

Making distributive clinical leadership work

The value of clinical leadership

A health system led by clinicians is better for patient care and safety, and makes better use of available resources. Doctors and other health professionals enjoy their work more when they are actively shaping the services they provide.

Sounds obvious, right? Yet survey after survey has shown that senior doctors and dentists working for district health boards (DHBs) are not being given enough opportunities to provide the leadership the health system needs.

That's despite successive governments and Ministers of Health, as well as hospital bosses, espousing the value of clinical leadership.

What is distributive clinical leadership?

Simply put, it's about ensuring that clinicians of all types (including doctors) are able to make decisions based on quality of care and patient safety at every level of the health system.

It's not about your job title. You don't have to be in a formal leadership role to demonstrate clinical leadership in service design, configuration and best practice.

This type of leadership is distributed through the clinical workforce, and rests within it, by virtue of your highly specialised training and vocational requirements, along with your professional and legal responsibilities. Senior medical staff are natural 'understanders' of complexity. You have been trained to solve problems, critique and improve processes, and lead innovation.

How do DHBs benefit from this?

Public hospitals are major responsibilities for DHBs. Whether urban or provincial, they provide highly complex and integrated 24/7 services, including emergency, acute, chronic and elective care.

To provide the best possible health care, DHBs need to draw on your expertise when designing, configuring or delivering services. They need your input into all activities that will affect clinical decision-making, including (for example) whether to embark on procurement processes that affect patient services (and if so, the scope and form of the processes).

DHBs benefit from this involvement in terms of the quality of care they are able to provide and their financial performance. Engaging with you and supporting distributive clinical leadership is a win-win situation.

Not all SMOs have to become formal clinical leaders and don't need to. But distributive clinical leadership is much broader and potentially much more effective and sustained in terms of improved quality and financial performance.

So why isn't it everywhere?

Lack of time is the greatest barrier to distributive clinical leadership, coupled with entrenched medical workforce shortages and greater expectations being placed on senior medical and dental staff from both increased health care needs and government policies.

It's hard to make room in the diary for distributive clinical leadership activities when there aren't enough doctors in your specialty to do just the clinical work required, let alone using your skills and experience more widely.



Outdated management attitudes, the lack of availability of training in some skills, and doctors being unnecessarily sidelined with financial pressures leading to increased risky short-term decision making and administrative tasks are also barriers.

Clinical governance or clinical leadership – what’s the difference?

Clinical governance refers to the system where clinical goals are set and reported on.

Clinical leadership is the operational system that allows health workers to do what is needed based on these goals.

What does the DHB MECA say about this?

The MECA is very clear about the need for DHB engagement with senior doctors and dentists (see MECA preamble).

DHBs and the ASMS acknowledge the importance of promoting and establishing clinical leadership in the workplace, consistent with the principles in the Time for Quality agreement (jointly signed in 2008) (Clause 1.1).

In addition, DHBs have undertaken to:

- support leadership by senior doctors and dentists in service design, configuration and delivery (Clause 2).
- devolve decision-making to the appropriate level (Clause 2) and to provide the resources necessary (Clause 9).
- commit to a mutually agreed job size which enables doctors and dentists to discharge their non-clinical duties (Clause 42).
- consult senior doctors and dentists as to the purpose and process of any review, involve them in any review, and agree on a process if there are professional concerns arising out of a review (Clause 48).

How does the MECA support distributive clinical leadership?

The MECA entitles you to leave for professional activities, including meetings, sabbaticals, secondments and CME. DHBs have also committed to encouraging medical specialists to carry out research.

The MECA recognises the profession’s standard that 30% of job-size should be available for non-clinical work, including distributive clinical leadership. This is distinct from time being made available for formal clinical leadership, which must be recognised separately (Clause 48.2(e)).

How can I ensure distributive clinical leadership is in place at my workplace?

You can propose improvements to services based on evidence, research and work already done on quality improvement.

This should be the starting point within a DHB for any changes that will affect your clinical practice.

You should expect to be involved right from the start in any changes that are likely to affect your service – from the initial ‘bright idea’ through to the decision-making and implementation stages. Your input is essential to ensure the idea makes clinical sense.

We have a good idea but management says there’s no money to proceed

Management cannot simply ignore proposals for improvement based on clinical need or to avoid clinical risk.

The primary concern of senior doctors and dentists is for patient care (Clauses 39 and 40). You have the right to speak out as necessary to advocate for what your patients need.

Clause 41 also provides a mechanism to deal with barriers to change on the grounds that “there is no money”, by requiring DHBs and the ASMS to agree on a process to resolve the concerns that have been raised.

The ‘Time for Quality’ clause in the MECA does refer to an obligation to operate services within the resources available. However, DHB managers tend to focus on the short-term rather than looking at the best use of resources over a longer timeframe. Short-term decision-making often results in more expensive outcomes in the long run. Medium to longer term decision-making based on what makes good clinical sense is likely to be more fiscally responsible and sustainable.

What about managers (or others) who try to impose change without consultation?

The first question to ask is whether you or your colleagues are leading the development of a particular initiative or if you’ve been placed in the role of having to react to it.

Your involvement is needed from the start to ensure an initiative makes good clinical sense and it should not proceed without the support of you and your colleagues.

If you find your involvement is being marginalised to simply implementing an initiative designed by others, or that you are being asked to react (rather than lead) an initiative, discuss this with your colleagues and, as a group, let the DHB know that this is not acceptable. If that doesn’t work, contact your local ASMS branch officer or ASMS industrial officer and ask them to follow up at either a local or national level.

Ultimately, the imposition of changes without consultation is likely to breach the MECA and may require legal action to be taken.

Your right to speak out

A discussion of resources can be a political issue and you may wish to use your professional society or your right to present your case to the public.

The right to speak out is protected in the MECA (Clause 40) and also Schedule 1B of the Employment Relations Act 2000.



Do I have to take on a leadership role?

The professional and ethical obligations of senior doctors and dentists mean you are obliged, where possible, to undertake some type of leadership role in delivering care to patients, attending departmental meetings, and participating in quality and safety activities such as teaching, research, clinical audits and peer review.

You will have various opportunities over the course of your career to take on a leadership role, be it large or small, formal or informal.

Even a sole specialist at a small DHB needs to be engaged in shaping services and should be appropriately job-sized to take on the task.

For many people, it is another way of drawing on the expertise, experience and insights you have acquired over many years of clinical practice to improve health care within New Zealand.

Relevant reading



ASMS DHB MECA 2013-2016
<http://goo.gl/IAi8XX>



ASMS Standpoint –
Hours of work and job size
<http://goo.gl/rtJul2>



A quick guide to job sizing
<http://goo.gl/w3kgOq>



In Good Hands
<http://goo.gl/tB2bmJ>

