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FEELING ONE STEP BEHIND: THE LIVED EXPERIENCE OF WOMEN IN THE SENIOR MEDICAL WORKFORCE

DR CHARLOTTE CHAMBERS | ASMS PRINCIPAL ANALYST (POLICY & RESEARCH)

On the first day of this year's ASMS annual conference, I presented findings from a qualitative study looking at the thorny question of what it's like to be a younger women in the New Zealand senior medical workforce.

This research was driven by the concerning findings from the ASMS burnout study conducted in 2016 that found women in their thirties had the highest rates of burnout of all the senior doctors surveyed; 70.5% of women in this age group scored as having high rates of burnout using the Copenhagen Burnout Inventory (CBI) (Chambers et al., 2016).

Alongside this research, other ASMS studies into rates of working through illness (presenteeism) and bullying had also found significant gender differences where women were scoring negatively across a range of indicators in contrast to their male counterparts (Chambers et al., 2017, Chambers et al., 2018).

FOLLOW-UP TO BURNOUT RESEARCH

Due to the limitations of the quantitative survey methodology, it was not possible to interrogate in the original study why women in this cohort had such high burnout rates. As a consequence, a qualitative study was designed to explore risk factors for burnout by talking to women from the age cohort of concern. I placed adverts asking for women aged between 30-39 who were interested in talking to me about their experiences of working in medicine. These adverts were placed on the New Zealand Women in Medicine Facebook page as well as the ASMS *Specialist* publication. I had numerous responses from interested women and in the end managed to complete 14 interviews by the end of November 2017.

The women interviewed came from a range of different sized DHBs and worked in a range of medical specialties; given the low proportion of women working in surgical specialties, it was particularly pleasing to have three women from surgical specialties involved in the research.

The interviews were designed as an exploration of their individual histories touching on such issues as choice of speciality, their feelings concerning their work-life balance, their reflections on whether and how their gender had shaped their career and what their thoughts were concerning the high rates of burnout for their age cohort. Many but not all of the women interviewed had children and one identified as an international medical graduate.

To ensure anonymity of responses, I have taken care not to specify place of work or medical specialty in the responses, but for some, it is more obvious as to their specialty than others. The interviews were long and intense; some went for nearly four hours. All interviews were fully transcribed by an independent transcriber and coded thematically using a thematic analysis approach.

The research presented at the conference focused on three core themes which emerged from the different interviews: time, role conflict and gender bias. These themes not only circumscribe the lived experiences of the women in my study but appear to play a key role in shaping the propensity of women in this cohort to experience burnout in subtle yet significant ways. These themes are summarised as follows.

TIME

This theme of time describes research participants' reflections concerning the temporal norms of medicine where dedication and commitment are equated with temporal availability. In this theme, research participants spoke about tensions perceived with working less than full time hours due to domestic or family commitments and reflected on the stress associated with trying to complete their work in the hours allocated even when working full time.

This theme also speaks of the tensions in conceptualising medicine as vocation rather than simply a 'job' and how women interviewed struggled with the pressure to 'lean in' to their work often at the expense of their health and well-being. The women interviewed described their propensity for experiencing burnout as a consequence of the demands placed on their time due to ever-growing workloads and the inability to complete the work in allocated work hours.

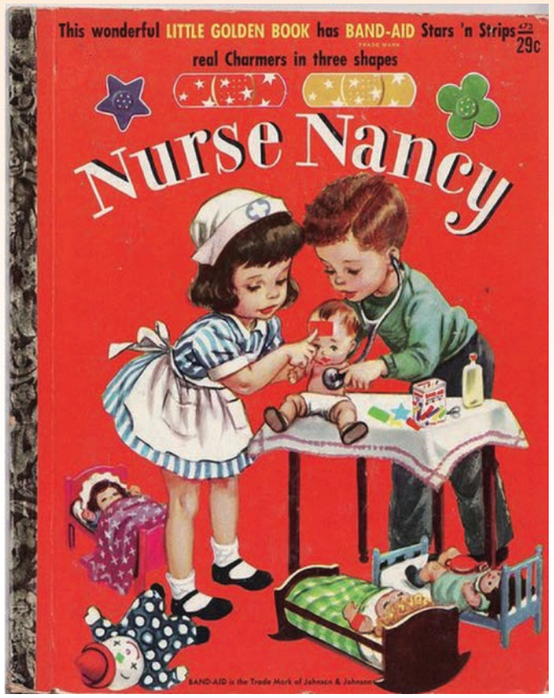

FIGURE 1: INNOCENT GENDER STEREOTYPES?

ROLE CONFLICT

The second related theme is that of role conflict where the women interviewed, particularly those who were parents, spoke about the stress and tensions around balancing their career with their domestic commitments and ever-growing work pressures. The theme of role conflict also spoke to issues of identity conflict where the women described implicit expectations concerning what it means to be a good doctor and often framed this in opposition to ideals about being a good mother or partner.

For the women interviewed, their perceived conflict between work and their domestic commitments was a key source of stress and exhaustion and many expressed feelings of disillusionment that things would ever change: "You go into this profession knowing fully what it holds, so keep that up. When you come to work, leave out the responsibilities as a mum, parent, partner. We don't want to know about it. Keep that out the door and come in".

GENDER BIAS

The final theme was that of gender bias, which describes the implicit and explicit gender-based expectations, behaviours and associations that were described as shaping the daily experiences of the women interviewed in their medical encounters. All of the women spoke of frustrating gendered encounters with patients where they were mistaken for nurses, and negative encounters with other medical colleagues, particularly other female colleagues, where they felt that their gender was received quite differently to their male counterparts.

As a consequence, many spoke of struggling to walk an invisible line of behaviour between being approachable and empathetic but not 'too uppity'. Constantly having to walk this fine line was described as fraught and exhausting for the women in the study.

Overall, the women interviewed for this research described their propensity for experiencing burnout as a consequence of the demands placed on their time due to ever-growing workloads and the pressure to 'lean in' to their work. The research suggests that female doctors are at risk of burnout due to their experiences of significant work-life conflict, for example, when trying to balance their domestic commitments, including but not limited to childcare, with the demands and pressures of their medical careers. The research demonstrates how persistent gender bias continues to shape the experiences of and opportunities for women in medicine. Cultural stereotypes (figure 1) that boys become doctors and girls become nurses are not innocent and the research seeks to unpick how these shape the lived experiences of the women interviewed in subtle yet pernicious ways.

CLARION CALL

The experiences of the women interviewed act as a clarion call to the need for changes in the medical system, not least in terms of acknowledging the negative consequences of structural pressures in terms of workloads and short staffing. But we need to couple this with fundamental shifts in values and expectations. Focusing on the issues raised by examining the pervasive gendered norms in medicine is not meant as a threat; it's actually an opportunity. Improving gender equity in medicine is essential for the future of our health system and it will pay dividends for our parlous rates of burnout, bullying and presenteeism. Addressing these issues will pay dividends for the next generation of doctors, both men and women, in terms of enabling them to participate in medicine to their full potential without sacrificing their personal lives.

The full detail of the research is currently in preparation and will be released as an ASMS *Health Dialogue* early in 2019. The presentation is available on the ASMS website (**www.asms.org.nz**).

QUOTES FROM THE RESEARCH INCLUDE THE FOLLOWING:

"I don't think I know a single woman that doesn't feel guilty about one thing at times... you don't wanna be seen as slacking off, because I know that I'm only part-time and I wanna spend time with my kids."

"I feel like there's a bit of a culture in surgery... the old guys [think] 'we did it... we walked through the snow in our bare feet, so you can do it' but... why not try and make things better for everyone else?"

"IF YOU'RE FORCEFUL AND PROACTIVE, THEN YOU'RE A BIT OF A BITCH. AND IF YOU SIT BACK AND ARE DOCILE AND FEMININE, THEN YOU GET WALKED ALL OVER AND YOU DON'T WIN EITHER WAY."

"Just because the era has changed and you're now allowed to work, it's not like' [men] have stepped into the domestic area. We have to keep asking and it's as good as doing it ourselves. So it's like having two full time jobs and doing everything at home, even though you're delegating it. You still have to delegate and that's the most tiring thing because you have to keep chasing up on it."

"HOW CAN I BE EXPERIENCING BURNOUT WHEN IT LOOKS LIKE I HAVE EVERYTHING? I'M NOT COMING IN [ON THE WEEKENDS] I'M NOT WORKING LATE. I'M ACTUALLY GOING HOME TO A FAMILY THAT LOVES ME, AND YOU KNOW, IT LOOKS LIKE I HAVE EVERYTHING. IT LOOKS LIKE I'M JUST NOT STRONG ENOUGH, LIKE MY THRESHOLD'S REALLY LOW... I COULD GIVE THE APPEARANCE OF... A WEAKLING WHO WHINES."

"I think [medicine] is like a calling and it's your life. It's part of your life. You don't clock off at five. It's hard for other people to realise that you do have to put work first, it's quite hard to juggle... and I know for a lot of women, it's been a juggle to balance having the absolute best opportunities on their fellowships, going somewhere amazing, working really, really long hours, but if they've got kids, what do they do with the kids? How do they balance that?"

"You try and do it all, you want to be as good as the guys but we also want to do an amazing job as a mum."

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Increasingly inadequate DHB hospital funding is resulting in inability to recruit enough senior and resident doctors, fund high quality modern IT equipment and medical records systems, or employ enough ISG staff to keep systems running smoothly.

PRESIDENTIAL ADDRESS ASMS ANNUAL CONFERENCE 2018

PROF MURRAY BARCLAY | ASMS NATIONAL PRESIDENT

Prof Murray Barclay

Recently I was on-call in our hospital over the weekend. It was a relatively typical weekend but highlighted to me a number of challenges faced by hospital specialists in New Zealand hospitals today. I should preface the following by saying that I work in a DHB that is high performing compared with some others, and prides itself on systems improvement so my description is not a reflection on my particular DHB.

Firstly, on the Saturday morning the registrar on the ward with me was a relief registrar who had not worked in our service before. This is now a common scenario. The registrar had no patient handover for the weekend. I was therefore the person providing continuity of patient information and patient care. This always used to be the responsibility of the resident medical staff in training and is being progressively shifted more towards the specialists.

We now have many more RMOs in our hospitals than ever before, but it is more difficult to find resident doctors to provide cover, and we work with our own trainees less than ever before.

The marginalisation of senior medical staff influence by DHBs in shaping its implementation has meant that Schedule 10 of the national multi-employer collective agreement (MECA), negotiated by the Resident Doctors' Association, and the 20 DHBs has markedly worsened this situation with frequent rostered days off for resident doctors. In contrast, senior doctors frequently work 12 days in a row when on weekend call. Schedule 10 may have been a good thing for addressing fatigue issues in resident doctors. However, the consequence of reducing fatigue for resident doctors may be increasing fatigue for senior doctors.

Secondly, although there were five mobile laptop computers on my ward for the round, they were not particularly new or fast, none were plugged in to keep charged, and so we tried all five before finding one that had enough charge.

There was a further delay of many minutes while the laptop booted up and it therefore took approximately 30 minutes before we could start to review patient information and start the round. We were then needing to use three different electronic devices to view patient results, medication chart and patient observations at one time.

Rather than making our lives easier overall, going paperless has so far been shown to increase doctors' workload significantly, and time spent on computer documentation is one of the strongest predictors of burnout.

MORE PATIENTS TO LOOK AFTER

Thirdly, there were approximately four times as many patients to look after on the ward as compared with a weekend in 2000.

Next, there was a delay in reporting a radiology test for a patient from the previous day, making a treatment decision more difficult. Our radiology service has been the envy of other services and other DHBs but test delays have now become more common due to excessive workload for radiology staff and understaffing. Another patient was awaiting cardiology advice and an ECHO cardiogram after appearing to have a small cardiac event with an upper GI endoscopy three days earlier. However, there is a major shortage of cardiac ECHO technicians and so the ECHO had been delayed until a cardiologist could do this himself. We were therefore unsure whether the patient's chest pain was related to her oesophageal procedure or a heart attack.

Like radiology, our cardiology service has previously always had a good reputation for rapid response and high quality.

Our DHB has done exceedingly well in reducing hospital length of admission but when significant short-staffing causes delays for tests, then it is inevitable that lengths of stay will go up again.

I could go on but I'm sure you get the picture and will all recognise these issues that are common across New Zealand hospitals.

INADEQUATE HOSPITAL FUNDING

Increasingly inadequate DHB hospital funding is resulting in inability to recruit enough senior and resident doctors, fund high quality modern IT equipment and medical records systems, or employ enough ISG staff to keep systems running smoothly.

Further, the 20 DHBs often have up to 20 different IT systems that don't integrate. This suggests a lack of good leadership at the highest levels. Whilst this is what specialists are dealing with on our wards, at the same time our work space conditions are steadily eroding. Due to having outdated hospitals with lack of space, offices that were once used by individual doctors to work efficiently without distraction are being converted to be used by two, three or four doctors, or doctors alongside nurses and administrators.

In new hospital rebuilds, senior doctors are now asked to work in large open-plan spaces with colleagues, resident doctors, secretaries and administrators. We are told that this is the "way forward" and will encourage increased communication between staff for better outcomes. However, virtually every piece of research assessing open-plan offices concludes that the theory is mistaken. From almost any angle one cares to look at, open-plan offices are damaging and not a good idea.

This environment results in worse relationships between staff, worse communication, reduced privacy and patient confidentiality, reduced ability to concentrate, and importantly up to 30% reduced productivity. This reduced productivity alone rapidly negates and exceeds any cost savings from reduced building costs by the use of open-plan offices, making open-plan the more expensive option medium to long term. Recruitment and retention of staff would also be expected to worsen, leading to even greater costs.

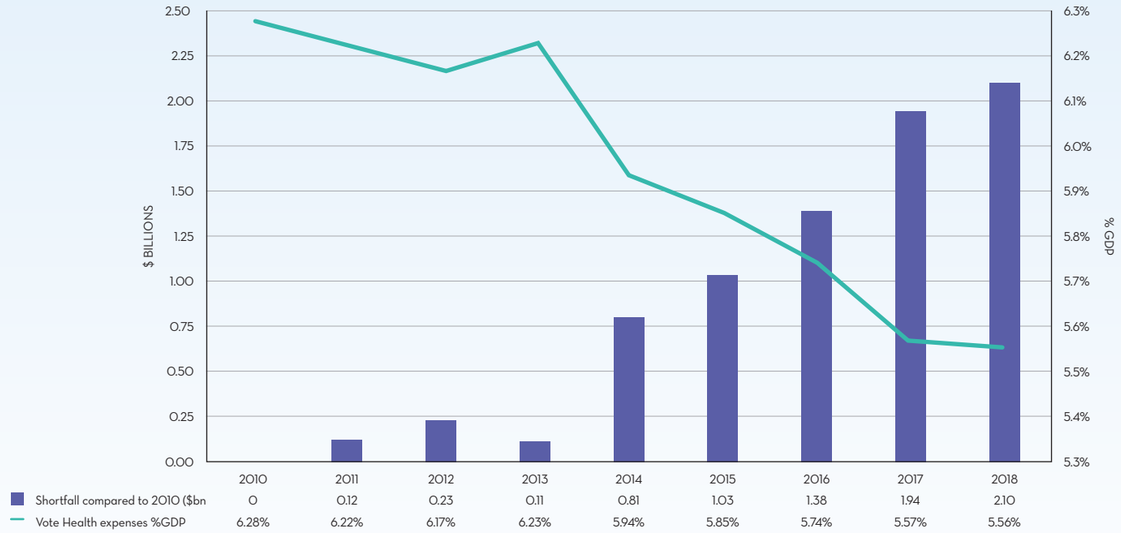
FATIGUE AND BURNOUT

So, what happens to senior doctors when they are placed in an environment where there is too much work, reducing resident doctor support, increasing need to use electronic systems that take up more time than paper-based systems, and suboptimal work spaces with lost ability to work quietly and reflect?

The answers are in ASMS surveys from the past three years. Half of us are fatigued to the point of burnout (70% for younger female doctors), a third to half of us are subjected to or witness bullying on a

Despite the challenges ASMS members face in New Zealand, there are also many opportunities to be taken and ASMS will continue to make important differences in our work lives.

Half of us are fatigued to the point of burnout (70% for younger female doctors), a third to half of us are subjected to or witness bullying on a weekly basis, and we work when we shouldn't work due to illness, worsening the burnout.



	2010	2011	2012	2013	2014	2015	2016	2017	2018
Shortfall compared to 2010 ($bn	0	0.12	0.23	0.11	0.81	1.03	1.38	1.94	2.10
Vote Health expenses %GDP	6.28%	6.22%	6.17%	6.23%	5.94%	5.85%	5.74%	5.57%	5.56%

VOTE HEALTH EXPENSES AS % GDP, COMPARED TO 2010

Courtesy of Dr Bill Rosenberg, NZCTU

weekly basis, and we work when we shouldn't work due to illness, worsening the burnout.

One-quarter of us plan to leave the medical workforce in the next five years.

And all of these things are worse for women doctors, with rates 10 to 20% worse.

IMPACT ON PATIENT CARE

But perhaps most importantly, what happens to patient care in this environment? Not only is there large unmet need whereby many patients don't get seen at all because there are too few doctors, or wait for months or years for treatment they should be rightly having within days or weeks, but when they do get to see a doctor, there is a 50% chance that the doctor, due to burnout, will not be able to express compassion or empathy for their condition or give the time and energy required, factors that are so important to getting good patient outcomes.

Patients understand this. They recognise when their doctor is burnt out. Think about the number of times you have heard from a patient that they felt their doctor was not listening to them or had no empathy. Sadly, many people seem to be resigned to this situation now, especially the elderly, beyond the point of being able to fight for their rights.

At this point it is worth recalling the 2013 Presidential Address of our past President Hein Stander. His focus was on compassion. He described that compassion drives you to want to do something about the other person's suffering or problem, to step in and help. This seems pretty important for good patient care. Lack of compassion is frequently mentioned as a factor in Health and Disability Commissioner complaint reports. Lack of compassion was a contributing factor in events at Mid-Staffordshire. And yet, burnout will mean that 50% of us will not be able to provide compassion.

MISMATCH BETWEEN FUNDING AND NEED

Between around 2010 and 2017, we witnessed a steadily worsening mismatch between DHB funding and patient need, each year being told by the Health Minister that we shouldn't complain because he was giving more money to DHBs every year. This is not strictly untrue, but disguised the fact that less and less was being spent on health over this time as a percent of GDP.

It has been encouraging that the new government is appearing to listen, and can see the precarious state that our health system has now reached. It is now a huge test for the government to respond appropriately and raise the priority of the health of New Zealand citizens to at least a similar level as other comparable countries.

Our member surveys and economic analyses show that we need approximately one fifth (around 20%) more senior doctors than we have right now just to deal with current patient loads. This figure seems to be relatively consistent across our DHBs, with data coming from Clinical Directors in each service.

Just last week, results or a national survey of gastroenterology services showed that we lag well behind similar comparator countries in specialist numbers at a time when we are expected to start providing bowel cancer screening colonoscopies on top of current endoscopy workload.

Another consistent finding from our research, as hinted before, is that the negative effects on specialists from overwork and suboptimal working environments, are worse for our female colleagues in every case; worse burnout, bullying and presenteeism. Almost 40% of our members are female and the results we are seeing cannot be ignored.

You will see that ASMS is increasing its efforts to gather data to address possible gender inequity. Addressing this will almost certainly result in gains for both females and males. Good medicine and patient outcomes are very dependent on good teamwork. If a team member perceives that they are not being treated equitably to other members of the team, they will not want to contribute wholeheartedly. Everyone gains by addressing inequity. Discovering factors that improve work life balance for female doctors will almost certainly result in gains for male doctors also.

The issues I have described have been very well researched and analysed by our ASMS national office team and the challenges are clear. The Association is working hard on all fronts to improve the situation for senior doctors in New Zealand, from helping individuals with difficult workplace issues, working with DHBs and the Ministry to give SMOs a voice locally and nationally, gathering and analysing important research data to look for solutions to some of the issues, or expressing the viewpoint of members through our communications team. This all requires a lot of commitment from our ASMS team. I continue to find the dedication and professionalism of the ASMS team to be inspiring and humbling, and their services seem more important than ever right now.

IMPORTANCE OF JOB SIZING

Regarding addressing inadequate doctor numbers, the best tool we have is job sizing (which usually commences from service sizing) and especially if this can become a regular exercise. Job sizing is an entitlement in the ASMS negotiated MECA.

ASMS has recently advocated for a staffing accord between Government, ASMS and the DHBs for senior doctors and dentists employed by DHBs designed to recognise the precarious state of this critical workforce and committing to address it by using the tools available, which includes more widespread use of service-sizing and job-sizing.

Sadly, the DHB chief executives have responded verbally that they do not have a "strong appetite" for an accord. The Minister of Health has verbally responded positively. We trust that Dr Clark will commit to being part of the solution instead of part of the problem and require DHBs to significantly improve their engagement with senior doctors on this issue.

THE YEAR AHEAD

As you may know, ASMS is about to go through a major transition. Our first and only Executive Director of almost 30 years will be moving on late next year. Ian Powell has always been the face of ASMS, and one could say that ASMS has been his life's work. He has overseen his organisation grow and develop hugely in range of services and numbers of staff from 2 to 18. We will be celebrating his leaving in a significant way closer to the time. However, Ian's moving on has given the Executive much to think about.

Furthermore, half of the Executive is new this time around. We have therefore taken this opportunity to reassess our governance and financial processes with outside professional advice to be sure that ASMS remains strong and well organised into the future and that the Executive can add as much value to the Association as possible. We intend to be in a very solid and stable position during the upcoming transition.

Despite the challenges ASMS members face in New Zealand, there are also many opportunities to be taken and ASMS will continue to make important differences in our work lives.

The biggest challenge lies with our current Government, however, to recognise the data showing that health expenditure is an investment with a return, and to ensure that New Zealanders have the health care that they deserve by being cared for by adequately resourced health professionals who are not so burnt out that they can't provide compassion, and who have the time and energy to improve the efficiency of our health systems. In summary, we need around 20% more hospital specialists in our DHBs urgently.

2018 ASMS ANNUAL CONFERENCE

A cool Wellington day greeted delegates to the 30th ASMS Annual Conference at Te Papa, Wellington, at the end of November.

After a mihi by Immediate Past President Hein Stander, National Vice President Julian Fuller welcomed SMO delegates from around New Zealand as well as observers from the Federal Australian Salaried Medical Officers Association (Federal, New South Wales and South Australia) and the New Zealand Medical Students Association.

Both Julian Fuller and National President Murray Barclay briefly paid tribute to ASMS Executive Director Ian Powell, who has signalled his intention to leave the organisation at the end of next year, after 30 years in the role (since the Association's formation).

Murray Barclay delivered his Presidential address to the conference, noting the impact of workloads, problems with technology, increasing patient numbers and inadequate hospital funding on senior doctors and dentists (see separate article).

Professor Geoff Dobb, President of the Federal Australian Salaried Medical Officers Federation, and Jibi Kunnethedam, outgoing President of the New Zealand Medical Students Association briefly addressed the Conference. Professor Dobb noted the many common issues between the two countries.

"Australian executives see New Zealand as an endless source of ideas – cost-cutting ideas, so we are here to see what might be coming to us in the future," he said.

National Secretary Paul Wilson presented the Association's Annual Report, including the financial report, to the Conference, and this was discussed. Delegates voted to accept the financial report and also to increase the membership subscription for the next year (see separate box).

ASMS Principal Analyst (Policy & Research) Charlotte Chambers presented her research on the lived experience of women in New Zealand's senior medical and dental workforce (see separate article). This was followed by a panel discussion about what needs to change for women in medicine, with the panel comprising delegates Tanya Wilton, Tule Misa, Susie Farrelly and Charlotte Chambers, and convened by ASMS Industrial Officer Sarah Dalton.

Each panel member spoke of their own experiences of navigating a career in medicine, and other people's expectations and responses. Tule Misa recalled attending a function in Wellington and being stopped by the security guard on the door who assumed that she was in the wrong place, while Tanya Wilton spoke of the conflict in her roles as an emergency physician and a mother.

A Conference highlight for female delegates was the women's network breakfast, which featured an address by reproductive rights advocate and retired former ASMS member Dame Margaret Sparrow (see separate article).

Drs David Galler and Rob Burrell from Counties Manukau DHB addressed the Conference about climate change, health care and SMOs (see separate article).

Ian Powell spoke about the precariousness of the senior medical and dental workforce, as well as the challenge of safer hours and continuity of training and care.

Health Minister David Clark addressed delegates, acknowledging the contribution and dedication of members to New Zealand's public health system. He emphasised the importance of good relationships within the sector, and spoke about some of the challenges to do with resourcing health and ensuring the workforce was capable and well supported. He acknowledged the concerns of members which ASMS has articulated, and thanked senior doctors and dentists for their frank feedback in the past year.

The Director-General of Health, Ashley Bloomfield, followed the Minister the next day. He talked about changes to leadership and structure within the Ministry of Health to align it better with the health sector.

Sean O'Sullivan (Panel lawyer, MPS) and Dr Zarko Kamenica (Head of Advisory Services, MPS) spoke about the Dr Bawa-Garba case and what this might mean for doctors in New Zealand. They concluded that the situation that occurred in the UK was unlikely to happen in New Zealand.

Videos of the Conference presentations will be available on the ASMS website (**www.asms.org.nz**) soon.

CONFERENCE RESOLUTION:

Delegates at the Annual Conference voted to increase the Association's membership subscription to $1,100 (GST inclusive) for the financial year 1 April 2019 to 31 March 2020.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Garba
• Recently returned from 14 months maternity leave.
• No previous complaints against her, held in a high regard by colleagues.

The Association would like to thank MAS for sponsoring our pre-Conference social function and MPS for sponsoring our Conference dinner. This support is greatly appreciated.

SUPPORTING OUR WOMEN MEMBERS

Female delegates at the ASMS Annual Conference took part in another successful Women's Network Breakfast on Friday 30 November. About 60 turned out at Te Papa's Marae to share breakfast, make new connections, and to hear an inspirational address by long-time advocate for reproductive rights, Dame Margaret Sparrow.

The Women's Network Breakfast is in its third year and has become a regular part of the Annual Conference. It is part of the work by ASMS to develop and strengthen networking among our women members. One of the key achievements to emerge from the Breakfast was the establishment of the Women in Medicine Facebook group, which has nearly 4600 members and is open to women doctors across the career spectrum.

We have also published interviews with ASMS members about what it is like to work as a female senior doctor or dentist, and promoted the ground-breaking research by ASMS Principal Analyst Dr Charlotte Chambers into women's lived experience of medicine.

Members in a number of DHBs around the country have established groups for women senior doctors; some of these are long-running while others are newer. We encourage ASMS women members to network locally by joining one of these groups – and if your group isn't profiled in these pages, please contact ASMS Communications Advisor Lydia Schumacher at **lydia.schumacher@asms.org.nz** and she will include details of your group in the next issue of *The Specialist*.

WELLINGTON GATHERINGS

Following an opinion from an older colleague that "women have made it now, we've had a female prime minister, and other women in high positions. We don't need articles about women anymore", Marion Leighton set it upon herself to collect current statistics about women in medicine to see if she was right. Unfortunately, women had not 'made it'.

This also prompted her to track down women SMOs at Capital and Coast DHB and ask them to go out for a drink. This alone was quite a process at the time as there wasn't even an email list of SMOs, let alone female SMOs.

The response was positive when Marion Leighton first sent around the email. Apparently male SMOs were upset in one department, but she says that "to be honest, if a man wanted to come along and acknowledged that the groups focus was to support women, we may not turn him away, but if he took over the conversation, he might be asked not to come back!"

The women's group is run on an informal basis and normally involves a drink after work at one of the local bars or restaurants. The nights and venues vary to allow for more inclusion of part timers and those that don't drink alcohol.

The group has expanded to include other local senior doctors working at the Ministry of Health, the Health Quality and Safety Commission and sexual health for example, as these women can feel quite isolated from their peers. Marion encourages members to invite their female trainees in the area, too.

She is now handing over the organisation reins but if you are interested in being added to the invite list, please contact Lydia Schumacher at ASMS and she will be able to put you in touch with the next organiser, **lydia.schumacher@asms.org.nz.**

SWIM@CDHB – SUPPORTING WOMEN IN MEDICINE

Supporting women in medicine or SWIM@CDHB is a group that has been set up by and for female senior medical and dental officers at Canterbury DHB. SWIM@CDHBs focus is on peer support and well-being.

"Collectively we aim to nurture, model and sustain a positive and supportive environment to enhance the quality of our professional lives," the group's administrators tell new members.

One of the major drivers behind the group is providing opportunities for people to get to know each other as part of building a supportive network across the CDHB.

Past SWIM events include Christmas dinners, summer soirees and mid-winter get-togethers.

New female employees at CDHB are automatically invited to join the group and there are over 200 members.

If you are interested in finding out more please contact Philippa Depree at **Philippa.Depree@cdhb.health.nz.**

MIDCENTRAL MEET-UPS

Inspired by the NZ Women in Medicine Facebook page and the work of Wahīne Connect, Nathalie de Vries decided to create a women in medicine group at her DHB.

"I had a need myself to connect with female colleagues and wondered whether my female colleagues would feel the same." Says Nathalie.

She created a survey and asked what types of events suited the women at MidCentral best and results showed that variety was preferred. Care is taken to hold events on different days of the week so that everyone has the opportunity to attend.

Events so far include a social event with drinks and nibbles, a pre-Christmas drink and a speaker session where Charlotte Chambers, Principal Analyst (Policy & Research) ASMS spoke about her research Feeling 'one step behind' Exploring the lived experiences of women in the NZ senior medical workforce. About 30 women attended, including RMOs and SMOs. GPs are invited to events with speakers.

The events alternate between being social and educational and are low-key. There is no obligation to attend.

"It needs to be a good opportunity to meet other female doctors and have a chat about work or family, hobbies etc. I am hoping these events can build up some kind of network, while we're at work we all work in silo-ed areas."

If you're interested in being added to the invite list, please contact Nathalie de Vries at **Nathalie.deVries@midcentraldhb.govt.nz.**

WAIKATO – THE HERD

Have you heard about HERd? Being aware of the hard time that new colleagues often experience when starting out, Vicki Quincey would often organise social events to encourage collegiality at her DHB. Following a conference in Australia, her workmate shared the idea of a social journal club for women that some of their Australian colleagues attended, she decided to introduce the same idea of a women's journal club to Waikato DHB, and that is how HERd was established.

HERd is open to all of the females in the hospital SMO group. Vicki describes it as a social support network, a chance to meet women you wouldn't normally meet, and a chance to share knowledge and discuss issues. The group puts faces to names, so you know who you're talking to in different departments, or who to email when you have questions.

The group has been going just over a year, there are about 60 women on the email list, although actual attendance waxes and wanes depending on schedules. Events vary from going out for a drink, a pot luck at someone's home, or mid-winter and Christmas celebrations. The invite was extended to the RMO advanced trainee group at the recent Christmas celebration pictured.

Vicki Quincey said the response to the group has been positive.

At the request of the interim CEO, she has also set up the more formal Women in Leadership group. The group includes several female executives and looks at specific women's issues in the workplace. The group is still in its infancy and they are establishing their goals and ways to garner executive support for the important issues raised.

If you're interested in finding out more or being added to the invite list, please contact Vicki Quincey **Vicki.Quincey@waikatodhb.health.nz.**

A LIFETIME OF SPEAKING OUT – DAME MARGARET SPARROW

EILEEN GOODWIN | ASMS SENIOR COMMUNICATIONS ADVISOR

Dame Margaret Sparrow is a retired sexual health physician and a former ASMS member. She worked in Family Planning for 34 years and as a venereologist for 28 years. For 17 years she was an abortionist at Parkview Clinic, Wellington Hospital. She is also a director of a not-for-profit company which imports Mifegyne (mifepristone) into New Zealand for medical abortion. Since retiring, she has published three books on the history of abortion in New Zealand and has a long history of speaking out on reproductive rights.

Know who and where your allies are before entering the public fray.

That's the advice Dame Margaret Sparrow gave women delegates to the ASMS Annual Conference in Wellington last month. She was the keynote speaker at the annual women's network breakfast, now into its third year.

Collegial support is vital if you do decide to speak out publicly, she says.

Vitriol from opponents is often less problematic – and less hurtful - than a lack of support from colleagues.

Over the years she encountered strong opposition to her advocacy for abortion rights.

"The abortion clinic opened in 1980, and the next decade there was a lot of protest. You never quite knew when you went to work whether there'd be two or three people praying or a whole lot of protesters with signs.

"You almost expect either prayers or abuse. I've had a lot of people pray for me."

MORE SCRUTINY

Public figures are under more scrutiny now with social media, and while the abortion debate is itself somewhat calmer, the public sphere is more heated.

She believes there is now more awareness of the need to support doctors who speak out, but she is grateful for the support and friendship she had at the time from peers such as Dr Carol Shand.

And her message to senior doctors and dentists at the ASMS women's network breakfast?

"People don't like change, but one of the important things is to find out is where your allies are so you do have some support.

"You don't have to go it alone."

Dame Margaret says she is now more open about sharing personal information to inform debate. In recent years she has talked about being one of the first women in New Zealand to use the contraceptive pill and about her own abortion. She had been brought up to keep her personal life separate from work, but the world has changed.

Protecting family from scrutiny remains a priority, as they have not chosen to enter the public domain.

IMPORTANCE OF ADVOCACY

She went into medicine with the expectation of being a "good doctor" who kept her head down, but realised she would have to do more, and advocate for patients.

Dame Margaret and Dr Shand lobbied for the establishment of Wellington's first abortion clinic, which opened in 1980 (the third clinic in New Zealand). She was president of the Abortion Law Reform Association of New Zealand for 30 years.

Dame Margaret believes there is increased pressure on professionals today because there is less time for relaxation and family. This adds to pressure on those who adopt a public role.

There is more awareness of the risk of burnout, and Dame Margaret has her own experience to relate.

In the late 1980s she was "shattered" from a conflict with a colleague. Her male clinical leader at the time told her to take six weeks leave. The break was invaluable and meant she was able to return. She's still grateful for the wise counsel of her senior colleague.

"He'd obviously seen that in other doctors working under him. I don't think I was the first one who had difficult time. I guess if it hadn't been handled well, I would have given up," she says.

**** The right and duty of doctors to speak out and engage in public debate about the health service was covered in an earlier issue of* The Specialist *(p5, https://www.asms.org.nz/wp-content/uploads/2015/09/10768-The-Specialist_Sept15_WEB.pdf).***

FULL TEXT OF ADDRESS TO THE ASMS WOMEN'S NETWORK BREAKFAST BY DAME MARGARET SPARROW

Tena koutou, Tena koutou, Katoa. Good morning. I am honoured that you have invited me to say a few words at this breakfast session.

Let me start with a little about my background. I was born in Taranaki where my father was a farmer. When I left school I studied for a science degree at Victoria University, then a medical degree at Otago. At graduation I was married with two young children but soon after that my husband and I separated and I became a solo mother. After working in hospitals for two years and in public health for four years, I came to Wellington as a Student Health doctor, at Victoria University. The students needed contraception so I became involved in Family Planning. In 1976 I qualified for sabbatical leave and for nine months based myself and my two teenage children in London. I gained several new skills, a Diploma in Venereology and how to do two operations – abortion and vasectomy.

Along with others I was involved with the opening of Parkview Abortion Clinic in 1980 and was an operating doctor there for over 17 years. In 1981 I gave up my full-time job at the University to concentrate on my three part-time careers in Family Planning, venereology and abortion. I retired at the age of 70 but I am still active as a company director of Istar, a not-for-profit venture that imports the abortion pill from France, so that New Zealand women have the choice between a medical and a surgical abortion.

One of the topics that was suggested I might speak about today is my experience advocating and speaking out about sexual and reproductive health issues. I am mindful that my working life has been very different to yours and some of the lessons that I have learned along the way will not be relevant today, due to the enormous social changes that have occurred since I graduated in 1963. But I also know that some things are enduring. The most satisfying part of my career has been helping patients and it was only reluctantly that I entered the public and political domain, when I realised that I couldn't help patients unless I challenged the prevailing system.

My views about sexuality and gender equality were radically challenged when the feminist move exploded in the 1970s. Consciousness raising and women's liberation were new terms in my vocabulary. I avidly read all the feminist authors – Simone de Beauvoir, Germaine Greer, Betty Friedan, Kate Millett, Robin Morgan, Gloria Steinem and Marilyn French. 1972 was a watershed year for me with the visit of Germaine Greer, the publication of 'The Little Red School Book', and my introducing the 'morning-after' pill.

That taught me several things, especially how to cope with criticism when the conventional wisdom is challenged, and never to be afraid to

ask for help. When I began to prescribe the emergency contraceptive pill, some colleagues thought this was too risky as there had not been a lot of studies on its use. It certainly was new but I had carefully researched it and would have been prepared to stand up in court or justify my actions to a disciplinary panel if necessary. When I asked for help, Professor Mont Liggins was supportive on the theoretical side. But when one of my patients ended up in hospital with an ectopic pregnancy, I was devastated and seriously doubted my judgement. Had I been wrong after all? The specialist who admitted her was reassuring and helpfully suggested I should write a paper in which I could discuss the benefits and risks of the method – which I did.

Sometimes you have to take risks. I don't mean being foolish or reckless, but taking a calculated risk can often be advantageous. In 1956, there were no pregnancy tests and abortion was a dark secret because it was a crime with a maximum penalty of seven years in gaol. When I needed an abortion, like many other women of my generation, I carried out a self-abortion with a mixture obtained from a mail order pharmacist. Yes, that was taking a risk but there were also other more risky options. That experience is the basis for my unwavering commitment to change the abortion laws.

In 1961 I had just given birth to my second child and the new fangled contraceptive pill arrived in New Zealand. I was taking time off studies and my medical student husband, who was learning about general practice, came home with some sample pills, Anovlar, which a pharmaceutical rep had left at the doctor's surgery. I didn't discuss taking them with a proper doctor (not recommended) but I came to no harm and wouldn't have finished my medical degree without the fertility control that the pill provided. That experience is the basis for my unwavering support of family planning.

Never let obstacles stop you from doing what you believe is right. When I started at the Student Health Service in 1969, it was considered unethical for doctors to prescribe the contraceptive pill to the unmarried. It was not illegal, just an ethical ruling by the Medical Association. I discovered that the students were going to a nearby doctor who ignored this ruling. I felt strongly that we should be providing this service for students. My boss disagreed, and I could have lost my job over that, but I took a stand and after an uncomfortable two weeks of 'no speaks', we agreed to disagree. Preventing unplanned pregnancies was more important to me than conforming to a rigid moral code.

Identifying strengths and weaknesses is pretty basic advice. In 1974 I was a member of the Government delegation to the United Nations World Population Conference in Bucharest, Romania. That was most interesting but once was enough. I was very happy to leave the international political stage to others more skilled in the language of diplomacy and return to the familiarity of the consulting room. However, with regard to abortion, I had to become involved in national politics because I could see that it was necessary to be able to advocate for patients.

I have never stopped learning. I graduated with a science degree in 1956 and in my first job as the research assistant to the Professor of Surgery, we were fortunate to have a visit from a future Nobel Prize winner, the British biologist Sir Peter Medawar. He astonished us all with the news that other scientists had just discovered there were 46 human chromosomes. In my science degree I had been taught that there were 48, and this brought home to me in a very tangible way that learning would be life-long.

When the AIDS virus first appeared in the early 1980s, medicine and science struggled to make sense of this brand new disease. It was a very difficult time, not knowing how best to help patients. I remember with gratitude some of the gay activists who provided more tangible support to patients than I did, while waiting for medicine and science to catch up. Did you know that tomorrow is World AIDS Day and that today is Red Friday? I am wearing red in support of the AIDS Foundation.

I knew virtually nothing about intersex conditions when Mani Mitchell came to the Sexual Health Service in 1997 but I made it my business to find out and support Mani in advocating for the human rights of intersex persons. Another steep learning curve.

Whatever field you are, make sure you have support networks with people you trust. On the abortion issue, I have had to defend my actions in a court of law on more than one occasion. I have also had to deal with a lot of protest activity and at times have been grateful for police protection. But the strongest protection comes from supportive colleagues, friends (both male and female, but especially female) and even neighbours.

On one occasion when I was working at Family Planning I had an unexpected phone call from my next door neighbour, Helen, saying that she had just stopped a truck driver from delivering a load of wet concrete on my driveway and although she felt sure I would not have ordered this, she was just checking to confirm it. This happened at a time of my life when anti-abortionists were very active, either attacking me or praying for me.

However, vitriol from opponents was expected. If anything, it strengthened my resolve. I found it more difficult to deal with attacks from within the ranks. On one occasion this led to a breakdown or what you would now describe as burnout. I fell to pieces. The supervisor of the abortion clinic was sympathetic. He said firmly: "You just take six weeks leave." I continued with my other two jobs. Although there was no counselling, that break was invaluable and meant I was able to return to the work I had always found rewarding.

Because of that experience, I have been interested in the research on burnout in doctors and pleased to see it as one of the topics at this conference. I come from an era where it was usual to keep one's personal life private, and I was always very protective of my family. But times have changed, and it is now regarded as healthier if we pay attention to all aspects of our lives and be more aware of how they interact. I admire the way that you are making use of technology and social media. I like the initiative you have taken to establish a women's network group, using modern tools to share experiences and gain collegial support.

WHAT DOES IT TAKE TO REACH SAFE STAFFING LEVELS?

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

A health workforce with an adequate supply of senior doctors underpins the delivery of high quality health care.

Governments are instrumental in determining their populations' needs for health care, and what constitutes an adequate medical workforce to meet those needs. The evidence gathered over many years shows successive governments have been found wanting on both counts.

New Zealand's system of primary care 'gate keeping' has seen the gate effectively closed for many. The Government's recently implemented primary care initiatives is a welcome step that will go some way to improving access to general practice.

For patients needing referrals to hospital care, however, the news may not be so good. Research published in the New Zealand Medical Journal in 2017 indicated nearly one in 10 people reported an unmet need for hospital care that had been identified by a doctor or other health professional in the previous five years. Unpublished district health board information shows long delays in getting an appointment with a hospital specialist after referral from a general practitioner. And waiting times for elective services are longer than in many comparable countries.

The primary care gate is now a little wider, but the hospital door appears to be getting narrower – at least for those seeking treatment deemed non-urgent.

As indicated in *The Specialist* (July 2018, p16), non-urgent inpatient cases have risen by just over 5% in the six years to 2017 while acute inpatient cases increased by 20% over the same period. While the senior medical workforce has increased by 22%, the population aged 65 and over (who in the United Kingdom have been reported to occupy nearly two-thirds of hospital beds days) has increased by nearly 25%.

Further, the growth in New Zealand's senior medical workforce has started from a low base when compared internationally. Despite the growth in New Zealand's specialist workforce, on a per capita measure it remains one of the smallest in the Organisation for Economic Cooperation and Development (OECD). That is not obvious when looking at performance measures on quality of care, for example, where New Zealand is ranked highly. But it comes at a cost.

ASMS research revealing high levels of burnout and 'presenteeism' in DHB-employed senior doctors and dentists highlights the effects of long-term workforce shortages that have become so entrenched they have become the 'norm'. There is ample evidence showing such conditions are not only bad for doctors' health, they are a barrier to a more accessible, more effective, more cost-efficient health service. The question is: what is required to achieve a healthy and more productive norm?

The ASMS has been putting that question, in effect, to DHB heads of departments in its series of surveys to ascertain how many Senior Medical Officers (SMOs) are required, in their assessment, to provide safe, good quality and timely health care for those who need it.

The surveys ask not only about the adequacy of staffing to meet clinical needs but also to fulfil other essential roles such as training and supervising, and time to provide effective 'patient centred care', which involves among other things SMOs spending more time with their patients so they are better informed about their condition, their treatment, any treatment options, and benefits and risks. Questions also seek estimated staffing requirements to enable SMOs adequate access to leave, including sick leave.

To date, six studies have been completed, starting with Hawke's Bay DHB in February 2016, followed by MidCentral (2016), Capital & Coast (2016), Nelson-Marlborough (2016/17) and Counties Manukau (2016/17) and Canterbury (2017). A further study, at Waitemata DHB (2018), was being analysed at the time of writing. The estimated additional SMOs needed to provide safe, quality and timely health care at the time of the surveys is summarised in Figure 1.

While the senior medical workforce has increased by 22%, the population aged 65 and over has increased by nearly 25%.

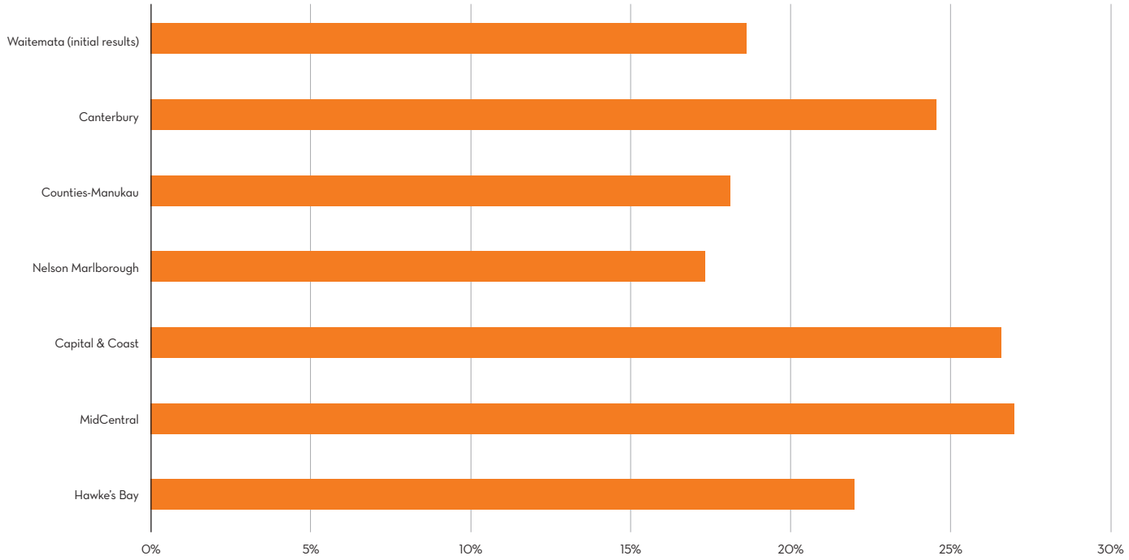


FIGURE 1: ESTIMATED SMO STAFFING SHORTFALL AS A PERCENTAGE OF CURRENT STAFFING ALLOCATIONS

Source: ASMS surveys of clinical leaders. Full reports available: **https://www.asms.org.nz/publications/researchbrief/**

The average assessed SMO staffing shortage across the surveyed DHBs is 21.8%. Translated across the whole SMO workforce, this would have amounted to a shortage of approximately 1000 specialists and 100 medical and dental officers in 2016.

INTERNATIONAL COMPARISONS

Another way to consider the adequacy of the medical workforce is to compare the number of doctors relative to the population across countries and over time.

A World Health Organization (WHO) report discussing health system performance indicators says measuring doctor numbers "represents a critical starting point for understanding the health system resources situation in a country", but it has obvious limitations. It does not take into account a country's health needs, nor its quality, efficiency or health system objectives.

On the latter, Health Minister David Clark told the news service Newshub that, "We want to make sure we are the best health system in the world, and we compare relatively well to many of the countries we would compare ourselves...". It can be reasonably assumed, then, the 'benchmark' on which to gauge the adequacy of supply of New Zealand's senior medical workforce is that of being a world leader in terms of access, effectiveness and timeliness of hospital treatment.

On the available evidence, considering measures of access to specialist services alongside the broader measures of quality, equity and health outcomes, the Netherlands stands out. It is the top performer of 35 countries in a Euro Health Consumer Index which reports a range of measures relating to accessibility, outcomes, range and reach of services and patient information, among others. It is also ranked best in terms of access and second-best on equity in a New York-based Commonwealth Fund study comparing the health system performance of 11 countries. Further, rates of premature mortality, including mortality amenable to health care, is relatively low, and an OECD 'state of health' report on the Netherlands indicates "there is no sign of acute shortages of health professionals" (though there are concerns of growing waiting lists).

The main weakness of the Netherlands' health system, which runs as a private insurance market under regulated competition, lies in poor measures of administrative efficiencies, but most indictors reflecting on the adequacy of the workforce get a tick.

Based on European specialist workforce data and supporting information, in 2016 the Netherlands had an estimated 140 specialists per 100,000 population. Based on New Zealand Ministry of Health data, New Zealand had 120/100,000.

On those figures, to be on a par with the Netherlands in 2016, once again New Zealand would have needed approximately 1000 additional specialists.

An ASMS Research Brief examining this issue in further detail is to be published in 2019.

Despite the growth in New Zealand's specialist workforce, on a per capita measure it remains one of the smallest in the OECD.

DEAR DAVID, THERE'S A HOLE IN THE SMO BUCKET

IAN POWELL | ASMS EXECUTIVE DIRECTOR

Since the coming into being of the Public Health and Disability Act 2000 and before last year's surprise general election outcome, we have had five health ministers – Annette King (six years), Pete Hodgson (two years), David Cunliffe (one year), Tony Ryall (six years) and Jonathan Coleman (three years). Now we have a sixth minister, David Clark, who has now been in post for a little over a year.

David Clark has the high-risk attributes of being both a theologian and economist – a potentially deadly combination. The most famous person with these combined attributes is Scotland's Adam Smith who, in the 18th century, skilfully constructed the foundations of classical free market economic theory with his most notable publication being The Wealth of Nations. But even the free market-driven Smith had a sense of the need for some level of public good. In his ideological construct, this was provided by his notion of an 'invisible hand'.

But the invisible hand of Adam Smith was operating in the economy of the baker, butcher and candlestick maker, not today's modern complex economy and society. The closest New Zealand has come to applying classical free market economic theory in our public health service was in the ideological binge of commercially competing public hospitals run by state-owned companies in the 1990s. By this time there was no invisible hand. Instead we had a cumbersome iron fist without a velvet glove.

Fortunately, despite both being Presbyterian, Dr Clark is from a broader church than the church of Dr Smith and

The Minister's instructions to DHBs does not include a requirement to address the precarious situation of their specialist workforce – a significant oversight.

has a strong sense of why New Zealand needs and has a universal public health service.

DAVID'S TREAT

One of the special treats of the Minister of Health is to send an annual Letter of Expectations to the Chairs of the country's 20 district health boards. It is a letter of instruction. His Letter for the 2018/19 year was the first opportunity to get a fuller sense of the new Government's direction of travel for health.

In this Letter, Dr Clark gave DHBs a clear signal about the Government's health priorities. There is a welcome Government intention to focus on primary care, mental health, public delivery of health services, and improved equity in health outcomes. These are all worthwhile.

The focus on public delivery of health services represents a significant change in approach from the previous government. This clear signal on public delivery should strengthen confidence in the Government's commitment to public hospitals which have been under threat of privatisation for so long. The signal had already been given by the Minister's earlier decision to stop the controversial and financially precarious Public Private Partnerships promoted by the former Government (surprisingly, however, the Minister opted not to publicise this decision which would have been well-received by those working in DHBs and the wider public).

THE MISSING INSTRUCTION TO DHBs

Unfortunately, the Minister's instructions to DHBs does not include a requirement to address the precarious situation of their specialist workforce. This is a significant oversight as hospital specialists are a stressed and stretched workforce, and they have been shouldering the burden of an under-resourced public health system for years to the detriment of their own health.

ASMS published research shows high levels of burnout (50%) among DHB-employed senior medical and dental staff. It also shows 88% having to work through general illness and 75% having to work through infectious illness.

ASMS surveys in five DHBs to date (Counties Manukau, Hawke's Bay, MidCentral, Nelson Marlborough and Canterbury) illustrate the extent of senior medical and dental officer shortages as identified by clinical leaders. They show existing shortages of around 20%, suggesting a national shortage of around 800 to 1,000.

ASMS' survey last year of members workforce intentions revealed that on top of these existing shortages, around 25% intended to leave DHB employment in the next five years. Much of this is due to the aging of the workforce but job dissatisfaction is a noticeable contributing factor. On top of this, Ministry of Health analysis of Medical Council data predicts an annual loss from almost all branches of medicine of around 5% from the medical workforce subject to no changes in policy direction.

David Clark and his government colleagues must ask themselves: how on earth can senior doctors be expected to maintain their personal health and well-being and to ensure safe and quality patient care in such a precarious position? If a high priority of a transformational government is not to require DHBs to ensure staffing levels of senior doctors that are safe for both themselves and their patients, what is?

To his credit, when addressing the Resident Doctors Association's safer hours conference in November, Minister Clark acknowledged the seriousness of burnout among the senior medical and dental workforce and DHBs, and the importance of addressing it which, by implication, includes addressing specialist shortages.

But he must go further. ASMS is promoting an initiative of a safe staffing accord between Government, DHBs and ASMS to ensure DHBs have a sufficient number of specialists to provide comprehensive quality patient-centred care, and to look after the well-being of these specialists.

To paraphrase an old nursery rhyme: there is a hole in the specialist bucket, so fix it dear David, fix it.

"Interventions that are not supported by evidence do not lead to high-quality care and may even cause harm."

MORE CLINICIANS AWARE OF NEED TO REDUCE UNNECESSARY MEDICAL INTERVENTIONS

A survey has found that knowledge of the *Choosing Wisely* campaign has doubled among health professionals over the past two years. *Choosing Wisely* (https://choosingwisely.org.nz/), coordinated by the Council of Medical Colleges, supports reducing unnecessary tests, treatments and procedures in health care.

The survey was undertaken by the *Choosing Wisely* campaign in September and October 2018, working with the Association of Salaried Medical Specialists (ASMS), the New Zealand Medical Association (NZMA), and the New Zealand Nurses Organisation (NZNO). It repeats a survey undertaken with ASMS and NZMA in 2016. The 2018 survey was completed by 783 doctors and 20 nurses.

It found knowledge of *Choosing Wisely* had increased from 41 percent of those surveyed in 2016 to 80 percent in 2018.

Other findings included:

- an increase in the percentage of health professionals advising against a particular test, procedure or treatment and not providing it (77 percent to 84 percent)
- a decrease in the percentage of health professionals advising against a test but providing it anyway (14 percent to 9 percent)
- an increase in the percentage of health professionals who consider the provision of unnecessary tests, procedures or treatments a somewhat serious or very serious issue for New Zealand (62 percent to 68 percent).

Choosing Wisely Chair Dr Derek Sherwood says the survey sought to determine how much of an issue clinicians considered the provision of unnecessary tests and procedures was, both in their areas of practice and in the New Zealand health sector more generally.

"*Choosing Wisely* is now in place in 15 DHBs and is supported by a number of PHOs and GP practices. Thirty-one medical colleges, specialty societies and health practitioners' associations are linked to the campaign. Over 154 lists of tests, treatments and procedures that should be questioned have been developed, along with 45 patient resources.

"The survey suggests these activities are having an impact on awareness of the campaign, and in clinicians' attitudes to potentially unnecessary tests, procedures and treatments."

Dr Sherwood says with the complexity of tests, treatments and procedures available to modern medicine, many do not always add value.

"Interventions that are not supported by evidence do not lead to high-quality care and may even cause harm."

He says reasons given for unnecessary interventions include lack of time for shared decision-making, fear of missing a diagnosis or complaints, financial incentives, the way doctors are taught, patient expectations and avoiding telling patients they do not need specific tests or treatment.

"The *Choosing Wisely* campaign challenges health professionals to question the notion that 'more is always better'. We encourage clinicians to talk with their colleagues about what care is truly needed – identifying which practices are helpful and which are not."

Dr Sherwood says it is encouraging to see the high levels of understanding among clinicians about the need to consider whether a test, procedure or treatment is really necessary, before recommending it to a consumer.

"The key is to have a really good discussion with consumers about the pros and cons of interventions, so a decision about going ahead can be made together."

The ASMS survey covered senior medical officers across a range of specialties working in hospitals. There were 726 responses.

Forty percent of respondents to the NZMA survey worked in general practice, 10 percent were resident medical officers, while 50 percent were 'other', which included internal medicine, emergency medicine, paediatric surgery, physician or were in the general practitioner education programme. Twenty nurse prescribers were also included in the NZMA responses. There were 77 responses to the NZMA survey.

"We encourage clinicians to talk with their colleagues about what care is truly needed."

SUMMARIES OF CHOOSING WISELY SURVEYS 2016 AND 2018

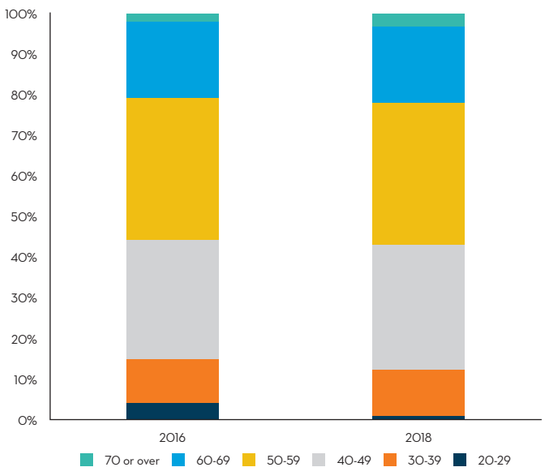
AGE-GENDER MIX FROM THE TWO SAMPLES.

2018 - GENDER		
	FREQUENCY	PERCENT
Female	355	44.7%
Male	440	55.3%
Total	**795**	**100%**

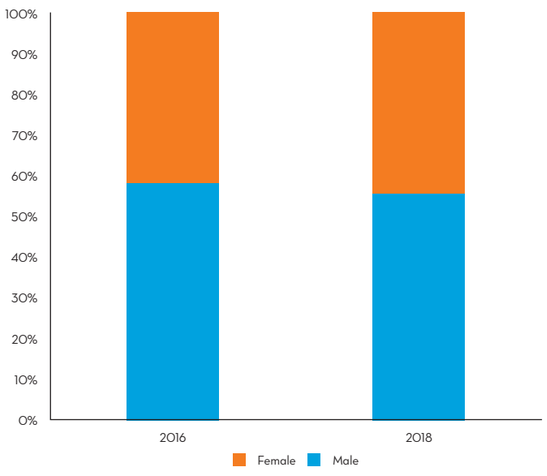
2016 - GENDER		
	FREQUENCY	PERCENT
Female	589	42.2%
Male	807	57.8%
Total	**1396**	**100%**

2018 - AGE GROUP		
	FREQUENCY	PERCENT
20-29	5	0.6%
30-39	92	11.5%
40-49	244	30.6%
50-59	280	35.1%
60-69	151	18.9%
70 or over	25	3.1%
Total	**797**	**100%**

2016 - AGE GROUP		
	FREQUENCY	PERCENT
20-29	62	4.4%
30-39	142	10.2%
40-49	412	29.5%
50-59	489	35.0%
60-69	263	18.8%
70 or over	29	2.1%
Total	**1397**	**100%**



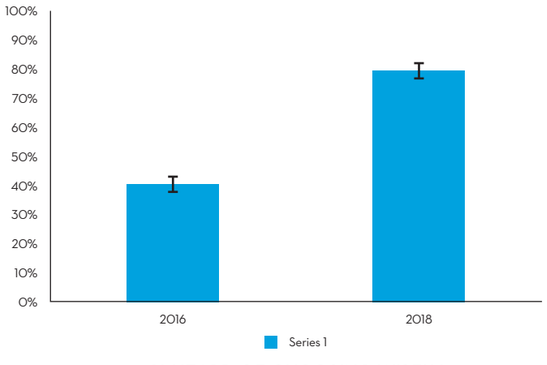
AGE



GENDER

2018 - COMBINED		
HEARD OF *CHOOSING WISELY*		
RESPONSE	FREQUENCY	PERCENT
No	134	16.8%
Unsure	24	3.0%
Yes	640	80.2%
Total	**798**	**100%**

2016 - COMBINED		
HEARD OF *CHOOSING WISELY*		
RESPONSE	FREQUENCY	PERCENT
No	767	54.6%
Unsure	63	4.5%
Yes	575	40.9%
Total	**1405**	**100%**



% HEARD OF *CHOOSING WISELY*

QUESTION RESPONSES

2018 - COURSE OF ACTION		
RESPONSE	FREQUENCY	PERCENT
Advise against and not provide test, procedure or treatment	647	83.9%
Not sure	53	6.9%
Advise against but provide test, procedure or treatment	68	8.8%
Provide requested test, procedure or treatment	3	0.4%
Total	**771**	**100%**

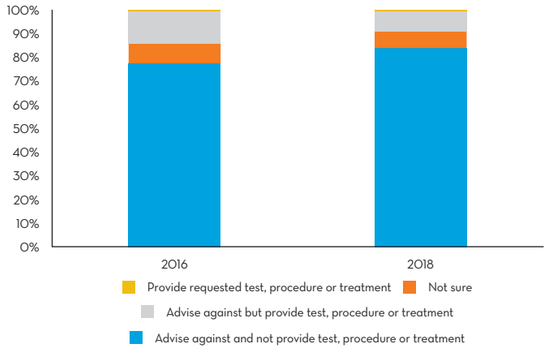
2016 - COURSE OF ACTION		
RESPONSE	FREQUENCY	PERCENT
Advise against and not provide test, procedure or treatment	1043	77.1%
Not sure	121	8.9%
Advise against but provide test, procedure or treatment	184	13.6%
Provide requested test, procedure or treatment	5	0.4%
Total	**1353**	**100%**

2018 - ISSUE IN CURRENT AREA		
RESPONSE	FREQUENCY	PERCENT
A very serious issue	98	12.3%
A somewhat serious issue	304	38.2%
Not too serious an issue	297	37.3%
Unsure	44	5.5%
Not an issue	53	6.7%
Total	**796**	**100%**

2016 - ISSUE IN CURRENT AREA		
RESPONSE	FREQUENCY	PERCENT
A very serious issue	168	12.0%
A somewhat serious issue	528	37.7%
Not too serious an issue	497	35.5%
Unsure	80	5.7%
Not an issue	126	9.0%
Total	**1399**	**100%**

2018 - ISSUE IN NEW ZEALAND		
RESPONSE	FREQUENCY	PERCENT
A very serious issue	147	18.3%
A somewhat serious issue	399	49.8%
Not too serious an issue	88	11.0%
Unsure	161	20.1%
Not an issue	7	0.9%
Total	**802**	**100%**

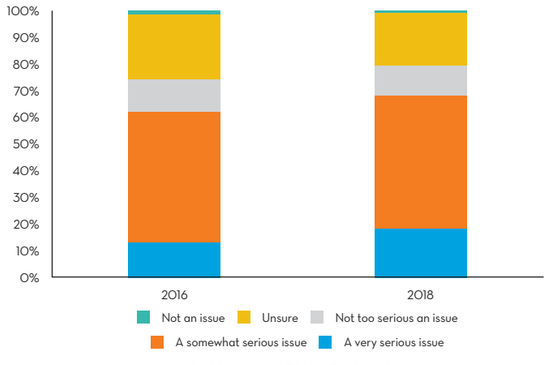
2016 - ISSUE IN NEW ZEALAND		
RESPONSE	FREQUENCY	PERCENT
A very serious issue	183	13.1%
A somewhat serious issue	681	48.6%
Not too serious an issue	176	12.6%
Unsure	338	24.1%
Not an issue	24	1.7%
Total	**1402**	**100%**



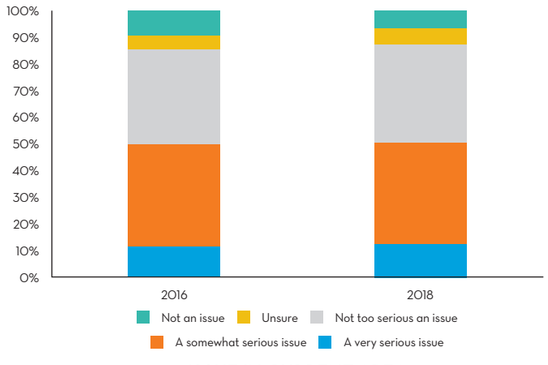
COURSE OF ACTION

KEY SUMMARIES

- The sample size for 2018 is down on 2016. ASMS response is down slightly (approx. 990 to 720).
- The age-gender mix of the samples are largely comparable across both surveys.
- The course of action shows some trends towards more advising against the test/procedure/treatment and not providing it (77.1% to 83.9%) and fewer advising against but providing it (13.6% to 8.8%).
- The issue for New Zealand has seen a modest increase in the percentage who consider it a somewhat serious or a very serious issue has risen from 61.7% to 68.1%.



ISSUE IN NEW ZEALAND



ISSUE IN CURRENT AREA

Dr David Galler

HEALTH SECTOR NEEDS TO LEAD THE WAY ON CLIMATE CHANGE

Health care has a role to play in helping New Zealand become net carbon neutral by 2050, and Counties Manukau DHB is helping lead the way, writes Middlemore Hospital intensivist David Galler, who is a former ASMS National President and long-standing Executive member.

At Auckland's Middlemore Hospital, a small group of doctors, nurses, and other workers have achieved a remarkable reduction in Counties Manukau DHB's carbon footprint.

Late last year the group celebrated a 21.2% carbon footprint reduction achieved over five years.

We did this doing the simple things that most of our staff currently do, recycling and reducing waste, but as an organisation we were greatly helped by joining Environmark's Certified Emission, Measurement and Reduction Scheme.

In developed nations, health care accounts for between 5% and 8% of a nation's greenhouse gas emissions, with health care establishments reportedly using twice as much energy per square metre as traditional office space. Of our footprint waste, energy and transport make up only 40% of health's carbon footprint with the rest, roughly 60% generated by the carbon costs associated with the manufacture, packaging, transport, use and disposal of the medicines and devices we use every day. So even if all our healthcare facilities ran on renewable energy that would not be enough.

Hence the purchase cost of those items we use every day should include the carbon cost of each item's manufacture, packaging, transport, use, and disposal. So if the health sector is to play its part helping the nation become net carbon neutral by 2050, we need policy changes to ensure that our major purchaser of medicines and devices, Pharmac, direct its considerable expertise and muscle to include carbon and life-cycle costs in purchasing decisions. The Minister of Health's Letter of Expectation to Pharmac opens the door for this.

A SHIFT IN FOCUS

The role of health professionals has shifted in the past decade or so from a sole focus on disease to a broader mandate of wellness and health and increasingly, too, investing to create health and wellness and in healthcare are seen as providing a platform for individuals, whanau and communities to become increasingly self-reliant and productive and to reach their potential for themselves and the nation. That shift helps us promote social and environmental causes and adds an even greater incentive for the healthcare sector to embrace greenhouse gas reduction.

However, CME and expense claim rules have not kept pace with this shift, and need to change to reflect the role of doctors as advocates. By way of example, membership and involvement in organisations like OraTaiao, the New Zealand Climate and Health Council, **http://www.orataiao.org.nz/** should be treated like any medical professional college for claiming entitlements.

We need to do more to encourage doctors to speak up for things that make a much bigger difference to our population than what happens in individual consulting rooms. I believe this strategy will also help reduce burnout.

AN EXAMPLE FROM ANAESTHESIA

In the meantime, things are happening now. A good example is from the world of anaesthesia, an initiative led by my colleague, Dr Rob Burrell. His department started to track the use of common anaesthetic drugs, desflurane, sevoflurane, and nitrous oxide, all of which carry a massive carbon footprint. These are gases inhaled by patients to keep them asleep during surgery. Desflurane has an emission profile 20 times greater than a similarly priced drug, sevoflurane.

With better knowledge, regular auditing of use, advanced technology, and perfecting alternative techniques, the anaesthetic department has dropped its carbon footprint from gases to about a third of where it once was. The use of desflurane has almost stopped, and the same occurred with nitrous oxide, which is also a significant part of New Zealand's agricultural emissions. It hangs around for 140 years, destroys the ozone layer in the atmosphere, and has an enormous warming effect, in addition to its massive carbon footprint. With Counties Anaesthetic staff aware of environmental impacts, nitrous oxide is rarely used in anaesthesia, and nor is desflurane. Costs have come down, the environment is better off, and there is more money left over for the patient. These changes in behaviour are tremendous examples of the beneficial consequences of triple bottom line reporting and thinking.

It is heartening to know that the work done at Counties is happening, being matched and in some areas exceeded by other DHBs. Auckland, Waitemata and Canterbury DHBs have joined the Certified Emission Measurement and Reduction Scheme (CEMARS) community, and our network is becoming stronger thanks to the support of many, including organisations like Ora Taiao.

Figure 1 illustrates the direction of our carbon footprint, as measured by the CEMARS certification programme.

The financial and environmental savings of the programme are significant.

Table 1 summarises the outcomes of three key focal areas of work over a 12 month timeframe and an overall saving as a result of carbon savings over the duration of the programme.

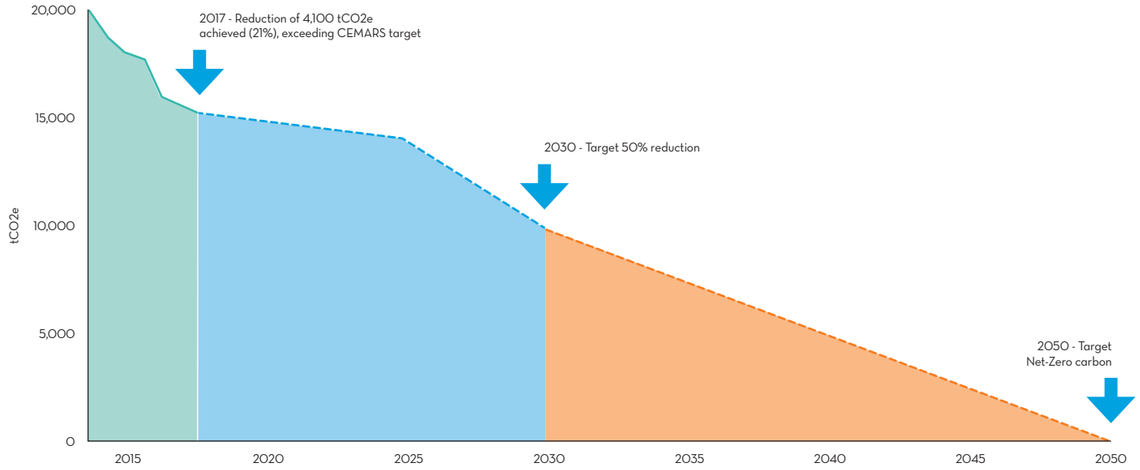


FIGURE 1: MIDDLEMORE HOSPITAL AND MANUKAU SUPERCLINIC/SURGERY CENTRE CARBON FOOTPRINT DATA AND FUTURE TARGET

TABLE 1: FINANCIAL AND ENVIRONMENTAL OUTCOMES OF THREE KEY FOCAL AREAS AND THE PROGRAMME OVERALL

AREA	FINANCIAL SAVINGS 12 MONTHS (2016-2017)	GHG EMISSIONS AVOIDED (TONNES OF CO2E)
Energy	$190,000	400
Computer sleep	$50,000	62
Anaesthetic gases	$160,000	14.5
Overall outcomes over the duration of the programme	**Financial Savings**	**Emissions**
	$3.15 million*	4,100

* External costs (or the environmental cost indicator) are based on European methodology. For global warming this value equates to NZ$ 0.77/kg CO2e.

Over the years our work, led by our Sustainability Officer, Ms Debbie Wilson, has steadily gained traction within the DHB. As a result, support from front line staff has grown and we have reduced waste, increased recycling, and improved energy efficiency. We have also developed a travel strategy for staff, patients and the public. While we have made progress, there is potential to achieve even more.

WHAT NEXT?

We have come to a hard point in our conversation, forced to decide what we choose to value. There is little chance that New Zealand will become net carbon neutral or that our DHBs and other parts of the public sector will be able to contribute meaningfully to that goal until we have a change of heart. Carbon costs must become part of the value equation alongside fiscal and social costs to assess outcomes, also known as triple bottom line reporting.

If we fall short, we will be in a lose-lose situation, out-gunned by innovators abroad, forced to pay more through the purchase of scarce and expensive carbon credits, while subsidising local activities that still rely on fossil fuels.

The argument for accounting for carbon in health is strong. There is a welcome and proven double benefit from reducing emissions from this sector because what is good for health is also good for the environment. Interventions to drive down emissions will further incentivise the kinds of changes in health care that we have been striving to achieve for a long time.

This relationship has been extensively explored by many commentators around the world but perhaps is best articulated in the work of the UK's Sustainable Development Unit, a small independent group that sits outside of the English NHS to advise them on specific actions that organisations can take to help the UK reach its own emissions target.

FROM HUMBLE BEGINNINGS

On reflection, we were a naïve bunch at Middlemore when all of this started in 2011. We have come a long way and are different people now, with expertise, knowledge and a bold aspiration to do more and do better. We not only understand the complex relationship between health care and climate change, we are well placed to lead the public sector in its efforts to accelerate New Zealand's ability to reach its own target before 2050, something that according to Westpac and Vivid Economics, will save the country tens of billions of dollars.

Underpinning that confidence sits a sound understanding of the specific actions that will be necessary to achieve that goal, but perhaps more importantly, the benefits of the change in mindset that will be necessary for that to happen. When one understands this, one starts to understand the importance of the interdependencies that exist between individuals, families and communities and between all of them and the environment that sustains us.

This notion of the interconnectedness of all things (recently coined as "interbeing" by the contemporary American thought leader Charles Eisenstein) then fosters a realisation that changes the way we see the world and opens up an opportunity to truly create "the better world we all know is possible".

To illustrate, let's reflect on the different outcomes that might have been possible with triple bottom line reporting in two specific instances where value-for-money-alone thinking prevailed.

The first, the Compass food contract, signed off by Health Benefits Ltd in 2014/15, contracting the UK multinational Compass Foods for 15 years to supply inpatient meals, and meals on wheels, for all 20 DHBs. As we understand it, only six DHBs - the three Auckland metro DHBs plus Tairawhiti, Nelson Marlborough, and Southern - accepted the Compass deal and they now carry the financial liability for all 20 DHBs for the duration of the contract.

In late 2014, the sustainability group at Counties argued against the contract proceeding, on the basis of poor food quality; duration of the contract being absurdly long; and, most importantly, because the deal effectively cut local suppliers out of the economy created by the DHBs, one of the biggest employers in each region and did nothing to promote the wellbeing of local communities.

If properly assessed, considering social, health, environmental and fiscal costs, the Compass contract could have been an opportunity to promote healthy eating and put money into the pockets of the local community, instead of becoming the liability that it now must be. A stunningly innovative and mutually beneficial result could have been achieved by ensuring that where possible all food was sourced locally, our food waste composted rather than sent to landfill, and compost returned to the suppliers to grow more food.

The Environmental Sustainability Advisory Group at Counties Manuaku DHB has since developed a business case to make better use of our food waste, which at present goes to landfill and thereby incurs a charge. Landfill prices will steeply rise in the near future. The option chosen is one using the compost for community gardens to promote healthy eating. This approach is used in the Wiri Men's Prison, with their compost being used to grow their own vegetables. We understand that the Compass contract is deadlocked and wonder whether this proposal might be a way of restarting negotiations with them to reconcile around agreed priorities.

A second example is the poor state of buildings at Middlemore (and most likely elsewhere across the public sector). Buildings account for at least 20% of our country's carbon footprint and the operational costs of a building over its lifespan is usually 10 to 12 times more than the initial cost of construction. Requests for capital investments (new buildings) in health are referred to the Capital Investment Committee and they in turn provide advice to the Director General of Health and the Ministers of Health and Finance to ensure that government objectives are appropriately prioritized in the decision-making process. This is a reliable and sound system but sadly the process is skewed toward valuing short term costs over opportunities for longer term savings.

If social, health and environmental costs had been factored in, and more paid up front to meet the cost of constructing efficient buildings, outcomes would be far better.

US ANALYSIS OF HEALTH BENEFITS

The benefits of this approach have been elegantly demonstrated in a paper recently published by a group of experts from Harvard University. They examined a subset of green-certified buildings over a 16-year period in six countries including the United States, China, India, Brazil, Germany and Turkey. In that time these green buildings saved $7.5 billion in energy costs and $5.8 billion in climate and health costs.

In the United States alone the health benefits derive from avoiding an estimated 172 to 405 premature deaths, 171 hospital admissions, 11,000 asthma exacerbations, 54,000 respiratory symptoms, 21,000 lost days of work, and 16,000 lost days of school.

It is clear New Zealand will not become net carbon neutral by simply saying it will. We will only reach our goal if all parts of society contribute, including the considerable public sector, which tends to be more conservative than the private sector.

Our story is a simple one that started with a small group of committed people, a goal, and a method and with measures to guide our progress. The gains made to date are there for all to achieve and that will be our focus from now.

THE CALL TO ACTION

In summary, our network is strongly advocating that:

- All DHBs join the CEMARS programme, use the same definitions and measures to work together and learn from each other, accelerate each other's progress in reducing emissions, improve health outcomes and reduce costs. We believe a consistent approach typified by the CEMARS methodology of target setting, measurement, management and third-party independent verification of progress to reduce emissions should be adopted by the entire NZ public sector for those very same reasons.
- The Ministry of Health actively promotes and assists DHBs in this work.
- Health care organisations, especially DHBs, should develop climate change adaptation and mitigation plans, as well as a detailed plan to become net carbon neutral by 2050. Ideally, the DHBs should work together to develop areas where there is common ground and make suitable additions that that are specific to their area.
- The Government and Ministry of Business, Innovation and Employment adjust national procurement requirements to mandate Pharmac and other public sector procurement agencies to account for environmental and social costs in its purchasing processes. The Minister of Health's recent Letter of Expectation to Pharmac opens the door for further discussions about the need for them to account for the carbon costs of medicines and devices associated with their manufacture, transport, use and disposal.
- The detailed business cases for new capital works across the public sector must include options that clearly define the long-term savings in operational costs and improved productivity that arise from differing levels of upfront investment in the design and build process, and that this approach be standardised.

CONFERENCE RESOLUTIONS ON CLIMATE CHANGE

The ASMS Annual Conference last month passed two resolutions with regard to climate change:

1. That members be encouraged to contemplate the full cost of CME-related air travel, including atmospheric carbon release. To that end, members should consider carbon offsetting, and the ASMS support employer reimbursement of air-travel related carbon costs as part of legitimate CME travel expenses. The ASMS itself should move to routine carbon offsetting for work-related air travel for its employees, and its members.
2. That the Association endorse the position statement of the New Zealand Medical Association on 'Health and Climate Change' October 2018.

Please see also an ASMS media release on this issue, urging the health sector to take a lead in the fight against climate change: **https://www.asms.org.nz/news/asms-news/2018/11/29/senior-doctors-urge-action-on-climate-change/**

ABOUT ORATAIAO: THE NEW ZEALAND CLIMATE AND HEALTH COUNCIL

http://www.orataiao.org.nz/

OraTaiao is a health professional society concerned with:

- realising the health gains that are possible through strong, health-centred climate action
- reducing the health sector's contribution to climate change
- raising awareness and taking action to reduce the negative health impacts of climate change
- highlighting the impacts of climate change on those who already experience disadvantage or ill-health (equity impacts).

The organisation is part of a worldwide network of similar professional societies and health organisations urgently focusing on the health challenges of climate change and the health opportunities of climate action.

The Council is a not-for-profit, politically non-partisan incorporated society and relies entirely on membership subscriptions and donations for its operations.

DR ROBYN CAREY IS THE CHIEF MEDICAL OFFICER OF SOUTH CANTERBURY DHB, AND CLINICAL DIRECTOR OF THE EMERGENCY DEPARTMENT.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

Before I went into medicine I had completed a Bachelor of Arts in sociology and education, then an Honours degree in Philosophy at what was then Victoria University of Wellington. Following that I went to Princeton University and completed a master's in philosophy. But I always had a feeling that with academia, unless you were absolutely exceptional, your potential to do human good was limited. I wanted to help people.

I worked at a medical ethics organisation called Public Responsibility in Medicine and Ethics in Boston, MA while I was trying to decide what to do with my life, and also volunteered at a hospice. That's where I decided that medicine would be a good combination of intellectual and worthwhile work for me.

I have a high level of job satisfaction working in medicine. It is intellectually challenging, practical and intrinsically meaningful.

I am a Fellow of the Division of Rural Hospital Medicine New Zealand (DRHMNZ) and also a Fellow of the Royal New Zealand College of Urgent Care (RNZCUC).

I've been working at South Canterbury DHB in the Timaru Hospital Emergency Department since 2001.

I recently took on the position of Chief Medical Officer and I'm the first female in South Canterbury to be employed in that role.

WHAT DO YOU LOVE ABOUT YOUR JOB?

In my clinical work, in the department I work for, there aren't any middle level staff. There is an onus on the emergency department to provide a diagnosis and the initial treatment or a practical procedure before we send patients on. We don't just triage, and I like that. It can be very satisfying. There's also a good variety of work.

I've been the Clinical Director of the Emergency Department since October 2016, and through that position, and the cooperation of the Senior Leadership team, I've been able to increase staffing and make changes that have been really rewarding and I hope I provide an improved service to the public.

WHAT ARE SOME OF THE MOST CHALLENGING ASPECTS OF PRACTISING MEDICINE/BEING CMO IN THE CURRENT HEALTH ENVIRONMENT?

Recently the opportunity arose to apply for the position of CMO, which I did. I gained the job in January this year, and with that is whole new set of challenges. Having worked in the clinical director's role previously was great preparation, but being the CMO carries new responsibilities in all aspects of the DHB. But it's also a great opportunity to learn more about the job and medicine in general.

Working in the Emergency Department has given me a good base for being CMO because of the contact I had with others in the hospital, and also with general practice and other referrers.

HOW DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

I've always found ASMS very supportive.

There were guidelines in the MECA that were very influential in informing our job sizing in the Emergency Department when we expanded. ASMS Industrial Officer Dianne Vogel was also very supportive of me personally and of the job sizing exercise. She's been very available to me which I've really appreciated, and I'd like to thank her for the support.

As well as that, I attend JCC meetings when possible and the ASMS presence is a good reminder that ASMS is always on hand when it comes to issues that arise from time to time.

WHAT HAVE YOU GAINED OR LEARNED FROM YOUR ASMS INVOLVEMENT?

I've mostly appreciated the tailored advice from the ASMS industrial officers on contract stipulations, employment relations, conduct and the various growth opportunities. The local ASMS reps, Dr Matthew Hills and Dr Peter Doran are also very approachable and provide valuable advice on work force issues.

VITAL STATISTICS

PERCENTAGE OF FEMALES ENROLLED IN NEW ZEALAND MEDICAL SCHOOLS: 56.3%

Specialties with 50% or more females in vocational training:

Clinical genetics	50%	Pain medicine	67%
Dermatology	100%	Palliative medicine	90%
Emergency medicine	52%	Pathology	56%
Family planning	100%	Public health medicine	67%
General practice	65%	Rehabilitation medicine	67%
Musculoskeletal medicine	50%	Rural hospital medicine	59%
Obstetrics and gynaecology	82%	Sexual health medicine	100%
Paediatrics	71%		

SOURCES:
Medical Deans: 2017 Medical Student Statistics
MCNZ Workforce Survey 2016 (updated June 2018)

SEASON'S GREETINGS

The ASMS National Executive and national office staff wish you all a safe and happy holiday season. The national office will close early on the afternoon of Monday 24 December 2018 and reopen on Thursday 3 January 2019. If you have an urgent query over this period, please email sl@asms.nz and someone will get back to you.

DID YOU KNOW

...ABOUT CLOSE-DOWNS?

An employer can close its operations or discontinue the work of one or more employees over the Christmas break and require employees to take annual leave. This can only be done in limited circumstances though and you are entitled to not less than 14 days' notice. If you are asked to work at any time during the close-down though (including being on call), the close-down does not apply to you. If your employer proposes a close-down, it is well worth contacting your Industrial Officer to discuss the requirements.

...ABOUT PUBLIC HOLIDAYS?

If you would normally work on a public holiday, you are entitled to a day off on full pay. If you actually work or are on call on "any part of" any of these days, you are entitled to a day-in-lieu on full pay at a later date, plus your usual pay for the day worked, plus a loading of 50% of your "relevant daily rate" for every hour worked on the public holiday. The loading would not apply though to any existing T1.5 arrangements.

If you are a shift worker, eg, in ICU or ED, and you have a rostered day off on a public holiday, you are entitled to a day-in-lieu on full pay on another mutually convenient day.

HISTORIC MOMENTS

EACH ISSUE OF *THE SPECIALIST* WILL FEATURE A PHOTOGRAPH OR DOCUMENT FROM THE ASMS ARCHIVES. YOU CAN FIND MORE SLICES OF HISTORY ON THE ASMS WEBSITE (**WWW.ASMS.NZ**) UNDER 'ABOUT US'.

Executive Director's Column

Ian Powell

Changing Times

Times are certainly changing in the industrial relations area particularly insofar as employees in the state services including doctors and dentists are concerned. I remember reading over 15 years ago an article which argued that it was only a matter of time before "white-collar" employees and professionals would be unionised.

At the time I thought this was simply crystal ball gazing and naive speculation. However, the dramatic legislative changes effective from 1 April 1989 in the form of the State Sector and Area Health Boards' Amendment Acts have demonstrated the accuracy of this hypothesis. The effect of these legislative changes was both to merge the industrial relations system applying to both the private and the state sector together under the Labour Relations Act (in fact, this merger was really extending the private sector system across to the state sector) and taking out groups such as senior doctors and dentists from the auspices of the Higher Salaries Commission.

One of the effects of the new environment is that doctors and dentists are now seen as workers. However, the term worker is used in a *legalistic* rather than in a colloquial sense. Under industrial law the term worker has a specific legal meaning and is sufficiently embracing to include all those people employed on wages and salaries regardless of their level of income or status. In a legal sense the term worker is not confined to people employed in "blue-collar" or lower paid jobs.

As a consequence of the legislative changes and the wider definition of the term worker, the scope of unionism has also changed. Traditionally unions have been seen as representing "blue-collar" workers with some limited extension into the "white-collar" area. The historical basis for the terms blue and white-collar originated with the notion that people who worked in manual occupations or with their hands could not wear white collar shirts because the dirt would show too easily. Therefore they were called "blue-collar" workers. Gradually over the years unionism has extended in scope to cover a number of "white-collar" occupations more so in the state rather than the private sector. The new environment now means that unionism has gone well beyond its "blue-collar" and cloth cap image to incorporate the wider definition of worker and, in particular, to encapsulate salaried professionals such as doctors and dentists.

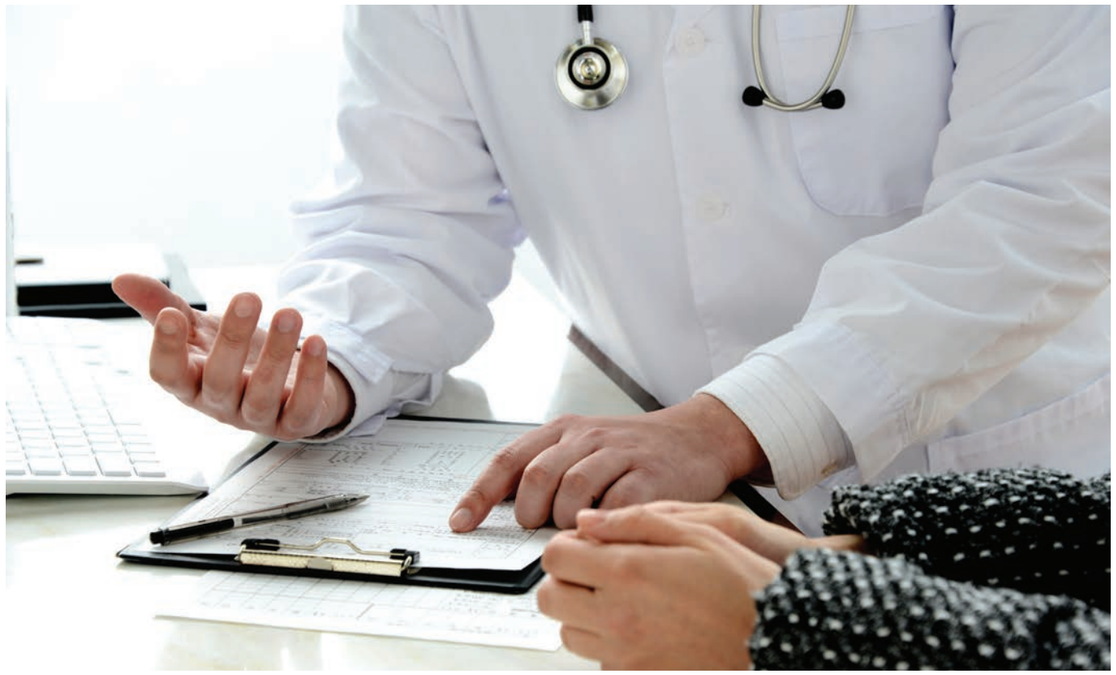
The new environment also means that the distinction between what is professional and what is industrial is becoming increasingly blurred. In the case of teachers, the provision of sufficient teaching tools and resources along with access to in-service courses is becoming increasingly as much a condition of employment requirement as a professional matter.

Already the Association has made a submission on an issue that traditionally may have been seen as the prerogative of the NZ Medical Association. The informed consent issue not only has serious implications for the quality and quantity of patient care, but also because of its impact on their routine working life has significant implications for the ability of health professionals to perform the requirements of their employment. As such informed consent is also a condition of employment issue.

The new environment is now with us and may well survive any swings on the electoral pendulum. The Association therefore has a critical role on behalf of senior doctors and dentists in ensuring that they are well and effectively represented under the new rules of the game.

Ian Powell

ASMS Newsletter No. 1, October 1989



SUPPORTING DOCTORS IN DIFFICULTY

DR LYNNE MCKINLAY | BMEDSC, MBBS(HONS), FRACP, FAFRM, FRACMA, SENIOR MEDICAL EDUCATOR, COGNITIVE INSTITUTE

'The vast majority (of doctors) practise medicine of very high quality. A small proportion practise at a standard that is not acceptable, whether through inadequate training, insufficient support, ill health, lack of motivation, or, on rare occasions, malice. Most doctors know of another doctor whom, on balance, they would prefer not to treat their own family.'[1]

'...rude language and hostile behavior among health care professionals goes beyond being unpleasant and poses a serious threat to patient safety and the overall quality of care.'[2]

These two quotes illustrate the two predominant issues facing medical practitioners who find themselves in difficulty with regulators, ombudsmen, employers or complaints systems. The first being below-standard knowledge or skills, the second referring to attitudes and behaviours, which pose a threat to patient care and teamwork.

Despite more than 10 years having passed since these words were written, clinicians continue to find themselves facing complaints or disciplinary action and the question arises on how best to support them, and what kinds of programmes or remediation are available to help them improve their skills in order to continue to practice.

Vukmir[3] identifies three types of difficulty which may threaten the safety of patients and adversely impact the career and reputation of a doctor and their employer.

There is the clinician who is technically incompetent, lacking skill in providing consistent, quality care (which may include deficiencies in skill, training, experience, or expertise). Secondly the doctor who

Redefining those behaviours as undermining a culture of safety takes a patient-centred focus and this language reinforces the importance of behaviour that promotes teamwork and safety.

Formal complaints are likely to be the tip of the iceberg comprised of a larger number of injured or dissatisfied patients who never complain.

is impaired, having transiently limited capability because of a medical condition, mental illness or substance abuse. Lastly, the doctor may demonstrate attitudes or behaviours that undermine a culture of safety. They may be technically competent - even technically excellent - but their performance is let down by limited non-technical skills, such as poor communication.

This article focuses on what kind of support should be considered for those in the last category of difficulty, those who demonstrate behaviours or communication skills considered unprofessional.

These behaviours may include what is often referred to in the literature as 'disruptive' behaviours, defined as 'the use of inappropriate words, or actions and inactions, which interferes with (their) ability to collaborate, or may interfere with the delivery of quality health care or the safety or perceived safety of others'[4]. The term disruptive tends to imply overt or aggressive problem behaviours, whereas the interactional styles that are passive or passive aggressive may be just as much a risk to quality of care and teamwork.

Redefining those behaviours as undermining a culture of safety takes a patient-centred focus and this language reinforces the importance of behaviour that promotes teamwork and safety.

While defining problem behaviours is important, it is also important to consider which actions, while at times challenging or confronting for managers and colleagues, probably should not be considered disruptive[5,6], including:

- healthy criticism offered in good faith, such as feedback while teaching or during a performance review
- making a complaint
- good faith advocacy for patients
- raising a concern
- criticism of the established system through appropriate channels
- presentation of controversial ideas.

You could argue that many of these actions are critical to robust discussion, quality improvement and forward-thinking health care. However, well intended clinicians trying to effect change or influence their organisation to improvement, can find themselves in difficulty if the behaviours they exhibit while doing so are perceived as bullying, threatening or unprofessional.

WHAT IS THE EXTENT OF THE PROBLEM?

The presence of disruptive behaviour in our health environments is unfortunately not a rare event, with the international literature suggesting 89-96% of clinicians report witnessing disruptive behaviour[7], 70% report being treated with incivility, 49-63% report being subject to bullying or harassment[8], and 75% of health care workers report being concerned about a peer's poor teamwork[9].

In Australia, 25% of the medical workforce report bullying or harassment, with 44% reported to be from senior doctors[10].
In New Zealand, a recent study of 1759 registered medical and dental practitioners found that 37% of respondents reported having been bullied to some degree in the prior six months, from very rarely to almost daily, with 2.5% reporting that they had been bullied either several times a week or almost daily[11].

Despite the high frequency of such concerning experiences, the actual number of clinicians demonstrating such behaviours is not large, with studies suggesting prevalence is about 3-6%[12].
This aligns well with the published evidence on formal complaints to the health service commissions in Australia, as a possible indicator of professionalism. In a study of all registered medical practitioners in seven jurisdictions, Bismark and colleagues[13] found that 88% of doctors never received a complaint, with 3% of doctors accounting for 49% of complaints, and 1% receiving a quarter of all complaints. The distribution of complaints is heavily skewed to a small cohort. Of further interest, subsequent study has shown that after a complaint to the regulator there is a sharp increase in risk of a subsequent complaint in the following six months.[14,15]

These authors proposed that we should consider treating complaints like sentinel events[13]. Formal complaints are likely to be the tip of the iceberg comprised of a larger number of injured or dissatisfied patients who never complain. If that is the case, it makes sense to identify doctors at risk, and to intervene early after the first event or complaint, to provide remediation for the non-technical skills of these doctors.

WHAT DOES THE LITERATURE SUGGEST CAN BE DONE?

Leape and Fromson[16] published early on the link between disruptive behaviour and patient safety. They suggested that an organisational approach is required.

Health care organisations need to adopt and promote standards, be they a statement of values, code of conduct, by-laws or behavioural expectations. Explicitly stating expectations allows leaders and managers to require compliance, and to support this through regular monitoring of performance, and effective feedback and early intervention to correct deficiencies or deviations from expectations.

Education in communication skills for the doctors identified as needing remediation is important. The Vanderbilt Center for Professional Health (CPH) provides an example of a programme offering intensive education for remediation for physicians demonstrating distressed behaviour[17].
Equally important may be education for those who need to provide feedback, have a challenging conversation, or provide coaching or mentorship.

Building on a technique of peer mentorship called academic detailing, which has been shown to be effective in correcting inappropriate antibiotic prescribing practices by clinicians[18], there is good evidence to support the effectiveness of non-judgemental feedback by a peer about a colleague's undermining behaviours to influence their future behaviour. This feedback allows a colleague to gain insight into their behaviour and the impact it is having around them, and the majority go on to modify their own behaviour going forward. This peer feedback model forms the basis of the well-established Vanderbilt Center for Patient and Professional Advocacy model, being rolled out in the Asia-Pacific region as the Promoting Professional Accountability Programme[19].

Another programme with demonstrated success has been an intensive, small group education programme, that uses actor facilitated training and physician coaching over a number of contact episodes that focus on developing communications skills.

Between 2005 and 2010, 145 physicians with a measured high medico-legal risk profile attended the Clinical Communication Programme. The numbers of events (claims, pre-claims, disciplinary

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actions and referrals to regulator) were examined before and after the intervention. The number of events per year declined markedly and significantly, from 0.42 events per member year to 0.26 events per member year, and these results were sustained, despite these doctors considered to be from the highest one percent of the high-risk group[20].

Communication skills training can influence future behaviours. One-on-one communication skills training and physician coaching are other methods to provide skilled, personalised support for these otherwise high-performing clinicians. All of these programmes are available through the Cognitive Institute.

One last thought for your consideration: it is important to remember that a doctor in difficulty may be impaired by illness, addiction or burnout, so there is great value in approaching the issue from a wellness perspective, ensuring the best care for both patients and clinicians.

CONFLICT OF INTEREST STATEMENT

Lynne McKinlay works as a Senior Medical Educator for the Cognitive Institute, part of the Medical Protection Society. The Promoting Professional Accountability Programme is delivered by Cognitive Institute.

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