IMPORTANCE OF MEDICAL LEADERSHIP IN HEALTH CARE MANAGEMENT

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Abstract

Doctor's involvement with leadership and decision-making in an organisation is critical to the success of the changes. In the hospital setting, effective governance is crucial in maximizing the effective management of care. The importance of effective leadership in ensuring a high quality health care system that consistently provides safe and efficient care has been reiterated in the scholarly literature and in various government reports. Recent inquiries, commissions, and reports have promoted clinician engagement and leadership as critical to achieving and sustaining improvements to care quality and patient safety. This paper looks at the policy background to involving doctors in leadership, definitions of leadership, including clinical leadership and current approaches to leadership theory and practice; In particular, it will focus on shared leadership for practice.

Key words: Leadership, Medical leadership, Shared leadership

Introduction

Historically, the involvement of doctors with leadership in hospitals can be traced back to the 1980s, with the development of directorate structures based on the model developed at Guys hospital, London, in the UK, and the Johns Hopkins hospital, Baltimore, in the USA (Stephen George, G.Wibberley, 2015). A "hybrid" leadership model, combining the clinical and management responsibilities (O'Riordan and McDermott, 2012), has become the established way of involving doctors in leadership in hospitals in the UK. The importance of effective leadership in ensuring a high quality health care system that consistently provides safe and efficient care has been reiterated in the scholarly literature and various government reports. (Department of Health. High Quality Care for All 2008; Francis R. Report of the Mid Staffordshire, 2013). Recent inquiries, commissions, and reports have promoted clinician engagement and clinical leadership as critical to improving quality and safety (Jowsey T et al.,2009).

In the United States, leadership has also been identified as a key driver of health service performance, with the Committee on Quality of Healthcare suggesting considerable improvements in quality can only be achieved by actively engaging clinicians and patients in there form process (Stephen George, G.Wibberley, 2015). The UK advanced programs have been instituted and run for leaders since 2001 by the National Health System Leadership Centre (Edmonstone J., 2009) and there are some similar innovations in other countries. This point to the realization that the cost and consequences of poor leadership greatly outweigh the costs and potential benefits of provision of formal programs to enhance leadership capacity ideally in a multidisciplinary health care team context. (Edmonstone J., 2009).

Leadership or management has received less attention in primary care where doctors have not generally occupied such roles outside their practices (O'Riordan and McDermott, 2012). More generally, it has been noted that there has been a shift in policy and use of terminology from administration, to management, to a focus on leadership; and also a shift towards involving a wider range of stakeholders in leadership, regardless of formal position in the organisation (Martin and Learmonth, 2010). The involvement of doctors with leadership is a part of this shift and is now generally accepted, particularly given the perceived link between leadership and quality (Bekas, 2014). The latter places a much stronger emphasis on medical leaders improving quality in health care (Dickinson *et al.,* 2013). In the hospital sector, the demands placed upon leaders have become more complex, and the need for different forms of leadership is increasingly evident (Stephen George, G.Wibberley, 2015). To derive cost efficiency and improve productivity, there has been intense reorganization. Coupled with

these reforms has been increasing attention upon improving safety and quality, with programs instituted to move attention beyond singular patient–clinician interpretations of safety toward addressing organizational systems and issues of culture (Parand A etal.,2010). Arising from these reforms has been growing recognition that many assumptions of common leadership models are not well suited to delivering change at the point-of-care delivery or to assuring increased clinician and patient engagement in decision making (MacPhee M, et.al. 2013) .

Defining leadership

Defining leadership, generally, is difficult, given the diversity of contexts, and this has inevitably led to the development of different approaches, models and frameworks and continuing controversy (Howieson and Thiagarajah, 2011). Hartley and Allison believe that it is possible to coalesce different definitions or approaches around three overarching perspectives: person, position and process. The first two are about the individual leader, for example, personal qualities or skills or formal position in the organisation. The third is about the process of social interaction and group dynamics (Malby *et al.*, 2011). Definitions of leadership have tended to shift from the individualistic, to the latter – distributed, or shared, definitions of leadership with an emphasis on process (Carr *et al.*, 2009).

A specific definition of leadership in healthcare, distinguishing it from generic definitions, is to focus on the link with patients, or quality, and define it as "clinical" leadership (Willcocks *et al.*, 2013). Clinical leadership is widely accepted, although some observers are sceptical about the "almost magical powers ascribed to" it (Checkland, 2014). One definition of clinical leadership is that it is about facilitating evidence-based practice and delivering patient outcomes (Stephen George, G.Wibberley, 2015). Similarly, clinical leadership is said to be about leading the process of service improvement with a view to delivering excellent patient care (Howieson and Thiagarajah, 2011).

Approaches to leadership

The approach to leadership theory and practice in healthcare has varied, but, in essence, it has focused on individualistic, charismatic and "heroic" approaches or conceptualisations of leadership (Fulop, 2012, Willcocks *et al.*, 2013). Leadership programmes for doctors are no exception in that they tend to be individualistic and prescriptive. (Bekas, 2014) However, the Medical Leadership Competency Framework, as mentioned above, is a change from other approaches to leadership in that it emphasises the distribution of leadership across the medical team. It says "shared leadership" is integrated into the doctors' role (Academy of Medical Royal Colleges,2010). According to the Medical Leadership Competency Framework, leadership focuses on the dynamic relational process and the interaction within groups (Academy of Medical Royal Colleges, 2010).

Current leadership theory and practice suggests that shared or collective leadership might be the way forward (Stephen George, G.Wibberley, 2015). The Kings Fund, for example, concludes that leadership in should be "collective and distributed rather than left to a few individuals at the top of these organisations"(Ham, 2014). Similarly, West *et al.* believe that a collective approach to leadership is vital in delivering the overall aim of high-quality patient care and transforming the culture. "Collective [shared] leadership creates the culture in which high quality, compassionate care can be delivered"(West *et al.*, 2014).

Shared leadership

Defining shared leadership as part of the relationship process, involving group dynamics and social interaction, is particularly apposite when applied to the healthcare context. The latter is characterised in terms of professional cultures where team working, autonomy and devolved authority tend to be emphasised (Stephen George, G.Wibberley, 2015). Historically, such professional cultures feature a large amount of professional autonomy and control and an emphasis on the informal influence process (Dickinson and Ham, 2008). Shared or distributed leadership may be seen as a characteristic of such cultures, known as professional bureaucracies, where leaders' may be from a professional background and not necessarily occupying positions of formal

power and authority (Dickinson and Ham). One of the perceived benefits of shared leadership is that it involves an inclusive decision-making process and an emphasis on participative styles of leadership. Such features are compatible with clinical leadership and decision-making in healthcare organisations (Stephen George, G.Wibberley, 2015). It can also be argued that shared leadership has a role in nurturing and supporting change, for example, developing "new practices and innovations" in health care (Turnbull James, 2011). Hunter and Goodwin make the point that collaborative (shared) leadership might be a way to encourage: "others to influence and bring about intra and inter-organisational change" (Hunter and Goodwin, 2014).

Collective [shared] leadership cultures are characterised by all staff focusing on continual learning and through this, on the improvement of patient care" (West *et al.*, 2014). Shared leadership provides a collaborative approach underpinned by continuous learning. (Ham, 2014) Given the above features, it can be argued that shared leadership will have a positive impact on healthcare organisations, partner organisations and organisations in other health or social care systems, such as local government agencies, independent healthcare organisations and voluntary organisations (Stephen George, G.Wibberley, 2015).

Conclusion

Although there is no "one right way" in terms of leadership approach for doctors, it is equally the case that any approach taken should be compatible with both culture and policy context. Shared leadership may be the way forward, in terms of facilitating cultural change, subject to various preconditions. One may argue that the benefits in developing shared leadership are likely to outweigh the costs in the healthcare context. Shared leadership is a way of encouraging a more inclusive and democratic culture in healthcare organisations at a time when these organisations need to be mutually supportive in the face of constraint and financial uncertainty.

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