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Engaging Doctors in Leadership:

What we can learn from international experience and research evidence?

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Doctors have enjoyed a large measure of clinical autonomy since the inception of the NHS.

Clinical autonomy began to be challenged in the 1980s following the Griffiths Report and the introduction of general management.

The Griffiths Report started the process of doctors taking on leadership roles as medical directors and clinical directors.

The research evidence suggests that doctors retained significant autonomy even after the introduction of general management.

Professional bureaucracies

These research findings are best understood by reference to Mintzberg's analysis of health care organisations as professional bureaucracies.

In professional bureaucracies, front line staff have a large measure of control by virtue of their training and professional knowledge.

Leaders in professional bureaucracies have to negotiate rather than impose new policies and practices, and work in a way that is sensitive to the culture of these organisations.

Control in professional bureaucracies is achieved primarily through horizontal rather than hierarchical processes.

Three implications follow: professionals themselves play key leadership roles, leadership is often dispersed and distributed in microsystems, and collective leadership is important.

Followership is also important to avoid professional bureaucracies becoming disconnected hierarchies or organised anarchies.

Medical leaders in the NHS

Progress has been made in appointing doctors as medical directors and clinical directors but the effectiveness of these arrangements is variable.

In some organisations there appears to be much greater potential for involving doctors in leading change; in others there are difficulties in developing medical leaders and supporting them to function effectively.

Part of the explanation of these findings is the resourcing put into medical leadership and the limited recognition and rewards for doctors who take on leadership roles.

Also important is the continuing influence of informal leaders and networks operating alongside formal management structures.

Tribalism remains strongly ingrained in the NHS and staff who occupy hybrid roles, like doctors who go into leadership, face the challenge of bridging different cultures.

Quality improvement programmes

The research evidence suggests that there is a link between the engagement of doctors in leadership and quality improvement.

Quality improvement programmes that fail to engage doctors and that are not sensitive to the nature of medical work tend to have a limited impact.

However, many factors influence the impact of quality improvement programmes besides the engagement of doctors and medical leadership.

Medical leadership is therefore best seen as a necessary but not sufficient condition for quality improvement in health care.

International experience

Among the countries we reviewed, Denmark stands out for its efforts to engage doctors in leadership roles and to provide training and support.

In the United States, Kaiser Permanente is a good example of an integrated delivery system that has succeeded in involving a high proportion of doctors in leadership.

In Kaiser Permanente, there is close alignment between the health plan and the medical group, and this contributes significantly to the levels of performance that are achieved.

Change is led by doctors in a culture that has been characterised as one of commitment by physicians themselves to improve care rather than compliance with external requirements.

Conclusion

The NHS has an opportunity to learn from international experience to become an exemplar in medical leadership and its development.

The education and development of doctors as leaders needs to be linked to appropriate incentives and career structures, and reward and recognition for those taking on leadership roles.

Introduction

In January 2007 the NHS Institute for Innovation and Improvement commissioned the Health Services Management Centre at the University of Birmingham to carry out two reviews in support of the Enhancing Engagement in Medical Leadership project being undertaken in association with the Academy of Medical Royal Colleges.

The first review was a rapid survey of experience in a number of countries of arrangements for medical leadership and the training and support provided to doctors in leadership roles. Experts in these countries were commissioned to write papers for the review, and these were discussed at a workshop in May. The papers were subsequently revised and edited, and a full report on this work can be accessed at www.institute.nhs.uk/medicalleadership. Appendix 1 provides a high level summary of the main findings of the international survey.

The second review focused on the literature on medical leadership. The review sought to examine the use of the term medical engagement and the existence of any empirical evidence for its linkage to organisational or clinical aspects of performance. It also reviewed approaches to the measurement of levels of medical engagement in leadership. In addition, the review examined research on experience in the NHS of involving doctors in leadership. A paper presenting the results of the literature review can be accessed at www.institute.nhs.uk/medicalleadership.

The aim of this paper is to summarise key points from both reviews. Much of the paper is based on published literature drawn from peer reviewed journals. Its summary of the evidence reflects the findings of research into medical leadership undertaken during the last twenty five years. This evidence provides a systematic and research based overview of the evolution of medical leadership and the reasons why a concerted focus on the training and support for doctors taking on leadership roles is needed. Full references and sources for the material presented here can be found in the background papers prepared for this project.

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The NHS context

Doctors have enjoyed a large measure of freedom to practise in the way they consider appropriate for much of the history of the NHS. As the Department of Health put it in 1978:

> *'At the inception of the NHS, the Government made clear that its intention was to provide a framework within which the health professions could provide treatment and care for patients according to their own independent professional judgement of the patients' needs. This independence has continued to be a central feature of the organisation and management of health services. Thus hospital consultants have clinical autonomy and are fully responsible for the treatment they prescribe for their patients. They are required to act within broad limits of acceptable medical practice and within policy for the use of resources, but they are not held accountable to NHS authorities for their clinical judgements.' (DHSS evidence to the Normansfield Report, 1978: 424-5).*

Clinical autonomy was based on the negotiations that took place at the formation of the NHS and the concessions the government made to the British Medical Association to secure the support of the medical profession. Rudolf Klein has described the deal that was struck in the following way:

> *'Implicit in the structure of the NHS was a bargain between the State and the medical profession. While central government controlled the budget, doctors controlled what happened within that budget. Financial power was concentrated at the centre; clinical power was concentrated at the periphery. Politicians in Cabinet made the decisions about how much to spend; doctors made the decisions about which patient should get what kind of treatment' (Klein, 2006: 61).*

Phil Strong and Jane Robinson argue that as a result of this deal the NHS was 'fundamentally syndicalist in nature' (1990: 15) in that the medical profession was able to control and regulate its own activities without interference from politicians or managers.

As Klein has emphasised, the bargain struck at the inception of the NHS was a temporary truce rather than a final settlement. If, as Harrison and Pollitt maintain, the role of the manager until 1982 was to act as a diplomat, appointed '*to provide and organise the facilities and resources for professionals to get on with their work*' (1994: 36), then the financial pressures facing the NHS in the 1980s caused a fundamental reappraisal of this role and the relationship between managers on the one hand, and doctors and the other health professions on the other. These issues came to a head with the publication of the report of the Griffiths inquiry into NHS management which argued for a system of general management to be introduced in place of consensus management. The Griffiths report contended that general management was needed to provide the NHS with effective leadership and to ensure clear accountability for decision making. The report also argued that hospital doctors *'must accept the management responsibility which goes with clinical freedom'* (Griffiths Report, 1983: 18).

To this end, a number of demonstration projects were set up to test out what was termed 'management budgeting' and in 1986 this was superseded by the resource management initiative. Building on these efforts, most NHS hospitals implemented a system of medical management centred on the appointment of senior doctors as clinical directors responsible for leading the work of different services within the hospital. Clinical directors combine their management and leadership roles with continuing but reduced clinical duties. They usually work with a nurse manager and a business manager in a directorate management team known as a triumvirate. Clinical directors often come together as a group with the medical director and chief executive to advise on developments across the hospital as a whole. The involvement of hospital doctors in management was influenced not only by the Griffiths report but also by developments at Guy's Hospital which pioneered this approach, drawing on the experience of Johns Hopkins Hospital in the United States (Chantler, 1999).

Evidence on the impact of general management found that a more active management style resulted in which managers were increasingly involved in questioning medical priorities (Flynn, 1991). The extent to which this led to a shift in the frontier of control between managers and doctors is disputed with the balance of evidence maintaining that change was limited and that

doctors retained significant autonomy and influence (Harrison, 1988; Harrison and Pollitt, 1994; Strong and Robinson, 1990). As Steve Harrison summarised the evidence:

> *'…although managers are more clearly agents of government than before, and although the frontier of control between government and doctors has shifted a little, in favour of the former, there is as yet little evidence that managers have secured greater control over doctors' (Harrison, 1988: 122).*

Likewise, research into organisational change concluded that many of the transformational changes that had been initiated were not well embedded, and the dominance of the medical profession remained largely intact (Ferlie et al, 1996). These findings are reinforced by the review of events leading up to the failures in paediatric heart surgery at Bristol in the 1990s which described a hospital in which the chief executive (himself a doctor) delegated a large measure of responsibility to individual doctors and clinical directors, and a culture that emphasised the importance of clinical autonomy (Kennedy Report, 2001).

This brief summary of the evidence highlights the robustness of established relationships of power and influence in the NHS, and the strength of 'tribalism', in the face of attempts to make the NHS more businesslike and to bridge the divide between managers and doctors. As Phil Strong and Jane Robinson concluded in their ethnographic study of the impact of general management, the Griffiths report threw down a radical challenge to the NHS, in particular a *'challenge to the syndicalist notion that the clinical trades knew best'* (97), but it was only a partial break with the past. From this perspective, the changes initiated by the Griffiths report are best seen as the start of a long term process of renegotiating the role of the medical profession in the NHS. This process was to continue into the introduction of the internal market into the NHS in the 1990s and beyond, and was therefore more akin to a permanent revolution than a sudden coup (Strong and Robinson, 1990: 100).

To help interpret the findings of research into general management, we now draw on the literature on health care organisations as professional bureaucracies, as this literature provides important insights into the challenges involved in leadership in hospitals. Having highlighted the way in which organisational theory can help in understanding the role of doctors and managers in health care organisations, we will then return to NHS experience and focus more specifically on research into the role of clinical directorates and medical leadership.

Health care organisations as professional bureaucracies

In the language of organisational theorists such as Henry Mintzberg, health care organisations are professional bureaucracies rather than machine bureaucracies (Mintzberg, 1979). One of the characteristics of professional bureaucracies is that front line staff have a large measure of control over the content of work by virtue of their training and specialist knowledge. Consequently, hierarchical directives issued by those nominally in control often have limited impact, and indeed may be resisted by front line staff.

In this respect, as in others, professional bureaucracies are different from machine bureaucracies (such as government departments). More specifically, they have an inverted power structure in which staff at the bottom of the organisation generally have greater influence over decision making on a day to day basis than staff in formal positions of authority. It follows that organisational leaders have to negotiate rather than impose new policies and practices, working in a way that is sensitive to the culture of these organisations. The following observation from a study of the impact of business process reengineering in an English hospital summarises the challenge in this way:

> *'Significant change in clinical domains cannot be achieved without the co-operation and support of clinicians. . . . Clinical support is associated with process redesign that resonates with clinical agendas related to patient care, services development and professional development. . . . To a large degree interesting doctors in re-engineering involves persuasion that is often informal, one consultant at a time, and interactive over time . . . clinical commitment to change, ownership of change and support for change constantly need to be checked, reinforced and worked upon' (Bowns and McNulty, 1999: 66–7)*

Control in professional bureaucracies is achieved primarily through horizontal rather than hierarchical processes. These processes are driven by professionals themselves who use collegial influences to secure co-ordination of work. In health care organisations, professional networks play an important role in ensuring control and co-ordination, both within and between organisations, alongside peer review and peer pressure. Collegial influences depend critically on the credibility of the professionals at their core, rather than simply the power of people in formal positions of authority.

An important feature of professional bureaucracies in Mintzberg's view is that they are oriented to stability rather than change. Not only this, but also they are characterised by tribalism and turf wars between professionals who often identify more strongly with 'their' part of the organisation, than with the organisation as a whole. Put another way, professional bureaucracies are made up of collections of 'microsystems', to adapt the language used by Paul Batalden and colleagues at Dartmouth, comprising multi-professional teams responsible for day to day work (Batalden et al, 2003).

Three implications for leadership follow. First, **in professional bureaucracies, professionals play key leadership roles**, both informally and where they are appointed to formal positions. Much more so than in machine bureaucracies, the background of leaders and their standing among peers have a major bearing on their ability to exercise effective leadership, and to bring about change.

Second, **professional bureaucracies are characterised by dispersed or distributed leadership**. In health care organisations, clinical microsystems are a particularly important focus for leadership. It follows that in professional bureaucracies there is a need for large numbers of leaders from clinical backgrounds at different levels. A focus on leadership only at the top or most senior levels risks missing a central feature of these bureaucracies.

Third, much of **the evidence highlights the importance of collective leadership in health care organisations**. Collective leadership has two dimensions: first, it refers to the role of leadership teams rather than charismatic individuals; and second, it draws attention to the need to bring together constellations of leaders at different levels when major change programmes are undertaken, as demonstrated by empirical research into leadership in Canadian hospitals undertaken by Jean-Louis Denis and his colleagues (Denis et al, 2001).

To draw out these implications is to underscore not just the nature of leadership in professional bureaucracies but also the importance of 'followership'. Put simply, the large measure of control that front line staff have

over the content of work can result in professional bureaucracies becoming disconnected hierarchies or even organised anarchies. Appointing respected and experienced professionals to leadership roles is often advocated as the response to this challenge. Chantler is one of the foremost advocates of this approach, arguing that in Guy's Hospital:

> *'By giving significant responsibility for the organisation to those who actually delivered the service, we aimed to reduce the disconnection that occurs in hospitals, as pointed out by Mintzberg, between those at the top who organise the strategy and those at the service end who deliver care to patients' (Chantler, 1999: 1179)*

However, in itself this may not be sufficient to address the need for control, co-ordination and innovation. As well, health care organisations have increasingly recognised the requirement to strengthen the role of all staff as followers (Silversin and Kornacki, 2000, emphasise this in their work on medical leadership in the United States) by investing in organisation development and not just leadership development.

As a final comment on the organisational theory literature, it is worth noting the argument that professional bureaucracies have been superseded by newer organisational forms. Two such forms have been described, namely the managed professional business (Cooper, Hinings, Greenwood and Brown, 1996) and the quasi market hospital archetype (Kitchener, 1999). In both forms, it is argued that management structures and business values have been superimposed on professional bureaucracies and changed their nature. As we show in the next section, the evidence for the ascendancy of new kinds of professional organisations is weak, and it is for this reason that we have emphasised the continuing importance of Mintzberg's writings in understanding leadership and relationships in health care organisations.

The role of medical leaders in the NHS

In our summary of the impact of the Griffiths report, we emphasised the importance of seeing the report as the start of a long term process of renegotiating the role of the medical profession in the NHS. Subsequent research in this area has underlined the challenges of changing deeply entrenched relationships. While some hospitals have made progress in using clinical directorates to engage doctors in leadership roles and to achieve improvements in performance, others have experienced difficulties. These difficulties are starkly illustrated in a detailed study of leadership in an NHS hospital in the 1990s undertaken by Paul Bate (2000).

In this hospital, consultants did not accept the legitimacy of management, and as a result were able to undermine managerial power. The hospital was characterised by sub-cultures centred on microsystems that were isolated from each other. This was problematic when change was attempted involving more than one microsystem, as it led to tensions and often gridlock. Doctors held power and managers became afraid to challenge doctors lest they should face a vote of no confidence. Progress only became possible when doctors and managers agreed to establish a 'network community' (504) in place of the system of clinical directorates which was seen to have been 'a failed experiment' (509).

A more mixed picture emerged from a survey of clinical directorates in Scotland conducted by Lorna McKee and colleagues. This survey found wide variations in the way directorates were constructed and conducted their business. Three major directorate types were identified (McKee, Marnoch and Dinnie, 1999). The dominant type was described as **'traditionalist'** and this was characterised by a strong focus on operational issues and limited scope for innovation and change. Relationships between clinical directors and clinical colleagues remained embedded in a collegiate clinical network and were based on consensus building and facilitation.

The second type was described as **'managerialist'** and was characterised by a business oriented approach more in line with the philosophy of the Griffiths report. Clinical directors in managerialist directorates had direct links with top managers in the hospital and were better placed to influence overall strategy and direction than those in traditionalist directorates. The third type was described as **'power-sharing'** and involved clinical directors working across established specialty boundaries and operating as a team with the business manager and nurse manager.

McKee and colleagues note that the variability between clinical directorates shows the ability of doctors to adapt managerial initiatives. More importantly, they emphasise the overwhelming sense of continuity rather than change, and *'few examples of trusts creating a new climate in which clinical directors of the future were being spotted, nurtured or sustained'* (110). Furthermore, clinical management was very thinly resourced, with many directorates run on a shoestring. The minority of directorates that were not traditionalist held out the prospect that clinicians could be developed into innovative leaders, but for this to happen:

> *'more, and more senior, doctors will have to be given the incentive to get involved, the relevance of management will have to be actively marketed and the clinical legitimacy of doctor-managers will have to be safeguarded' (112).*

In many ways, this study reaffirmed evidence from the organisational theory literature relating to the tendency of professional bureaucracies to be oriented to stability rather than change, while also underlining the limited progress in moving from professional bureaucracies to managed professional businesses.

Further confirmation of the persistence of established relationships comes from Kitchener's study of the impact of quasi-market reforms on NHS hospitals (Kitchener, 1999). Drawing on Mintzberg's writings, Kitchener hypothesises that the NHS reforms are an attempt to replace the professional bureaucracy with the quasi-market hospital archetype. In this new archetype, the hospital is based around clinical directorates and medical cost centres, and a more businesslike approach to management is adopted, centred on medical cost centres and using enhanced management information systems. Kitchener found that in practice the impact of this new archetype was limited and warns that:

'The fact that some hospital doctors have accepted medical-manager roles within a more integrated formal structure should not…be conflated with either a loss of their professional autonomy or a replacement of key elements of the PB (professional bureaucracy) interpretive scheme' (197).

He concludes that the notion of the professional bureaucracy continues to provide an appropriate basis for understanding the nature of hospitals as organisations.

The challenges facing clinical directors were highlighted in a survey of doctor-manager relationships in Great Britain by Huw Davies and colleagues. This survey found that senior managers such as chief executives and medical directors were more positive about these relationships than managers at directorate level. Among all the groups surveyed, clinical directors were the least impressed with management and the most dissatisfied with the role and influence of clinicians. Davies and colleagues argued that unless the divergence of views they found were addressed then it would be difficult to engage medical leaders in the government's modernisation agenda (Davies, Hodges and Rundall, 2003).

This conclusion echoes other work which concluded that clinical directors and other doctors in leadership roles occupied a 'no man's land' between the managerial and clinical communities (Marnoch, McKee and Dinnie, 2000). It is also consistent with the research of Degeling and colleagues (2003) which has described the differences that exist among staff groups in relation to individualist versus systematised conceptions of clinical work, and in terms of conceptions of the financial and accountability aspects of clinical work. The existence of these differences confirms the persistence of tribal relationships in hospitals and the difficulties facing staff like doctors who go into management roles in bridging different cultures.

On a more positive note, one of the most comprehensive studies of medical managers noted evidence that clinical leaders can play an influential role as promoters of change. However, Louise Fitzgerald and colleagues observed that, notwithstanding the proliferation of clinical director and medical director roles, and the establishment of the British Association of Medical Managers (BAMM) as a professional association, clinical managers lacked a coherent identity and accepted knowledge base. They commented that:

'Externally, there is no recognition of clinical management as a specialty, with limited opportunities or credentials – and an unwillingness to undertake major training. Other medical professionals do not consider clinical management to represent a medical specialty – rather clinical managers uncomfortably span the managerial/clinical divide and are not full or influential members of either occupational group' (Fitzgerald, Lilley, Ferlie, Addicott, McGivern and Buchanan, 2006: 170).

In its work, BAMM has reviewed the development of medical management roles in the NHS, and has set out a proposed career structure for medical managers such as medical directors, clinical directors and associate medical directors (BAMM, 2004). BAMM's proposals emphasise the need to properly reward and recognise the part played by medical management, and to make it an attractive career option for skilled and motivated doctors. These recommendations underline the need to link the development of medical leadership to appropriate incentives and career structures. As BAMM has argued:

'It is essential that medical management is rewarded and supported in a way that will attract the strongest applicants to the posts. Currently there are a number of major deterrents – for example the relative difficulties in describing and defining management activities. These activities can be more difficult to define as coherent sessions than is the case for clinical work. The lack of a clear concept of where a medical management career move will take the individual also proves to be a major barrier' (BAMM, 2004: 24).

Primary care was largely bypassed by the changes that flowed from the Griffiths report, and only recently have there been moves to strengthen management and leadership in primary care. Work by Rod Sheaff and colleagues (2003) has described the impact of these moves in primary care groups and trusts in England. Lacking any formal, hierarchical authority over GPs, primary care groups and trusts worked through GPs

who took on the role of clinical governance leads, and managers exercised influence by proxy through these leads. Sheaff and his co-authors argue that clinical governance leads used a range of informal techniques to implement clinical governance in primary care, and they use the terms 'soft governance' and 'soft bureaucracy' to describe the relationships and organisations they studied.

In summary, research into medical leadership in the NHS since the Griffiths report highlights the challenges involved in developing the role of medical managers. While progress has been made in appointing doctors as clinical directors and in establishing clinical directorates within hospitals, the effectiveness of these arrangements is variable. If in some organisations there appears to be much greater potential for involving doctors in leading change, in most there remain difficulties in changing established ways of doing things and in supporting medical leaders to play an effective part in bridging the divide between doctors and managers. Part of the explanation of these findings is the resourcing put into medical leadership and the limited recognition and rewards for doctors who take on leadership roles. Also important is the continuing influence of informal leaders and networks operating alongside formal management structures. Summarising the mixed experience of clinical directorates, Marnoch concluded his assessment in the following way:

'The means of controlling the operational performance of hospital doctors have advanced somewhat since the introduction of general management in the 1980s. Nevertheless, the Griffiths-inspired drive to push resource-consuming decisions down to the level where they could best be made is far from complete. A traditional centralised style of management has been used to make the internal market work. This form of control remains constrained in its influence over clinical behaviour. At worst, medical directors and clinical directors will be used as go-betweens in a familiar book-balancing exercise that involves closing wards periodically, not filling vacancies and cancelling operations. At best they are the basis for a new strategically led style of corporate management in the NHS' (Marnoch, 1996: 61)

Evidence from quality improvement programmes

While engaging doctors in leadership may be important in its own right, it is usually seen as a means to improving the quality of health care. Evidence from a number of studies shows that there is a link between medical leadership and organisational performance. For example, an evaluation of the introduction of total quality management (TQM) into the NHS by Richard Joss and Maurice Kogan found that the impact of TQM varied across the pilot sites. In explaining variations in impact, the study concluded that the application of TQM to the NHS had to be done in a way that made sense to staff and that engaged doctors fully in its implementation (Joss and Kogan, 1995).

These findings were echoed in a detailed analysis of the impact of business process reengineering (BPR) at the Leicester Royal Infirmary by Terry McNulty and Ewan Ferlie (2002). As in the evaluation of TQM, this analysis showed that BPR had variable impact in the hospital, with the authors emphasising the difficulty of implementing a programme of this kind in professional bureaucracies. Despite the fact that there was top management support for BPR, this was insufficient for widespread organisational change. Of critical importance was the power of consultants in the hospital and their ability to promote or inhibit change. Implementation of BPR had to be sensitive to the nature of medical work, and the importance of negotiating change with consultants.

Similar conclusions were reached by Chris Ham and colleagues in a study of the implementation of the national booked admissions programme in 24 pilot sites. The study found substantial variation in progress between the sites. Some areas were more receptive to change than others and the most successful pilots were those with a combination of a chief executive who made it clear that booking was a high priority for the organisation and medical champions who were willing to lead by example and exert peer pressure on reluctant colleagues (Ham et al, 2003).

Evidence from outside the UK confirms these findings and also emphasises the range of factors that affect the impact of quality improvement programmes. David Blumenthal and Ann Scheck reported on the application of total quality management to hospitals in the United States, drawing on the work of various researchers to highlight the potential contribution of TQM while also acknowledging the challenges of engaging physicians in so doing (Blumenthal and Scheck, 1995). Stephen Walston and John Kimberley's review of reengineering in United States hospitals summarised the facilitators of change as: establishing and maintaining a consistent vision; preparing and training for change; planning smooth transitions in re-engineering efforts; establishing multiple communication channels; ensuring strong support and involvement; creating mechanisms to measure progress; establishing new authority relationships; and involving physicians (Walston and Kimberley, 1997).

In another review, Ewan Ferlie and Steve Shortell (2001) conclude that medical leadership is an important but not exclusive contribution to the effort to lead quality improvement in health care. They emphasise also the influence of what they term core properties such as organisational culture, team and microsystem development and information technology. As Ferlie and Shortell argue, system wide quality improvement hinges on action at a number of different levels – the individual, microsystem, organisational and larger system – and is likely to result in pockets of innovation and change unless action at these levels and in relation to core properties is co-ordinated.

International Experience

Appendix 1 summarises at a high level the main findings from the review of international experience that we undertook, covering Australia, New Zealand, Denmark, Sweden, Finland, Norway, the Netherlands and Germany. The table shows the variety of arrangements between countries in the involvement of doctors in leadership roles.

While it is unusual for chief executives of health care organisations to come from medical backgrounds, in all countries it is common for medical directors to be represented at board level, and for physicians to take on leadership roles within hospitals, analogous to the roles of clinical directors in the NHS. Often this is as part of a leadership team or triumvirate comprising a physician, nurse manager and general manager. It appears that medical leadership in primary care is less well developed, other than the leadership roles that physicians take on in their medical practices.

Denmark stands out in the review as the country where there is an explicit aim of increasing the involvement of doctors in leadership roles. Specifically, there are medical directors on the boards of all hospitals, and clinical departments are required to have a physician as leader. Doctors are supported to take on leadership roles through mandatory training at the postgraduate level that is based on demonstrating core competences in seven roles (derived from CanMEDS approach developed in Canada). The training includes a 10 day leadership course provided by the Danish regions and the National Board of Health. After appointment as consultants, doctors are offered a five day leadership course.

Arrangements in the other countries included in the review are less well developed. In the Nordic countries other than Denmark, there has been some weakening of the traditionally dominant role of doctors in leadership, driven by reforms that have strengthened the role of managers and challenged professional autonomy. In Australia and New Zealand, there is no explicit policy to increase the involvement of doctors in leadership roles, and training to support medical leadership is patchy (for example, in Australia training is focused at the state level, and is heavily dependent on the role of professional bodies rather than government agencies). Only in the Netherlands is there evidence of a more systematic approach with the CanMEDS approach having recently been adopted as a framework for leadership development.

In none of the countries reviewed is leadership training included in the undergraduate curriculum, and in all countries there is a range of voluntary provision available to physicians in mid career, provided by universities, medical associations, and others.

Kaiser Permanente

A widely cited example of an organisation in which medical leadership is well developed is Kaiser Permanente in the United States.

Kaiser Permanente comprises the Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and the Permanente Medical Groups. The Permanente Medical Groups have a mutually exclusive relationship with the health plan and this generates a high degree of commitment on the part of physicians to Kaiser's performance and success. This relationship means that the fate of the medical groups and the plan is intertwined, and there is therefore a strong incentive for working in partnership. It is this close alignment of interests that lies behind Kaiser's performance.

A high proportion of doctors take on leadership roles in the medical groups and these groups are in effect self managing medical guilds working under contract to the health plan. It is within the medical groups that agreement is reached on how care should be delivered to patients. Change and improvement occur through the commitment of physicians to deliver the care they believe to be appropriate, rather than compliance with an externally imposed standard.

The result is a culture in which the most powerful staff group has taken responsibility for the performance of the organisation. Peer accountability for performance is emphasised within this culture and doctors are expected to engage with their colleagues in reviewing practice and performance. A substantial commitment is made to career long education and professional development in order to sustain this way of working.

There is a degree of self selection in the medical groups which tend to attract doctors who prefer working within an organised framework rather than in office based practice. Part of this organised framework is a commitment to team working and to practising in

collaboration rather than competition. After serving an 'apprenticeship', doctors are elected by their peers into membership of the medical groups, at which point they become shareholders in the groups.

Permanente physicians are paid market rates and some of their income is in the form of bonuses based on performance in areas like quality outcomes and patient satisfaction. The remuneration package on offer creates an incentive for doctors to stay within the groups for their entire career with pension entitlements being enhanced as retirement is reached. There is a strong feeling of all physicians working together and with managers in the organisation in a closely aligned relationship.

Conclusion

For much of the history of the NHS, doctors have enjoyed a large measure of freedom to practise in the way they consider appropriate, and the development of clinical directorates since the Griffiths report in 1983 has met with only partial success. Tribalism remains strongly ingrained in the NHS and staff who occupy hybrid roles, like doctors who become clinical directors, face the challenge of bridging different cultures. Research into the impact of clinical directors highlights the difficulties of introducing new ways of working into the NHS, the strength of traditional relationships, and the orientation to stability rather than change. The evidence also suggests that medical management has often been under resourced and the incentives for doctors to become involved in management have been weak.

The findings from empirical research confirm the persistence of hospitals as professional bureaucracies in which front line staff have a large measure of control by virtue of their training and specialist knowledge. Control and co-ordination are achieved primarily through professional networks and collegial processes. In these bureaucracies, professionals themselves play key leadership roles, both informally and where they are appointed to formal positions; leadership is dispersed and distributed; and collective leadership is critically important. In the absence of hierarchical control, followership is also important in enabling leaders to function effectively, as is the role of doctors who are leaders by virtue of their personal credibility. The use of 'soft governance' techniques by medical leaders is also relevant. There is little evidence that professional bureaucracies have been superseded by newer organisational forms such as the managed professional business and the quasi market hospital archetype.

On the basis of the review of international experience, it appears that there is most potential for learning from Denmark and Kaiser Permanente. The learning from Kaiser Permanente relates not only to its investment in leadership development, important as this is, but also to the creation of a system, shaped over many years, that is closely aligned with the challenges of leadership in professional bureaucracies. Key features of this system are the appointment of a large number of doctors to leadership roles, an emphasis on horizontal or collegial processes of control and co-ordination, and a culture in which autonomous professionals accept the need to work in partnership with their peers and with managers.

One important caveat that needs to be registered is that medical leadership *in itself* is unlikely to deliver the transformational changes the NHS is seeking to implement. As the review of the evidence shows, bringing about change and improvement in health care organisations is complex and hinges on the interaction of several factors. Medical leadership needs to be developed alongside other strategies and has to be supported and valued by strategic leaders at all levels in the NHS, including those at the very top.

What our work also confirms is that there is an opportunity for the UK to use this learning and to become an exemplar in medical leadership and its development, building on existing activities. With the exceptions noted here, none of the countries studied appears to have made more progress on these issues than the UK, and the project being led by the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges has the potential to position the UK at the leading edge of international practice. As this project goes forward, it is important to learn from the experience that has been gained in the 25 years that has elapsed since the Griffiths report, not least to ensure that a renewed commitment to the education and development of doctors as leaders is linked to appropriate incentives and career structures, and reward and recognition for those taking on leadership roles.

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Summary of Findings
Appendix 1

1. How are physicians involved in leadership roles in hospitals?								
a) Are hospital chief executives usually from medical backgrounds?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
Very few CEOs come from a medical background.	The majority of chief executives do not have a medical background. In 2007 it is one out of ten CEOs.	CEOs are only occasionally physicians.	One out of twenty of the present CEOs is a physician.	Two out of four regional health enterprise CEOs and six out of twenty-seven local enterprise CEOs are physicians.	CEOs may come from medical backgrounds but do not usually do so.	In private hospitals they are usually from a financial and business background. In university, public and non-for-profit hospitals it varies.	They can be from medical backgrounds, but there is no requirement for CEOs to be from medical backgrounds but nor is there any reason why they cannot be from such backgrounds.	Occasionally, but not as a general rule in most states. Queensland and Western Australia are encouraging the appointment of chief executives from medical backgrounds for major hospitals.
b) Do hospitals have medical directors who sit on the board?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
Yes, this is a requirement, and there is an increasing tendency for medical directors to be recruited externally.	Yes, the medical directors sit on the board of directors, often as one out of three: the CEO, nursing director and the medical director. Medical directors do not serve on the political governing boards.	Medical directors are members of the management team, but they have no "production responsibility" (they handle quality, safety, patient complaints and medical negligence issues).	Hospital medical directors are members of the management team, but they have no "production responsibility" (they issue clinical guidelines and supervise practitioners, and handle patient complaints and medical negligence issues).	Medical directors are members of the management team, but they have no "production responsibility" (they handle quality, safety, patient complaints and medical negligence issues).	Almost all hospital boards consist of two or three board members, including a medical director.	In university, public and non-for-profit hospitals they do; in private hospitals they do not as the management structure is more business oriented.	Not as a formal arrangement where a medical director is on the board ex officio. However, some clinicians are elected to their DHB governing Board or to other DHB Boards.	Yes, usually.

1. How are physicians involved in leadership roles in hospitals?								
c) Do physicians have leadership roles within hospital, e.g. as leaders of clinics and divisions?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
Yes, they take on a range of roles, often as clinical or divisional directors. Others may take on some corporate roles e.g. clinical governance, education and training, research and development.	Yes, many Danish physicians are leaders of clinics and divisions. Only very few non-physicians are leaders of divisions at large hospitals and only physicians are leaders of clinics.	Many division and department heads are physicians, but a legal requirement reserving those posts for physicians was abolished in 1994.	Most division and department heads are physicians, but municipal regulations requiring a medical qualification were abolished during the 1990s.	Most division and department heads are physicians but the posts are open to other professionals also.	Yes, leadership roles at all levels of the hospital organisation.	In university, public and non-for-profit hospitals they do; mainly as medical heads of clinical departments (Chefärzte). Alongside their clinical tasks they are increasingly involved in managerial and financial aspects of their departments and hospital. In private hospitals physicians are limited to their clinical tasks and are not involved in managerial aspects (they can be involved in management, but not as physicians).	Yes. There is generally a Chief Medical Officer role which is often part of the executive team of the hospital; and clinical leaders operating at clinic and division levels.	Yes. There is usually a medical/clinical director role and directors of clinical divisions.

2. How are physicians involved in leadership roles in primary care?

a) Do primary care organisations have chief executives who come from medical backgrounds?

United Kingdom	Denmark	Sweden	Finland	Norway	Netherlands	Germany	New Zealand	Australia
Very few CEOs come from a medical background.	In Denmark we have no separate primary care organisations. Primary care is managed by the five Regions, in which the Directors for Primary Care are non-physicians.	Very seldom in publicly owned primary care centres. Private organisations are often physician-owned and lead.	Many primary care centre CEOs, especially in small and middle size organisations, are "chief physicians" (medical directors).	Municipal "healthcare directors", who lead public health and primary care are very seldom physicians. Primary care physicians are private practitioners contracted by the municipality.	Health centres are run by CEOs with an economic and/or administrative background. Most primary care is provided by GPs either in solo practice or small groups. GPs provide the leadership in these practices.	Primary care is typically based on physicians in solo practices run as small businesses.	This is not a requirement; and no research has been done on this issue; however, some Primary Healthcare Organisations (PHOs) may have CEOs with medical backgrounds.	The divisions of General Practice usually have a chief executive with a medical background.

b) Do primary care organisations have medical directors who sit on the board?

United Kingdom	Denmark	Sweden	Finland	Norway	Netherlands	Germany	New Zealand	Australia
Yes, on the boards of primary care trusts.	We have no medical directors for primary care.	The medical director function is usually organised on the county level (county healthcare organisations include primary care).	The chief physician is a member of the management team.	No.	Generally not.	No.	Again, there is no formal research on this issue, but it is likely that some PHOs have medical directors who sit on their boards or at least have medical experience on the board (eg, representing the interests of GPs).	Yes – on the Boards of Divisions of General Practice.

2. How are physicians involved in leadership roles in primary care?

c) Do physicians have other leadership roles within primary care organisations?

United Kingdom	Denmark	Sweden	Finland	Norway	Netherlands	Germany	New Zealand	Australia
Some doctors will have leadership roles in primary care trusts, e.g. clinical governance, education and training, research and development, and many are leaders in their own practices. Some are positively embracing the new leadership opportunities afforded by Practice-Based Commissioning.	Many physicians run a one-person enterprise in primary care, where they take care of daily leadership of secretary and nurse. Some primary care physicians are grouped together at the same location. In these places one of the physicians looks after the daily management and leadership.	About half of the primary care centre managers are physicians (the other half being nurses).	All "health stations" (surgeries) of a primary care organisation are led by "head physicians".	No, see above Q2a). But municipal healthcare organisations are required by law to salary a medical officer responsible for infectious disease control and the management of acute care and environmental health.	The main leadership role of physicians in primary care is in running their own practices.	They may do in larger partnership and medical units but there is no research into the leadership roles of physicians in these organisations.	Yes, although this is not well documented.	Not obviously, the emphasis in primary care is on the GP.

3. Is it an explicit aim of health policy to increase the involvement of doctors in leadership roles?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
Yes, this has been an objective since the Griffiths report of 1983, and has recently been reiterated both by the Secretary of State in The Next Stage Review and by the chief executive of the NHS.	Yes, already twenty five years ago the importance of getting doctors more involved in the leadership of hospitals was acknowledged. After that medical directors were appointed into the boards of directors at all hospitals. Also the current health policy approves that a clinical department should have a physician as a leader.	No.	No.	No.	Not explicitly, but implicitly. In the new curricula physicians are trained to 'master' all competences of the CanMEDS model. Leadership and management is only one of the competences and is therefore not seen as the primary aim.	A first attempt is made from the German Medical Association (Bundesärztekammer) with the development of the curriculum on medical leadership. But they are representing one voice, the interests of physicians, of many voices in the decentralised and fragmented self-governing health care system of Germany.	Not really. There are statements about the benefits of clinicians in leadership roles but no official policy that we are aware of.	No (not federally). The only State policy initiatives that come close to this are the clinical network arrangements in many States.

4. At the undergraduate level, what training and preparation do physicians receive for leadership roles? What is the content of this training? Who provides it? Is competence assessed and if so how?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
Not in general, although the focus on professionalism at the undergraduate level covers some aspects of medical leadership.	The medical students will not get any formal training for future leadership roles. During their clinical training in the hospital departments students will meet consultants, clinical directors and medical directors, all of whom in their leadership behaviour as role models somehow will influence the way medical graduates look into medical leadership. Competence is not assessed.	Medical school curricula vary. Usually public health, community medicine and forensic medicine courses cover the basics of the healthcare system, legislation, the professional role, responsibilities and duties of healthcare practitioners and the importance of teamwork. No specific leadership training.	Medical school curricula vary. Usually public health, community medicine and forensic medicine courses cover the basics of the healthcare system, legislation, the professional role, responsibilities and duties of healthcare practitioners and the importance of teamwork. No specific leadership training.	Medical school curricula vary. Usually public health, community medicine and forensic medicine courses cover the basics of the healthcare system, legislation, the professional role, responsibilities and duties of healthcare practitioners and the importance of teamwork. No specific leadership training.	Undergraduate students do not receive any training at all concerning leadership roles.	Not in general; although there are increasingly reform-curricula which take this aspect into account.	There is no such formal training offered.	The new Australian Curriculum Framework for Junior Doctors implies this will be the case but currently practice is unclear. Australian Medical Students Association (AMSA) has a National Leadership Development seminar, and mentoring for medical students. Content more focused on understanding and influencing the health system and political system. Australian Indigenous Doctors Association (AIDA) and Royal Australasian College of Physicians (RACP) mentoring for indigenous medical students. None of these initiatives assess competence, however one expects that the curriculum framework would require some assessment of competence.

5. At the postgraduate level, what training and preparation do physicians receive for leadership roles? What is the content of this training? Who provides it? Is competence assessed and if so how?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
Optional training is provided, mainly through the postgraduate deaneries. The courses on offer are mainly didactic in orientation and may also include assessment of a project. Various Medical Royal Colleges do offer some leadership programmes as well as private training companies.	During speciality training it is mandatory that future medical specialists can document core competences in seven basic roles. These are assessed by education talks with their peer superiors. The training includes a ten day mandatory course in "Leadership, administration and collaboration", provided by the Danish Regions (hospital owners) and the National Board of Health.	Some elective courses are offered to registrars by specialty associations or medical schools. No defined "core curriculum" or formal assessment of competency.	House officers have a mandatory sixteen hour course on the healthcare system and legislation as well as social insurance. Registrars have a twenty hours mandatory course in "health administration", which also covers the specialist's role as the leader of a clinical team or unit. The courses are organised by medical schools (departments of public health). No defined "core curriculum" or formal assessment of competency.	House officers may take elective courses on management and leadership offered by some universities. Registrars have a one-week mandatory course on "administration and leadership".	Compulsory training and preparation based on the seven competences of the CanMEDS model, and provided by university departments in collaboration with regional institutes. Students' competences are assessed by using several assessment forms.	No.	There is very little formal postgraduate training offered. Some privately funded courses are offered, discussed in the paper. Competence does not appear to be assessed.	Practice is not consistent nationally. Professional development of registrars national programme piloted. Content focused on practical team management, mentoring, communication and self management skills. Competence does not appear to be assessed.

6. What training and development in leadership do physicians receive after registration? What is the content of this training? Who provides it? Is competence assessed and if so how?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
This is variable. An increasing number of NHS trusts provide training in-house, and some doctors may choose to take a Masters degree which includes elements of leadership. The British Association of Medical Managers offers a range of leadership development interventions. A number of Royal Colleges, universities, training organisations and consultancy companies also offer a range of clinical leadership programmes.	After registration as specialists they are offered a five day basic leadership course in the programme: "Education for Physician Leadership and Management". The main issues are leading professionals, quality, change, leadership in a political context and personal leadership. Provided by the Danish Regions and the Danish Medical Association (the employees organisation). Competences are assessed in own organisation by mandatory yearly talks with superiors.	In-house leadership development organised by counties. No defined "core curriculum" or formal assessment of competency. Courses are also offered by consultancy firms and business schools.	In-house leadership development organised by hospitals or municipalities. No defined "core curriculum" or formal assessment of competency. A three-level multiprofessional leadership development programme with a national curriculum will start in the autumn of 2007. Course organisers will be medical schools in cooperation with other faculties (business, political science). Formal examinations will be performed.	In-house leadership development organised by health enterprises. Health enterprises offer jointly a "top leadership programme" over four months to senior leaders of all professions, the curriculum covering strategic and financial management and an international module with study tours to Sweden and Denmark.	Voluntary training and development programmes are provided by individual institutes. Most common are short-term management courses, such as hospital management, hospital finances and health care law. However, competences are generally not assessed.	The curriculum on medical leadership as one programme out of the many and mainly medically focussed continuing medical education programmes offered by the Medical Assemblies *(Länderärztekammer)*. The competence is not assessed; the requirements of the programme are fulfilled by completing previously agreed tasks etc.	There is very little formal postgraduate training offered. Some privately funded courses are offered, as discussed in the paper. Competence does not appear to be assessed.	Generally training is voluntary, although participation in some programmes will formally count towards continuing professional development. Content is generally self awareness, strategic thinking, management skills, some understanding of leadership concepts. Assessment of competence varies according to the provider. Mostly there will be no formal assessment. The exception is RACMA who do assess competence often through viva, or preceptor report.

7. After registration, is training provided on a national basis or is it left to individual hospitals and primary care organisations?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
Training is not provided on any systematic basis nationally and is a matter for individual hospitals and health care organisations.	Training courses are provided on a national basis. The course during speciality training is free and paid by the National Board of Health. The five day leadership course after speciality registration are left for individual hospitals to take care of and pay for. A rough guideline is that new specialists are supposed to attend during the first two-three years after first appointment.	See previous answer.	See previous answer.	See previous answer.	It is provided on an individual basis.	The training is organised on a federal and Länder-level; but it is left to the individual physician if she / he wants to follow such a programme or not. There are no mandatory standards to do so. In private hospitals the situation is different; but also there it is very much under the discretion of the specific hospital how to provide additional training on leadership.	There is a national leadership programme offered by District Health Boards New Zealand (DHBNZ) but attendance and funding is left to individual hospitals and primary care organisations.	Not national currently. Generally left to State health departments, Area Health Services & hospitals, medical and professional colleges/ associations.

8. Does a national competency framework exist for medical management and leadership and competency?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
The British Association of Medical Managers has developed a leadership competency framework – a syllabus for Doctors in Management and Leadership Positions in Healthcare. The joint NHS Institute and Academy of Medical Royal Colleges project has developed a medical leadership competency framework for all doctors in their practitioner roles.	Yes as part of the documentation of core competences during speciality training. One of the seven competences is being a good leader and administrator with focus on priorities, management of resources, rational management of clinic, economy management and personal leadership with priority of own use of time.	No.	No.	No.	Since 2007 the CanMEDS 2000 model has been introduced. One of the competences within this model focuses on medical management and leadership.	The curriculum on leadership can be considered as a competency framework; but it is voluntary and not compulsory.	No; however, it may be that this is included in upcoming development of a national competency framework for doctors.	No.

9. Please list any other significant features on medical leadership in your country?								
United Kingdom	**Denmark**	**Sweden**	**Finland**	**Norway**	**Netherlands**	**Germany**	**New Zealand**	**Australia**
The importance of medical leadership is increasingly recognised as is the need to do more to support doctors to take on leadership roles and to strengthen training in leadership.	It is well acknowledged in the medical community that education and training for medical leadership is necessary and mandatory for being a good physician leader of a department or clinical director. It is not enough just being a medical expert since more broad competences are required for a good medical leadership.	Increasing concerns among political decision-makers and administrators regarding the difficulties to recruit physician leaders.	New legislation on improved access to care that introduced national treatment indications for 80 % of elective procedures has highlighted the legal responsibility of medical directors and clinical department heads to oversee the adherence to clinical guidelines "reinstating" a medical hierarchy.	The 2001 and 2002 reforms re-established GPs as private entrepreneurs and introduced general management into hospitals, which demonstrably showed the decline of the previously very strong medical influence in Norwegian healthcare.	Medical leadership is common in almost all Dutch hospitals. However, only since the restructuring of the postgraduate curricula physicians receive (compulsory) leadership training and management development courses.	Difference in management structure between private hospitals on the one hand and university, public and private houses on the other hand; trend towards assimilation of management structures in university, public and non-for-profit hospitals to private hospitals through increasing privatisation of hospitals.	Medical leadership (as with leadership in health care in NZ generally) is seriously underdeveloped in New Zealand. There is basically no national policy on the issue, and the training is very ad hoc.	The health system fragmentation and complexity may make it harder for an individual to be seen to lead from within it. Institutional mechanisms, like clinical networks, seem to be more popular to encourage engagement in leadership than education.

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