Health Care Reform: Is There Really any Hope?

In all the responses received to my columns from professionals and the public, this is the question that keeps recurring and breaks my heart. As recently as this morning I was asked that question, again, by a retired health professional NB. The same question arose in discussions at two public speaking engagements. These are intelligent citizens of New Brunswick who vote, pay taxes, and not system abusers at any level.

The question often gets framed: "from all that you have written, and based on your experience in the system, do you have any hope that change will happen?" Sobering for public officials; it should make some feel dreadfully guilty.

Those posing the question have seen repeating themes for years in press coverage ranging from over-stretched specialists to nursing staff distress, Emergency overcrowding and wait times. To the public there is a theme and they don't like it.

Yesterday's Gleaner front page story contributes to the sense of resignation and despair of hope. Dr. Ben Hoyt, a wonderful ENT specialist surgeon, expressing the frustration that has been building up in his part of the system. When it gets to the point that patients have to wait a full year to see someone of his caliber with the skills he offers, taxpayers are being cheated. But it is not his fault.

You would not see that type of headline story with Mayo Clinic nor Lahey Clinic nor the Kaiser Permanente system, nor even at the Kingston General, my alma mater. Why? How do you prevent or otherwise head off those crises in essential service levels? That is done in a governance model that understands what is the reality of the key product they produce. In the case of the health authorities, it is about providing consistent quality of care to an ever-aging population.

It is not possible to provide consistently excellent care while working from crisis to crisis.

It actually requires a different form of governance model, one in which professional leadership is fully integrated into the management system with the training required to ensure their leadership success and the income protection to encourage it.

Physicians in New Brunswick, not unlike most jurisdictions in Canada, have enjoyed the privilege of personal, independent practice model which is built around their own cash flow requirements. Through a loose arrangement with the health authorities, doctors come together in service-specific departments such as Surgery, Internal Medicine, and Family Practice. That departmental structure is intended to provide a means by which doctors can share wisdom, practice patterns and successes, challenges, and organize call coverage group arrangements. It is the same basic organizational concept that has been in place for years long prior to the advent of the health authorities.

In this model, typically the office of Departmental Chair is a voluntary act of service; sometimes it is done in rotation allowing for different leadership periodically. These jobs are not as you see in the Queens and Dalhousie Medical School environment where department head positions carried great prestige and influence; great doctors competed for these roles.

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In the models of those other centres referenced, the appointment of heads of Clinical Departments involves a lengthy process of service review, prescribing departmental needs, followed by a search and selection process that engages leaders in the governance structure. But this is not the New Brunswick model.

Clinical leadership now requires much more than having privileges in a specific department. The Canadian Medical Association and the Canadian College of Health Executives, decades ago, prescribed and organized a specific training program for physicians who would be leaders. Physicians who have completed the program will acknowledge its life-altering nature in that it exposes physicians to essential skills of leaders, legal issues, economic issues, organizational concepts. In short, it was set originally as a major crash course in management for physicians.

The CMA now offers an Ambassador program which helps physicians with leadership responsibilities.

With this knowledge level to help, the department head can devote time and attention to dealing with issues that, left unattended, eventually erupt into crises. They can do that because not only do they have some additional training but the compensation model enables them to dedicate major energy to activity that does not generate clinical income.

The same approach can and must be taken in the nursing sector of the health authorities. The roles of nurses who function in supervisory functions must afford them the protection to execute the elements of the position that are essential to good management such as monitoring absenteeism, dealing with employee issues that often are not pleasant. This is at the core of what managers do and must do well.

In organizations the size of health authorities or any one of its parts, dealing with employee matters cannot be centralized into someone “at the top” because they are “management and not union”. The organization eventually will implode.

Managing and leading people, whether physicians, nurses, technical staff or office staff, is not for the faint of heart. It is both tough yet enormously rewarding. Just ask Daphne Noonan who has, with her board, created an entirely new workplace culture at Nashwaak Villa Nursing Home. They persevered through many issues and challenges to get to the state where they are now recognized internationally as leaders. Do her employees love the new culture? Absolutely. Does the local community think a miracle has taken place? You bet. Has it been professionally satisfying for the CEO.

So I have hope and faith that in the end those in leadership will see the new directions required and take them.

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