The risks of reputational damage

J.A. McNamara says the dilemmas experienced protecting services, even if this is patently in conflict with extant clinical evidence or government policy, raise difficult issues of loyalty, trust, leadership and perspective

The Irish health service is challenged with implementing a radical change programme that is focused on developing an integrated system, incorporating care pathways designed to improve the patient's experience. Central to this process is the implementation of a programme of reconfiguration of services designed to create new structures and processes that can improve the use of resources embedded in the system and the manner in which they are applied. This article seeks to promote a process of reflection on the part of leaders on the implications that their individual and corporate behaviours may have on these processes and on public confidence in the health service.

Many would argue that the critical necessity to meet internationally determined clinical governance standards and service delivery models is long overdue, no less so in the hospital system than in community services. And I think that in the reconfiguration we are now undergoing, it would be very helpful if we used the words specialist centres rather than centres of excellence.

Change does not come easily when it potentially threatens the delivery of services that have evolved incrementally over many years and in which individuals and institutions have invested financial resources, intellectual capital and expertise.

The perception in communities served by such hospitals for example is that the services provided are optimal and accord with best international evidence – even in the absence of objective evaluation – which serves to make the change process ever more difficult. Yet the emergence of well organised coalitions of resistance to the reconfiguration process and the implementation of the national cancer programme has been particularly disappointing and raises the spectre of reputational damage being inflicted at hospital, specialty and individual practitioner level. These coalitions based variously on patronage, collegiality and professional association occasionally play out routines in local and national media through the selective leaking of sensitive reports and briefing papers in a manner that presents a very real challenge to policy makers and those charged with its implementation.

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The dilemmas being experienced by entities at multiple levels to protect services, even if this is patently in conflict with extant clinical evidence or government policy, raise difficult issues of loyalty, trust, leadership and perspective that are perhaps inevitable in a complex change programme. There is little doubt for example that local communities are mistrustful of policy makers at the centre developing strategies into which they have little input or opportunity to contribute. Indeed it is almost inevitable that policy on the location of services is determined in this way in order to avoid eternal inertia!!

Leadership challenges

Furthermore leaders are challenged to demonstrate institutional and community loyalty in opposition to any strategy that might be perceived as diminishing the services available to the local public. Recognising that these dilemmas exist is a critical first step in creating a broad system-wide appreciation that they need to be managed.

Nevertheless the response to centralisation of hospital services to date has seen a propensity to criticise fellow hospitals as being deficient in terms of capacity to assimilate servic-

es or in raising doubts as to the organisational competence to meet necessary service standards. In this respect the emergence of service standards set by the Health Information and Quality Authority, the Health Service Executive Management Board or the National Cancer Control Programme provide a much needed benchmark against which to objectively measure performance.

However in a health system in which a small number of individual medical specialists and specialty teams are identifiable, it is inevitable that criticism is frequently taken personally even where this is unintended. The resultant tension makes all the more difficult the implementation of change programmes and the merging of differing cultures and maximising potential synergies that would benefit patients and users of services. The spectre of different entities which form part of a larger healthcare system pursuing self-centred goals at the cost of damaging reputations adds further to the political and public frustration at implementing change in the health service. The result is to diminish the entire health system and create the unintended consequence of undermining public confidence in it.

It is the function of those charged with providing leadership at board, executive and clinical level to act in the best interest of the community they serve even if that results in a perceived diminution of their service or hospital. In this regard local sectional self-interest must not be allowed impede the implementation of strategies that have emerged from the application of scientific rigour and transference of learning from other jurisdictions.

Goal

The implementation of these critically important programmes demands leadership that can respond to the substantial challenges that these initiatives present and the goal must be the creation of an integrated system in which all its components function in the interest of patients and in which each plays a role that reflects its strength. Nothing will be gained from engaging in damaging rhetoric except to undermine the confidence of the public and leaders would do well to reflect on this reality.

A necessary response perhaps has to be to acknowledge the commitment of expert staff and healthcare leaders in many hospitals whose collective vision and energy resulted in the incremental development of specialist services. Leaders must encourage a new language in which there are not seen to be winners and losers but rather the creation of something new in the form of excellence in the organisation and delivery of patient services that may not exist presently.

This change in mindset demands that larger centres avoid becoming arrogant and complacent but rather recognise the challenge that a new service profile poses in terms of developing competencies and organisation capacity. One of the most powerful behaviours for leaders is the capacity to recognise the history and contribution made by service providers over many decades in the context of the emergent nature of healthcare strategy as a result of the need to reflect changes in technology, treatments and societal demographics.

The challenge is then for leaders at multiple levels to recognise that this change programme presents dilemmas that are uncomfortable and perhaps threatening at a micro-level. Nevertheless leadership demands that sometimes bold and imaginative initiatives are taken which set the tone for the organisation and its public. How many examples have we seen where inspirational clinical leadership for example has changed the nature of debate on specific issues and has diluted public and political objection to change. In this regard the system is challenged to move from Evidence Based Medicine to Evidence Based Management where it can be scientifically demonstrated that established delivery models provide better outcomes for patients.

Regrettably a failure to implement leadership at executive and clinical level will result in a sterile debate in which the primary focus will be on the retention of a system that has been proven to have many failings and the perpetuation of apparent dysfunction which can only serve to damage reputations at multiple levels including the health system overall. We would do well to reflect on the often unanticipated outcomes of our actions particularly at what is the beginning rather than the end of this much needed change process. HM

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