Engaging health professionals with leadership and management development.

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Introduction
Evidence-based medicine has a long and established conceptual understanding in healthcare and has been traced by Claridge and Fabian (2005) through timeframes that they have designated as the Ancient Era (examples from biblical times and the Song Dynasty, 1061), Renaissance Era (seventeenth century to the late nineteenth century), Transitional Era (late nineteenth century to the 1970s) and the Modern Era (from the late twentieth century).

A more recent development is the emergence of evidence-based policy and practice in healthcare (Hunter, 2003). Hunter (2003, pp.195) describes evidence-based policy and practice in healthcare as a rational, linear model of how research and evidence are acted upon:

Policy ideas give rise to policy development and implementation and, at the end of the process, policy evaluation is undertaken to determine the success or otherwise of the policy.

Translating the concept of evidence-based policy and practice to learning within healthcare sees a rational, linear model of research and evidence informing learning policy and practice. Learning evaluation is then undertaken to determine the success or otherwise of the learning policy.

This paper will consider evidence as it applies to the understanding of the leadership and management capability development requirements of healthcare professionals. The paper will then consider whether any such evidence has informed healthcare learning policy and the learning practices of healthcare professionals.

Evidence
Health services in countries throughout the world are under increasing pressure to deliver services in a climate of aging populations, epidemics (for example HIV Aids) and skill shortages (World Health Organisation, 2006). Some health systems, under these pressures, experience extreme breakdowns in performance and are the subject of governmental inquiry. The Bristol Royal Infirmary Inquiry (2001) and the Queensland Health Systems Review (Forster, 2005) are two examples. These inquiries arose from
community concerns regarding the standards of health care provided by the respective systems, especially with regard to serious adverse outcomes resulting in mortality. In both of the inquiries, deficiencies in management and leadership have been identified as factors contributing to systemic breakdowns. Both inquiries recommend improvements in the leadership and management capability development of clinicians in the respective organisations.

The inquiries found that the organisational cultures were such that, even though concerns existed, it was difficult for staff to raise issues or speak openly. The inquiries also found that the hierarchical structures within and between the healthcare professions contributed to significant cultural weaknesses and that fiction existed between clinicians and managers with poor understanding of how each needed to work together to contribute to overall patient care.

The Bristol Royal Infirmary Inquiry (2001) found that:
   One of the most effective ways to foster an understanding about and respect for various professional roles and the value of multi-professional teams is to expose medical and nursing students, other healthcare professionals and managers to shared education and training.

The Bristol Royal Infirmary Inquiry (2001) and the Queensland Health Systems Review (Forster, 2005) both recommended the engagement of clinicians with leadership programs and particularly the leadership work developed by the National Health Service (NHS). The NHS (2007, pp.1), for its part, asserts that patients and the public expect and need doctors to work effectively with colleagues of all disciplines in the delivery of safe quality services.

The importance of a shared understanding of the clinical and managerial professions is supported by Buchanan et al (1997, pp.132) who remind us that the decisions of doctors commit hospitals to expenditure for which doctors themselves are not directly accountable. Lin et al. (2005, pp.2) assert that nurses also have established structures within health systems that include clearly defined management roles. These roles include managing nursing resources, influencing hospital strategy and planning to respond to the hospital’s environment. Owen and Phillips (2000, pp.121) view that the clinical perspective can be seen as focussing on the needs of the individual patient whereas the managerial perspective focuses on the needs of groups of patients, but that both perspectives are critical to the effectiveness of the overall system.

**Policy Response - Skills and Competencies**

One of the policy responses to the evidence of the need for healthcare professionals to develop leadership and management capability is the
identification of the required leadership and management skills, competencies, capabilities and qualities.

The NHS (2006) describes 15 leadership qualities developed as a result of behavioural event interviewing with recognised leaders in their organisation. These qualities are clustered in three areas of: personal qualities; setting direction; and delivering the service. Although the qualities have been criticised by some, including Wood and Gosling (2003) for the methodology used in their development, they have been adopted by a number of health services including Queensland Health.

Buchanan et al. (1997, pp.142-143) developed their own sets of qualities for a clinical director with clusters of: context factors; personal stance; core understanding; behavioural capabilities; and specific skills.

Other authors who have described leadership and management skills, competencies, capabilities and qualities for clinicians include:

- Purcell and Milner (2005) - Nursing competencies developed in Ireland for nurse and midwife managers
- Lin et al (2005) - Management Activities and Skills of Nurse Managers
- Clark and Armit (2008) – Medical Leadership Competency Framework
- Courtney et al (2002) - professional development needs of Queensland public sector nursing executives

Whilst a detailed analysis of the similarities between these models and frameworks is outside the scope of this paper, it can nonetheless be seen that there are, quite expectedly, commonalities and overlaps all within a healthcare context.

**Practice - Programs**

Evidence has led to policy response, that is, the identification of the required leadership and management skills, competencies, capabilities and qualities. In a learning context, the embodiment of practice is the delivery of learning programs. A number of leadership and management development programs for clinicians are described in the literature.

Crofts (2006) describes a leadership program for clinicians involved in critical care which was conducted across six NHS hospitals in the UK. Whilst participants were primarily nurses, other health professionals also participated in the program which was based on the Kouzes and Posner (cited in Crofts, 2006) leadership model. The program had mixed success with organisational culture and organisational endorsement cited as being contributing factors.
Hewison and Griffiths (2004) critique a number of NHS leadership development programs including the Royal College of Nursing Clinical Leadership Program, the NHS Leading Empowered Organisations Program and the NHS National Nursing Leadership Program. Hewison and Griffiths (2004) found that in addition to development activities, health care organisations need to create conditions which support and enhance new models of leadership.

Wolf et al (2006) explores three levels of programs for developing health care leaders. The programs are designed for: nurses transitioning into their first leadership roles (level 1); nurses experienced in managing others and who are counted on to drive change and impact staff performance (level 2); vice-president level or aspiring executive level leaders (level 3). Graduates of the programs have contributed to $500,000 in savings to the system with more than $38 million identified in potential future savings for strategic initiatives. Scheck McAlearney et al (2005) critique an internal physician leadership program, the Medical Leadership Program, at the Columbus Children’s Hospital, Ohio. The program was designed to support an organisational transformation change effort and involve physicians in organisational leadership and was successful in achieving these objectives.

A management development program for health care professionals that comprised a joint qualification of a level 5 national vocational qualification and a diploma in management is described by Loan-Clark (1996). Creswell et al. (1997) describe a residential management program for clinician managers in Australian hospitals. They claim that the Management for Clinicians Program promotes increased understanding and acceptance of the role of clinicians as managers.

Owen and Phillips (2000) explore the Trent program, an interdisciplinary program for doctors and managers which explores roles and relationships, values, agendas for change, and barriers to joint working and which has led to closer collaboration in practice.

Not all the literature describes success stories, Currie (1999) describes a program where there is resistance to a management development program due to the designer’s failure to adequately consider the health context.

All of the programs had a face-to-face traditional workshop or session component, one qualification based program reported by Loan-Clarke (1996) also had distance learning, tutorial and assessment components. The program described by Wolf et al. (2006), in addition to face-to-face workshops, had on-line assessment as an entry component and work based projects post workshops.
Engagement
The preceding discussion highlights for us that:

- the literature is able to clearly present evidence for the need for clinician engagement with leadership and management capability development
- that policy exists in the form of skill and competency frameworks
- that there are many examples of practice (programs) that provide development opportunities for clinicians

Many clinicians, however, view engaging in hospital management as a waste of their highly developed skills and training and better left to others (Creswell et al., 1997, pp.20). They fear that their collegial relationships with their peers will be compromised if they are seen to be aligning with management and taking on management responsibilities. Those clinicians that do try to take on management responsibilities often try to apply their medical paradigm and apply specific skills and a scientific approach. When confronted with the political nuances and ambiguity of organisational management they find their skills are ineffective which leads to frustration.

Buchanan et al. (1997, pp.132) report that doctors do not find managerial posts attractive, given their commitment to patient care, lack of management skills and the lack of career benefit.

Nurses, as with other clinical groups, according to Harris et al. (2006, pp.435), also separate nursing practice from nursing administration and do not see nursing administration as advanced practice.

Owen and Phillips (2000, pp.121) help us to broaden our perspective on the issues by asking us to think that while we try to coax doctors on to management territory and to equip them with appropriate skills to perform effectively once they are there, there is not an equivalent emphasis on analysis of the perceptions and practices of all parties within the medicine/management relationship.

The Audit Commission (2007) reports that clinicians at the front line of service delivery make decisions on a continual basis that commit organisational resources and services and that these commitments have a direct and immediate impact on the financial performance of their facility. They further report that engagement between clinicians, general managers and finance staff leads to improvement in the quality of financial information, improves efficiency and provides better patient care. They describe engagement as mutual understanding and cooperation that involves the finance and clinical cultures coming together.
Buchanan et al. (1997, pp.133) propose involvement in the management process and give reasons why doctors might look with favour on the opportunity to influence the management process:

- they are among the best educated members of the hospital’s staff and responsible for most of the decisions committing resources
- involvement is a way of preventing an erosion of discretion by professional managers
- fear of being managed by others is a key motivator
- doctors are not comfortable with the notion of decisions affecting patient care being taken by non-medically trained personnel

There is some support, therefore, from the literature to consider the engagement of clinicians with leadership and management capability development as a method by which to engage them with the management process and decisions without necessarily requiring them to move from their clinical roles into management positions.

**Links to Adult Learning**

Thus far, this paper has endeavoured to establish evidence that health systems need to engage health professionals with leadership and management capabilities to enable more effective and efficient use of resources. Further, the paper has endeavoured to establish that policy and practice in the form of competency sets and programs have been, and continue to be developed to build these capabilities. However, the paper has also raised concerns that clinicians remain reluctant to engage with these management and leadership capability development opportunities.

In order to further explore the issue of engagement it is useful to consider fundamental principles of adult learning and consider clinicians in the context of individual adult learners and models of andragogy (Kapp cited in Knowles, 2005, pp.59).

Knowles’ (2005, pp.159) andragogical principles can be summarised as follows:

1. Adults need to know why they need to learn something before learning it
2. The self-concept of adults is heavily dependent upon a move toward self-direction
3. Prior experiences of the learner provide a rich resource for learning
4. Adults typically become ready to learn when they experience a need to cope with a life situation or perform a task
5. Adults orientation to learning is life-centred; education is a process of developing increased competency levels to achieve their full potential
6. The motivation for adult learners is internal rather than external
Each of these principles will be considered as they apply to health professionals and their engagement with leadership and management development.

Adults need to know why they need to learn something before learning it
It appears from the literature that little attention has been paid to exploring the need for health professionals as individual adults to learn leadership and management capabilities. Whilst the organisational benefits are clear from the literature (Bristol Royal Infirmary Inquiry, 2001; Forster, 2005), what is less well understood is why individual clinicians need to, or should bother to, learn about leadership and management.

The self-concept of adults is heavily dependent upon a move toward self-direction
The self concept of health professionals, doctors and nurses as examples, are strongly linked to their profession. Leadership, in their view, is most often seen within the context of their professions and their desire to be leading clinicians in their fields of practice and expertise (Harris et al, 2006; Creswell et al, 1997). Organisational leadership, and management in particular, is not associated with their view of their own self-concept.

Prior experiences of the learner provide a rich resource for learning
Clinical experience is not necessarily a resource that can be drawn upon for building leadership and management capability. The application of clinical skills to leadership and management problems can create poor outcomes and lead to frustration (Creswell et al, 1997).

Adults typically become ready to learn when they experience a need to cope with a life situation or perform a task
Health systems have their origins in early models of military organisation and military hospitals and often have highly mechanised authoritarian models of control and management (Forster, 2005). Within such organisational structures, roles and responsibilities are clearly defined and professional boundaries and cultures are quite distinct. The opportunities and need for clinicians to perform organisational management tasks are few.

Adults orientation to learning is life-centred; education is a process of developing increased competency levels to achieve their full potential
Clinicians’ orientations are towards achieving their full potential as clinicians, becoming specialists in their fields. Their focus is on increasing competency within their specialities (Buchanan et al, 1997).

The motivation for adult learners is internal rather than external
Although Buchanan et al (1997) propose that there is little sense of doctors engaging in management with any sense of purpose or ambition; they have identified six factors that motivate doctors to assume management
responsibilities: power; ability to play a shaping role; influence; being “in the know”; status and prestige; and career progression.

Conclusion
The effective broad engagement of health professionals with leadership and management capability development requires better conceptual approaches that recognise how evidence informs policy and practice and requires that this practice is underpinned with sound theoretical models of adult learning.

These new approaches need to consider the motivations of individual health professionals and align with adult learning principles. Further, models that enable clinicians to engage with organisational leadership and management, whilst still enabling them to remain practising clinicians, need to be more fully explored.

Areas for improved understanding through research include:
- What are the factors that motivate health professionals to engage with leadership and management capability development initiatives where those initiatives are driven by organisational evidence and policy?
- When considering management and leadership capability development for healthcare professionals, what are the factors to be taken into account when developing learning policy to ensure the resulting learning practice meets the needs of both the individual and the organisation?

References
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