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The Specialist

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ASMS
TOI MATA HAUORA
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Teaching Doctors: time for a culture change?

Peter Roberts, Postgraduate Mentor CCDHB, RACP [Adult Division] CPD Director, Fellow Academy of Medical Educators, ASMS Life Member and former President.

Doctors' practice and their knowledge, skills and attitudes toward teaching have been under review for a number of reasons. Many of us have a fundamental misunderstanding about the nature of the apprenticeship model and put the master, rather than the novice, at the centre. In addition, the way doctors learn is rapidly changing because of technological, sociological and pedagogical advances, but learning-by-doing is becoming progressively harder to accomplish in the face of competing value systems and organisational culture.

Due to single-minded pursuit of organisational efficiency – measured by throughput criteria – we face a crisis in giving new learners adequate access to experience-based learning as well as a means to provide timely feedback to practitioners in danger of falling behind in their knowledge or keeping their skills honed.

Continues next page

ASMS 25 YEARS OF ENGAGEMENT 1989-2014

A very special issue

We're delighted to bring you the 100th edition of The Specialist. Since the ASMS was formed 25 years ago, we've been publishing a magazine for members four times each year. Inside, you'll find lots of great reading– in-depth, relevant and offering fresh perspectives. We start a new regular feature in this issue to profile ASMS Branch Officers and once again we showcase two great cartoons by Chris Slane. Happy reading!

In this issue

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Every registration body in the world, as well as the vast majority of professional colleges, has recognised the limited medical educational skills available to provide learners guidance, objective assessment and well-informed mentoring/supervision. We simply don't have a teaching workforce up to the job. The Medical Council of New Zealand *Curriculum Framework for Prevocational Medical Training* requires a major commitment to teaching by many DHB-employed doctors as well as GPs, who must provide fully accredited clinical attachments for trainees by 2015. Supervision has often been practised as bullying-in-disguise or criticism of trainees' 'time management' and is more related to task specification than guidance and support of learning on the job.

Not only must we educate the next generation but we also need to keep educating ourselves, documenting our own learning and inviting constant real-time assessment to show we are 'fit for purpose'.

The apprenticeship model

Before the word doctor meant a practitioner of healing arts, it meant teacher, in particular, an especially learned person authorised and qualified to teach a particular subject.

Unfortunately, some of us think that trainees need only 'watch us work', memorise our lists, follow our rules and learn 'by example.' Some have come to think we set an ultimate standard and the apprentice either reaches it or they don't. In fact, research has shown that far more trainees look to those who take a personal interest in them for their role model rather than the great expositor of facts or a much-lauded researcher.

Seniors provide the confidence to question and 'have a go', safely, the feedback of a learned supportive eye and the values that can define a job well done. They provide fair assessment and on-the-spot feedback. The entire learning environment is often the master's greatest accomplishment.

Learning theory

Would any of us trust a practitioner who had no theory of what they were doing? And yet, many of us try to teach our art with little or no theoretical background, much less actual training by those with recognised 'expertise'.

Besides behavioural learning, cognitive learning studies have shown how knowledge is built, stored and retrieved in clinical reasoning. In essence, we must know when we are following intuition and when we are using analytical thought processes. If we can recognise these aspects in our own reasoning, we can better guide those who wonder, or don't, at our judgment.

We often think of medical education as a highly academic process creating scientists who follow completely logical principles to arrive at the clearest path for action every time. However, that is not how doctors think, much less how we behave. Doctors are actually practitioners who have far more variables than could possibly be handled in a purely scientific manner.

Memory – verbatim or gist?

We depend on many different aspects of memory in our practice. As young practitioners we pass exams in which

assessment depends on 'verbatim' memory. However, with the passage of time, we rely more and more on 'gist' memory. This memory understands the nature of relationships at a more fundamental level and we anticipate the models recognised at a deeper level, even if we are not totally 'up-to-date' with the most recent verbatim information that may just be coming into regular use.[1] Both forms are important to practitioners, but mitigation of verbatim memory deficits is relatively easy – access to new information, while loss of gist memory requires a highly structured process of 're-learning', something quite hard to do.

Learning on the job, like learning to drive, requires the learner to 'overlearn' – ie, use the knowledge and practise the skill beyond the point where they need to think about what they are doing, just as we can find that we have driven a familiar route 'automatically'. Herein lies one of the roles of clinical educators- developing the means to safely allow this sort of learning from mistakes, often by telling stories on ourselves, without injuring patients.

Trust

Doctors must be able to demonstrate attainment and maintenance of levels of expertise in ways that everyone can trust. How can we know we can trust our colleagues as they train? For that matter, how do we know that a practitioner has kept his/her skill levels at an acceptable level? One way would be to create regular, standardised scenarios in which both generations of doctors can be assessed on their knowledge, skills and even attitudes. If they are performing these tasks together, they also socialise in a controlled environment where errors are not reasons to blame or criticise, but lessons to be learned and applied in real life.

What grows out of such an interaction is not only an individual's sense of accomplishment, but a greater knowledge of how other people perform and a shared 'mindfulness' which is critical to maintaining safe behaviour.

Culture changes necessary

The managerialist focus on 'command and control' to rack up throughput has replaced many of the finest aspects of doing/being the doctor/teachers' traditional role with the next generation.

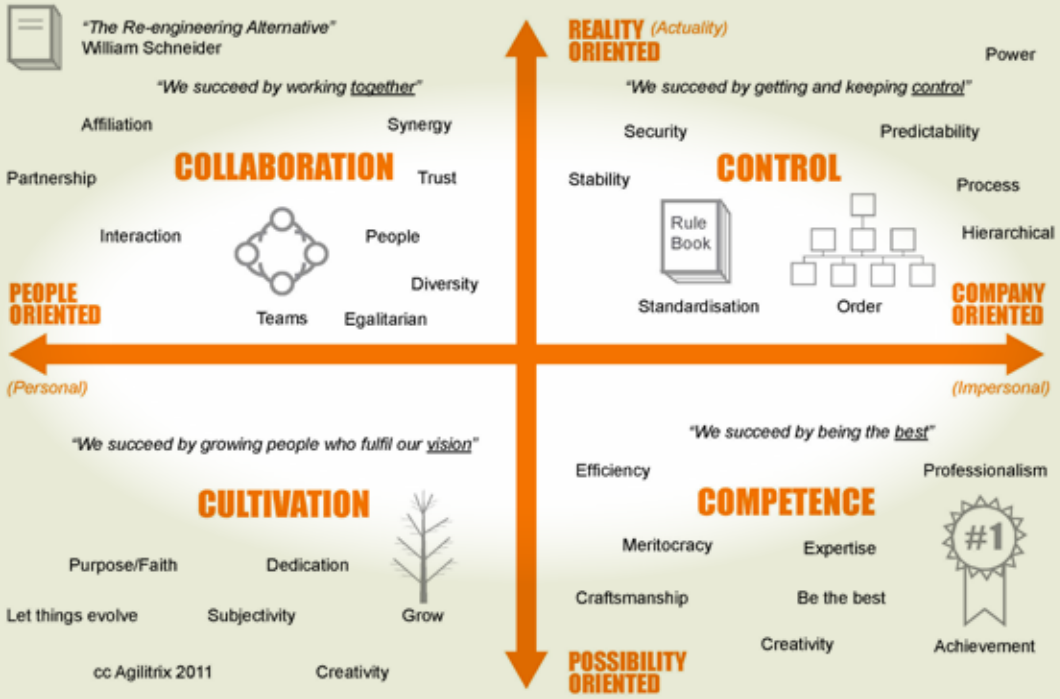
William Schneider has drawn the clash of cultures as a tension between orientation towards reality over possibilities and organisational – versus people-oriented goals [below]. An organisation that refocuses on the cultivation of learning and collaboration among professionals offers a great deal more toward the future and engenders an environment where teaching and learning from experience once again become part of the nature of things.

**This is an abridged version of a longer article by Peter Roberts, which can be read in full on the ASMS website http://www.asms.org.nz/perspectives/*

"We are social beings and learn best when immersed in meaningful activities and in an environment that is supportive and full of opportunities."

Tim Wilkinson, NZMJ 2007

Organisational cultures concerning goals and orientation toward production or people



Schneider, W. (2000) The Reengineering Alternative New York, McGraw-Hill.

1 Lloyd, R., Reyna, V. Clinical Gist and Medical Education: Connecting the Dots JAMA 2009; 302: 1332-1333.

DEPUTY EXECUTIVE DIRECTOR

A snapshot of SMO staffing in District Health Boards

Between 14 May and 6 June 2014 the ASMS asked members at district health boards (DHBs) to participate in an electronic survey to provide a snapshot of SMO staffing in public hospitals. We received 637 replies from 384 different departments. The survey results give us a better understanding of staffing levels and the recruitment challenges facing departments, and we will build on this with a follow up survey further down the track.

Recent recruits

We asked respondents whether the most recent vacancy in their department was filled by an overseas or New Zealand-trained applicant.

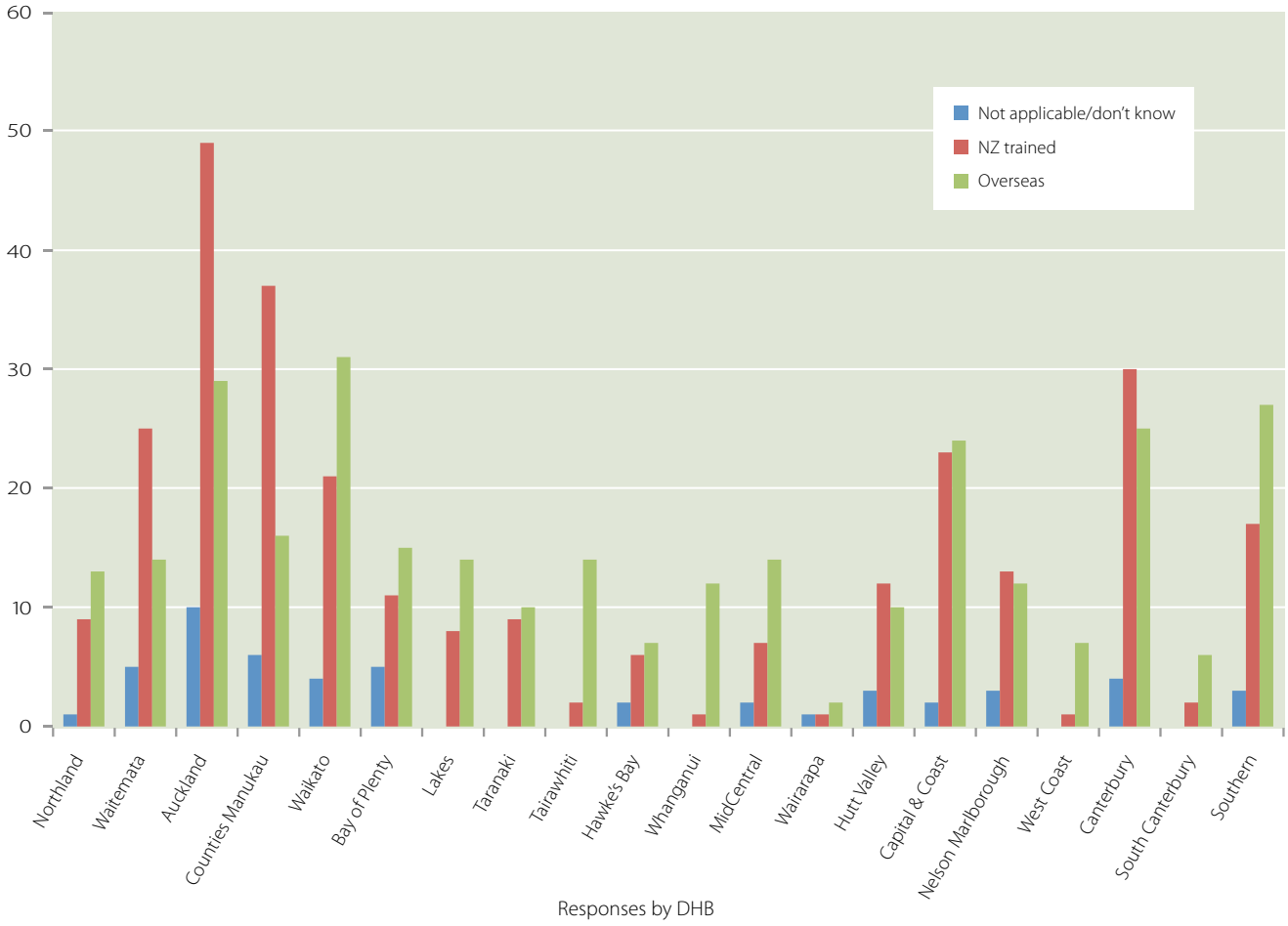
Graph 1 shows that members at the three Auckland DHBs appear to have had their latest service or departmental vacancies filled by a New Zealand-trained recruit, by a large margin. A second group of DHBs is fairly evenly split between overseas recruits and New Zealand-trained applicants (Canterbury, Capital & Coast, Hutt Valley, Nelson Marlborough and Taranaki). For all other DHBs (big and small), the last departmental recruit was from overseas, sometimes by an overwhelming margin of respondents.

"We are exclusively staffed by overseas trained doctors. I am unaware of any NZ trained doctor even applying to our department at least in the past 6 years."

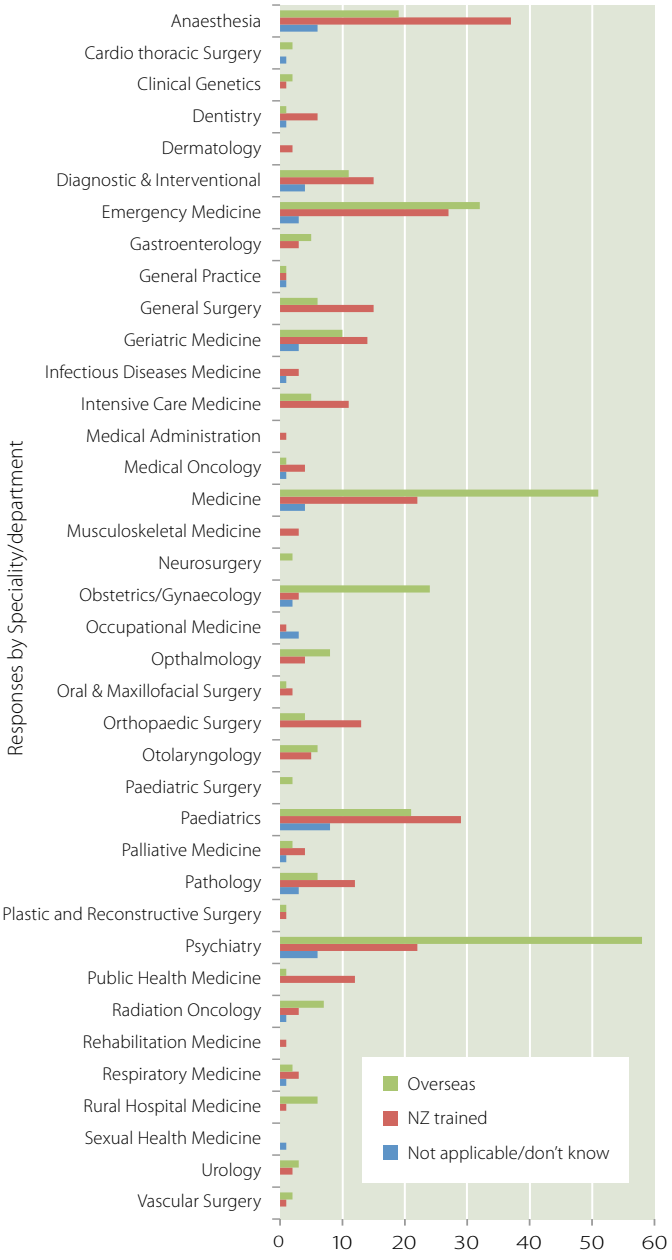
Often this was not viewed by respondents as a problem where the excellence of recent overseas appointees was noted. However:

"First and only New Zealand candidate excellent… Challenge in provincial post to have generalists with community and cultural awareness and motivation to address disparities whether IMG or local. (Local grads have fewer reasons to be unaware or detached from the issues)."

Graph 1. Was the most recent vacancy in your DHB filled by an overseas or NZ-trained applicant?



Graph 2. Was the most recent vacancy in your DHB filled by an overseas or NZ-trained applicant?

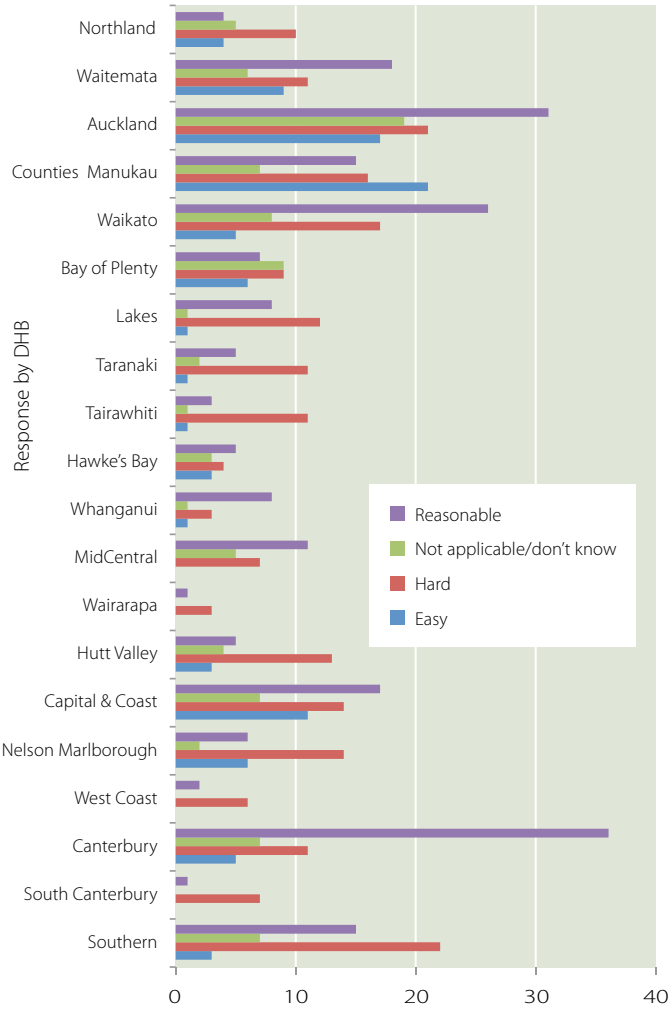


Graph 2 shows responses to the same question but from the perspective of individual specialties, rather than DHBs. In some specialties the number of responses was too low to draw even the most general of conclusions. However, most members in hospital anaesthesia departments reported that their most recent recruits had been New Zealand-trained, as did diagnostic and interventional radiology, paediatrics, general surgery, geriatric medicine, intensive care, orthopaedic surgery, pathology and public health medicine. Some of these specialities are those with substantive private practice opportunities particularly in the surgical and diagnostic areas. It is interesting that the arguably largest of the generalist specialities paediatrics is also in this category. By way of comparison, most respondents in psychiatry, obstetrics and gynaecology and medicine reported that the last recruit in their specialty came from overseas.

Filling vacancies

Members were asked to rank the difficulty of filling vacancies in their service or department. 35% of respondents said it was hard to fill vacancies. 35% said that it was reasonably easy to fill these gaps. Another 15% said that it was easy to fill the vacancies in their service or department. Looking only at those who answered the question 41% reported that vacancies were hard to fill.

Graph 3. How easy is it to fill vacancies in your service/department currently?



Difficulty in recruiting occurred for a number of reasons, based on the comments we received, but onerous after-hours call was mentioned by many.

> *"Need the right people with work life balance in mind and prepared to do the increased frequency of call. Life in rural New Zealand."*

> *"Major issue is with suitability of applicants ... not locally sensitive and need degree of independence and experience to safely work here."*

> *"It has been very hard in recent years as all our trainees want to work in Auckland and our last four consultants have been from USA and UK. I am currently the only NZ trained surgeon working in active clinical work in the public sector."*

Coupled with other workload demands the situation proved intolerable for some SMOs:

> *"The requirement to provide ward cover, GP advice and do specialist outpatients clinics simultaneously during the day (as well as one call out of hours) is intolerable and I will therefore leave…. Much as I like New Zealand and enjoy many aspects of the hospitals work, I am too old to endure this crap any longer."*

Hiring freeze?

Nationally, 29% of respondents said their service or department was recruiting. Of that group, 57% reported they were looking for one SMO, with 24% reporting recruitment for two SMOs and 7% for three (1% of respondents indicated that their department was looking for four SMOs and another 1% for six SMOs).

Despite this several DHBs appear to have an explicit staffing freeze in place. Many respondents explicitly commented on this at Auckland DHB and Capital and Coast DHB in particular. One department appears to be looking at losing accreditation because of the freeze.

Other respondents reported that their DHB was likely to delay filling vacancies or cancel funding.

> *"Tendency of the organisation to delay advertising vacancies several months then with generally slow process is about six months or more after the previous person signalled resignation before it is filled."*

> *"Ignoring [request for more staffing] so can balance finances at the cost of patient care."*

> *"Each time a doctor has resigned this position has not been reallocated and we have lost the funding."*

> *"Moratorium from DHB on recruitment to additional positions."*

Extent of shortages

We asked how many FTE positions they believed their department should have, which we then compared with their responses about current FTE. An attempt was made to control for duplication of response in respect of the same department. (The answers to this question were somewhat compromised by the failure of the drop down menu to allow for other than whole numbers).

Of the responses 84% said they needed additional SMO FTE – 49% of departments said they needed at least one to two more FTE; 16% said they needed three to four; 9% said they needed between five and nine more SMOs and 4% said they needed more than 10 more FTE in their department. In contrast, 21% said that the FTE in their department didn't need to change and 1% of people said they needed fewer FTE.

The most common reason given for the need for extra staff was increased workload or unmet patient need and patient safety.

Some respondents reported a satisfactory situation:

"We are an identified area of need by Government and have had a huge increase in demand. I do feel that management has been sympathetic and helpful to our needs."

"Good staffing levels and plenty of interest from local and overseas trained specialists to come and work here."

"Not needed. We have good succession planning/recruiting. We advertise when the doctor we want is ready."

"We are currently lucky to be adequately staffed with a fantastic bunch of SMOs – long may that continue!"

"Much better than it was a few years ago and manageable with our current FTEs but nevertheless an exhausting and stressful job at times and relentless in terms of on call and acutely ill patients."

Though they were not explicitly asked a question on this issue, 135 out of 637 respondents (21%) commented that their department was not able to recruit because the DHB was either not prepared to fund positions or had no money.

"No money … unless we make a balls up due to short staffing and then I am sure there will be plenty."

Sometimes respondents mentioned a recent job sizing showing that more SMOs were needed or a College visit suggesting additional SMO staffing. However, the most common reason given for the need for extra staff was increased workload or unmet patient need and patient safety.

"We are seeing a greater number of presentations … and are always playing catch up. At present we are staffed for 150 presentations per day but are seeing more than this number especially on weekends."

"I could write a book on this. … services for children with chronic disability are low priority when compared with services for acutely ill children."

"Clinical Pathology services are woefully under resourced nationally and regionally. There are increasing demands on us to lead national programmes, deliver newer initiatives such as the HQSC etc. We need more!"

"We have service growth of 6% per year but have been told we will not receive any growth in medical or nursing FTE to deal with this. We have been in this situation for I think at least three years."

"Ongoing lack of staff. Constantly being asked to do extra operating lists and clinics."

"Currently declining referrals to meet waiting time limits."

"It is now getting to the stage where we are trying to do work-arounds to improve the situation on weekends which are fraught with dangerous near misses due to patient volumes, higher acuity and the difficulty in patient flow."

A number of SMOs mentioned problems caused by a freeze on non-medical hiring.

"There has been a 24% population growth since the last increase in non-medical FTE. … SMOs effectively cover for a shortfall in non-medical FTE."

"There is a lack of administrative support for the department …. adding to the physician workload and subtracting from patient care time, there is a shortage of allied health personnel."

"Concerns also about clerical staff shortfalls inc. stress for remaining clerical staff and resulting in patient clinic/operating cancellations."

"For the past year there has been an FTE psychology position vacant which has not been advertised. The absence of this position increases the pressure on SMOs."

'No vacancy, no recent job sizing, no goal of meeting demand'

In some cases, the comments provided reflected despair that despite substantial patient need, SMO staffing was being frozen. Particularly galling was a failure to recruit despite the relatively new phenomenon in anaesthesia, radiology and emergency medicine at least of excellent New Zealand graduates looking for work. New positions were not being established and an opportunity was being lost, possibly forever, to recruit young New Zealand-trained specialists to meet that need.

"Newly qualified and about to become qualified excellent registrars in the training scheme are unable to become appointed. They are very despairing about this as they have commitments to Auckland... but will inevitably go overseas if they can't find work."

"We need more SMOs. We currently cannot cope with the workload. Lots of excellent NZ trained registrars available for consultant positions."

"We are currently unable to sustain the workload … This is due to ... increased population and increased reliance on imaging for diagnosis."

"We have colleagues including very well qualified FACEMs who are interested in coming here but the DHB claims to have no money. In the meantime the lack of staffing is creating a risk to our patients and is creating tremendous stress to our providers."

National services; the Auckland sub-specialty picture

A slightly different take on the same problem was presented by some Auckland 'super specialties' where respondents lamented that an inflexible approach was not allowing them to take advantage of a recently qualified specialist in their sub-specialty to secure the future. Because of the small size of the specialty, it was unlikely that a trainee would qualify at the exact time that a position was vacant, despite a retirement likely to occur within a few years. This was sometimes despite a demonstrated national need.

"We had a very good trainee looking for FTE ... With nothing available here despite our need she took a job in Brisbane instead so is lost to the New Zealand system."

Angela Belich

NATIONAL PRESIDENT

A birthday wish

25 Years of engagement. We are celebrating the 25th anniversary of the formation of the Association of Salaried Medical Specialists (ASMS).

As a paediatrician I am always fascinated by the natural, unaffected behaviour of young children. Birthday celebrations are no exception. The birthday cake, the excitement, you can see the anticipation build as the candles are lit and, as they prepare to blow them out, someone shouts: "Make a wish!" Now this is the bit that I find fascinating; within seconds the birthday boy or girl performs a very complex, nearly subconscious task. He or she thinks back over the past, considers the current situation and then makes a wish for the future before blowing out the candles with puffed cheeks and great enthusiasm.

We have the luxury to stand still for a bit longer, review and celebrate our past, assess our current situation and make a wish for the future, before blowing out our 25 candles.

> *An old Chinese proverb says: "The best time to plant a tree is 20 years ago. The second best time is now."*

The ASMS tree was planted 25 years ago. Founding National President George Downward and Executive Director Ian Powell would have led the tree planting ceremony. I can picture them, each with a spade in hand, turning over the first sod. That tree has thrived and grown to have strong roots, a big trunk and a lush green, leafy crown. Under the leadership of the immediate past president, Jeff Brown, it was decided that each of the tree's 20 branches should have its own President and Vice President. This has strengthened the tree further and improved communication with all the members in each branch.

We cannot exist without our members. In the past year we achieved yet another milestone: breaking through the 4000 members barrier (and counting). Membership subscription remains high, touching on 90% of eligible SMOs.

National treasure

In 2006, in an address to the New Zealand Society of Hospital and Community Dentistry, Ian Powell suggested the Government should adopt a more positive attitude toward our publicly-provided secondary and tertiary health services by regarding them as a national treasure. Eight years on we find ourselves celebrating in Te Papa Tongarewa (which translates as 'container of treasures'). Coincidence? I hope not. I hope there is an increasing realisation of what a treasure we do have in our public healthcare system. We have every right to be proud of our treasure. Not only are we an integral part of it but we stand at the pinnacle of our public health system, Toi Mata Hauora.

Roul Turley says that financial ruin from medical bills is almost exclusively an American disease. Unfortunately it is a contagious disease and it does not require personal contact to infect its next victim. It spreads through the fibres of the internet, telephone cables, cellular networks, communication satellites and even old fashioned printed documents. It can also rapidly increase its virulence by exporting health care managers between countries. This American disease is showing up elsewhere in the world. I have heard and read that parts of the English NHS are having early prodromal signs and symptoms, and that warnings from its health workers are largely ignored.

We are not immune in New Zealand. We must be vigilant and do everything we can to prevent a situation where personal medical bills can lead to financial hardship or, even worse, the inability to access health care. We are increasingly aware of the 'unmet health need' in New Zealand. We have to protect our secondary and tertiary public health system and by 'we', I mean we as a country, as a government, as the ASMS and as the health care workforce.

Robert Hunter, the first health care manager I worked with in New Zealand, and the person who introduced me to deep sea fishing, observed on more than one occasion that 'if you want to milk the cow, you have to feed the cow.' Wise words. Far too many people are willing to milk the cow but too few are willing to feed it, or even realise the poor animal needs feeding and looking after. This includes looking after and treasuring the health workforce. We are an integral part of the cow and we, too, have a responsibility to feed the cow.

The ASMS has been campaigning, on your behalf, for the establishment of distributive clinical leadership. As individuals we should heed the call (if given the time) and be willing to stand up and be counted and contribute to the system of health care delivery by actively participating in distributive clinical leadership.

Personally I feel that any criticism I have of the health care system is also squarely aimed at myself. I am part of the system and therefore have shared responsibility to look after it and improve it. The Government must also realise that rationing the cow's feed and expecting the same level, or even an increase in milk production, might not be realistic.

Workforce planning

Health Work Force New Zealand (HWNZ) has been tasked to provide the lead in workforce planning, on behalf of the Ministry of Health, but there is a limit to how much they can realistically achieve with a staff of 19 people.

Having said that, HWNZ is consulting more widely than previously, seeking the input from a range of organisations, including the ASMS. This is a positive development. Workforce planning can only be improved by combining the knowledge, data and intelligence each organisation has on the state of their workforce and the challenges they are facing.

The future

> *"A society grows great when old men plant trees whose shade they know they shall never sit in." An old Greek proverb. The modern version will include the ability of old women to plant trees as well.*

This proverb contains important messages that health care could learn from. The selfless act of planting a tree you know you will not benefit from is our contribution to the future and the generations to follow. Far too often we find that decision-making in our health care system is based on perceived short term benefits rather than achieving long term outcomes that might only be realised, perhaps, after our tenure – or even further into the future.

The best time to plant a tree is 20 years ago. Our predecessors had the foresight to plant our tree 25 years ago. The second best time to plant a tree is now. My wish is for the ASMS to continue its tradition of planting trees to benefit the health of generations to come. We have the knowledge and the skill to achieve this but we cannot do it alone. We invite other organisations and sectors of the health care system to join us in our efforts.

Hein Stander

FROM THE 2014 CONFERENCE 25

ASMS Commemorative Conference, 26 August 2014

More photos can be viewed at www.asms.org.nz

ASMS RESEARCHER

Taking the temperature of New Zealand's medical workforce

New Zealand's public health system is under pressure. Many people are struggling to get onto hospital waiting lists for surgery or to see a specialist, senior doctors are working longer and harder to cover staff shortages, and hospitals are spreading themselves more thinly than ever in order to do more with less money.

The Association of Salaried Medical Specialists (ASMS) is concerned about the pressure on the medical workforce and what this will mean for the provision of future health care.

After analysing the best available evidence, ASMS has prepared an update on the state of New Zealand's public hospital specialist workforce. It follows on from three major reports.

Summary

The pressure points on the supply of specialists

Between medical school graduation and vocational registration, many New Zealand doctors leave to practise overseas, which has contributed to a heavy dependence on international medical graduates (IMGs).

Retention of international medical graduates (IMGs)

IMG retention rates are even worse than those of New Zealand graduates and our growing dependence on IMGs is leading to an increasingly unstable medical workforce.

Australia's specialist workforce trends

To date, Australia has been the main destination for New Zealand's departing specialists, but conditions in Australia are changing, which may reduce employment opportunities in some specialties and some areas.

The growing importance of other countries for departing specialists

Increasing international demand for specialists, and New Zealand's high and increasing dependence on IMGs (many of whom tend to return to their country of origin), is likely to lead to medical emigration to a broader range of countries in future.

New Zealand's need for a well-balanced workforce

A small country like ours needs a significant emphasis on the generalist nature of specialists, but New Zealand's increasing dependence on recruiting specialists from larger countries overseas, which logically have a greater emphasis on sub-specialisation, is contributing to an imbalance between generalism and sub-specialism.

The changing demographics of the medical workforce in this country

A significant proportion of the specialist workforce is approaching retirement age, while a growing desire for a better work-life balance generally and particularly among the younger generations of doctors, is adding to current workforce pressures.

Current trends and future challenges

Five years after an ASMS submission to the Senior Medical Officers' Commission described the specialist workforce as a 'leaking bucket', Medical Council and DHB data show the flow into the bucket has increased but the holes have got bigger.

The first major specialist workforce report produced by the ASMS in January 2009 found clear evidence of chronic shortages across most specialties and an increasingly serious recruitment and retention issue, with many specialists leaving for better pay and conditions overseas. That paper, prepared for the Senior Medical Officers Commission, described the specialist workforce as a

'leaking bucket'. (*Repairing the Leaking Bucket*: A paper to the Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers employed by DHBs.)

In October 2010, Health Minister Tony Ryall acknowledged publicly: "We have a workforce crisis in New Zealand because we need to retain more of our hospital specialists".

A document published jointly by ASMS and the 20 district health boards (DHBs) the next month, titled *Securing a sustainable senior medical and dental officer workforce in New Zealand: The business case*, reaffirmed there was a specialist workforce crisis. It said this was causing serious risks for the public health system (including standards of patient care and financial waste), and set out actions to address the crisis.

> *DHBs were not recruiting enough specialists to enable safe and sustainable services.*

Those actions, which included a greater investment in developing the specialist workforce, were never implemented.

Specialist shortages

In February 2013, the ASMS produced a further comprehensive analysis of the DHB specialist workforce, *Public Hospitals in New Zealand: Getting from Crisis to Opportunity*. It found specialist shortages had become so entrenched they were now the 'norm' for many public hospital departments.

Specifically:

DHBs were not recruiting enough specialists to enable safe and sustainable services, as ASMS had previously agreed with the DHBs. To fill the service gaps, DHBs were calling on short-term (and significantly more expensive) locums and were depending more and more on recruiting overseas-trained specialists – international medical graduates (IMGs) – who had a higher turnover rate than doctors trained in this country.

Retention of new specialists and potential future specialists was getting worse, especially among IMG doctors.

On current retirement trends, in the next five years an estimated 19% of the specialist workforce could be lost due to a drop-off of doctors from the age of 55.

The latest status report on the medical workforce pays particular attention to the three issues outlined above – and examines how a changing international market for medical specialists poses new risks for New Zealand's health services.

The full report is available on the ASMS website at **www.asms.org.nz** under **'publications'** and then **'reports'.**

Lyndon Keene

Past Presidents of the ASMS (L-R): Drs Allen Fraser, David Galler, Jeff Brown, Peter Roberts, Hein Stander (current President) and George Downward. Absent: John Hawke (deceased).

FROM THE 2014 CONFERENCE

EXECUTIVE DIRECTOR

Command and control DHB leadership on the rise

There are increasing concerns over DHBs moving towards a more leadership 'command and control' style which is the sharp edge of managerialism.

This culture appeared to be on the decline in the late 2000s but is now undergoing a revival as DHB leaders struggle to cope with the dual pressures of increased political micro-management and financial retrenchment.

This is regrettable because 'command and control' leads to a stifling environment which is the antithesis of innovation and fiscal efficiency.

It isn't about Nigel

My rationale for this assessment is not, however, as some might think, in reference to the controversial return of Nigel Murray from Vancouver's Fraser Health Authority to New Zealand to take up the position of Waikato DHB chief executive. Certainly he is a highly visible example of the 'command and control' leadership style which caused major difficulties and alienated senior doctors at Auckland and Southland DHBs. The Fraser Health Authority has been damned in a recent external review, which described its

public hospitals as among the worst performers in Canada.

Nigel Murray's appointment as Waikato DHB CEO was driven by a local circumstance. The Waikato Board Chair, suffering from what the humourist might describe as serious insight deficiency, made a decision that will define his reputation in health leadership. Had he listened to advice not to confirm the appointment until the review of Fraser Health Authority, then he would have had more information to consider and a different decision may have been made.

Micro-management and financial squeezing

Instead my assessment is based on what is already happening in DHB leadership prior to the Murray appointment. DHBs are subject to a high level of political micro-management and unprecedented financial pressures, with funding increases continuing to fall well below the cost of providing services.

> *"DHBs are subject to a high level of political micro-management and unprecedented financial pressure."*

In the case of micro-management, much of this is about the excessive monitoring and ranking of targets that only cover those things that are easily countable and only cover a small part of the clinical and related services that DHBs provide. They don't include, for example, acute work, most chronic conditions, mental health and community services. It is not that the targets are wrong but that their application and monitoring sometimes are.

According to the best analysis of the 2014-15 Budget I've seen (I have to say this; our excellent researcher Lyndon Keene was a co-author), Vote Health has a shortfall of an estimated $232 million behind what is needed to cover announced new services, increased costs, population growth and the effects of an aging population. DHBs, meanwhile, are underfunded by an estimated $94 million just to cover increased costs and demographic changes. When the costs of new services they are expected to provide are taken into account, the shortfall is likely to be well over $100 million.

The relevance of this huge shortfall could be minimised if the Government was to allow the development of a workforce investment strategy based on comprehensive clinical leadership at all levels, along the lines of the business case jointly developed by ASMS and the DHBs in 2010.

Consequently, in the absence of a workforce investment strategy and distributive clinical leadership, the public system is getting squeezed more and more, and there is a major leadership deficit from Government (and its agencies) and DHBs over how to respond. It is exposing the worst in DHB leadership (as well as revealing the best).

Doing more with relatively less

Not only are DHBs under increasing pressure to do more with relatively less; cope with increasing acute and chronic illness pressures; meet disproportionately dominant targets that cover a relatively small proportion of the services DHBs provide; and cope with the challenge of an aging population (and their own aging workforce); but they are also having to do this in the context of a rigid deadline, ie, the end of a financial year. Financial timeframes rarely coincide with the timeframe of safe clinical practice.

> *"Short-term decision-making results in too many decisions being made under pressure and without the necessary clinical leadership to get it right."*

This creates a propensity toward short-term decision-making where too many decisions are made under pressure and without the necessary clinical leadership to get it right. A decision to review, for example, the way hospital laboratory referrals are made is sensible when it is part of normal business (as it should be) but when it is made under immediate financial stress, the chances of risky outcomes through errors under pressure increases.

There is also outright short-sighted and counterproductive silliness over continuing medical education, including expenses. Applications and associated expenses approved as being reasonable by clinical directors or department heads are being frustrated in a petty way that ends up costing more. For example, opportunities for cheaper flights are lost as a result of procrastination. When flights are eventually approved, the costs are greater.

Increased command and control is also evident in the refusal of some health leaders to face up to their responsibilities over job sizing/hours of work. Increasingly, more and more senior doctors are working well in excess of their formal job sizing, which is becoming more notional than actual. Further, the continuing 'clinical creep' is reducing time for critical non-clinical duties not directly related to the care of an individual patient (eg, clinical audit, mortality reviews, and teaching).

In effect, health managers are hiding behind an over-stretched workforce and manufactured vacancy numbers that significantly understate the entrenched specialist shortages that have been allowed to become the norm in DHBs. It is a form of exploitation that gives little regard to quality and the requirement to behave like a good employer.

> *"Health managers are hiding behind an over-stretched workforce and manufactured vacancy numbers."*

In this environment, too many DHBs have lost sight of the fact that there are two main things that drive clinically and financially sustainable innovative change – workforce and technology, wrapped in a cloak of distributive clinical leadership. We seem to have moved from the excellent aspirations of *In Good Hands* in 2009 (the Government's official advice to DHBs on clinical leadership) to the corrosive struggles of In Bad Hands today.

Ian Powell

COMMUNICATIONS DIRECTOR

A quarter century of ASMS engagement

The photographer perches on top of the ladder and holds his camera aloft. "Are you all right up there?" I don't fancy my chances of catching him.

"Don't worry, I'll be in good hands if I do fall," he assures me.

He's right.

Hundreds of years of medical expertise are gathered in the room. If he does take a tumble, a doctor will be at his side quicker than you can say 'fracture of femur'.

About 130 of the country's most senior public hospital doctors and dentists are at Te Papa in Wellington for a special one-day conference to mark the ASMS' 25th birthday.

It's a chance to reflect on gains made in the past quarter century as well as the challenges still facing public health, and an opportunity to connect with colleagues not seen for a while.

The day starts with a mihi whakatau and is followed by an address from paediatrician Dr Hein Stander, who is also the National President of the ASMS. He talks about the importance of the ASMS' 4000-plus members, the way the organisation has strengthened over the years, and the need to continue focusing on workforce planning. The full text of his speech can be read on page 8.

Dr Michael Chen-Xu

"We get to blow out 25 candles today and make a wish for the future," he beams at the audience.

Next, one of the people who assisted at the birth of the ASMS in 1989, foundation President Dr George Downward, describes the process of creating a union for hospital specialists: developing a set of union rules, enrolling members, the first set of negotiations. He singles out ASMS Executive Director Ian Powell as a key factor in ASMS's success over the years, and says it's important to put things in place that matter.

"When we design the future, we're not designing it for us," he says. "We're designing it for future generations."

Professor Martin McKee from the London School of Hygiene & Tropical Medicine provides the day's keynote address, titled 'Health and wealth: the argument for investment'. The two reporters present take notes, and everyone concentrates as the evidence is presented, slide by slide. There is a good case for spending on health, says Professor McKee. It will have wide-ranging effects not just on health outcomes but also on productivity and economic growth. A separate article on Professor McKee's visit is on page 16.

A lively panel discussion follows, involving Professor Peter Crampton, Dean of Otago University's medical school, political commentator Colin James and business journalist Rod Oram.

"Poverty is strongly associated with ill health," says Professor Crampton. "We don't need any more research on this, we just need more action. ASMS is a very important voice on this issue."

Panel (L – R): Hein Stander, Peter Crampton, Colin James, Rod Oram.

More photos can be viewed at www.asms.org.nz

FROM THE 2014 CONFERENCE 25

After the lunch break I walk into the hall with a tall man who is probably the youngest person in the room.

"It's an honour to be asked here to give an address," he says, somehow managing to look both worried and pleased.

"You'll be great," I say, and he is. The tall young man is Dr Michael Chen-Xu, past President of the New Zealand Medical Students Association and first year house surgeon, and he painstakingly lays out the challenges that the next generation of hospital specialists – his generation – will have to face.

There are two more panel sessions and plenty of questions from the floor. The coffee urn works overtime. The discussion is lively and the afternoon passes quickly.

Later, there is cake and music and catching up and dinner and photographs. There are short speeches, a lot of laughter and raised glasses.

For 25 years the ASMS has provided a voice for hospital specialists and other senior doctors on the need for quality public health care, along with advice, support, and representation on employment issues.

A doctor emails us afterwards: "I am delighted to be a member of ASMS."

And someone else posts on Facebook: "Here's to the next 25 years."

Cushla Managh

Professor Martin McKee

25 FROM THE 2014 CONFERENCE

The argument for investment in public health

For many years now Professor Martin McKee from the London School of Hygiene & Tropical Medicine has been shining light on the funding of health care around the world and the consequences for individuals and their communities.

Thanks to sponsorship from MAS, the ASMS was able to bring Professor McKee to New Zealand in August to address a special conference in Wellington to mark the ASMS' 25th birthday.

"It was a real coup to get him here as he is one of the world's leading thinkers on the operation of health systems in times of economic austerity," says ASMS Executive Director Ian Powell.

> *"For every dollar of government money spent, you get about 1.6 dollars of economic growth."*

Professor McKee qualified in medicine in Northern Ireland, with subsequent training in internal medicine and public health. In addition to his position at the London School, he co-directs the European Centre on Health of Societies in Transition and is research director of the European Observatory on Health Systems and Policies. He has published hundreds of scientific papers as well as 42 books, and held editorial positions with both the European Journal of Public Health and The Lancet.

Professor McKee gave the keynote address at the ASMS commemorative conference at Te Papa on 26 August, followed by presentations to the Treasury, ASMS branch officers and members in Wellington and Christchurch, and health professionals at Ko Awatea in Auckland.

He described the significant economic and health gains to be achieved from governments spending on public health. The argument that economic growth would fall if a country's debt-to-GDP ratio rose above 90 percent was due to a simple spreadsheet error on the part of two Harvard researchers, he says. Once this was corrected, quite a different picture emerged.

"In fact recalculation of the figures shows that for every dollar of government money spent, you get about 1.6 dollars of economic growth – and the figures are even higher for education (8.2 dollars) and health (4.3 dollars)."

Audio of Professor McKee's address is available at http://www.asms.org.nz/news/asms-news/2014/08/26/asms-celebrating-25-years-engagement/ *and videos will be available on the website. His comments are also covered in more detail on the ASMS website.*

Celebrating the ASMS' 25th birthday

Taranaki DHB going the extra mile for IMGs

Helping overseas-trained doctors settle into their new jobs at Taranaki District Health Board is as much about the personal touches as the organisational processes.

The TDHB arranges for staff to meet new arrivals at New Plymouth airport, drive them to their new homes, hand them the keys to a car they can use temporarily, and help them sort out their family's needs including schooling, immigration requirements, applying for IRD numbers, setting up bank accounts and so on.

Sometimes the heads of department will even turn up on the doctor's first night in town with a bag of groceries to help the family settle in, says TDHB Recruitment Manager Charles Hunt.

"We want them to feel welcome here and positive about the contribution they can make to health in this community," he says. "International medical graduates make up 60% of the TDHB's medical workforce so they're really important to us."

> *"The hospital provided us with free accommodation and a car until we could arrange these ourselves, and it made a big difference."*

The TDHB is in regular contact with the doctors long before they arrive in New Zealand, providing information about a wide range of things they or their family will need to know. When they start work at the TDHB they will then go through the hospital's own orientation programme to familiarise them with medical systems and processes, as well as the TDHB's policies and procedures.

But it's the personal contact that makes a real difference to their experience of settling into the new job, says Charles Hunt.

Obstetrics and gynaecology specialist Dr Anene Chukwujama, who moved to New Zealand in May from the United Kingdom, praised the level of support he had received from the TDHB.

"The reception I received was overwhelming," he says. "Even before I set foot on New Zealand soil, I received unprecedented support from Charles Hunt with the daunting amount of paperwork for the job, immigration and registration with the Medical Council of New Zealand."

He was met at the airport on arrival in New Plymouth and taken to the accommodation the TDHB had arranged for him and his family. The next day he was given a tour of the city and assistance with opening a bank account, obtaining a tax number and a cellphone.

"The hospital provided us with free accommodation and a car until we could arrange these ourselves, and it made a big difference," he says.

Head of department, obstetrics & gynaecology Jeremy Smith and hospital service manager, maternity and child health, Leigh Cleland, welcomed him to the hospital, and he found the TDHB's induction process excellent.

Photo: New Plymouth District Council

"My overall experience made me feel very supported and valued."

Charles Hunt says the head of department was knowledgeable about Nigeria, where Dr Chukwujama was originally from, and was able to put him in contact with a group within the TDHB which supported doctors from Africa. He also invited Dr Chukwujama and his family to his house for dinner to welcome them to New Zealand.

Another recent arrival, American emergency specialist Dr Mark Sagarin, says it was a relief to have someone else drive him, his wife and three children to their new temporary house next door to the hospital.

"The idea of arriving in the country, feeling jetlagged and trying to drive on the left on New Zealand's roads was not something I wanted to do right away, so I appreciated the help. "

Obstetrics and gynaecology specialist Dr Anene Chukwujama

American emergency specialist Dr Mark Sagarin

The next day a staff member from the TDHB took him for a short driving lesson to familiarise him with the differences in New Zealand's road rules.

> *"We want them to feel welcome here."*

He, too, was welcomed with a bag of groceries on his first night and given the temporary use of a car.

"All of these things gave us time to adjust to being in a new city and a new work environment, and made the transition a lot easier than it could have been," he said.

Note: The ASMS discussed the issue of IMG orientation in DHBs at a recent meeting of ASMS Branch Officers, and we will report back in the next issue of The Specialist.

Photo: Taranaki DHB

CLINICAL HEAD, PAEDIATRIC PATHOLOGIST, ANATOMIC PATHOLOGY, LABPLUS, AUCKLAND HOSPITAL, PRESIDENT AUCKLAND BRANCH OF ASMS

Five minutes with Jeannette McFarlane

What inspired you to become a doctor?

I decided to become a doctor when I was five or six years old. I was inspired by our family doctor in Derbyshire in the UK, who was always kind and gentle. He would speak to me as a person in my own right and I remember being impressed by how he looked after my family whenever we saw him.

I knew even at a young age that my skill and interest was in laboratory medicine. After reading my father's collection of true crime books, I decided at secondary school to become a forensic pathologist. I pursued that, doing my medical school elective in forensic pathology at Guy's Hospital, London, and eventually becoming a consultant forensic pathologist in Glasgow in 1991.

Then, in my early 40s, I was increasingly missing hospital medicine so I retrained as a paediatric pathologist. Following that, my husband was looking at job opportunities in Auckland. I wrote to the then Head of Department at LabPlus and discovered that the paediatric pathologist post at Starship was vacant. We were invited to visit, and decided to move to New Zealand. I've never regretted retraining or moving here. Retraining was difficult at times and very stressful, but I've gained so much from the change of direction, both personally and professionally.

What do you love about your job?

I enjoy working with other doctors and drawing on their expertise, and feeling that I am doing something very worthwhile for patients.

In paediatric pathology, you feel really involved and get to know the patients very well, even though you don't meet them.

I also enjoy the unpredictability of the work – you never know what's going to appear on your desk. At least once a week I see something I've never seen before or I come across a new problem. In many ways it reminds me of the parts of forensic pathology I enjoyed most, particularly scene of crime examination. It's about solving puzzles, digging through things, the complete unpredictability of the exploration and discovery.

> *"I've always considered it a privilege to practise medicine. It's the patients I remember, the faces I can still see in my mind's eye."*

I've always considered it a privilege to practise medicine. It's the patients I remember, the faces I can still see in my mind's eye even today, many years after leaving clinical practice. There are some cases where you're not able to help, where a child dies and you can't cure them, but there are so many cases where you do get good results and it's so worthwhile. Some people find paediatric pathology very difficult but I've always taken the view that I'm doing the best I can for a family and a patient. The good definitely outweighs the bad.

What is the most challenging aspect of practising medicine?

The unpredictable nature of the work, while good, can also be challenging. Pathology and the laboratory-based disciplines can sometimes be overlooked in service planning so it's important to make sure we are on the hospital's radar.

The financial constraints we face can also be challenging. I'm a very strong supporter of the public health system and want to see New Zealanders value the good work being done by so many staff in our hospitals, which I feel is much more important than many of the bad news stories.

> *"I'm a very strong supporter of the public health system and want to see New Zealanders value the good work being done."*

Why did you decide to become a branch officer for the ASMS?

When I was working in Glasgow I got involved in the rough end of an employment dispute with my employer. It was very divisive within the department. I had enormous support from the British Medical Association (BMA), and it saved my career and my health. Once the case was over (which we won), I was asked to appear in the BMA's advertising leaflets about the value of representation.

When we were considering moving to New Zealand, I looked very closely at the DHB MECA here and compared it with the British employment agreement, went through it all in fine detail. Then when I arrived here, I discovered that people weren't claiming their entitlements, and I started helping colleagues in the department. People started coming to me for assistance and I began attending Joint Consultation Committee (JCC) meetings with ASMS and DHB management, and eventually I put my hand up for the role of Branch President.

Jeannette McFarlane at a crime scene.

My motivation with getting involved in union work is to help and support my colleagues. I know how valuable it is to have support, and I feel obliged to repay the favour.

What have you learnt from this experience so far?

It's a very difficult time at the moment for the profession. Resources are in short supply in the health sector and we are dealing with a lot of financial constraints. These have placed a lot of stress on all groups of staff and in some areas have been detrimental to working relationships within clinical teams. It's easy to focus on the negative, with all of the current emphasis on money and health targets but I think it's very important to remember the value of the work we do, and how it helps people.

MPS MEDICAL DIRECTOR

Professionalism: leading the next generation

Defining professionalism is difficult, teaching it is even harder. Rob Hendry offers some practical tips on how to encourage professionalism in health care teams.

Working as a doctor is a huge privilege, we have the power to change lives. Opinion polls consistently show that we command huge public confidence and trust. Part of being a doctor is continuing to earn and justify this trust.

Being a successful doctor means so much more than knowing the facts and performing the procedures. It is about acquiring the broader qualities around integrity, honesty and clinical competence that make up the professional aspects of the role.

The Health and Disability Commissioner is currently investigating the causes behind a rising tide of complaints about health workers. Doctors are expected to lead by example for other members of the team – unprofessional behaviour has no place in the conduct of an upstanding professional person.

Unprofessional healthcare teams

The American Medical Association describes unprofessional behaviour as "disruptive behaviour" characterised by "a style of interaction with other doctors, medical staff, patients and family members or others that interferes with patient care."[1]

Communication issues and poor doctor-patient relationships are major causes of medicolegal action and complaints.[2] Examples of unprofessional behaviour include:

- poor communication (not being listened to, lack of empathy, lack of information)
- disempowerment (feeling devalued, not being understood or taken seriously)
- desertion (feeling abandoned, family excluded, staff arrogance).[3]

Patient-centred v doctor-centred

Healthcare teams can become doctor-centred as opposed to being patient-centred, in other words, where the focus is on 'me' and not the patient. Be alert to phrases such as: "I don't see why I should …" or "Patients need to realise that I'm not a miracle maker …" or "I had the usual heart-sink patients in this morning …"

Causes of unprofessional behaviour

Poor behaviour is caused by a complex interplay between work, systems, health and personality issues. For example, a team member may lack the skills to constructively express an alternative opinion, or they may suffer from fatigue, a physical illness, or domestic issues, or they may be the byproduct of system stressors, such as inadequate staffing or roster issues.

Any concerns about a colleague's competence and conduct should be reported to the Medical Council if you feel it may pose a risk of harm to the public.[4]

Managing disruptive teams

Unprofessional behaviour can disrupt team dynamics and at its worse affect patient care. It should be tackled promptly taking into account the specific context of the situation. Follow this five-step approach:

1) make it clear that the behaviour is unacceptable

2) develop policies and processes to manage the behaviour

3) ensure that all staff are aware of behavioural expectations and reporting processes

4) address the problem

5) understand your obligations.[5]

Lead by example

Leading by example is one way of inspiring professionalism in your healthcare teams. You should:

- take part in audit, peer review, and CPD
- respond constructively to the results of audits, appraisals and performance reviews
- contribute to significant event recognition and inquiries
- report suspected drug reactions using the relevant reporting scheme
- share information with organisations monitoring public health
- lead reviews of standards and remedy deficiencies.[6]

Teaching professionalism

The first lesson in teaching professionalism is not to assume that your health care team will automatically acquire it. It's relatively easy to teach a specific skill like cannulating a wrist and assessing whether a trainee has acquired that skill – the same cannot be said for professionalism.

Imparting aspects of professionalism can be achieved by teaching the knowledge and skills to develop capability and encouraging trainees to display appropriate levels of professional behaviour. Residents need to be cognisant in the basics around communication and consent in order to be professional.

Coaching residents

Coaching residents by asking them about how they'd deal with key issues around confidentiality, consent, chaperones, and so on, can be an effective way of teaching professionalism. For example, asking "how would you respond to a request for information about a child from a divorced parent?" will assess how well they grasp the complexities of confidentiality.

Values such as integrity, openness, compassion and accountability are associated with doctors. Why not assess the values of your health care team by

asking them attitudinal questions, such as "how much do you agree that it is important to apologise to patients when a mistake has occurred?"

Other ways to assess the professional behaviour of your team is by role play, case-based discussions, and observation. Gather feedback from a variety of sources, then encourage reflection, self assessment and self correction.

Patient expectations

The gap between what patients want and doctors can deliver is certainly expanding. With higher expectations, patients are more likely to be disappointed and complain about their care. During such times your professional attributes can really come to the fore and make all the difference when under pressure.

As health care leaders we have a duty to develop the professional skills of the next generation, particularly the characteristics and behaviours that uphold professional qualities.

To end on the words of Alistair Cooke, a famous American journalist (1908-2004): "A professional is someone who can do his best when he doesn't feel like it."

Rob Hendry

1 AMA, Physicians and disruptive behavior, Chicago (2004)

2 Beckman H et al, The doctor-patient relationship and malpractice: lessons from plaintiff depositions, Arch Intern Med 154(12) :1365 (1994)

3 Stephen F et al, A Study of Medical Negligence Claiming in Scotland, Scottish Government (2012)

4 MCNZ, Statement on employment of doctors and the Health Practitioner's Competence Assurance Act, Wellington (2003/5) www.mcnz.org.nz

5 MCNZ, Unprofessional behavior and the health care team: protecting patient safety, Wellington (2009)

6 MCNZ, Good Medical Practice (2013) par 82

ASMS services to members

As a professional association we promote:

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

As a union of professionals we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer;
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in district health boards which ensures minimum terms and conditions for more than 4000 doctors and dentists, nearly 90% of this workforce;
- advise and represent members when necessary;
- support workplace empowerment and clinical leadership.

Other services

www.asms.org.nz

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

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

ASMS job vacancies online www.jobs.asms.org.nz

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

Substantial discounts are offered for bulk and continued advertising.

ASMS email broadcast

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

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

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Have you changed address or phone number recently? We're updating the ASMS database and would be very grateful if you could email any changes to your contact details to: **asms@asms.org.nz**

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