Presidential Address - ASMS Annual Conference 2018

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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.

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.

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.

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 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 percent worse.

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.

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 of 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. You will see from the annual report that 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.

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.

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. You will see that tomorrow we have a session using Polleverywhere to get active delegate feedback on ASMS direction and activity, to help the Executive and national office with decision-making in the year ahead and beyond. 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.