

VMOs, staff specialists and academics

Symphony or disharmony?



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There are many reasons for going to work – money (definitely), nothing else to do (relatively unlikely), preferable to home (alas, sometimes) – but some obstetricians even look forward to going to work.

Surgical procedures provide some satisfaction – at least when they go well. A grateful patient is the privilege of some – but how often is this the patient for whom you have done almost nothing; the one for whom you have toiled so long and hard, sees only the imperfections. Not much job satisfaction in that. Undoubtedly the obstetrician that really looks forward to going to work each day, is the one who enjoys the collegiality with others

in the workplace – the clerical staff, the midwives, the theatre staff, even the anaesthetists – but above all, fellow obstetricians. Why then has one hospital after another been troubled by conflict between the VMOs, the staff specialists and the academic staff? The cost is an understaffed public system with an increasing number of obstetricians electing to practice without any public hospital appointment.

The VMO

The VMO brings invaluable experience to the hospital. In many hospitals VMOs do the bulk of the labour ward roster – a priceless contribution that enables a busy hospital to function with a relatively small group of academics and staff specialists. Without any VMO contribution, the labour ward roster of a large hospital becomes very arduous for a relatively small number of staff specialists and/or academics. I love our VMOs.

As a role model for medical students and young residents, an inspirational VMO can do as much to encourage a career in obstetrics and gynaecology as a brilliant lecture from an academic or stoic early morning tutorials from the staff specialist. Prospective trainees do not want to 'do obstetrics and gynaecology'; they want to 'be an obstetrician and a gynaecologist'. Seeing the VMOs able to successfully combine both a public and private practice (and a family!) may go a long way to consolidating that career path.

The Staff Specialist

The staff specialists keep the rhythm. Every hospital needs a group of specialists that provide a continuity of O and G presence. Such continuity is essential within a hospital if an O and G voice is to have any say in the day-to-day 'issues' that are so important in the life of a hospital. How can a busy O and G VMO compete in the committee room for precious hospital resources with staff paediatricians/anaesthetists/physicians...etc? These 'power groups' in our hospitals have seemingly endless hours to of 'administrative time' to harass hospital administrators into submission. On occasions, even the midwives have been known to have a contrary agenda

– an agenda that may become a veritable tsunami equipped with an overwhelming numerical and time advantage. By reliably being able to attend the necessary meetings and even allocate a little time to some background preparation, the staff specialist is well placed to fight these battles on behalf of the O and G staff - and most importantly, on behalf of the patients. The VMOs and academics may assist by providing wound care and then fresh armour for the next encounter.

Like the VMO, the staff specialist is also a role model and an increasingly important one. As part of the medical student feedback at the end of each O and G term, we explore reasons why they might or might not consider a career in our discipline. Overwhelmingly, lifestyle and working hours remain the main disincentive. Prospective specialists must appreciate that numerous O and G specialists around the country are able to effectively work in their chosen discipline, not only without destroying their family life, but often functioning as model parents.

The Academic

Above all, the academic has a charter that compliments both the VMO and staff specialist. To begin with, the finely tuned skills of the clinicians, shine all the brighter in the presence of a small group of well credentialled but less experienced academic colleagues. The VMOs and staff specialists should have nothing to fear clinically from a true academic. Equally, even the dullest academic (some might use the author of this article as an example), equipped with moderate endeavour can still mount a record in research and teaching that few VMOs or staff specialists will have time for. No threat. Harmony.

The Golden Rules of Obstetric Staffing

1. Disharmony comes with a high price.

I have had the doubtful pleasure of writing numerous reports at the request of the medical defence organisations and the public hospital insurers. With almost every case, 'There but for the grace of...go I'. Most claims are settled. Most should never have reached a lawyer in the first place. Do parents intuitively believe that their neonatal misfortune must have obstetric error at the heart of it?

Hindsight is a powerful weapon in the hands of a colleague, disgruntled by factional rivalry. Having been managed in the one sector and endured a poor outcome, a patient is quite likely to attend the contrary sector for subsequent pregnancy management. Subconsciously allowing intra-professional rivalries to influence these consultations can be very damaging. Not the least to the patient who must add to her misery, the

usually erroneous belief that all was preventable and may launch the grief-stricken parents into fruitless litigation from which only the solicitors profit.

2. Equality in rostering.

All members of the obstetric staff must do their share on the roster. 'Jammy' rostering of one professional group relative to others may be 'convenient', but ends up being inflammatory.

Clinical obstetric academic staff should also do their share. Credibility in teaching and training necessitates a clinical commitment. With ever increasing pressure on university clinical staff to attract more research grants and produce more publications, it has become increasingly difficult for academics to allocate the time needed to preserve clinical skills. When it becomes no longer possible for a senior academic to maintain a presence on the roster, then any traditional clinical leadership role should also pass to others.

What of the 'administrators'? Usually the nursing-midwifery administrator leaves direct patient care altogether when they move into administration. This is not the best way to administrate an O and G service. Time spent at the coal-face is hugely beneficial to efficient administration. Recent 'on the ground' experience by O and G administrators, can be a telling advantage over nursing-midwifery competitors in the fight for hospital resources.

3. Avoid the evening handover.

The time will come when labour wards in larger obstetric units are staffed overnight by obstetric consultants who have no commitments the following day. Our staff anaesthetists and paediatricians enjoy this 'luxury' already. Alas, our O and G consultants do not and it seems unlikely that will happen in the foreseeable future.

With the on-call O and G specialist burdened with substantial commitments the following day, it is imperative that the overnight workload is controlled. The 24-hour labor ward roster makes a major contribution to minimising overnight workload through efficient daytime planning.

The evening handover (usually around 6 pm), is a recipe for disharmony. Having one obstetrician responsible during the day and another at night, ensures abundant combustible material for the fire of discontent.

'Why was Mrs Jones induced at 2pm – why not earlier or left until tomorrow?' Which can be roughly translated as: 'I am very grumpy after a long day and.....(expletive followed by surname) deliberately did a late induction, just to make me even more miserable.'

'Why didn't he do the caesarean section for Mrs Smith in the afternoon when it was obvious she was going to obstruct?' Which can be translated as: 'I am very grumpy after a long day and now I have to do the work which that.....(another more evocative expletive) has maliciously deferred through laziness and a sadistic pleasure derived in ruining my evening.'

Managing a busy labor ward (I share the view that a 'berth suite' is for ships), is largely about time management. Starting the inductions early, timely augmentation for slow progress, promptly getting on with the planned elective caesarean section that has been admitted in early labor, not waiting to 'call' the 'seemingly inevitable' caesarean section until the absolute last minute ...etc. Vigilant planning during the day will

reduce the nocturnal frenzy. It actually becomes safer for patients by minimising deliveries at times when staffing levels are at their lowest. If one consultant covers both day and night, the motivation to get things 'out of the way' appears to be greater. Amazing.

4. Plan for the inevitable need for a VMO to attend private deliveries.

Co-location of private and public facilities should be the highest priority of every health administrator. Unfortunately, this has not always been so - it must be in the future, even for the most short-sighted of administrators.

So what then of the VMO who gets called to a private delivery when the private hospital is remote? There is no easy solution to this potential cause of inter-sector conflict but again, each must recognise their failings. Sure an academic or staff specialist colleague may need to stay longer in clinic or cover the public labor ward during the absence of the VMO to attend a private delivery. But the others also draw from the great favour bank of life. Conference leave, sabbatical leave, administrative and research sessions are all benefits that the VMO is less likely to obtain as part of their public hospital employment. Also, there are likely to be many non-remunerated tasks undertaken by the VMO during the week: medical student teaching, registrar teaching and training, clinical and administrative meetings, contributing to guidelines...etc. The list is a long one if the hospital maximally utilises the extensive experience of the VMOs. I am very happy to cover those absences – even if a touch grumpy at the time. The hospital gets a lot in return.

5. All groups participate in the development of Clinical Guidelines within the hospital.

Protocols and Clinical Guidelines must be owned and developed by the entire staff. Much as the academic may claim a superior knowledge of the latest literature, the collective clinical experience of the staff specialists and VMOs can be invaluable in clinical guideline development. 'Level 4 evidence' ('body of expert opinion') is imperative in clinical situations where higher levels of evidence are deficient or only tenuously applicable. A 'body of experts' is also needed to decide which trials are of relevance and what are the reasonable conclusions (if any). Unfortunately, an all too contemporary scenario is for a 'body of non-experts' to write a clinical guideline that is justified by a bizarre interpretation of very selected evidence. If an RCT is amongst the throng, it is then labelled 'level 1', when it may be more accurately described as 'level 99'.

6. Place emphasis on those issues which all O and G sectors share in common.

Here I am on shakier ground. It is very easy for the O and G academics to align with other university clinicians on hospital issues of importance. The same goes for the VMO and staff specialist sectors. This is very dangerous to harmony within O and G. Even more so when one O and G sector regularly aligns with the nurse-midwifery agenda against the other obstetricians. A unified O and G stance may necessitate compromise, but will inevitably win the day.

7. All aboard the Gravy Train.

Money may not be the root of all evil, but it does little to help staff our public hospitals. The difference in incomes between the private and public sectors has never been greater. Does this create bitterness? Of course it does and that bitterness can be very damaging to harmony in the hospital.

Where possible, the staff specialists and academic staff might participate in some private practice arrangement. Not only does this go a small way to addressing the disparity in incomes, but it also leads to a better insight into the realities of VMO practice outside the public system. '7.30 am, little private hospital, primigravida 8cm dilated, OP, thick meconium and a terrible CTG. Sixteen anaesthetists rung – all about to commence their lucrative private cataract/orthopaedic/ colonoscopy lists and 'unable' to attend.' Maybe 'private practice' was not such a good idea after all.

Conclusion

A harmonious relationship between the three professional sectors of our discipline is very achievable, being founded on mutual respect, rostering structures designed to avoid discontent and a continuing effort to prioritise intra-professional harmony in the interest of the best possible patient care.

My thanks to my VMO, staff specialist and academic colleagues for their ongoing endurance. I trust no sector feels unduly offended by the above. It was certainly not my intent.

Although somewhat unflattering of the clinical expertise of my fellow academics, it happens that the most competent clinician I know comes from that sector, as well as being a very gifted musician. Some people are just good at everything.

Dates for your diary

RANZCOG Provincial Fellows Annual Scientific Meeting 2008

25-27 April 2008
Peppers Pier Resort, Hervey Bay, QLD

Contact: Ms Kate Lawrey
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email: klawrey@ranzcoq.edu.au
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The RANZCOG Fetal Surveillance Education Program (FSEP) delivers highly regarded fetal surveillance education to healthcare professionals in over 140 centres throughout Australia and New Zealand. As a RANZCOG program, the FSEP is not-for-profit and remains the leading cost-effective CTG education provider in Australasia.

- Our clinical content continues to be of the highest quality, comprehensively addressing CTG use and fetal surveillance. We are continuing to develop additional education modules as well as developing and validating a competency assessment tool.
- Our popular face-to-face program facilitates adult learning whilst being time and resource efficient. We are currently building an online facility to support our face-to-face format. We are co-developing a fetal surveillance handbook to act as an additional resource and meet individual learning needs.
- Our workshops are accredited with the appropriate medical representative bodies and attract RANZCOG PR&CRM points. Additional PR&CRM points can also be earned by using our straightforward audit tool.

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For further information, please contact:

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