Case Conference

The Bioethicist at Matukituki General Hospital was approached by a house-surgeon who was deeply upset and contemplating giving up her medical career. She had been working for a consultant who seemed to delight in taking every opportunity possible on ward rounds to point out if she had made a mistake or done something that he did not completely agree with. He was a senior and well respected consultant and when this first started happening she began to seriously doubt her abilities. She noticed however that she had never had this problem with any other consultant and that in general the decisions she made had been perfectly acceptable in the case of patients cared for by other consultants, even on the same service. She was sufficiently disturbed by this that she talked to some of her junior medical colleagues. She found that this particular consultant was prone every now and then to take exception to somebody and to make their life a misery by disagreeing with every decision they made, even when that decision would have been a reasonable one in the case concerned.

In her case whenever there was the slightest suggestion that she had, at her relatively junior stage, overlooked something or done something in a less than optimal way this was mercilessly pointed out, usually in the presence of patients, nursing staff and any other members of the team that happened to be present. Things came to a head one evening when she was asked to see a person in the Accident and Emergency Department. She assessed this person as possibly having an early myocardial infarct. There was no ECG evidence but she had been warned that in the presence of a good history it was better to be safe than sorry. She knew that the particular consultant with which she was having difficulty was on call that evening and so attempted to ring him to be sure that that would be the course of action of which he would approve. She had already checked with the Registrar who thought it was a reasonable, although not mandatory, step to admit the patient and suggested that she check it out with the consultant. The house surgeon duly admitted the patient to the ward and the patient was reviewed when the consultant did his round the next morning (This was relatively normal practice). When he reviewed the case he dismissed her fears as being ill-informed and inexperienced and said that she had no business cluttering up his beds with patients who did not need to be in hospital and that the patient should be told to pack her bags and leave as soon as possible. The house surgeon had found the way her behaviour was lambasted in front of others extremely distressing, so she came to see the bioethicist about what she should do about the problem.

Commentary One

Robyn Carey
Sixth Year Medical Student

The rigours of life as a junior doctor are well recognised, and have been subject to extensive study in the US and UK, and to some local comment.

The first year as a house surgeon marks the transition from student to employee, and as such is often particularly stressful. (Although this transition has been softened by the introduction of the Trainee Intern year, where for a proportion of the sixth year of the MBCHB undergraduate degree, medical students are apprenticed to house surgeons.)

The long hours, heavy workload and significant levels of responsibility have all been mentioned as sources of stress for junior doctors, along with outcomes such as emotional distress. Yet ironically, the first few years of practice have the potential to be challenging and satisfying. R. Downie writes that

> House officers work long hours; they are often poorly supervised; and the objectives of the period of training are unclear. There is little or no time for educational activities; and they may not even be encouraged. During this period many attitudes and habits are set, and the process of indoctrination or initiation, the hidden agenda of medical practice takes place. Yet it should be a time of excitement, learning and growth. (Downie, RS and Charlton, B 1992).

As a significant stressor for junior doctors, verbal abuse is seldom mentioned. This may be because it does not occur in any magnitude, or because it occurs but is not reported. Verbal abuse of medical students is discussed in the recent Life-skills Working Party Final Report, which gives a working definition as:

> abuse is to treat in a harmful, injurious or offensive way; to attack in words; to speak insultingly, harshly or unjustly to or about a person; to revile. (Reynolds, M. 1993)

The case before us suggests that verbal abuse can continue into the junior doctor years. Given that this house surgeon's practice of clinical medicine is acceptable to most, this must give us reason to suspect that consultant's interpretation of her ability. However, in this commentary I assume that it was appropriate for this house surgeon to admit the person without ECG evidence of a myocardial infarction.

In clinical medicine, it is often assumed that for any one situation, there is a right answer or course of action, and a wrong one. In the example to hand, the consultant at Matukituki General Hospital clearly thought that he was the source of the right answers, and his house surgeon the wrong ones. As noted by Professor Grant Gillett, such situations convey the message that "medicine is about power and that being right is almost always found in company with being powerful." (Gillett, G. 1995) Professor Gillett is concerned to develop a theory of truth and meaning whereby exclusive views of particular events or situations are suspect partly in virtue of their exclusivity. In this example then, what strikes us is not only the poor pedagogic techniques and the injustice of the junior doctor's inability to gain a right of reply or defence but also the dangers of a single consultant claiming a monopoly on truth, and an inability to hear the voices of others. Indeed, the inability to consider other views

was a key element in the continuation of the infamous Unfortunate Experiment at National Women's Hospital.

When such a situation as this occurs, where can house surgeons go for support and advice? When house surgeons begin their first year of practice at a hospital in New Zealand, generally they are not provided with any information about support services available to them as employees. Information disseminated during the previous six years as medical students on services such as the Doctors Health Advisory Service (DHAS) may not be easily retrieved. It may be difficult to obtain local support without violating confidentiality and involving other members of the profession. Contact persons for harassment are often available within a university system for students, but not for young doctors working in small hospitals. Crown Health enterprises seeking accreditation must appoint intern supervisors, however, since they are usually working in the same hospital as the house surgeons, they may not be an appropriate person to turn to for advice and support. The concepts of "mentors" and "Balint support groups" are being explored at the registrar level for the General Practice and Psychiatry training programmes, but this is beyond the stage of first year graduates. Thus it seems that a coordinated effort needs to be implemented between various interested parties such as the DHAS, the Medical Council, the Resident Doctors Association and CHE personnel managers to develop a programme of assistance for new graduates and other junior medical staff who find themselves with work related difficulties.

Downie, RS. and Charlton, B. *The making of a doctor: Medical education in theory and practice.* 1992. Oxford University Press. Oxford.

Reynolds, M. 1993, Research essay, "Medical Student Abuse". cited *in The Life-Skills Working Party Final Report.* November. 1993

Gillett, G. *Is there anything wrong with Hitler these days: Ethics in a post modern world.* 1995 Inaugural Professorial Lecture. University of Otago.

Commentary Two

Professor Gil Barbezat
Otago Medical School

The situation described, although fortunately not too common, is one which occurs intermittently with varying degrees of complexity. The episode is of great significance, not only for the house-surgeon concerned, but also for the consultant. It is important that the issues are clear for both sides.

Taken at face value we have an understandably very distressed house-surgeon who has a complaint which she feels is serious enough for her to contemplate giving up her medical career. At best she would feel that her future could also be compromised particularly in the field practised by this consultant. Being a house-surgeon facing this situation, she is clearly insecure, particularly with regard to her senior consultant persecutor. Her judgement and her values have been questioned and what confidence she has built up over the years has now been called into question. It would appear that her work for other consultants has been satisfactory and she feels that the criticisms are unwarranted and that she is being picked on for reasons which she has not (nor may not wish) expressed. She also feels that she has been humiliated in front of her working colleagues. This is indeed difficult to accept.

From the information available we know that the consultant is a senior person and that some junior colleagues have recognised him as a bully who picks out people for "individual attention". He would appear to be merciless and repetitive in his treatment of his victims and indiscreet in his criticisms of his junior colleagues.

The final incident which resulted in her approach to the bioethicist would suggest that the house-surgeon followed the normal procession of opinions via the registrar to the consultant for confirmation of her management of a patient with chest pain. Although the consultant was on call he could not be reached by telephone before she took the decision to admit the patient. She was faced with the responsibility of the patient's care and took the eminently justifiable decision to give the patient the benefit of the doubt and admit her to the ward for observation. The following day the consultant's comments were ill-informed (and some would say clearly wrong) and he appeared to have more concern about possible inappropriate use of beds than appropriate care of patients. His attitude could be regarded as rude and inappropriate, particularly as it was expressed in front of others. While it may have been true that the house-surgeon was inexperienced, this would be an additional reason for a positive caring approach towards correction of any error (performed in private) rather than the method adopted.

How does one react to such a situation? The bioethicist would be well advised in the first instance to check the information. It is clearly charged with emotion and a potential disaster. Besides personal feeling, the situation could be loaded with nuances of sexual difference between a young vulnerable female and an older domineering male, as well as a fledgling doctor facing a senior consultant. Discreet inquiry to individuals would establish a data base which would only be to her benefit (while making it clear to the house-surgeon that we would not do this because of disbelieving her story). The house-surgeon could indeed suggest people who might be approached on a discreet confidential basis (in private) to comment on the situation. Sooner or later, the senior consultant concerned would need to be approached. It would be only fair to obtain his side of the story. While there is always the perceived danger of comparing one person's word against another, it is nevertheless important to hear both sides of the story. With the experience in dealing with people over time we should have confidence that the bioethicist would be capable of forming an opinion concerning the depth of the problem. Is the picture truly as described above, or is this a relatively minor problem which has been exaggerated out of context? There is little doubt that a problem does exist and that an appropriate solution needs to be evolved. The consultant needs to be reminded of his responsibilities towards the education and nurture of junior colleagues and needs to be in no doubt that a problem exists and that the problem could well be a very serious one.

What happens next would depend on the findings of the above inquiry and the attitude of the consultant concerned. Assuming the events have been verified, it would be rare for such a consultant to offer an apology and change his ways. (Of course that would be the desirable path to follow.) He should be under no illusion that his attitude is a major problem and not only a poor role model for his junior colleagues and the profession, but also completely unacceptable. This should be expressed in writing and if at all possible and appropriate, linked to ongoing verbal discussions, although these are often rather difficult. It is often useful to have a written consensus of the discussion(s) which should be agreed and signed by the parties present; an independent witness may be useful. A written record minimises the risk of ambiguity and argument over what was agreed. Except for minor personal problems, it would be important to discuss this type of situation with the head of the medical firm or medical department so that the consultant's immediate supervisor is aware of the situation. This supervisor may like to discuss this with the house-surgeon concerned so that she feels she has a channel of official communication and that her complaints have been taken seriously. Depending on the circumstances it would be advisable for the house-surgeon to be moved to another team. Paradoxically, it is usually the junior person who is shifted sideways. The head of firm or department should keep a watch on the consultant's behaviour to try to ensure such a situation does not recur, and if it should, to be sensitive to the problem at an early stage. If the house-surgeon continues to work for the consultant concerned, she should not simply be sent back into the open-ended fray, but have a predetermined course of action set for review of the situation by the bioethicist or head of department or chosen confidante which could be activated as an urgency if required.

Discord of a minor degree is bound to occur in any human relationship. Misunderstandings can often be prevented by early open discussion of problems at an informal level. Peers and colleagues should be attuned to this on a day-to-day basis to help others deal with "prickly personalities" which exist in any walk of life. Maintaining a happy team approach minimises this risk

Commentary Three

Dr Tom Fiddes
Department of Obstetrics and Gynaecology
Otago Medical School

A most disagreeable situation has arisen between professional colleagues. Hopefully this occurs less now than in older, more paternalistic times or is this the false hope of an older commentator not exposed to senior doctors "victimisation" or, worse, does the commentator not see the "mote in his own eye?"

The case situation calls for urgent action - a young doctor with at least seven years training is considering quitting. What misery and despair must lie behind this consideration.

An older, more senior doctor risks losing the respect of junior doctors, nurses and patients.

The solution to this must encompass some first aid, or exploration of the interaction of the pain, a seeking for exonerating or mitigating features, and finally, the vigorous application of a remedy.

The hardest part of the resolution process will be the exploration of the breakdown of the relationship. Accounts from the consultant may be illuminating; they may however be self-seeking justifications, half truths; vital information may be withheld for perceived gain in any confrontation. The most likely material to come from this process will include senior behaviour that is "bloody minded", ie no rational basis can be obtained, a personally troubled senior with a disintegrating family relationship, a senior with alcohol problems, monetary problems, or a career perceived as less than desired. Other issues that might be thrown up are a dislike of females as practitioners, an attitude that nobody can do the job as well as the senior (misplaced conscientiousness). It may be as simple as an objection to dress or lack of expected deference. Has the consultant had a major problem in the past with a junior which continues to colour his relationship? The problem is less likely to be with the junior as we have the evidence, albeit from other juniors, that this particular senior is "prone every now and then to take exception to somebody".

For completeness sake, the ethicist should ensure that the junior is not unduly stressed in her job as a whole, is not bone weary, is not overburdened with the responsibility of front line care and has an appropriate level of communication. After interviewing the junior and senior it would be prudent to seek independent views on the relationship. It would be courteous to inform the pair of this action but I don't believe their permission need be sought. In this case the "brawls" have been in public - junior medical staff, nursing staff and even patients may be important sources of collaboration or rebuttal.

The gathering of the above information with sensitivity is an exacting task and thought needs to be given to who is best placed to achieve the best result. I suspect there are no hard and fast rules and in general one would want an open minded experienced practitioner who does not see things in black and white, one who is capable of weighting evidence and one who is capable of interpreting the pauses, the hesitations and evasions. It is more important to have the above attributes than to be in any particular office. The house surgeon has come to the bioethicist because she believes she will get the best outcome and this may well be the case. The senior may interpret this contact as part of an unlikely alliance and react against it. Others that may play a part include the intern supervisor, senior medical personnel, a senior nurse, a staff development officer or a sexual harassment officer.

Depending on the information gained and the weightings and interpretations applied, some remedial action will be planned. This might range from an "old boy chat to the senior" or a confronting of him with unpalatable facts about his professional, social or personal life together with offers of help in these areas.

If the junior is exacerbating the situation because of her own inadequacies or manner, these should be addressed in a sympathetic way. The resolution may include separate feedback sessions, sessions where the junior and senior are encouraged to make a commitment to their professional relationship and its improvement, and should also include some ongoing monitoring of the relationship. The first aid measure of shifting the house surgeon off the run

should be seriously considered. This will allow the ongoing trauma to be halted and give time for the investigative phase to be completed. It should not be viewed as a loss of face by either party as the ultimate aim is to bring the pair together in a harmonious and satisfactory professional relationship. In the current cost cutting of New Zealand CHEs this type of time consuming review will be harder and harder to implement. Staff development departments are being broken up and their duties devolved down the line. In some cases talented individuals will take up the challenge, but in many instances sophisticated analysis and remedial action will not be able to be mounted with the result of less than optimum development of all concerned and of course the insidious erosion of patient care.

Book Reviews

Title: ***Whaiora.*** *Maori Health Development (1994)*
Author: Mason Durie
Publisher: Oxford University Press Auckland
Reviewer: Hunaara Kaa, Director, Maori Health Unit, Department of Community Health

Whaiora is a very readable book of 217 A5 pages and comprises twelve chapters, well set out and organised in logical sequence. The book is a treatise on Maori health in what I would describe as the first contemporary text on Maori health to bring together all the essential issues concerning Maori today. This book has brought together that of the past and the present, and provides a foundation upon which future Maori health can develop, be strong and confident. Throughout the book traditional and eurocentric themes are analysed, and frameworks developed for future consideration and action.

Whaiora is an absolute requisite for students wishing to incorporate Maori health in their studies agenda, and at the same time is a very useful text for the most experienced persons in the health arena, both Maori and non-Maori. This is the base text I am using in our Masters in Public Health course, An Introduction to Maori Health.

With the untimely death of Professor Eru Pomare, Professor Mason Durie now stands alone as our top Maori health scholar and leader, and the publication of Whaiora late in 1994 was most timely as a much needed text to incorporate the crucial elements concerning contemporary Maori health during this epoch of major social and economic reform.

Chapter one summarises the books structure, while chapters two and three look at the trials and discoveries of the past. Chapters four through nine look at the energies and initiatives of contemporary Maori society. Key themes include the Treaty of Waitangi and biculturism. Chapter ten looks at a Government perspective for Maori health and their objectives for a Maori health future. Chapters eleven and twelve look at health priorities and plans by Maori for the future.

The chapters covering the historical aspect look at traditional approaches to Maori healing and public health measures. Particularly relevant are the concepts of tapu and noa as crucial processes for conservation. Tapu is that which is sacred and must be respected. Noa is that which is profane and implies freedom of usage within appropriate bounds. Chapter four looks at twentieth-century recovery and growth, and focuses on three patterns of Maori participation in health: Mana rangatira, Mana wahine, and Mana Maori. One criticism is that while some of the work of the Maori Womens Welfare League and other organisations is acknowledged, Mason has not described the major position women have taken in Maori health today. That much of the recent progress was bought about by the actions of many radical women, which had been hard fought and at cost to them, has gone unheralded. Rather, the progress has been made to sound almost matter of fact.

Chapter six includes a description of the origin of the concept of the now widely known and accepted Maori health model, Te whare tapa wha (the four walls of the house) but more commonly known as the four cornerstones. The description of the historic meeting where this milestone Maori health model was created I found quite moving. This single event was to have a profound impact in enabling a new direction for Maori health that Maori would be able to claim as being by them and for them. This notion is fundamental to the concept of tino rangatiratanga.

Having said this, Mason has difficulty explaining the relationship and linkages between the four components, which is not surprising when considering such esoteric mediums as spirituality and mentality. My own feeling is that this difficulty is reflected in the actual application of the model within the health field. The four cornerstones perspective is often espoused in mission statements and health charters, illustrating its recognition as being of great importance. From this point on however, one is left with a sense of uncertainty as to where the plot goes from there. More work is required on the model.

Chapter eleven, titled Whainga Maori, looks at the identification of priorities and themes for Maori health from numerous health hui over the last two decades. Despite the diverse realities that Maori live in today, a high level of consensus was achieved in identifying ten health priorities, that are discussed within three broad groups.

The last chapter is a short summary and provides suggestions focused on future directions for wellbeing that will not only benefit Maori but the nation as a whole. Perhaps two quotes from this chapter will make a fitting conclusion '...Maori health is more complicated than illness, injury or lifestyle. People belong to families, communities and a nation and are reflections of the values and policies therein' and finally ...'Continued gains in health for Maori can be anticipated. Maori vitality is too exuberant to expect otherwise. Importantly, however, there is now a greater need to aim for standards of health which transcend physical dimensions and encompass those aspects which have been relatively neglected: wairua, hinengaro, and whanau'.