Time for Rangatiratanga

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As July the first rolls around, in the time of renewal following Matariki, and the proposed revamp of the public health system is operationalised, Howard et al., in the current issue of the Journal, provide a timely reminder of the importance and responsibilities of clinical leadership in the health system. The history of clinical leadership in the New Zealand health system has similarities to the well-known children’s story. The initial iteration of district health boards was in response to hospitals largely managed by medical superintendents and chief nurses—too much clinical leadership, while the subsequent Crown Health Enterprises were considered to have too little. The latest and last iteration of district health boards were often considered to have it just right with the term “Clinical Co-Governance” frequently used—“co-governance” attracting less disapproval from parts of our communities than currently. However, the phasing out of the district health board model would suggest that this was not case.

As Howard et al. point out, the assumption of management positions by clinicians has, at times, been by a default process. The person with the available time, with fewer clinical, teaching and research commitments, was often the individual appointed. Some were recently employed and relatively junior, or occasionally older clinicians looking to move out of front line clinical careers did so via the management suite. With some notable exceptions, few had any managerial experience and even fewer had managerial experience outside the public health system, and tertiary commercial or managerial qualifications were rare. To be fair, these caveats also apply to many full-time managers as well. Admittedly, appointment was based on clinical qualification and what that might bring to the management suite and, ironically, usually final signoff was by management staff meaning that they, not clinicians, determined who represented the clinical perspective. Unsurprisingly, Savage et al. have shown that such “incidental leaders” are less effective than trained and willing leaders, and struggle to bridge the management-clinician divide. Clinician managers are often a solitary presence at meetings numerically dominated by full-time managers, there to confirm consultation rather than to directly contribute to the setting of organisational priorities and resource allocation. For their own part, clinicians involved in management often relocated offices to the hospital management suite, reinforcing the divide and often losing touch with the people they were appointed to represent, becoming a conduit for management to communicate with clinical staff, rather than representing the views of clinical staff to management. Frequently, clinician managers have been used only to assist in the operationalisation of organisational strategy, already decided at a higher governance table, and to help manage the fallout when such strategies have come unstuck. In their defence, many clinician managers have been appointed to very part-time positions, expected to fit management work around pre-existing clinical commitments, not provided with administrative support and no resourced time to work on organisational strategy or big picture projects.

Howard et al. rightly advocate that development of a management expertise and skillset should become a bona fide and respected career path for those clinicians who wish to pursue it. They should be supported, by their colleagues and institutions, in obtaining relevant qualifications and experience. To avoid “incidental” or “default” clinician managers, recruitment should be formalised with clear financial incentives and administrative resource allocation. Identification of clinician managers should commence early and should be facilitated with opportunities for both theoretical and practical learning. Selection of clinician managers should be part of every departmental talent identification system in the same way that clinicians with teaching, research or other skill sets are targeted, recruited, developed and contribute to departmental, divisional and institutional achievement. Clinician managers should be subject to audit and assessment of their qualifications and achievements, commit to continuing education in the area and be prepared to undergo regular 360° assessments with detailed feedback—in the same way that clinical and research workstreams are regularly assessed.

However, clinician managers in Aotearoa New Zealand face another challenge that is unique in a global sense, in that the primary aim of the coming health reforms will be to ensure that the public health system delivers equal access and outcomes for all—
particularly Māori and Pacific peoples. The recent issues around the provision of COVID-19 vaccination to Māori and Pacific communities in early 2021 clearly demonstrate the limitations of the vertical, “command and control” system of management historically used throughout our health institutions and also the persistent divide between health management and clinicians. As was well documented, qualified clinicians repeatedly indicated to central government and health institutions that new approaches to create meaningful relationships with these communities would need to be used in order to optimise vaccination rates. For their trouble, many were ignored and some vilified before being permitted to implement their own systems when the crisis had arrived and time was almost up. We all owe them a great debt for the dignity with which they have conducted themselves and for the whānau focus they have maintained. Vertical management practices restrict nuanced assessments and dynamic responses to health issues, particularly across distinct communities with differing health needs and, when coupled with time and political imperatives, encourage authoritarian behaviour to achieve predetermined goals—even when those goals do not correlate with the best available clinical advice. This also discourages clinicians who are genuinely interested in system change from engaging. For these reasons vertical management systems are no longer favoured for health providers internationally.

Te Tiriti o Waitangi is entrenched in health and a cornerstone of the new reforms. The term “Rangatiratanga” has been extensively discussed in relation to Te Tiriti and is referred to in Article 2, defining the concepts of sovereignty, chieftainship, leadership and self-determination. Rangatiratanga guides a philosophy of bringing people together, learning from one another, sharing wisdom, and building mana. This form of leadership embraces collectivism, nurturing relationships, reciprocity, and a system of interdependent leadership that accounts for the common goals of all people. Incorporating Māori knowledge systems into health leadership will help foster a safe, equitable operational culture driven by a governance strategy that is inclusive and informed by all. Rangatiratanga can be described as an admixture of servant leadership (where leaders do so with humility and empower followers) and ethical leadership (where leaders exemplify actions that are driven by moral and ethical values and admonish actions that are not). Shifting health leadership to adopt an integrative, collectivist, and future-focused model has been associated with improved organisational processes and improved team outcomes in health systems in way that vertical leadership systems have not.

For Aotearoa New Zealand, our health issues are similar to those seen in many countries; however, our communities are unique, and we need to address these issues in a way that that reflects who we are. Expediency cannot be allowed to drive simplistic and crude interventions to address our equity issues. Historically, clinical co-governance has not consistently equated to power sharing or co-design. Now more than ever well qualified clinician managers are needed, who must be prepared to demand a place at high table and who, with data driven strategies, drive the creation of a health system that does provide equal access and outcome, high quality care for all of us. This must be done carefully listening to their colleagues and to our communities. This is no easy task right now, with every part of the health system essentially managing crises only, but if not now, when, and if not us, who?
COMPETING INTERESTS
Nil.

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URL
www.nzma.org.nz/journal-articles/time-for-rangatiratanga

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