Presidential Address
Dr Jeff Brown

Are we there yet?

The incessant refrain from the backseat of any long journey. The repeated measure of boredom when only the destination seems important. The frustration from the backseat bunch whose hands are not allowed on the steering wheel, let alone able to reach the accelerator or brake.

Are we there yet?

We have certainly mapped out a whole new journey in the last few years, with significant milestones along the way. The concept of doctor as victim, of attack from all sides in a name, shame and blame game, has matured into looking at systems errors, of remedying the results of inevitable slip-ups. Complexity causing cock-ups is starting to be addressed rather than reacting with conspiracy theories swirling around knocking doctors off pedestals. We are learning from other industries, and being brave enough to share our own mistakes so others can learn from us.

Are we there yet?

We have established clinical leadership at the core of Government policy. But is it embedded? A year ago the newly warranted Minister of Health, Tony Ryall, addressed this Conference and made a pledge to reinstate elected representation to the Medical Council. He also followed up his desire for engagement by appointing a Task Group which I had the honour of chairing. Building on “Time for Quality” which had been facilitated by the previous Minister, David Cunliffe, our group produced “In Good Hands”. This report outlined core principles and the transformations which are required for DHBs to have real clinical governance.

There have been several flurries of activity throughout the sector in response to “In Good Hands”. Some attempted to marginalise it to maintain the mantra of managerialism. The Minister made it clear that the report is Government policy, The Ministry surveyed DHBs asking how “In Good Hands” was being implemented. The responses were variable to say the least. Some were encouraging but many assumed that a few appointed leaders ticked the boxes. They failed to grasp that clinical leadership must extend to every layer of the system, empowering the entire workforce. A further group was convened to formulate a guide for the Ministry. A guide on actively reporting achievements in DHBs towards transforming clinical governance. The essence of this reporting is that you and I are all involved in affirming the report, before it is sent in. Maybe we will have another set of league tables to publish.

Are we there yet?

The first nine months of the year also saw the gestation and delivery of, and responses to, the Ministerial Review Group report. Many of the recommendations of this large report resonated with specialists. Most of us would strongly support the thrust to strengthen clinical leadership, to reduce bureaucratic wastage, to centralise several of the 21-fold duplications of
DHB land, to cut through the 80 plus PHOs, multifarious NGOs, and countless contractual cobwebs clogging up clinical care.

The sticking point became the parenting of the new child, the National Health Board. Initially intended to be an isolated infant, learning to crawl, walk and run on its own, we argued that the NHB needed to be nurtured within the Ministry. Albeit a reshaped parent body. The Minister listened. The NHB will now be a part of the Ministry, and wholesale restructuring with all its associated confusion has been avoided.

The MRG report and the new NHB signal that the hard decisions are only just beginning. We face the triple whammy of shrinking recessional spending, insatiable demand for health dollars, and workforce crises calling for major engineering, not just tinkering, at medical student, postgraduate and specialist levels.

We will have to ration. Ration our time between patients and teaching. Ration our time between patients and leadership. Ration our time between all this work and our out of work lives.

We will have to ration. Ration our technology and skills. Ration our high cost - low utility interventions. We will have to convince our politicians and public to openly debate rationing health care. Because rationing is already happening. By stealth. By income. By post code. By age.

Are we all honest enough to entertain the rationing debates without fear or favour?

**Are we there yet?**

Next year we enter a new wave of MECA negotiations, and already your Executive has met with DHB representatives in open discussion about the big issues.

There is a huge gap between what specialists can earn in Australia and in New Zealand. Specialists who often train in common Colleges. And who work in a common market for employment, not infrequently with connections through living on both sides of the Tasman during their attractive and reproductive years. There are shortages of specialists in Australia. There are shortages of specialists in New Zealand. Who wins?

Should the next MECA aim to level that playing field? And if so, how soon? By 2025 or earlier? Do we take the recession on the chin, claiming our profession is the most serious in need of replenishment? Or do we sacrifice financial incentives aimed at attracting and retaining more of us? Sacrifice personal gain in the forlorn hope that money will go to the lowest paid in the system? Is the country’s debt ours to own, or is the quality of health care dependent on keeping highly paid specialists at home? Over the next two days this Conference must give direction, must govern our collective imperative. You must have the fortitude to decide the flavour of our approach to next year’s MECA. How to season our expectations and set our goals. What we might gain in a short trip and what we might aim for in a long journey.
Are we there yet?

Today and tomorrow we will contemplate the funding of the health system, engage with the Minister of Health, compare the New Zealand system with other countries, hear an insider’s guide to clinical networks, and inspect the implications of integrating primary and secondary care. Our journey together will look inside and outside the system we know, love and hate. We may even have some ideas on what needs fixing, and how we might help fix it. Ethically.

Doctors undoubtedly experience pleasure and reward when repairing broken bodies and broken minds. Is it possible to experience the same delight when repairing broken bits of a health system? It takes much longer, throws up more frustrations, and has more compliance and adherence issues than the most recalcitrant patient. The journey’s destination may appear unachievable, the horizon keeps shifting, the goals more than abstract, and measurement of achievement harder to agree on.

Trying to fix the health system has more in common with general rather than hospital practice. Like dealing with the patient journey through health and illness rather than admissions of major catastrophe and drama. Rewards earned more from encounters and engagement than from episodic euphoria. I suggest we will have a more rewarding journey trying to transform the health system if we explore joint efforts with our general practice colleagues. Explore how we can integrate the system for the patient journey.

You are here because you are not just a spectator at the edges, but have at least a hint of participatory leadership in your veins. Matthew Taylor opines that it is the attitude of the spectator that induces pessimism, the experience of the participant that brings hope. He says the problem is not that change brings fear and disorientation (there's nothing new in this), it is that we lack the spaces and places where people can renew hope and develop solutions.

We can join with primary care leaders to blur boundaries and break down walls. Get together in rooms both real and virtual to decide the best place to make the best decisions for the best clinical outcomes. Then populate those places with the expertise when and where it is needed. Then require the contracts and transactions to enable, not control, the pathways and processes we have designed. Together.

Are we there yet?

We hear a lot about focussing on the patient journey. And how that focus will help avoid waste, reduce error, and improve outcomes. All laudable stuff. But the patient is not alone on their journey. We are with them, especially when the going is toughest. I submit that we have often ignored the doctor journey. We have improved patient spaces in clinics and wards, but ignored the physical spaces and tools, especially electronic, that improve the doctor’s life and work. We have focussed on communication and empathy for the anxious and aching, but often treated the specialist as impervious to emotional harm. Our health care organisations have an unfortunate habit of leaving the pastoral care of our medics at the end any agenda, to be got around to when all the other work is done. And we ourselves are often the source of difficulties for our closest colleagues.

One challenge I give you is to look after yourselves, and to intervene before relationships sour. To improve the pastoral care of ourselves. To model, for those who will step into our shoes,
how great our job really is. How brilliant our profession can be. How wonderful our calling. To improve, and enjoy, the doctor journey.

**Are we there yet?**

Geoff Shaw said recently in Christchurch that clinical leaders have two requirements: one, a stomach for controversy, and two, ability to face harsh realities. I do not think he was suggesting we should be gluttons for controversy, but have the stomach to digest it without blowing off or suffering the screaming runs. And that harsh realities are to be expected, even embraced. When you do something real, people pay attention and there will always be responses equal in intensity and opposition because what you have done is truly remarkable. Not easy, but remarkable.

Reflecting on the challenges of leadership, I offer a new variation on an old misquote. The price of clinical governance is eternal diligence.

Personal diligence to keep up to date, not only with clinical medicine’s knowledge and skills, but also with modern teaching, leadership, teams, and change. And group diligence to maintain momentum for marginalising managerialism, embedding clinical leadership, and refocusing attitudes and relationships on the patient journey and the doctor journey.

Diligence unbundling the edifices others have built around us. Diligence rebuilding from within the networks so critical to quality patient care. Diligence blowing the cobwebs away from constricting contractual conceits. Diligence reinforcing relationships with ourselves, and with those who walk with us on our journey.

I call on you all over the next two days, and henceforth, to embrace the doctor journey, on behalf of the patient journey, to transform our health system. All within the restraints of recession and the challenges of workforce crises. To garner reward from the journey, whatever the destination. To enjoy the back seat, if that is your desire, but not to nark at those who want their hands on the throttles, brakes and steering wheels. To grab the wheel, press the throttle, and pump the brakes if you have a moment to lead, an inclination to govern. To embed clinicians in the driving seat of the system from top to bottom and back again.

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Dr Jeff Brown
3 December 2009