

Medical leadership: an international perspective

Doctors are increasingly seen as key to embedding health service improvements and there has been much international debate over how best this can be achieved. This article takes an international perspective on medical leadership and leadership development through discussion of case study examples and initiatives from around the world.

Significant proportions of developed (and developing) countries' economic activity are devoted to delivering health care and many concerns have been expressed about how to improve the quality of health care within a climate of financial constraints and rising expectations. As the costs of health care have risen, so have pressures to manage these costs and improve performance, with increased financial and clinical accountability at organizational, department or unit and individual levels.

Ham and other authors argue that the combination of heightened expectations and lagging improvements in performance can be attributed to the fact that health-care systems behave as a professional bureaucracy (Ham, 2008; Baker and Denis, 2011). In professional bureaucracies positional power resides in highly qualified and well-educated professionals that deliver the front-line service (Mintzberg, 1983). This type of organization is highly resistant to change, especially change resulting from policy or managerial directives (Baker and Denis, 2011).

To gain improvements through change in this type of organization it is crucial to engage the professionals in the leadership and management of that change. This engagement is fundamental to recent approaches in the UK based upon the engaging medical leadership project

Dr Helen O'Sullivan is Director of the Centre for Excellence in Evidence Based Learning and Teaching, Faculty of Health and Life Sciences, Director of Postgraduate Studies, School of Medicine, The University of Liverpool, Liverpool L69 3GE and **Professor Judy McKimm** is Dean of Medical Education in the College of Medicine, Swansea University, Swansea

Correspondence to: Dr H O'Sullivan
(h.m.osullivan@liverpool.ac.uk)

(NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010) and is echoed around the world in a range of initiatives aimed at engaging and developing doctors as health-care leaders.

Denmark and Kaiser Permanente: case studies of excellence

A scan of recent publications and commentaries highlights two systems of leadership development that are frequently held up as exemplars of excellence. These are the Danish system and a private health-care company in the USA – Kaiser Permanente.

Denmark

The Danish system stands out in comparison studies as having made the most progress towards engaging doctors with leadership and management (Ham, 2008; Kirkpatrick et al, 2009). Historically, Denmark has required a doctor to be present on the management board of each hospital and to be involved in decisions about general management. At clinic level only doctors and nurses are involved in management.

In this structure, clinicians dominate the leadership and management positions and these roles are seen to be valuable and valued by the medical profession. In addition, it is argued that the more consensual style of politics in Denmark has led to less resentment and confrontation between medical professionals and government-imposed changes and reorganizations (Kirkpatrick et al, 2009). Indeed Kirkpatrick et al (2009) argue that Danish doctors have developed a 'continental' style of professionalism with an emphasis of pursuing power and status through the organizations of the state. In contrast, UK medicine has remained a 'liberal profession' with the emphasis on independence and autonomy which leads to a culture

dominated by ideas of self employment and a detachment from administration.

In addition to the advantageous structural and cultural environment, Denmark has also set up a comprehensive leadership development framework in undergraduate and particularly in postgraduate education (Ham, 2008). This is based on the CanMEDs framework established in Canada (Royal College of Physicians and Surgeons of Canada, 2005) and includes 'The physician as a leader and administrator' as one of the key standards (Ham, 2008). Postgraduate medical education includes a compulsory 10-day leadership development programme with doctors being offered further training once they are appointed as specialists.

Kaiser Permanente

The health maintenance organization Kaiser Permanente, based in California in the United States, has been highlighted as a successful model of integrated, cost-effective care (Light and Dixon, 2004; Ham, 2008). This organization has many areas of interesting practise that have contributed to its success but three areas are highlighted by its chief executive as having been the most fundamental. These are joint leadership, alignment and management training for physicians (Crosson, 2003).

Joint leadership

At Kaiser Permanente a model of joint leadership is practised, where partnership working is modelled at the highest levels of the organization. This compares with the model of shared leadership that is the basis of the Medical Leadership Competency Framework in the UK (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010).

Alignment

The mission, strategy and operational goals of the organization are aligned and the values are shared by everyone working

for the organization. They have worked hard to remove the conflicting incentives that occur when physicians focus solely on patient care and administrators focus on resources and productivity.

Management training

At Kaiser Permanente all physicians undergo management training through a series of in-house staff development programmes as they believe that understanding how a complex organization works is as important as clinical skills. They also develop what they believe to be critical skills of collaboration and cooperation, negotiation and persuasion as well as delegation and teamwork.

This combination of shared values and goals, as well as a systematic approach to management and leadership training, ensures that Kaiser Permanente remains an exemplar of medical leadership (Ham, 2008).

Empirical and observational studies in other countries

While it is clear that there are moves in many different countries towards engaging doctors with health-care leadership and management, the impact of these changes on health improvements and quality has yet to be fully understood or investigated. This section focuses on some empirical and observational studies that aim to provide insight into these changes.

Canada

Chadi (2009) provides a comprehensive analysis of the Canadian system. Although the term 'medical leadership' has only recently come into regular use, it has been used in medical education since 2005 through the CanMEDS standards (Royal College of Physicians and Surgeons of Canada, 2005). Of the seven standards listed, 'manager' appears in the fourth position and is described as:

'The CanMEDS Manager Role describes the active engagement of all physicians as integral participants in decision-making in the operation of the healthcare system.' (Royal College of Physicians and Surgeons of Canada, 2005).

However, the CanMEDS framework, while widely referenced and respected, has

no regulatory or legislative powers. The Canadian Medical Association has started providing intense leadership courses through its Physician Manager Institute (Royal College of Physicians and Surgeons of Canada, 2005) in recognition of the need for a more formal development programme. Academic institutions also offer programmes that prepare physicians for leadership, for example, McGill offer a joint MD MBA programme that aims to prepare fully competent physicians who have also been fully trained in health-care management (www.mcgill.ca/desautels/mdmba) and the University of Toronto provides a 'Leadership Scholars' programme which is interprofessional, involving doctors as well as other health professionals.

Chadi (2009) describes several structural issues in the Canadian health-care systems that act as barriers to engagement by doctors in leadership which could be addressed through increasing recognition of leadership in the career structures of doctors and giving priority in leadership appointments to leaders with a strong clinical background. In addition, he notes a key positive element of Canadian health-care management is that health ministers in the government have recently been practising physicians, which gives a level of understanding of health-care provision that is beneficial to effective health-care delivery (Chadi, 2009). The article also comments on the selection of medical students and suggests that Canada finds ways to select students who have the potential to become great leaders.

Italy

Aardvold et al (2011) describe an educational visit made by five orthopaedic trainees and their consultants from the UK to the Rizzoli Orthopaedic Institute in Bologna, Italy. The purpose of the visit was to compare leadership styles and values in Italy with the systems that they were used to in the NHS. Although the trainees reported many areas in common between the NHS and the Rizzoli Orthopaedic Institute such as team working and multi-disciplinary working, there is a striking note of envy in the trainees' report at the working conditions that they were part of in Italy.

The differences that the trainees highlight seem to be related to two main issues. First that the surgeons in Italy were perceived to be more valued than their counterparts in the NHS. This manifested as respect from staff and tangible evidence such as professional quality offices and other facilities. The other issue was autonomy and a culture of trust. The Italian surgeons were able to choose interesting cases to show the trainees during their visit where as this would have been more difficulty in the UK where surgeons have little control over their lists. There was deemed to be more trust between the health-care professionals and the hospital managers. The report concluded with some recommendations for NHS leadership and particularly the need for doctor leaders in the NHS to be fully engaged.

Australia and New Zealand

The cultural backdrop in Australia and New Zealand is that of a need to engage doctors more fully at all levels in health-care leadership and management with a view to improving health-care outcomes (including those of indigenous peoples) and patient safety. The Royal Australasian College of Medical Administrators was established in Australia in 1976 and in New Zealand in the late 1990s. It provides opportunities for registered medical practitioners to gain vocational registration in medical administration (as a branch of medicine) through at least 3 years of supervised medical administrative experience and completion of a masters' degree in business administration (as opposed to clinical leadership).

The Royal Australasian College of Medical Administrators (2010) has defined a Medical Leadership Curriculum which includes a competency framework (*Table 1*) and sets out seven roles of the medical leader.

In both Australia and New Zealand, there has been increasing emphasis on the role of doctors as leaders and shapers of health care and clinical governance and recognition that medical leadership needs to be distributed at all levels, include the highest levels of government and in health boards. Management and leadership competencies are also enshrined in the Australian Medical Council (2009) Standards for under-

graduate education thus supporting the early development of doctors as leaders. Attention is also starting to be paid to leadership development opportunities aimed at improving health and opportunities for under-represented groups. One example is the collaboration between Medical Deans Australia and New Zealand and the Australian Indigenous Doctors Association Capacity Building

Table 1. Medical Leadership Curriculum of the Royal Australasian College of Medical Administrators

Medical expert	Systems and organizations
	Lead intelligently
	Governance
	Strategy and design
	Medical perspectives
Communicator	Effective communication
	Align competing interests
	Convey information
	Synthesize information
	Develop rapport
Advocate	Promote health
	Social determinants of health
	Identify community needs
	Respond to health issues
Scholar	Application of new knowledge
	Facilitate learning
	Evidence-based decision making
	Continuing professional development
Professional	Reflective practice
	Value systems
	Patient first behaviour
	Ethical practice
Collaborator	Facilitate consultation
	Build relationships
	Prevent and resolve conflict
	Lead teams
Manager	Line management
	People and performance
	Prioritize resources
	Systems at work
	Effective organizations

From Royal Australasian College of Medical Administrators (2010)

for Indigenous Medical Academic Leadership Project. Although Health Workforce Australia and Health Workforce New Zealand are each beginning to take a broader view of workforce needs, competencies, outcomes and training in their own countries, leadership development still tends to be siloed (in organizations, professional groupings and professional bodies) and unsystematic, rather than system-wide and interprofessional (McKimm et al, 2009).

Korea

In an article published in the *Korean Journal of Medical Education*, Lee et al (2010) investigated the leadership competencies defined as important to the medical faculty through interviews with a large number of medical professionals. A wide range of specialities was represented with varying levels of seniority. Factor analysis identified the following competencies:

- Professional ability, ethics/morality, self-management, self-development and passion
- Public interest, networking, social participation and active service
- Motivating, caring, promoting teamwork, nurturing, conflict management, directing, performance management and systems thinking
- Organizational orientation, collaboration, voluntary participation and cost-benefit orientation (Lee et al, 2010).

The authors concluded that these competencies should provide a framework for leadership development which could help plan educational activities, and inform career development plans and appointment to senior roles. Although these competencies emanate from a cultural perspective that is quite different from Anglo-Saxon cultures, there are significant areas of overlap with, for example, the UK Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010). However, there is perhaps a greater emphasis on public service and commitment to the organization than is found in other frameworks.

Conclusions

Over the last few years, there has been a shift in focus towards a more active engagement of doctors at all levels in both lead-

ing and managing health-care improvements, clearer definitions of the expectations of doctors and specific support for doctors being provided in the form of leadership development opportunities. In many countries, professional standards in undergraduate and postgraduate education and training include clinical leadership and management and in some countries (including the UK), specific medical leadership competency frameworks have been developed. Development programmes typically include in-house training courses, masters' level programmes, coaching and mentoring schemes, workplace-based learning and participation in health innovation projects. Many of these are now led by the relevant professional bodies, such as medical colleges, and there are examples of specific colleges or faculties being established in clinical leadership, management or administration which acknowledge the importance of this as a 'speciality' in its own right.

Although leadership must be learned and applied in context, we can gain insight into our own cultures by exploring and understanding how medical leadership is perceived and understood elsewhere. Many international studies comment that involving doctors in leadership cannot be achieved simply by providing training and development, but that system-wide approaches to enabling and expecting doctors and other clinicians to take responsibility for the improvement of health-care outcomes for communities and populations are required (Ham, 2008; Brook, 2010; Baker and Denis, 2011). This system-wide approach is now starting to be embedded in health-care strategy and policy initiatives (McKimm et al, 2011).

Taking an international perspective highlights a growing acknowledgement that developing doctors as leaders and managers needs to be considered within broader systemic and structural changes, through active engagement of students and practising professionals with quality and safety improvement initiatives. The challenges for all countries include how to effect such transformational change within relatively entrenched health systems, cultures and structures; how to facilitate inter-professional and collaborative learning; how to change ways of working and acknowledge the importance of follower-

ship, emotional labour and team working and provide effective leadership development opportunities for all those who need them. **BJHM**

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KEY POINTS

- As the costs of health care rise, there is increased pressure internationally to manage health-care resources more effectively and efficiently.
- Many countries have defined the leadership qualities that they want in their doctors through a series of competency-based frameworks.
- Historical and cultural factors are important in explaining the differences between approaches to medical leadership internationally.
- International comparisons are useful in improving medical leadership engagement and development in the UK.