International Medical Symposium

'Leading change in healthcare culture, education and practice" – Friday 10 March 2017

The education trust was kind enough to send four of us across to Melbourne for the annual Tri-nation Alliance International Medical Symposium.

The tri-nation alliance is a network of cooperation and collaboration between Australia, Canada and New Zealand. Why these three – the countries share similar characteristics both in health care provision, the socio-economic interaction of the public/private divide but also the legacy of our colonial past. Some excellent talks from representatives of all three countries including one of our ex-presidents Dr Walker will be covered in more depth later in the report. How healthcare in the 21st century manages to meet the needs of the public and our own training was the focus of the afternoon

Leading change in the culture of medicine

After the introduction and opening remarks from an emergency physician in Canada talking about his experience of being both trainee and trainer session one commenced. Titled 'Leading the change in the culture of medicine' the speakers were two surgeons, a paediatric surgeon working in Christchurch and a cardiothoracic specialist from Melbourne.

Operate with respect was the mantra repeated during the first talk – it was a report back on the efforts by the college of surgeons in response to the bullying and harassment that was first brought to light by a newspaper editorial in 2015. A subsequent review revealed a culture rife with harassment, intimidation and bullying with 63% of trainees that responded reporting being bullied, 30% sexually harassed and 71% witnesses to either. How did they combat this?

What followed was about forty minutes of taking through the new campaign "lets operate with respect" and detailing the meetings and agreements held. Whilst the room seemed to appreciate this, personally it came across as a black slapping exercise reporting how great they were because they have had several meetings. The media campaign similarly hollow with no clear indication of what exactly they are doing.

Second up was the CMO from one of the local hospitals. She also happened to be a cardiothoracic surgeon. From this paragon of work-life balance we had a talk about problem doctors – how they are identified and steps to be taken. The process outlined involved a reporting system and feedback system based on anonymity on the part of the complainant and a graded process from an informal chat with a colleague to a conversation with a line manager and upwards to a formal hearing. The speaker used the phrase 'bad hair day' multiple times to describe those once off situations that are out of character. I personally found this phrase irksome and insincere but as sound bites go I've heard worse. Again this was interesting but came across as a report card for steps taken and a request for praise and appreciation.

The conversation seemed to change in tone in the midst of this talk from bad behaviour to bad doctors and personalities suited to medicine. The unwritten conversations limited to corridors and off-hand remarks with no documentation allowing bad trainees to slip through and get into higher training positions. Encouraging these conversations to come out into the open allows for these individuals to be identified and an intervention to take place. This all seems sound but when opened up to floor comments there were a few that were both alarming and worrying that these influential clinical and academic leaders were so far removed from the day to day process.

Medicine is thirty different professional entities under one umbrella. The same personality traits that make the speaker able to juggle cardiothoracic surgery, hospital management and life mean that there may be other areas of medicine to which she is fundamentally not suited. I agree that this is no excuse for poor behaviour or abuse of staff but we need variety and breadth to our professions. The finesse required to be an excellent neurosurgeon is not always balanced with a garrulous and approachable personality. To weed out these individuals early on (or even before medical school as one audience member suggested), to my mind would devalue the profession.

An interesting morning. The insight into the processes of the colleges as they deal with unacceptable behaviour was as useful as it was frustrating as how a meeting about a meeting about a meeting impacts day to day life is difficult to fathom.

Leading change in indigenous healthcare

The second session of the Symposium was titled "Leading Change in Indigenous Healthcare". It is well documented that indigenous populations have much poorer health outcomes than colonizing populations and this session was aimed at discussing ways of reducing the inequity and inequality.

The first speaker was a Seneca doctor from the Six Nations Territory in Canada. He provided some shocking insights into the inequalities for indigenous people in the healthcare system in Canada. This was well summed up in one slide: "Question: why should indigenous people get special treatment; shouldn't they be treated like everyone else? Answer: they do get special treatment, they get third-world health care in a first-world country, so yes, they should be treated to the same standards that everyone expects." This was a stark reminder of why indigenous health is a major issue and should be at the forefront of all discussions about changing the future of medicine. He then went on to outline a framework for improving cultural competency among health practitioners. The CanMEDS framework highlights that there are six attributes of all medical experts and that all need to be utilised to improve cultural competence.

The second speaker was a doctor descended from the Warnman people of Western Australia, who is the current president of the Australian Indigenous Doctors Association. The topic of her talk was about making training programmes and colleges more culture-friendly. She outlined the major shortage of indigenous doctors and highlighted the need to not only increase the recruitment of indigenous medical students but also retain them. A key point she highlighted with regards to retaining indigenous doctors is allowing them to feel supported in a culturally appropriate way throughout their education and career. She also outlined a current campaign in Australia which is focussed on helping people understand that a person's culture and identity is not dictated by the colour of their skin or the "percentage of their blood". Someone can identify as aboriginal even when they do not look typically aboriginal. This is an innovative way of destigmatising indigenous culture.

The third speaker was NZRDA's ex-president and current MCNZ Chair; Dr Curtis Walker. The topic of his talk was on building cultural competence, equity and partnership in New Zealand. One key take home message was that clinical competence and cultural competence go hand in hand and you cannot have one without the other. Stating, "I treat all patients the same" does not equate to cultural competence. Without cultural competence indigenous patients will continue to get subpar treatment. This is not only an issue with individual practitioners though, the entire health system and the way it is designed does not factor in the cultural needs of our indigenous populations. Dr Walker then presented an overview to what the MCNZ is currently doing to tackle this huge issue. They have come up with 8 suggested components to integrate cultural competency into not only the health workforce but also the hospital system and the way it is governed.

Clearly Canada, Australia and New Zealand have all identified just how big an issue indigenous health is. We have clear evidence stating how poor indigenous health outcomes are. Now it is time to improve them. All three countries are developing innovative frameworks and initiatives that are being built into hospital systems and training programmes to improve the cultural competence of both clinicians and the healthcare structure. Only time will tell how successful we are, as these issues need to be improved now not in the future.

Leading change in medical education and technology

The third session was on medical education and technology, specifically, how technology can be used to transform medical education so that is it fit for purpose at both under-graduate and post-graduate levels. Medical education is an apprenticeship, however with the volume of work required of doctors difficulties arise in timely and accurate feedback of trainees. Professor Jonathan Frye, a liver transplant surgeon, gave a talk on an app named, SIMPL, an assessment tool used in parts of America that overcomes many of these challenges. SIMPL, is used by attendants (SMO) to feedback to residents (RMO) how well they performed on a procedure with ratings based on level of supervision required (based on the Zwisch scale of: show and tell/active help/passive help/supervision only). The app is available on smart phones and sends prompts to the SMO after a procedure to complete the assessment which is: identify the RMO, the procedure, the complexity of the procedure, and what level of supervision was required. It has a user friendly interface with timely prompts and pilot studies have shown 90% compliance. SIMPL implies that autonomy = competence which is the goal of an apprenticeship model. SIMPL is also used to collect data for the American College of Surgeons to help enhance the surgical training.

For example, SMO's prior to performing a laparoscopic cholecystectomy with a RMO can check what level of supervision the RMO needs. RMO's can check how many laparoscopic cholecystectomies they need passive-help supervision with before being expected to be at supervision only level, and how many laparoscopic cholecystectomies are performed at different centres. A great tool that provides timely feedback, is less cumbersome, and collects information that creates helpful data however, its applicability is limited to feedback on procedures only.

Highlighted by the need for the SIMPL app, quality feedback is essential for the success of any apprenticeship. To enhance medical education is to enhance feedback, was the topic covered in depth by the second speaker, Professor Elizabeth Molloy, who did her PhD on the role of the clinical educator in providing performance feedback to students. The practice of feedback in medicine (at all levels) has limited dialogue and is confronting with research showing many clinicians are not comfortable with giving honest feedback. Echoing the point mentioned in session one about the culture in medicine of "failing to failure". This is no surprise given how poor our feedback literacy is, however this does echo the hierarchical environments we work in. Unsurprisingly, solutions to help improve feedback include: trust, psychological safety, educators having the trainee's best interest at heart, reciprocal vulnerability, and educational alliance. A great talk directed more at SMO's with little take-home messages, from an RMO point of view.

The last speaker, Professor Ian Symonds, summed up the session with a talk on the direction medical education should take to become "fit for practice". There are many challenges that face the current medical workforce: the rising co-morbidity index, millennial learners, and technology to name a few and our training should adapt accordingly. He placed emphasis on leadership being a core skill that should be taught in medical school, an idea that is echoed by many stakeholders in medical education. The closing remarks "Medical education must adapt or die so that it can continue to be fit for practise" was a sombre finish to the session as there were very little practical solutions explored. Overall, it was a great session however, apart from the use of the SIMPL app I saw very few examples of how technology is shaping to improve medical education.

Leading change in systems and practice

The last session of the day focused on medical systems and practice – what is being done to improve healthcare service and delivery, and what we can do to encourage and implement change.

The session started off with a brief word from our own Dr Margaret Aimer, clinical lead for the Development and Delivery Team at Ko Awatea (Centre for Health System Innovation and Improvement for the Counties Manukau District Health Board). She detailed a number of programmes Ko Awatea have established to encourage and support system wide change in health and social sectors e.g. 'Handle the Jandal" a youth-led campaign aimed at improving Pacific youth mental health and wellbeing in South Auckland. By educating and empowering passionate Pacific youth leaders, the campaign supports and encourages youth across South Auckland to take responsibility for their own mental health and wellbeing by connecting with other youth. Dr Aimer also talked about 'Colab' - an interactive database established by Ko Awatea to enable the sharing of health improvement activities and projects from all over the world.

A great start to the session, highlighting projects that have been implemented in New Zealand an internationally, but I was keen to hear more about what could be done to further engage doctors in system level change.

Next up was Associate Professor Grant Phelps, a former gastroenterologist and current president of the adult division of the Royal Australasian College of Physicians. Associate professor Phelps works as an independent health quality and safety consultant, providing advice to hospitals and organisations on clinical leadership and safety and quality. His presentation focused on clinical engagement and governance, in particular the establishment and use of clinical networks. We need to bring expert clinicians together to push for change using evidence based practice.

Clinical networks (in theory) reduce variation in practice and outcomes through the development and dissemination of best practice protocols. Interestingly, Associate Professor Phelps highlighted the fact that clinical networks, as they are now, are by no means perfect. Evidence of their effect on patient outcomes is not robust. Strong leadership is required, and consumer/patient engagement is vital (and currently lacking). There is room for improvement, and given the increase in prevalence of comorbid disease, the organ specific networks we have currently may not be fit fir purpose in the future.

Professor David Story, Chair of Anaesthesia at the University of Melbourne, was next up, and spoke about inter-professional practice using perioperative care as an example. Apart from his somewhat irritating tendency to imply that anaesthetists are always right and everyone else (surgeons and physicians) are always wrong, his presentation was thought-provoking and highlighted the need for greater collaboration between different specialties and specialists, especially in the perioperative period. The frail elderly patient presenting with a fracture was used as an example, emphasizing the need for collaboration between specialists to ensure best outcomes (e.g. orthopaedic surgeon, anaesthetist, geriatrician/physician and general practitioner).

Last but by no means least, Professor Jeffrey Braithwaite, Foundation Director of the Australian Institute of Health Innovation, gave the keynote address. An engaging and charismatic speaker – Professor Braithwaite lived up to his resume (more than 600 publications and more than 800 conference presentations). His presentation focused on advancing healthcare systems, and detailed his work in 'implementation science' i.e. the systematic uptake of clinical and/or organisational research findings, and how these are put into practice. Interestingly, only 50% of medical care in Australia is evidence based – despite all of the medical profession's best efforts, patients still receive care that is highly variable, frequently inappropriate and too often unsafe. It is clear the medical profession does not know how to effect large scale system change, but what can we do about it? Drawing perspectives and opinions from the day's speakers, Professor Braithwaite left us thinking about the future; the challenges we face in implementing widespread and sustainable system change, and what can be done to overcome these challenges. Like so many other medical conferences and seminars, we were left with no answers, only questions.

***Our thanks to the education trust for sponsoring the trip. It was an interesting day, not always reassuring but interesting none the less. It exemplified how alien coalface medicine is to some of the individuals tasked with leading our futures as trainees. This exemplifies why we, as trainees need to have input and feedback into this process.* – Dr Jonathan Davis, Dr Courtney Brown, Dr Rebecca Craw, Dr Soane Misiloi**