



Leadership at night in New Zealand hospitals

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Hospitals are often conceptualised as simple mechanistic organisations, where one action is simply consequential upon another. Numerous protagonists on one issue or another have lamented the inability of a hospital or health board to solve an apparently simple “system problem” by taking the obvious action.

However most have failed to recognise that hospitals (to use systems-theory jargon) constitute a “complex adaptive system” where changes in one factor have numerous and sometimes unexpected consequences in many areas of function within the system.^{1,2} Appreciation of the complexities of interaction is central to real understanding and to deciding wisely on change. Failure to appreciate it will bring derision from those whose tasks or services are simply made more problematic.

In this issue of the *Journal*, Morton and colleagues (*New Zealand’s Christchurch Hospital at night: an audit of medical activity from 2230 to 0800 hours*; <http://www.nzma.org.nz/journal/119-1231/1916>) urge a new approach to the way in which we organise the delivery of medical care in our major hospitals at night. While there are many similarities between the findings in Christchurch Hospital and the findings in the four pilot Trust hospitals in the United Kingdom (UK), there are also some differences between the two systems and we need to be wary in uncritically adopting conclusions from the UK’s National Health System (NHS).

Most clinical teams in New Zealand (NZ) hospitals have a Registrar and a House Surgeon only, a far cry from the “old” British-style team of Senior Registrar, Registrar, and/or Senior House Officer (SHO) and one or two House Surgeons. The latter truly was a hierarchical “silo”.

In many NZ hospitals there has long been aggregation of cover across specialties at night, but this has occurred mainly in the smaller hospitals where a more generalist approach is accepted and expected. It is much harder to achieve in larger hospitals, which have always been the most forceful champions of sub-specialisation.

Clearly, however, there are some eminently sensible lessons to be learned from this work and from the “Hospital at Night” project in the NHS. The primacy of good handover and clear management plans; the accomplishment of “routine” tasks during the day or evening periods; the minimisation of the numbers of Resident Medical Officers (RMOs) awake and in the hospital at night; and the development of true teamwork and shared tasks to even out the workload are all laudable and achievable goals.

The practical accomplishment may, however, be an infinitely more difficult task as it requires widespread commitment to our hospitals themselves and to our communities, in a broader way than we are perhaps now accustomed. It requires a reassessment of the importance we accord acute and after-hours work and the resources we apply to it.

It also requires senior leadership, which will inevitably mean that some at least of our Consultants will need to be prepared to be in the hospital leading the team at night.

This requires a commitment to being more of a lateral thinker and a better all-round doctor than the recent climate of increasing specialisation has allowed or encouraged. It does not, however, necessarily mean that we all need to be experts in everything. The experts can still be available at the end of the phone, or able to come to perform the specialised tasks that only they can deliver.

What it will provide is the experience and confidence to identify the patients who are not in good shape and for whom the specialist needs to be called in; perhaps sooner than is currently the case. It promises much better oversight and practical guidance on the assessment and task prioritisation for sick patients.

For such initiatives to be successful we must reaffirm that we, as doctors, do indeed have a special responsibility to our communities and this is not just a job. Furthermore, our goals should not be confined solely to the successful development of our specialties or to our personal progress within them.

This in turn demands that the forces of relentless sub-specialisation, the forces of industrialisation of the professional workplace, and the inherently self-centred goal of ideal “work-life balance” are tempered by the realities and vital necessity of providing truly high-quality care not just to a selected subset of patients but to all comers, and at a reasonable price. That means, at least some of the time, that commitment to a wider vision must take precedence over ambition, comfort, or money.

If such an initiative can gain a foothold, it may hopefully start to bridge the widening gap between our Emergency Departments and the inpatient specialties; a gap which in Australia has long since resulted in Emergency Departments overflowing with the needy while the comparatively comfortable inpatient services a floor or two up can refuse admissions until they “have beds”, thereby refusing ownership of problems which clearly lie within their domain. The “Soweto” analogy is inescapable, and the morality is equally dubious. It is a growing problem here.

Can we rise to this new challenge of “modernisation” as servants of our community, or are our own interests more important? It is in many ways a defining opportunity for our profession.

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