NATIONAL PRESIDENT

The accidental clinical leader (and manager)

I bought my first desktop computer in 1989. Many a night was spent with a book on my lap in front of this impressive machine, with its 20 MB hard drive, learning DOS and a programme called Framework III. There was a choice between pixelated green or amber text on a black screen.

A year later when I became a registrar in paediatrics I was able to create, maintain and interrogate a basic spreadsheet. It soon became my duty to do the departmental on-call and leave rosters, from house surgeons all the way up to, and including, consultants.

In retrospect, this gave me a unique opportunity to interact with the whole department on a regular basis; at times there were some very tricky conversations and negotiations around rostering, annual leave and on call requests. When it came to choosing a registrar representative for the paediatric department, I was nominated and elected – most people already knew me due to my spreadsheet skills. From there it was a short jump to becoming a registrar representative on the University Hospital Registrar Board. This became part of my curriculum vitae. Six months into my first consultant job I was appointed Chief of Paediatrics and this was added to my CV – and so it became a self-fulfilling prophecy.

As you must realise by now, due to my ability to do a basic spreadsheet, I became an "accidental clinical leader." Without any formal training in clinical leadership, I somehow managed to wing it.

According to the 70/20/10 Model, 70% of what you learn is based on experience, 20% on feedback and coaching and 10% on formal training. There are many quotes about experience, all of them pretty disheartening and demoralising. "Experience is a good school, but the fees are high," said Heinrich Heine. And from Vern Law: "Experience is a hard teacher. She gives the test first and the lesson afterwards."

Believe me, as an accidental clinical leader I sometimes learned the hard way while my colleagues and family looked on and suffered the consequences of my learning experience.

So let us look at the 20% that consists of coaching and feedback. Not only should this occur but it should be done correctly. Practice is futile unless you actually practise the right thing in the right way. Vince Lombardi: "Practise does not make perfect. Only perfect practice makes perfect."

Experience is important but you can, and should, learn from the mistakes and ideas of others. A few years ago I stumbled across a TED talk which changed my thoughts on leadership and clinical leadership, and stimulated my appetite to read and learn more and to become less of an accidental leader. It was the now famous talk by Simon Sinek (16.5 million views on TED Talks). The catch phrase of his presentation and book is "people don't buy what you do, they buy why you do it". But something in his talk was of particular interest to me. If your 'followers' believe what you believe, they will commit wholeheartedly to your vision with their blood, sweat and tears. Martin Luther King did not get up on stage and urge people to get rid of racial inequality and outline a 10-step plan to do so. He started by describing his vision ("I have a dream"). People who had the same dream and belief trusted him and followed him as a leader.

Those who lead are able to do so because others trust that the decisions being made have the best interests of the group at heart and as a result they are prepared to work hard to achieve something bigger than themselves. Simon Sinek described the underlying principles of creating the 'active follower' – without this trust and confidence, you cannot be a leader.

So to recap, I come from a generation of "accidental clinical leaders". My journey started as a spreadsheet creator. The journey of others probably started differently. Some people would have been elected by their 'active followers', some would have been shoulder-tapped by management, and so on. However, we all have one thing in common - we mostly learned from hard-earned experience and "winged" it, and to various degrees, we are still "winging" it some, or most of the time.

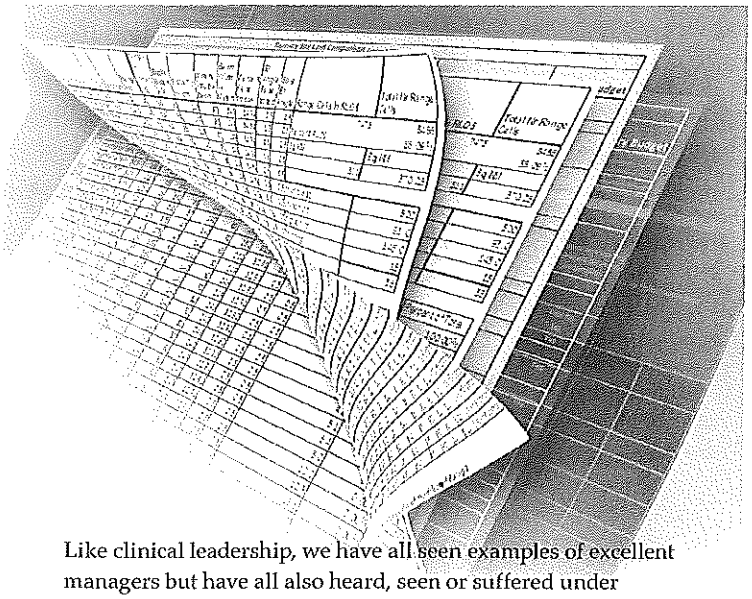
> *People already knew me due to my spreadsheet skills. From there it was a short jump to becoming a registrar.*

We have all seen examples of excellent clinical leadership but unfortunately we have also heard, seen or suffered under clinical-leadership-gone-bad.

While attending the Canadian Conference of Physician Leadership in 2011, I was exposed to a whole new world of fostering, training, supporting and recognising physician leadership. The Canadian Certified Physician Executive Program (CCPEP) was developed by the Canadian Medical Association and the Canadian Society of Physician Executives. The CCEP credential recognises physician leadership and excellence through a national, peer-generated, standards-based assessment process. Physicians awarded the CCPE have proved they have the leadership knowledge and skills needed to perform well and to direct and influence change in Canada's complex health care system.

Wow, a system that moves away from the accidental-clinical-leader-formula and changes the 70/20/10 model by increasing coaching, feedback and formal training! Physicians in clinical leadership positions no longer have to rely on experience 70% of the time. Standards are set and the Canadian certified physician executives are recognised for their qualification. In fact, it is asked for when applying for positions of leadership in the health care system.

Recently a thought hit me. If there is a generation of accidental clinical leaders, what does the managerial side of health care look like in New Zealand? What is the prevalence of accidental health managers? What training and qualifications do we accept and/or expect of a manager in health care? What does the career pathway of a health care manager look like?



Like clinical leadership, we have all seen examples of excellent managers but have all also heard, seen or suffered under management-gone-bad.

New Zealand has a health care budget of $14.5 billion. Whether we like it or not, we are also in the business of health care delivery. This business relies heavily on the skills, training, qualifications, strategy and foresight of its clinical leaders and health managers (hopefully supported by professional budgeting and business units which incorporates well trained and savvy accountants and business analysts).

The clinical leader/manager partnership should have a common purpose, or "why", which they share with their active followers. Unfortunately, and increasingly so, this common purpose and the "why" of health care delivery are pre-determined and orchestrated further and further away from the front line.

> *Those who lead are able to do so because others trust that the decisions being made have the best interests of the group at heart.*

I have total trust and a strong belief in my clinical colleagues across the whole spectrum of front line health care delivery. They work very hard on the shop floor. Their training, qualifications and performance are evaluated, re-evaluated and scrutinised on a recurring basis. They are expected to work harder, faster and safer, "at the top of their licence" and to adjust to a continuous stream of change, new initiatives and targets and at the same time do so within a relatively shrinking budget. Are they doing it with their blood, sweat and tears because they believe in the direction we are heading and because we all share a common belief..... or not?

Would it not be fair that they/we should expect a high level of training, qualification and evaluation of their/our clinical leaders and managers? Should there not be a structured training programme and recognised qualifications for clinical leaders and health managers? You might ask what the cost will be to the New Zealand health service to establish this? I ask you: "What is the cost of NOT doing it?"

It is time New Zealand's health care system invests a bit more of the $14.5 billion in supporting, fostering, coaching and formal training of clinical leaders and health managers to reduce the prevalence and degree of accidental clinical leaders and managers. This would make more sense than our current practice of spending money on high-flying external advisors who come in to our hospitals and clinical services, borrow our watches to tell us the time and then walk off with a nice slice of our budgets!

Hein Stander

West Coast efforts recognised

The hard work by ASMS West Coast Branch President Paul Holt and others has paid off with the Government's announcement it has finally signed off on the business case for funding of the Grey Hospital rebuild.

There were a lot of frustrating U-turns and dragging of heels over the business case, which caused unnecessary anxiety both for the senior doctors and other clinical staff working on the West Coast, and of course for local people wondering what health services they would end up with.

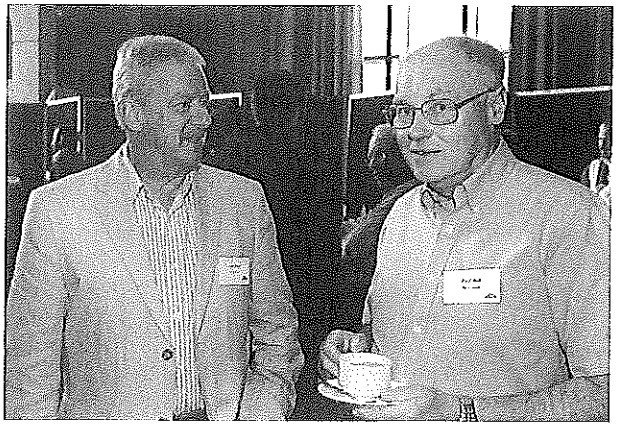
ASMS Executive Director Ian Powell praised Paul Holt's courage in speaking out against earlier attempts to reduce services on the Coast.

Dr Holt, meanwhile, says he's pleased the Government has listened to what doctors and other clinical staff have been saying about the level and type of services needed in the area.

"The feeling among people here is that the planned rebuild will adequately cater for health needs on the West Coast for the medium term," he says. "There's a strong sense of relief out in the community that we finally have some certainty.

"We do need to keep a watch on the Government's plans for Greymouth to make sure there is adequate space for consulting rooms, equipment, allied health and so on. We'll be looking at the detail of the Government's plans to make sure it's workable."

Paul Holt acknowledged the efforts of West Coast DHB Chief Executive David Meates and Programme Director Michael Frampton to get a good result for the region.



Paul Holt, right, talking to Canterbury Oral and Maxillofacial Surgeon Les Snape at last year's ASMS Annual Conference.