



The Royal Australasian
College of Physicians

New Zealand



PHYSICIANS AND PAEDIATRICIANS PRACTISING IN ISOLATION IN NEW ZEALAND

DISCUSSION DOCUMENT

Physicians and paediatricians want to ensure the best health outcomes for their patients. Health practitioners work within an integrated team and health system, and can only deliver quality care if they are well supported in their workplace. Many specialist physicians and paediatricians practice in geographical or professional isolation. This document outlines some of the issues facing those physicians and paediatricians practising in isolation and seeks to identify ways to ameliorate the situation.

1. PURPOSE OF PAPER

This paper updates the initial 2012 version that examined aspects of professional isolation (both geographical and psychological) which may encompass practising in a rural environment or practising within a small sub-speciality in a larger hospital.

2. BACKGROUND INFORMATION

There are significant consequences for physicians and paediatricians working in isolation. Physical isolation may impact on clinical practice, as the clinician has little opportunity to discuss their clinical decision-making or challenging cases with peers or those working in related fields on a routine basis. Paediatricians engaged in private practice may experience significant geographic and professional isolation compared to their colleagues working in hospital teams. Furthermore, having to make challenging or ethical decisions, such as the management of end-of-life care may place considerable strain on physicians working alone¹. Dr Ian St George states that:

"...apart from advancing age, lack of contact with peers appears to be the factor most clearly associated with loss of competence in physicians"².

Physicians and paediatricians working alone in a specific speciality or in a rural setting may also find it difficult to engage in continuing professional development (CPD) activities. Obstacles may include limited availability of appropriate staff to back-fill positions whilst attending workshops or courses, and significant travel requirements to attend speciality-relevant CPD activities in major centres. Some regional or tertiary services do not provide or group structured CPD activities into half or full day sessions that rural physicians could attend. Local CPD activities, such as generic hospital-based activities, may provide relevant CME (Continuing Medical Education) by focusing on professional qualities. Access to online learning and teleconferencing facilities are important to support CPD and peer review needs of isolated physicians, and reduce the need for travel or leave. The implementation of multidisciplinary case teleconferences via the regional cancer networks is an example of this.

The current Senior Medical Officers' (SMO) and District Health Boards' (DHB) Multi-Employer Collective Agreement (MECA) provides ten working days per annum for participation in CPD/CME activities for physicians working in the public health sector, and travel time is additional to this allowance. Non-patient contact time in physician's timetables should also be structured to facilitate video/teleconferencing and online activities. Some very isolated physicians and paediatricians may require additional time and resources for CPD activities especially if covering multiple areas of sub-speciality interest.

From a psychological perspective, an isolated physician may feel the burden of unrealistic demands being made upon him/her thus placing the individual at risk of burnout³ and stress⁴. It is important that all physicians and paediatricians, not just those practising in isolation, have their own General Practitioner⁵.

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- 1 Robert Wood Johnson Foundation. Clinical challenges and opportunities: Re-introducing palliative care into HIV care. Promoting Excellence in End of Life Care. Accessed 1 February 2015. http://www.promotingexcellence.org/hiv/hiv_report/pe5726.html
 - 2 St George I. Professional isolation and performance assessment in New Zealand J Contin Educ Health Prof (2006) Summer;26:215-221.
 - 3 Burnout is a state of emotional, mental and physical exhaustion caused by excessive and prolonged stress. It occurs when you feel overwhelmed and unable to meet constant demands. As the stress continues, you begin to lose interest or the motivation that led you to take on a certain role in the first place. Smith M, Segal J, Segal R. Preventing burnout: Signs, symptoms, causes and coping strategies. Help Guide. Accessed 1 February 2015. http://www.helpguide.org/mental/burnout_signs_symptoms.htm
 - 4 Council of Remote Area Nurses of Australia. Avoiding burnout in remote areas: Surviving the day-to-day hassles: A guide for remote health practitioners. Alice Springs: Council of Remote Area Nurses of Australia Incorporated; 2002.
 - 5 Medical Council of New Zealand. Statement on providing care to yourself and those close to you. Wellington: Medical Council of New Zealand; 2013.

It is critical that isolated physicians build a collegial relationship with another doctor. Different types of support may be needed to cover a range of issues e.g. another doctor, not necessarily, in the same speciality, to discuss a difficult situation (i.e. a medico-legal issue) or a fellow physician or paediatrician to 'run cases past'. These support systems need to be well established if they are to be effective in reducing stress for the isolated practitioner and helping to ensure safe clinical practice.

The public and the physician's employer have high expectations relating to the level of clinical care provided by physicians. However, working in isolation can compromise a physician's ability to consistently deliver high quality services and patient safety, thus placing both the public and the practitioner at risk. In New Zealand, two extreme cases, Dr Burkinshaw⁶ and Dr Bottrill⁷ have highlighted the risks of practitioners working in isolation. The Ministerial Inquiry identified several factors that contributed to Dr Bottrill's inability to provide the quality service expected by his patients:

- (a) he did not engage in any external quality control activities
- (b) he was not reading large volumes of slides per year
- (c) he was not engaged in an appropriate continuing education programme
- (d) he had few internal quality control systems in place. Typically, abnormal smears should be examined by at least two clinicians.

Dr. Bottrill practised in an environment where there was no objective or quantitative measure of his performance. It is not to say this is the situation for all practitioners working in isolation, however it does highlight the need to ensure that appropriate external peer review and/or audit of a practitioners' work is undertaken at regular intervals. These issues should be addressed during routine DHB credentialing exercises.

The configuration of secondary care public health services in New Zealand is based around four regions, each with one or two tertiary base hospitals and many smaller to middle sized secondary care hospitals scattered geographically across the nation. It is likely that a number of physicians will find themselves practising in relative isolation in these smaller hospitals.

The specialist workforce in New Zealand is not large; therefore some specialities or sub-specialties have very small numbers of actively practising physicians⁸. These physicians face slightly different issues relating to professional isolation and may find they need to seek second opinions from colleagues in Australia or elsewhere.

As an integrated model of health care is rolled-out, a greater number of physicians and paediatricians may find themselves working for periods in community health clinics or super-clinics. This scenario may result in some specialists being frequently 'cut-off' from their informal support networks, i.e. the chance encounters with their colleagues in informal work settings or the ability to engage in informal peer-review/second opinion.

Specialists working in some smaller hospitals also face high on-call demands covering duties for long periods of time and at a high frequency. In some cases the rota are dropping below 1 in 3. Anecdotal evidence suggests that when these specialists are technically not on-call they still feel morally obligated to provide clinical input into complex cases.

Credentialing allows for some assessment of the practitioner's competence but may place physicians working in smaller centres in an invidious situation, particularly if a minimum number of procedures are required to maintain their scope of practice. Employers must have systems in place that allow these physicians to meet their credentialing requirements.

In summary, for a variety of reasons physicians working in isolation may find it difficult to maintain their skills and engage in relevant CPD activities. At the heart of the Health Practitioners Competence Assurance Act 2003 is the notion that a competent practitioner is one who engages in CPD. The link between CPD and competence is further reinforced by the Medical Council's requirement that all registered health practitioners participate in a recognised recertification programme. It is the joint responsibility of the employer and the physicians to ensure that work commitments and environmental factors do not constrain the practitioner's ability to engage in appropriate CPD and peer review activities.

6 Ministry of Health. Ministerial inquiry into the under-reporting of cervical smear abnormalities. Wellington: Ministry of Health; 2000.

7 Miriyana A. Compensation not enough, say patients, Sunday Star Times 2 July 2000; p.4

8 The Medical Council of New Zealand's data on the New Zealand specialist workforce identifies only 25 rehabilitation medicine specialists, 21 sexual health medical practitioners and 63 palliative medicine specialists in New Zealand. Medical Council of New Zealand. 2014 Annual Report. Wellington: Medical Council of New Zealand; 2014.

3. ISSUES FOR DISCUSSION

a. Employer responsibilities

Most specialists practising in isolation are employed by District Health Boards (DHBs) and their employment conditions are covered by the SMO MECA. The employer is responsible for ensuring that work commitments and environmental factors are, as a minimum, consistent with the MECA and do not constrain the practitioner's ability to engage in appropriate CPD and peer review activities. In addition to the issues discussed below, DHBs that employ physicians working in isolation need to; ensure physician's timetables allow adequate non-patient contact time for online and video/teleconference activities, and regular peer review visits to regional centres; ensure their credentialing processes appropriately address issues related to physicians working in isolation; address issues relating to backfill and leave cover for offsite CPD leave; reduce the impact of any burdensome on-call arrangements; and take all necessary steps to fill any vacancies.

b. Relationships with larger regional centres & clinical networks

Opportunities to participate in CPD activities with larger or tertiary centres and/or attend clinical sessions with others specialists within the same or relevant specialty would be beneficial to those working in isolation⁹. Visits may range from regular video/teleconferences to a regular half or whole day visit monthly to several days or a week at a time. Longer periods should be available via sabbaticals of up to three months at a time every six years under the SMO MECA. Provision of backfill for sabbaticals remains the employer's responsibility.

Larger regional/national centres need to provide or structure some of their CPD and peer review activities into regular half or full day sessions that rural or isolated physicians from the region could attend.

Regional specialists should be encouraged to provide clinics at provincial hospitals on a regular basis to provide locally delivered specialist services and opportunities for local peer review and education.

Another approach has been tried in Scotland with some success¹⁰. Rather than structuring non-clinical time during each week, this system involves the physician working for a continuous block of days followed by a block of days free of clinical commitments. This non-clinical time can then be used for CPD activities and leave.

DHBs are encouraged to consider formal combined appointments with the majority of a physician's time spent in their provincial hospital with one a day a week in the tertiary hospital.

c. Informal networks of similar physicians

Clinical networks are increasingly utilised for service delivery and peer review. There are formally structured models such as the regional cancer and stroke networks but in some cases this degree of formalisation is not required.

Professional societies, associations and special interest groups have a role in developing and facilitating small informal groups linked together through new technologies such as Skype and shared sites, and/or social media. The development of informal networks will require commitment from the parties involved including the development of reliable technology.

The College may need to develop generic professional development programmes to support rural or isolated physicians.

9 Shallcross T. General medicine in a remote and rural hospital: problems and proposals – a personal view. Edinburgh: The Royal College of Physicians; 2005

10 Ibid.

d. Mentoring programmes

Evidence^{11,12} shows that mentoring is a valuable tool for developing skills and reducing isolation however it is often costly and time consuming. In order to be effective, mentoring programmes need to be highly structured. The College has developed a mentoring programme for rural trainees in Australia with comprehensive supporting materials. The possibility of adapting these materials for the clinicians in the New Zealand environment could be considered.

Mentoring programmes are likely to focus on providing support relating to professional issues rather than clinical issues; therefore it is important that physicians practising in isolation also have and maintain collegial relationships with peers.

e. Recruiting physicians to smaller centres

There are well recognised difficulties in recruiting and retaining physicians to rural or isolated areas¹³. The average age of an internal medicine specialist in NZ is 50.5 years¹⁴. Succession plans need to be developed on a regional basis as regions have a responsibility to support their provincial hospitals. The efforts of Health Work Force NZ and employers adequately addressing the issues relating to physicians practising in isolation regarding arrangements for CPD and peer review, and tertiary centre visits should facilitate this.

f. College relationships with physicians working in provincial hospitals

The NZ Adult Medicine Division Committee and the NZ CPD Committee could proactively engage with those practising in rural locations. One approach would be to contact these individuals regarding MyCPD and support them with their CPD activities. This action plan could then be used as a basis to developing on-going contact with them.

g. Video/teleconferencing facilities

Videoconferencing has been proven to be a useful medium to span the 'tyranny of distance'. In Australia many successful outreach programmes have been developed via videoconferencing. In NZ the new regional cancer networks have demonstrated successful utilisation of these facilities for multi-disciplinary meetings.

Videoconferencing provides isolated physicians with the opportunity to connect with their tertiary and other provincial colleagues on a regular basis. It would require action from both parties – the local isolated specialist joining the regional group and the regional centre providing quality support. Each DHB should encourage the utilisation of available video/telemedicine facilities and regional/national services need to provide services that link with provincial hospitals.

h. Regional and National Clinical Networks

There would need to be an expectation that both participation and provision of the networks are not optional. This could be facilitated by making it part of the SMO job description, providing access to tele and video conferencing (as above), providing special leave and costs of attending regional meetings and short sabbaticals to regional centres on an as required basis.

11 Scott GWS. Report of the fact finder on the issue of small/rural hospital emergency department physician service. Toronto: Ontario Ministry of Health, Ontario Hospital Association, Ontario Medical Association; 1995.

12 Dobbin LC. Report to Ministry of Health and Ministry responsible for Seniors. Victoria: British Columbia Ministry of Health; 1998.

13 The government has established a bonding system which has been well subscribed and it directs health practitioners to practice in areas of need.

14 Medical Council of New Zealand data cited in Association of Salaried Medical Specialists. Taking the temperature of the public hospital specialist workforce. Wellington: Association of Salaried Medical Specialists; 2014.

i. Supporting Physicians' Professionalism and Performance (SPPP)

The College encourages all physicians and paediatricians to engage with Supporting Physicians' Professionalism and Performance (SPPP)¹⁵. SPPP is a competency-based framework designed to enable physicians to reflect on and understand their own practice. The SPPP framework is comprised of nine domains encompassing communication, cultural competence, decision-making and leadership. The framework centralises quality and safety, a fundamental principle of physician practice. Quality and safety not only informs each domain in the framework, it defines the specific and unique technical skills applicable to each physician speciality. The nine domains of SPPP are regarded by the College as being core competencies of a physician's practice.

The flexible design of the SPPP framework allows it to be utilised by individual physicians (including those practising in isolation) or by collegial peer groups. Physicians may employ the Framework to inform their own learning and goal-setting or to support their working relationship with their employer or DHB through credentialing or other workplace practices.



Components of the Supporting Physicians' Professionalism and Performance (SPPP) framework

This paper was developed by the New Zealand Adult Medicine Division Committee, the New Zealand Paediatric and Child Health Division Committee, and the New Zealand CPD Committee. Comments and feedback can be sent to policy@racp.org.nz.

¹⁵ The Support Physicians' Professionalism and Performance (SPPP) program is an initiative developed by the RACP and the Medical Indemnity Industry Association of Australia. Further SPPP resources can be accessed via the RACP website: <http://www.racp.edu.au/fellows/supporting-physicians-professionalism-and-performance-%28sppp%29>



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About The Royal Australasian College of Physicians

The RACP trains, educates and advocates on behalf of more than 15,000 physicians – often referred to as medical specialists – and 7,300 trainees, across Australia and New Zealand. The College represents more than 34 medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

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