven, in part because most interpreters lack national codes of ethics and standards of practice to guide their work.

In 2004 The National Council of Interpreting in Healthcare, with funding from the California Endowment, undertook an environmental scan in 25 countries of standards of practice for interpreters. The scan found:

- Codes of ethics, conduct or professional responsibility easily outnumbered guidelines or standards of practice for interpreters by about 5:1.
- Documents were most commonly found in the industrialised nations with high levels of immigration: the US, Canada, Australia/New Zealand, and Europe.
- Few such documents were found in developing countries.

Findings of the scan fell into two major categories. How standards of practice are emerging around the world; and a comparison and analysis of the content of the standards

For Australia/New Zealand, the profession is highly advanced, particularly in Australia. A national professional association has issued a detailed Code of Ethics and Code of Practice and a national accreditation tests interpreters and certifies all types of interpreters at four professional levels. New Zealand although less advanced, is making earnest efforts in community interpreting. Both countries have national codes of ethics for sign language interpreters. However, in neither country are

there national standards or ethics specific to healthcare.

The report notes that in New Zealand the government has issued a national code of ethics for community interpreting but no standards of practice. Many untrained, informal interpreters (family members or friends) are still used. The government is engaged in broad educational efforts to promote the use of trained, professional interpreters whenever possible. The Sign Language Interpreters Association of New Zealand has laid down both a code of ethics and a code of practice for interpreters.

The scan found that the vast majority of principles and requirements found in the codes of ethics or conduct are also found in standards of practice, whereas the reverse is not so true. Documents about ethics or conduct serve to regulate interpreter behaviour and address issues of “right and wrong,” whereas standards of practice typically offer practical strategies to promote quality interpreting.

Standards for community and healthcare interpreters are often preoccupied with interpreters roles and boundaries, cultural mediation, client well being, and promoting client provider relationships to ensure the consumer’s end needs are well met.

Unlike codes of ethics, standards of practice often address such issues as roles, boundaries, meaning culture, and managing the communication flow. In particular standards of care for health care interpreters in the US and Canada consider the following points in some detail: navigating roles; cultural mediation or brokerage; strategies for promoting communication; decision making (about ethics, roles and advocacy); health care logistics; and client well being.

Interpreting in health care as a profession with standards of practice is more firmly established in the US than perhaps any other country in the world. However, no national standards of practice have been established in the US for interpreting in healthcare or community settings. The result has been a state of confusion across the country, where contradictory practices prevail even among trained interpreters. Overall, the quality of interpreting services is at best uneven. At worst, health care interpreting conducted without using reliable standards of practice puts the

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health and well being of clients at serious risk.

In the US, the National Council of Interpreting in Health-care, a not for profit organisation with a mission of promoting culturally competent interpreting in health care, is currently drafting national standards.

What makes standards of practice look different from codes of ethics? In general, ethics lay down the rules for interpreter conduct. Standards of practice allow practical strategies for ensuring not only professional conduct but the smooth flow of communication. Most standards of practice look closely at the following:

- Roles
- Boundaries
- Logistics; setting the stage for the encounter
- The message
- Culture
- Managing the communication flow

While there is consensus on a number of basic issues, such as confidentiality, other points in standards of practice are still open to discussion. A few examples are given in the following table. §

AREAS OF CONTROVERSY	
Statement or Principle	Contradictory Statement or Principle
Be impartial and neutral	Interpreter should spend some time alone with client to establish dialect match or establish rapport
Omit nothing	Educational interpreters may omit some things
Remain slightly behind the client	Adopt other positions (sign language and court interpreters also require good sight lines)
No advocacy: interpreter should interpret	Interpreter should advocate as needed
Interpreters should decline all gifts	Small gifts (such as food) are acceptable
Interpret offensive and vulgar language	Ask the speaker if they would like to rephrase
Offer post session information or referral	Restrict activities to interpreting
Interpret gestures, body language etc	Refrain from interpreting body language unless meaning is impaired
It is unethical to compete for business	Interpreters may compete for business
Simultaneous interpreting is not appropriate in health care	Simultaneous interpreting may be helpful in health care, especially when multiple parties are speaking
Look at provider and patient	Avoid eye contact with provider and patient
Offer no advice	Some information and referral or cultural guidance are acceptable

Tricky Wording... Read Slowly

- * Avoidable: What a bullfighter tries to do.
- * Bernadette: The act of torching a mortgage,
- * Counterfeiters: Workers who put together kitchen cabinets.
- * Eyedropper: A clumsy ophthalmologist.
- * Heroes: What a guy in a boat does.
- * Paradox: Two physicians
- * Parasites: What you see from the top of the Eiffel Tower
- * Polarize: What penguins see with.
- * Primate: Removing your spouse from in front of the TV.
- * Rubberneck: What you do to relax your wife.
- * Selfish: What the owner of a seafood store does.
- * Subdued . Like a guy, who works on one of those, like, submarines, man!



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Inform Editor Bruce Parkes

Seminar Programme

July 12th

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**Are you big enough for
your job; Is your job big
enough for you?**

**Exploring levels of work in
organisations**

By Dr Judith McMorland

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Helicopters, Consultation and Sacred Cows: When Best Practice Conflicts with Public Opinion

Both the intriguing title and the speaker were draw cards for the many members who attended our May seminar at Brightside Hospital. Dr David Rankin, General Manager of Healthwise – ACC, and NZIHM National Councillor, fulfilled attendees' expectations. Just look at this list of "sacred cows" David addressed:

- Rural Hospitals are necessary;
- Rural Surgery is better than nothing;
- Helicopters – the closer the better;
- Waiting lists are always bad;
- Magic rubs work;
- Expensive equipment is desirable;
- Specialists know best;
- Clinicians always make correct calls;
- Pricing is simple;
- Doctors make the best Health Leaders;
- Only Anaesthetists are Safe; and
- Stretch before exercising.

All of those sacred cows invite a "Tui ad response". Yet they don't they get it? Why not? David offered some guiding principles for sacred cows. They need to be supported by prominent community leaders - whose self interest might not be declared; coupled with a firmly held community belief of their validity, expressed through that community contributing to the service. As a failure or loss of the service is perceived to jeopardise community health, the arguments about the service are at the emotive, rather than rational level and often contrary to best practice.

David produced evidence to challenge all of these sacred cows and offered some cautionary lessons:

Never plan into a vacuum; Don't assume even distribution of knowledge; Beware of pictures; Be aware of community fears; Don't assume silence implies no change; Consult before you consult; Your peers are also interested parties; Don't consult on technical issues; and Never go on holiday after releasing a major strategy. §

Judith McMorland, our July presenter, has had a career-long interest in health organisations and their management since her PhD studies at Auckland Hospital in the late 1970s. As Director of the Health and Welfare programme in the Centre for Continuing Education she taught a wide range of health professionals in a number of contexts. She joined the Department of Management and Employment Relations in 1989 and has taught courses in Managing Change, Organisational Development and Training and Human Resource Development through the Executive Programme of the University of Auckland Business School, as well as supervising Masters and PhD theses in related topics, since that time.

In 1991 Judith established her own consulting company, CO-LEARNZ. Client organisations have included the Auckland Regional Health Authority, Ministry of Health, NZ Blood Service, Challenge Trust, NDSA and the School of Population Health.

The Levels of Work model to be presented in this session informs much of Judith's consultancy work, and is a key component of the Short Course *Capacity, Capability and Challenge*, offered in the Business School.

CO-LEARNZ is a management consultancy specialising in organisational learning offering a wide range of educative opportunities through strategic planning, organisational development workshops, team building, conflict resolution opportunities, and projects designed to enable clients to direct their own learning and inquiry through action learning, project development, and reflective practice.