Future Hospital Journal 2015 Vol 2, No 3: 218–20

Faculty of Medical Leadership and Management

An international perspective on medical leadership

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ABSTRACT

Medical leadership is a global policy priority worldwide as it aims at answering some of the greatest challenges of healthcare, including changing patient needs, budget cuts, increasing citizen demand for accountability and rising service expectations. However, the introduction of doctors in management roles is not easy, and the actual practice of medical management greatly varies across countries and within each country. In order to favour its development, policymakers and executives should have the courage to give autonomy to medical managers and to support them, and should acknowledge the specificities of such hybrid roles when selecting, training and appraising future medical leaders. At the same time, professionals and their associations should understand that clinical leadership is not about dismantling professionalism, but rather about reconfiguring it, incorporating new values and logics into the traditional medical culture.

KEYWORDS: Medical leadership, medical management, hybrids, professionalism, health reforms

Medical leadership: a global priority

Leadership is a very fashionable topic for health policymakers across a number of countries, and the development of medical leadership and management competences is now one of the goals of healthcare reforms across the globe.[1,2]

In particular, the interest toward frameworks for managerial skills for doctors has increased internationally, due to the initiatives of departments of health, medical societies and medical faculties. Some of these models have gained influence internationally, for example, the CanMEDS framework, developed by the Royal College of Physicians and Surgeons of Canada in 1996, that was then adopted in the Netherlands[3] and Australia.[4]

Medical leadership is a global policy priority worldwide, but is it only a fashion? We argue it is the response to a number of challenges and ongoing trends at an international level.

First, clinical needs are changing. Today patients suffer from multiple comorbidities and their average age has increased dramatically. Patients struggle to find adequate answers from within fragmented healthcare organisations, where service provision is broken into pieces according to rigid disciplinary boundaries. Integrated pathways and multidisciplinary approaches are now necessary. This means that the traditional healthcare organisation, made of independent professional 'clans' with autonomous hierarchies, fenced areas of practice and working rules, is no longer adequate.

Second, reforms in most Western countries have increased the pressure for cost containment in response to the rise of healthcare expenditure secondary to both ageing populations and new technologies. This has determined the need to introduce efficiency alongside efficacy, especially for those physicians who are in charge of medical staff.

Third, the spread of evidence-based medicine and accountability for results to patients directly and the general public has determined a shift away from the informal, peer-based and 'opaque' performance appraisals. Hospitals are now measuring performance, collecting data and reporting on it. Organisations are continuously compared on the basis of results and outcomes, as are individuals and groups within each organisation. This has generated new managerial needs, and calls for new competences such as performance management, value-based approaches and operations management.[5]

Finally, patients' expectations (in terms of quality of non-clinical services ie hospitality, waiting times, flexibility and customer support) have increased dramatically.

> *Nowadays people say: if I fly KLM, I can change my seat in the airplane the night before I fly, I can choose to be at the window. And here I have to wait six, seven weeks before somebody reads a letter of a colleague to see whether he can see me: that is not possible anymore! […] We are living in different times. We have different clients, people have a completely different idea about hospitality, and of course also efficiency.*

This quote from a recent study we performed in a large Dutch hospital clearly shows how healthcare services are increasingly exposed to societal pressures that call for more streamlined and patient-centred organisations.[6]

The complexity of involving doctors in management

Hybrid doctor–manager roles are often seen as the solution to respond to these challenges, to 'bridge the gap' between the old

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and new world, and for this reason they have been developed in a number of countries. Clinical leadership is not the panacea for the problems of healthcare; however it is one of the ways to go, as medical leaders are better equipped to effectively promote clinical governance, develop multidisciplinary and interprofessional collaboration and achieve cost savings, without compromising the quality of care.[7] Recent international evidence has also started to demonstrate that the introduction of good management and clinical leadership does have an impact on healthcare performances.[2,8,9]

However, this process is not easy. Despite the political enthusiasm that brought the introduction of medical managerial roles into most healthcare systems, the actual practice of medical management varies. Comparative research on the involvement of doctors in management shows a rather diversified picture at the international level, due to a number of factors. First the timing of healthcare managerial reforms: countries like Denmark, the UK or the Netherlands were among the pioneers of such reforms back in the 1980s and early 1990s, while Italy, Germany, and more recently, France implemented similar processes later on, contributing to them lagging behind.[1] However, comparative research also finds that a number of factors at the system or organisational level are important in explaining the degree of development of managerial roles and the engagement of doctors in them. Among them we find, for instance, the extent to which these roles are endowed with authority and autonomy for decision making (eg budgeting and planning of investments).

While in countries like UK or Italy, national policies supporting clinical management were in place, in Germany for instance, where the healthcare sector is fragmented into numerous local and private providers, a number of hospital owners were critical with regard to the development of clinical leadership and they avoided doctors' empowerment.[10] Another important factor is the financial and career incentives for doctors to get involved in management, eg whether the doctor works as an employee of the hospital or on a contractual fee-for-service basis. An interesting example of this case is the Netherlands, where there is great variability in the development of clinical leaders across large university hospitals and smaller local hospitals, also due to the fact that the latter employ staff on a contractual basis. Furthermore, the presence of strong non-clinical managerial roles in the system was found to hamper the development of hybrid leadership. In the UK, many decisions are taken by general managers, who are numerous and have a strong position in the NHS,[1] while in Italy it is the public health doctors who have historically been in charge of healthcare organisations, and therefore clinical management was seen as less urgent.[11] The influence of professional bodies in policymaking is also relevant, for example in France, where hospital management models were implemented in a professionally mediated way due to the power of medical associations.[12,13]

How to support medical leadership

Many other contextual factors have been identified that influence medical involvement in management.[14] Yet, on the basis of existing research we know that a number of choices can be taken to favour the development of medical leadership.

First, policymakers and executive managers should have the courage to give autonomy and 'space' to medical managers. Medical leadership cannot be intended as an exercise of problem-solving management, with the emphasis placed purely on administrative accountability and budgetary concerns. It has to do much more with 'doing the right things' rather than just 'doing things right'. Without true engagement of clinical leaders, decisions concerning what services should be delivered, to whom, when, where, and how, will be more and more difficult to deliver as they strive to cope with the challenges posed by new technologies and drugs, increasing therapeutic alternatives, turf wars, defensive medicine and inappropriate use of diagnostics, to name a few. Executives should not be afraid of facing the risks associated with such decision, and should be ready to effectively support clinical leaders through delegation of power, adequate staff and training, to give individuals the best opportunity to successfully perform in the role. Medical leadership is not only about medical leaders; it is about how medical leaders are led.[11]

Second, the specifics of healthcare must be acknowledged when selecting, training and appraising the new class of medical leaders. Healthcare organisations are complex professional bureaucracies, especially when they are part of the public or not-for-profit sector, as in many countries. Healthcare organisations are also highly interconnected with external stakeholders and politics. As a consequence, healthcare leaders continuously face highly complex problems, that cannot be treated successfully with traditional linear, analytical approaches.[15] Rather, leaders need the capacity to perform network management, not only to 'steer' but also to 'connect', build consensus, balance and compromise, overcoming conflicting objectives.[16] Clinical leadership requires a structured method to address problems, as well as considerable sensitivity to cope with complex dynamics through a strategic management approach.

Finally, professionals and professional associations should understand that clinical leadership is not about dismantling professionalism, but rather about reconfiguring it, incorporating new values and logics into the traditional medical culture in order to make it more responsive to societal changes and the new expectations from patients and citizens.[17] Medicine and management are not incompatible, rather management is about taking clinical problems at a higher level and not focusing exclusively on the specialty-based treatment of individual cases. Accordingly, healthcare can become more interconnected and organised, in order to become more responsive to the increasingly demanding external environments.

If this is what we know, what don't we yet appreciate and need to understand? There are few comparative studies on the challenges, impact and effect of clinical leadership, and the same can be said for a dearth of research and evidence.

It is time to get serious. If the next decade is about working inside the 'black box' using a value-based approach, clinical leadership is no longer optional. The correlations between effective clinical leadership, professional background, training schemes, organisational designs, decision-making and governance models, skill mix and leadership strategies are just some of the areas that need to be fully investigated. This

needs to be done now, quickly and in-depth. Our patients are waiting. ■

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