



WHAT KINDS OF LEADERSHIP STYLE
ARE EFFECTIVE IN RELATION TO THE
SENIOR MANAGEMENT OF HOSPITAL?

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Executive Summary

Hospital is such an organisation that has endured significant changes, despite that, still facing the needs and consistence of improving quality and access along with accomplishing success. Actions of managers and their leadership styles has great impact on organisational success. In addition, healthcare system is quite complex. It is a composition of various professional groups, sections and divisions and various expertise with special knowledge along with non-linear communications among them. Staff from various disciplines and departments of various diseases along with multidirectional goals makes the system unparalleled and intricate. It is important to be implemented the leadership styles in healthcare industry to successfully lead and manage this pattern as this sector is always transitional. Being introduced with local and new legislations, rules and regulations, care-coordination and payment models healthcare providers need to assimilate with the treatment to the patients as well as a great teamwork for the success. Physicians and other healthcare professional may need to change the belief on long establish leadership as team-built tactic develops more effectiveness at workplace. Therefore, the aim of this report is to determine the predominant leadership styles used by the medical leaders at senior management level of hospitals and factors influencing their choice of leadership style. To reach this aim this report follow three objectives a) to analyse which leadership styles are predominantly used by medical leaders, b) to identify factors influencing their use of different leadership styles and c) to explore what kinds of leadership style are effective in relation to the senior management of hospital. Various kinds of leadership has been discussed with in their importance in the healthcare organisation. Affiliative, coaching, commanding, democratic, pacesetting and authoritative leadership styles have been mentioned. However, after analysing it has been demonstrated that Authoritative, affiliative and democratic leadership styles are commonly used in hospitals. It can be also suggested that due to continuous changing environment in healthcare area, combination of different leadership styles with innovative process in applying them rather than using traditional leadership styles can act more efficiently in hospital settings. Besides, different external and internal factors in hospitals influence the leadership style. It has been suggested that leadership style should be different in public hospitals compare to the private hospitals because of structural and cultural difference between these sectors. In addition, different competence and skills have been described through different frameworks

which are well accepted in different countries' healthcare system. Among all the skills communication skill, decision-making skill, resource management skill, networking skills are mentioned several times. It has been also found that traditional leadership styles with traditional skills may not work in a hospital or clinic settings. Innovative process may be needed by the medical leaders to achieve the organisational goal. In addition, all the medical leadership and competence frameworks and studies focus on the shared leadership with the intension of meeting shared goal for the healthcare organisation. Moreover, it is important for doctors to possess non-clinical competencies that entails leadership and management skills in addition to sufficient clinical knowledge and skill for being the effective and safe medical leaders.

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1. INTRODUCTION

It is essential to employ active and efficient managers and employees for any organisation to achieve their aim and objectives. Organisations are social system where with the commitment and effort of employees they can reach to their goal. For healthcare organisations, this factor is a significant issue where special training is needed for different personnel. Therefore, actions of managers and their leadership styles has great impact on organisational success (Rad and Yarmohammadian, 2006).

Wikström and Dellve (2009) stated that the contemporary healthcare system is such an organisation that has endured significant changes, despite that, still facing the needs and consistence of improving quality and access along with accomplishing success of cost effectiveness. This process creates an exceptional environment for the enthusiastic leadership. While the shapes of leadership in a line organisation are linked describe the task clearly and areas of responsibility, within a process-oriented organisation, leadership shapes are to subjects that close-t-practice, boundary-spanning and shared responsibility. Consequently, the contemporary healthcare leadership appears to be shaped by certain complications that might create opportunities or difficulties.

It is important to be implemented the leadership styles in healthcare industry to successfully lead and manage this pattern as this sector is always transitional. Being introduced with local and new legislations, rules and regulations, care-coordination and payment models healthcare providers need to assimilate with the treatment to the patients as well as a great teamwork for the success. Physicians and other healthcare professional may need to change the belief on long establish leadership as team-built tactic develops more effectiveness at workplace (Warren and Carnall, 2011).

Dodson (2017) mentioned that healthcare is a very synchronised and regulated industry. There have been implemented numerous laws over the past few years on healthcare

professional and organisations. Therefore, it is the requirement of new management techniques and leadership to lead the teams through this change and control the pressure on existing infrastructure.

Warren and Carnall (2011) described that over the time, healthcare industry has been dealing the developing challenges which turns the required skills for leadership repetitively changing. In this industry, leader is the capability to balance all these challenges alongside the needs of patients, whether, it is responding to newly adapted legislations, new diagnostics or treatment process, pressures of bottom-line profitability or cohesive technological integrations into system developments.

All over the world it is a continuous struggle for healthcare industry against the increasing demands for services and increasing costs. Service design organisations and out-dated system of care subsidise funding anxieties. First, an example is the ongoing repetition in various situations to observe to the emergency department of a hospital to deliver what is fundamental, principle healthcare services. While there are some developments and modifications have been gained, various professionals arguments raise for the further system developments if the services are to be inexpensive and suitable the future. Secondly, they thin that, changes is always needed. In spite of, ages of development in the quality and the technology of healthcare system around the globe. This revolution and transformation must require leadership and this leadership must involve from doctors or clinicians, not obligatory they perform formal administrative role or not. A clinician or a physician or doctor, whatever we say in this profession, is not only capable for a better frontline decision but also the quality and efficiency of care and have the technical knowledge and better strategic management and excellent design to reach the goal (Daly, et al., 2014).

The difference between leadership and management is 'doing the right thing' and 'doing the thing right' respectively. Therefore, management is considered as managing the situation with learned knowledge, on the other hand, leadership faces unforeseen situations and confronting new challenges effectively. In fact, 'doing the right thing' in the future in the same way will not be affable. So, in response to the message raised from the recent challenging healthcare industry, 'adapt or die', innovation and development are the vital facts for leadership (Rad and Yarmohammadian, 2006).

In this modern time, numerous changes have been occurred in healthcare industry. transformational leadership is not well supported by the traditional bureaucratic organisations. NHS is a healthcare organisation in UK is an example where leadership is sometimes more considered by a culture of ignoring failure rather than campaign for a productive modernisation. However, there are opportunities for transformational leadership in healthcare services provided and growing by the private and charitable organisations or social enterprises (West, et al., 2014)

Healthcare system is quite complex. It is a composition of various professional groups, sections and divisions and various expertise with special knowledge along with non-linear communications among them. Staff from various disciplines and departments of various diseases along with multidirectional goals makes the system unparalleled and intricate. Specially in a large organisation of healthcare system, the various groups or departments can be struggled related their subcultures. In such situations, leadership must have the capabilities to exploit the diversifications within the organisation and encourage the expertise to work together for common goals. In a hospital or in any healthcare industry where the physicians are typically holding the positions of leaderships must balance with new changes in the industry along with the new demands required to lead the organisation efficiently through these challenging times. It is not to be effective today what was in the past. So, it is obligatory to be familiar with recent changes and bring the changes in leadership style for a successful organisation (Al-Sawai, 2013).

1.1. Aim

Therefore, the aim of this report is to determine the predominant leadership styles used by the medical leaders at senior management level of hospitals and factors influencing their choice of leadership style.

1.2. Objectives

- to analyse which leadership styles are predominantly used by medical leaders.

- to identify factors influencing their use of different leadership styles.
- to explore what kinds of leadership style are effective in relation to the senior management of hospital.

2. LITERATURE REVIEW

Organisations are the most important factor of the society and human resources are the foremost significant aspects in organisations. Consequently, managers in organisations have the principal roles for effectiveness and efficiency. Highly skilled leadership qualifications are for the managers obligatory for success and achievement. Successful leadership is the key of organisational success. True leaders can drive with the employees and personnel to achieve their goals. Beside this, employees' job satisfaction is very important and critical issues, specially, for highly qualified and attracting personnel in the organisations. This is particularly a fact in medical institutions or healthcare organisations, such as hospital, where professionals and specialists are highly important. The attitude of job satisfaction is when employees get their jobs and perform these jobs in the organisations perfectly and satisfactorily. In fact, the job satisfaction can be defined as employees' emotional response to the jobs depending on the assigned works and expected outcomes (Tchouaket, et al., 2012). In general, job satisfaction is a complicated concept in organisations. It is the feelings of employees about a various mixture of internal fundamental and external job elements. Depending on employees, it can be a particular point or includes of many aspects, such as salary, promotion, benefits, working environment, interpersonal relationship, administrative performance, supervision etc. In healthcare industry, it is as concerning as critical issue for the management. This sector is quite different than other organisations, however the motivation process for the job satisfaction to the other industry (Taylor, Taylor and Stoller, 2008). Different Researches found that there are lot of facts inspire employees regarding their job satisfaction in healthcare organisations. These are including: promotion, recognition, salaries, autonomy, benefits, degree of professionalism, genetic factor, working environment, job security, supervisory support, repetition of duties, patient care, on call duties, overtime, pressure of work, working with unskilled workers, working flexibility, relations with co-

worker, role expectations and ambiguity, individual and administrative factors etc. (Rad and Yarmohammadian, 2006).

Various studies in different countries found that there is strong relationship in between leadership and job satisfaction in health-related organisations. Organisational achievement and to reach their destinations depend on their leadership style. Appropriate leadership effects employees' job satisfaction. Leadership style is the outcome of managerial behaviour and attitude including, personal and administrative values (Straus, Soobiah and Levinson, 2013). Leadership is the capability of influencing employees to perform their duties with highest ability along with satisfaction. In addition, leadership skills include to respect workers, operate the team with honesty and endorses productivity and creates an excellent communication with co-workers (Tchouaket, et al., 2012).

Leadership is an 'stimulating topic' found by many researchers. For the theoretical progress for this topic, researchers are continuously searching for skilled leaders. For better organisational outcomes, researches are being done over decades on leadership behaviour to inspire employees (Piper, L., 2012). However, management professionals have always gone through a revolution to describe leadership and leadership behaviour over the past years but in recent years the ideas of leadership and leadership behaviour have significantly reformed. The modern formation of leadership is conceived by the better educated people, skilled employees, organisational and technological changes. Nowadays people can no longer be directed in the same way as they were before. The demands of involvement at work is now higher the earlier times. (Palarca, et al., 2008).

Mannix, Wilkes and Daly (2013) divided the leadership styles into several parts. These styles are transformational, transactional, situational, autocratic, democratic, bureaucratic, participative, charismatic and laissez-faire. It is not approved by many that any specific style of leadership can be effective for organisational performance and better outcomes. In fact, depending on the situations different style of leadership can be implemented, in this case, every leader must know the particular style of leadership style they need. Iran is country where leadership is still in its initial stages in healthcare industry. Not enough research has been done in this particular profession. However, in 2004, there was a research done by the

Isfahan University Hospitals (IUHs) to investigate the relationship between job satisfaction and leadership style. the research found that the employees in the hospital barely satisfied with their jobs. The findings show that the highest levels of dissatisfaction arise from three different areas where number one is salary and the other two are benefits and working conditions. The outcomes of this research helped to improve their understanding of relationship between manager' leadership style and employees job satisfaction and it encouraged them to do further research in different particular sectors in the hospital.

Nowadays, the requirement is increasing for management-leadership skills in healthcare organisations and the demand of management and leadership as profession are modern choice (Walton, L., et al., 2009). Townsend, et al (2012) describes, it is contrary and insufficient strives have been taken to develop leadership skills in healthcare organisations. In fact, in such organisations, management or leadership do not have the opportunity that a physician has and this is how the capability of management and leadership prove to be poor. (Dickinson *et al.*, 2013; Kuhlmann and von Knorring, 2014). In a hospital, healthcare professionals can create a supportive and good working environment when there is an effective clinical leadership (Mannix et al., 2013).

Characteristically, the leadership roles in hospital professions based on doctors, physicians, specialists, nurses. They receive different education and learn unique leadership styles and management skills. In addition, hospital or clinical management studies around the world are creating complex results and establishing insufficient leadership and management skills which have been in debate all over the world (Ackerly *et al.*, 2011; Townsend *et al.*, 2012).

Within the areas of clinical departments in hospitals, the strong organisational practices, professionalism, specialism and cultural features are management and leadership styles (Faltholm and Jansson, 2008). As a result, the monument and leadership learning programs and medical administrative care have been applied to endorse the management and leadership skills. In addition, the clinical professional need the supports of managers and leaders. A professional leadership is a dynamic for delivering a high quality healthcare services

and organisational accomplishment. Developing these qualities will need necessary resources and the sophisticate application of different educational practices such as coaching, training, action learning and networking (McCallin and Frankson, 2010).

3. DISCUSSION

3.1. LEADERS AND LEADERSHIP

Leadership is a process of influencing others to achieve objectives or goal by a person who is a leader and the leader guide them to confirm a clear and specific direction (Gentry, et al., 2012).

It is a debate over the decayed that leaders are born or made. There are lots of researches and theories on this topic. In 2013 a study of University College London. The study found that there is a remarkable connection between people's prospect to take on management roles and their DNA. They are now thinking that genetic has something more that they thought before. The study published online in the Quarterly Leadership journal and it was the first to identify an exact DNA order connected with every individual to get the position of leadership. The team used a big sample of twins and accessed that one fourth of the noticed dissimilarity in leadership styles can be classified among individuals by genes they got from their parents (Gentry, et al., 2012, UCL, 2013). De Neve, J. (2013) said that they have identified something called rs4950, which he explained that leadership is seems to be connected though the previous generations and the skills are being delivered to the new generations. Dr Neve's theory is against the traditional thinking, some scholars put their opinions that leadership is not utterly genetic and they think more study is need.

Generally, people think that leadership skill can be taught. The author of 'The Edge of Leadership' Dr Brigitte Hyacinth identified that proper training in an organised environment can make a leader to manage a team or start a new business. To lead a team project the rules, need to be learnt when a good management I based on rules.

In reality, there are much more in leadership than learning the rules and follow them. Over the decayed, all over the world, there are many great leaders in fact, who have thrown all theories and rules books (de Vries and Engellau, 2004).

Dr Keith Web (2014) describes leadership in his book, 'The coach model for Christian leaders (2014)', he said, it is the person who makes himself a leader. Undertaking any leadership action or obtaining any leadership position cannot make someone a leader. All great leaders of the world have a remarkable history behind them. They are leaders from the beginning of their journey. It is even true that they are made leaders from their environment, situations and the strong determination to reach their destination. No one born with any special qualities, not even leaders but the situation circumstances and the person can make himself a leader gaining the leadership skills. So, we can say that leaders are born and made (Witzel, M., 2013).

CanMEDS (2015) defined the physician leader as follows "the physician leader is an engaged individual who takes initiative to contribute in a collaborative way and to work towards positive and sustainable change in health care from the level of an individual patient to the level of the health care system." CanMEDS (2015) also suggested that the leaders do not require a formal designation to lead the organisation that is they do not essentially need to engage in charge. Moreover, in recent condition healthcare organisations are in need of leaders who can make it possible for the most skilled and suitable person to take the charge within a defined team and in a defined context.

3.2. DIFFERENT TYPES OF LEADERSHIP

Chapman, Johnson and Kilner (2014) describes that 'The types of leadership' is a concept that developed through out the traditional studies. It had been identified earlier that the democratic, authoritarian and laissez-faire leadership styles were established. Researchers thought that leadership style has philosophical effect on group activities as well as it creates connections with other members of other groups. Many other researchers enlarge the this thought of leadership style. Sing and Jampel (2010) figured the leadership style in five

different parts based on the consultative tendency and decision-making. Goleman (2000) identified leadership in six different categories. Based on the features of emotional intelligence which is connected to the leaders' efficiency and the organisational environment that impacted by advantages and disadvantages. Goleman's leadership styles have been explained briefly below:

3.2.1. Affiliative

Affiliative is an attractive leadership. In this type of leadership, leader creates a good relationship and perform an excellent communication within the group or associates. Leader is concern welfare of team members and take necessary steps to make an excellent team, such as spending time with the team and establishes high level of trust in the team. An affiliative leader loves to give flexibility to the team members to complete their jobs. She/he gives positive feedback to the team members and generates confidence to them and tries to overlook problematic conflicts. However, some member of the team may think that the leader should be more firm and forceful and should deliver strong direction to the team.

3.2.2. Coaching

A Coaching is concerned about the development of skills of team members. She/he surpasses assignments. Coaching leader is a good listener and loves open-ended questions to help everyone and to find a solution for the difficulties at work or tasks. The team members gets supports from the leader to identify their strength, weakness and opportunities. She/he find out the mistakes in individual members of the team and delivers ongoing feedback based on members performance and justify the underperformance and mistakes as learning opportunities. Nonetheless, specifically focusing on every individual may limit the outcomes of whole team.

3.2.3. Commanding

In commanding leadership style leaders are very straightforward, they love to deliver clear direction and expect the team to follow him. They can take quick decision comfortably with a little input from the team and can excel in disaster. They love to regard individuals for excellent performance as well as do not dither to confront any underperforming member.

Their listening skill is poor or have lack of patience to listen to others. Working under this type of leadership, some members may lose their enthusiasm or may feel demotivated at performing tasks.

3.2.4. Democratic

Democratic leaders inspire the team to participate in exchanging ideas and knowledge. They love to share team's activities, individual effectiveness, decision making and goal settings. However, when they face any negative situations, they listen to others considerably build consent and promote ideas and that may delay for taking tough decisions take ideas from other team members. In this case, some member of the team may think that leader should 'decide' more, besides, 'ease' less.

3.2.5. Pacesetting

Pacesetting leaders are quite different comparing to other types of leadership. Leaders here set the pace. They focus on achieving consequences and lead by examples, besides, they set high performance standard for themselves. They expect that followers should be capable to complete their jobs. When someone is discovered as underperformer, the pacesetting leader will unassign the job and reassign it to someone else in the team who considers more capable to do it.

3.2.6. Authoritative

This type of leadership has the similarity with commanding leadership. Authoritative leaders bring the team forward to achieve the goals by delivering a clear direction. When a team or services face difficulties, they are very effective and take necessary steps. They allow team members flexibility and give freedom to them for innovation and experiment. The authoritative leaders can use their motivational power to the team to complete the mission of the organisations. This type of leadership is attractive to the team members and effective for the organisations.

The concept of leadership style may vary from one to other. In healthcare organisation, there is no requirement or importance of leadership styles (Swanwick and McKimm, 2011). Kumar

(2013) suggested that doctors do not need to perform leadership roles in general. Francis (2013) doctors' involvement in medical leadership can effect on the patient care. Although there is general education on leadership in business comparatively provide a little knowledge in medical management sectors and they know a little how hospital leaders lead their organisations. Therefore, improving the medical leadership is significantly important for developing skills and delivering excellent services by using the resources and the quality of patient care (Chapman, Johnson and Kilner, 2014).

3.3. Skills needed for being medical managers

Dixon (2014) stated that almost every healthcare leaders are confronting challenges in day to day basis to maintain the pace with continuous changes and best of them drive the change. In addition to all other conventional changes in healthcare system there is also changes in leadership format and roles in healthcare organisations. We can see that new combined leadership such as chief information officer and the chief medical information officer has been created in many hospitals. Additionally, we may find new emerging roles in hospitals such as chief data officer or chief accountable officer. Besides, large amount of turnover in hospital or clinical setting including the highest chief executive officer (CEO) turnover has been observed in recent time. Therefore, each healthcare leader should keenly aware about the changing climate in management and administrative sector and this awareness is a significant demand toward the dealing with organisational change. Depending on this changing environment in the clinical industry, Dixon (2014) has mentioned top three skills for healthcare leaders:

3.3.1. Skill of interconnectivity

The healthcare leaders should know how to keep engaged themselves towards the flow of new information because amount of new information is so vast in present days. Acting in linear fashion cannot be effective anymore to lead the healthcare organisation successfully. Therefore, healthcare leader should follow nimble, non-linear, synaptic and inclusive fashion to lead the healthcare industry successfully.

3.3.2. Skill in innovative

To adjust with continuous changing environment and to create new model in providing the healthcare services healthcare should think in new ways. Medical leaders who possess innovative skill are significantly important in recent healthcare environment as innovation is considered as critical element towards the organisational success especially in complex industry such as hospitals. To better understand the role there are even Chief Innovation Officers who work as healthcare innovation leaders.

3.3.3. Skill of communication

The skill of communication is not new one and has been discussed for decades when there is concern of leadership. However, these skills create a new meaning when it is conjoined with interconnectivity and adaptiveness with the flow of new information. It is becoming increasingly essential as there is need to communicate and deal the greater amount of data and information in health system. It has been found that in recent healthcare environment, the accelerated amount of data has accomplished the decision of what is useful to communicate and how to communicate. Therefore, adaptivity with the data driven culture is a new demand that links with healthcare leaders' communication skills. Besides, greater leaders always own the skill of communication.

Dixon (2014) use the term 'Synaptic leadership' where there is successful combination of these three skills. This term has been borrowed from neurobiology and the concept of this term is a new and summarized breed of leadership. Therefore, to solve the wide varieties of issues and to manage and consolidate vast amount of information in complex organisation like hospital this 'Synaptic leadership' has significant importance.

3.4. Medical Leadership competency Framework (MLCF) in the UK

NHS III (NHS Institute for Innovation and Improvement) and the Academy of Medical Royal Colleges (AMRC) jointly develop a framework 'Medical Leadership competency Framework (MLCF)' (Figure 1-6) in 2008. This framework has been created to promote medical leadership and improve the healthcare organisational cultures by increasing the

engagement of doctors in management and leadership of health care services. This framework illustrates the competences that are required by the physicians of all disciplines. It helps to involve the clinicians in delivery, planning and transformation of health services actively (Faculty of Medical Leadership and Management (FMLM), 2018).



Figure: 1 (AMRC & NHS III, 2010)

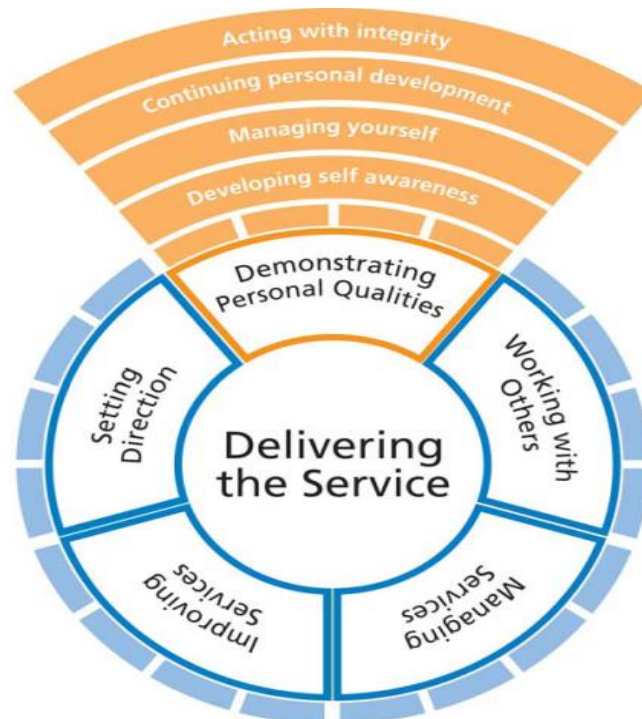


Figure: 2 (AMRC & NHS III, 2010)



Figure: 3 (AMRC & NHS III, 2010)



Figure: 4 (AMRC & NHS III, 2010)



Figure: 5 (AMRC & NHS III, 2010)

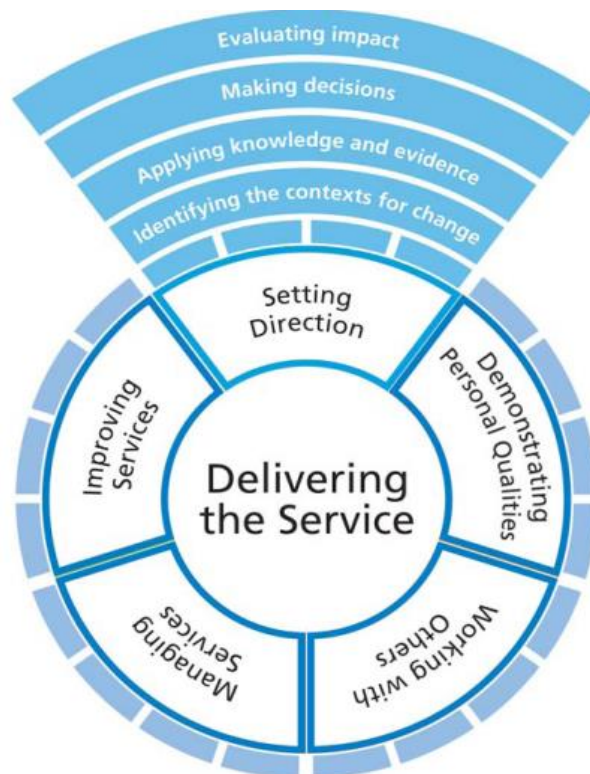


Figure: 6 (AMRC & NHS III, 2010)

MLCF is developed on the basis of concept of shared leadership. In shared leadership a shared sense of responsibility is maintained and leadership is not constrained to people who occupy the designated leadership role. Shared leadership is vitally important for the organisational services and success. Therefore, any working person in the organisation can act as a leaders when it is appropriate with time. Moreover, in shared responsibility the leaders focus on the achievement of group and organisational goal by actively working in effective environment rather than individual (AMRC & NHS III, 2010).

In addition, this leadership competency framework has been well accepted not only for doctors but also outside of this profession. Besides, its successful application in medical curriculum and general acceptance for leadership development among the doctors, raised the issues of its suitability for other clinical professionals (FMLM, 2018).

3.5. Criteria of medical leadership competence in USA

McKenna, Gartland and Pugno (2004) demonstrated that for the development of leadership competence among the doctor leaders, nine criteria have been described according to rank order (number one is most important). These are:

1. Medical leader should maintain interpersonal and communication skills.
2. They should follow the professional ethics as well as social responsibility.
3. Doctor leaders should go through continuous learning and development.
4. They should possess the ability to create partnership and support for bringing the changes
5. They must have the clinical excellence
6. They should be able to deliver the straight forward compelling vision
7. They should adopt the system based decision making or problem solving process
8. Doctor leaders should address the requirements of different stakeholders.
9. Medical leaders should have the knowledge of financial and resource management.

3.6. Criteria of medical competence in Australia

The key skills identified by the Royal Australasian College of Medical Administrators (RACMA) for medical leaders are communication skill, ability to involve medical staff in a team fashion, strategic thinking, personal skills to lead others and analytical skill. Medical administrators of RACMA had done a research and then determined the above mention skills to improve the medical leadership competences by the physicians (RACMA, 2006).

Clark and Armit (2010) claimed that there is a great similarities in all the frameworks and researches that identified medical leadership skills and competence. Moreover, there is a need of qualities of standard that embraces the skill of interaction with other staffs and working within and across the healthcare organisation. In sum following skills are very much important for doctor leaders to manage a hospital competently:

- Communication skill
- Resource management skill
- Administrative skill
- Ability to deliver improved services
- Engaging and working with others and leading them
- Analysing skill
- Strategic thinking
- Being a role model
- In addition, doctors should also be expert in their clinical role.

It has been found that usually, all the medical leadership and competence frameworks and studies focus on the individual competence that contribute to the shared leadership with the intension of meeting shared goal for the healthcare organisation. Moreover, it is important for doctors to possess non-clinical competencies that entails leadership and management skills in addition to sufficient clinical knowledge and skill for being the effective and safe medical leaders (Clark and Armit, 2010).

4. LEADERSHIP IN HOSPITALS

Daly, et al (2014) stated that hospitals are under huge pressure and enquires all over the world because of raising demands and economic strain. Therefore, all healthcare professionals are under pressure whether in clinical or non-clinical positions. Hospital is a most complex organisation because it is not only the representing healthcare organisation but also critical place where the most vulnerable groups of society such as aging people and children are exposed to the risk and adverse events within this organisation.

In relation to care services of hospital a number of influential reports have been created in response to the changes in accountability, visibility and scrutiny around the world. All the scrutiny in global healthcare system has increased the emphasis in monitoring the standards and promoting an evidence-based way of working for delivering healthcare services (Department of Health, 2008; Francis, 2013; Garling, 2008).

In the hospital setting the demand for different types of leadership is rapidly rising because of changing environment in healthcare area. Almost in every hospital there is intense reorganisation to improve the productivity as well as cost efficiency. Cultural issues are also affecting the safety and quality of care in hospitals. Besides, clinicians and patient engagement are increasing in decision making process in hospitals to address the organisational system and to deliver high quality patient-centred care. Therefore, because of these reforms and issues of healthcare culture, commonly used models of leadership are not well suited for hospital sectors (MacPhee, et al., 2013).

Daly, et al (2014) commented that in recent decades, a transformation can be demonstrated in hospital leadership which places clinicians in frontline considering them as crucial to leadership within organisation. To reshape the fundamental features of clinical practices or to ensure the changes at the frontline, this transformational shift in the concept of leadership in hospital or clinic setting is considered as an important step towards adopting values and mission.

Jowsey, et al. (2009) discussed that, there is considerable evidence that suggests that there is dissatisfaction among the workers in hospitals where working environment is poor and this

poor working environment associated with dissatisfaction of workers impact negatively during healthcare delivery and patient outcomes. Therefore, before achieving the target in leadership and management work environment should take into consideration.

Besides, hospitals are complex structure with socio-political bodies where involvement of doctors in leadership and management could be hampered by several issues such as disciplinary boundary, poor dynamics and competing discourses within organisation. Therefore, there is a need of proper working environment for every staff with cultural and structural elements in hospitals (McKee, et al., 2013). In addition, Edmonstone (2009) cautioned that engaging physicians in leadership without providing a proper working environment can bring deterioration of responsibilities within organisations. Therefore, for creating an effective leadership in hospitals sectors, the organisation should provide the structural and cultural elements to the selected persons for the leading roles to make them prepared and resourced.

In a study Warren and Carnall (2011) indicated that all doctors should acquire the knowledge of healthcare provision and resource allocation through engaging and training in healthcare management to gain the high standard medical leadership position in different hospitals. In addition, physicians should understand driving factors of the changing environment in hospitals such as economic, social, political and technological issues and therefore this understanding will influence them throughout their careers for being medical leaders. When physicians are in managing positions, they should learn about the government and organisational policies, source of funding, management knowledge to manage the hospitals or clinics efficiently. All these knowledges are integrated with each other. Who are been taught a little about the management and leadership policies in running the hospital, cannot be able to act appropriately. In addition, organisational culture that entails good information about current changes act as a tool for performance improvement in management and leadership. Besides, doctors should well-supported with reporting facilities as well as well-developed systems.

Warren and Carnall (2011) also suggested that when physician involves in leadership and management activities or other strategic roles of a hospital who previously were worked only as a medical practitioner should trained about followership. As followership is a rising concept

in leadership that introduces the significance of participation and allow others to lead. Doctors will be incapable to take part in discussions related to healthcare service deliver, will not be able to lead and navigate others through their organisational system where they work. Moreover, they will be significantly disadvantaged in their organisation. Besides, they will face toxic influences and face barriers to any change initiatives within the organisation. Medical leaders should require a wide range of non-technical skills and should utilise the knowledge properly to lead others, not just within medicine but also around their professional boundaries. Therefore, only simply having the healthcare information, knowledge and skill is not enough for those physicians who are engaged in different significant positional leadership roles in different hospitals or clinic. To become a potential leader in hospital doctors should create and communicate through a specific vision and clear direction, improve healthcare system through redesigning the service delivery method, negotiate efficiently, aware of both self and others and should follow a network and collaborative style. Alongside maintaining these highly significant leadership positions, doctors should retain a balanced interests and priorities to enhance peer credibility and to deliver high standard clinical care services. Therefore, medical leaders in hospital must hold voice and endorse strong personal values to influence others positively those are around them. In addition, they should consider the patient as centre of decision-making rather than considering them as the priorities of the provider.

5. THE DIFFERENCES OF LEADERSHIP BETWEEN PUBLIC AND PRIVATE HOSPITALS

Private hospitals have more freedom to operate on the other hand, public hospitals are governed by laws, rules, policies, traditions, and structural bureaucratic procedures. Therefore, there is debate whether the leadership is different in these sectors. It has been discussed so many times to find out the difference between the leadership in public and

private sectors. Some authors say that there is difference in leadership and managing styles between these two sectors, where others say the leadership should be the same whether it's public or private organisation (Andersen, 2010; Heres and Lasthuizen, 2012; Top, Akdere and Tarcan, 2015;). There are both public and private hospitals and they are different in organisational structure, context and culture.

Anderson (2010) argues that leadership is different in public administration in compare to the private organisations because managers of these two kinds of companies are working under different and very specific constrains. In his research he also mentioned that leadership depends on the organisational structure and organisation-context whether they are public or private organisation.

Bysted and Hansen (2015) stated that managers who work in a public sector in addition to the other roles he also possess a political role in his organisation. Therefore, managers in public sector represent the whole society or target group to those the public services are delivered. They might even hold political position in addition to their role in any public organisation. Political issues may rise controversial concerns in setting direction, creating compromises, promoting projects or even making compromises. For this reason, leadership style in public sector differ from the private sector. Besides, leadership in private sector mainly focus on the issues like organisational results and profit or performance and efficiency of workers within industry. On the other hand, the main focus for public leadership is allocation of powers among the different levels of governance. Therefore, different styles of leadership persist in two sectors. For private organisation there is mainly participative leadership which encourages the implication, support and teamwork among the employees. In contrast directive leadership is predominantly exist in public leadership where the leaders administer different rules and control them.

Anderson (2010) also demonstrated that there is difference in leadership style between public and private organisations when there is concern of decision making process. During decision making, leaders in public organisations mainly focus on the implementation of public policies that can represent the whole society or a specific and defined group. Moreover, traditional hierarchical decision-making process has been followed by the leaders in public organisations. In contrast the decision-making process in private sector is much more

organisation centred where the aim is to achieve the organisational goal. In addition, during decision making and leadership stakeholders have great influence in private industries on the other hand political issues act as an influential factor in case of public organisations. Therefore, it can be demonstrated that the difference between leadership in public and private organisations arise due to influence of different external and internal factors those directly impact the managerial competences, leadership styles and performance management of an organisation.

6. METHODS TO DEVELOP MEDICAL LEADERSHIP

Warren and Carnall (2011) demonstrated that the methodologies for leadership practice is vast and the range or practices are developing by times. Besides, the range of self-motivated learnings are increasing day by day. People are using books, audio and video trainings, participating seminars and taking one-to-one coaching and mentoring. In some cases, leadership learning occurs from self-influences and the person learn alone by entirely following the self-directions. In other instances, it happens in teams or participating in schemes, fellowships and generally taking the formal qualifications.

6.1. Courses and Schemes

Generally, many doctors in hospitals or healthcare organisations will join in the management or will become a leader. This will occur typically in certain period of times in the point of their careers. Suggestively a fewer will join the different programmes like, schemes, fellowship to develop their leadership skills. Organisation will clarify the specific objects of the programme or scheme. They will clarify the aims of the programme and decide what level of development need for doctors in leadership. Is it for specific doctors or all general practice trainees or is it to grow high potential medical leaders for the future. Leadership schemes and courses are significantly important for the junior doctors for developing their skills. Ham, Clark and

Spurgeon (2010) believe that the programme and the scheme will be beneficial when every individual or the team uses, 'real time' challenges.

6.2. Mentoring

The learners can be benefited significantly by this method. However, mentoring has been using in private sectors for several decades but recently this method is being used in public sectors also to support and develop the people through their careers and to develop the future leaders for the organisations. The research found that the relationship between mentor and mentee is associated to the vital career outcomes and job satisfaction. The mentoring method in medical literature is comparatively poor but mentoring within the medicine and traditionally been a casual system.

6.3. Coaching

Specially for the senior leaders the coaching method is increasing over the last few years. Coaching method is designed for the performance improvement for the specific area. It is goals oriented and has the tendency to moderately short-term process. The coach holds the ownership of the process and the goals are generally set in the connection to the coach. However, there is inadequate researches have been done in this method to support leadership development. Coaching is similarly combined into some UK schemes for junior doctors, NHS London's Darzi fellowships is an example for this process.

6.4. Action learning

When working with other there are many issues arise in the workplace. Action learnings the concept of problem solving of these issues by using the leadership knowledges, skills and attitudes. Typically, the action learning process ti set of 6 to 8 individuals with a mutual purpose.

6.5. Networking

In leadership development can play important part. Successful networking can be more effective over the coaching and mentoring methods. Networking is aim to include the formation of independent. The influence of networking is very influential. It effects the individuals to support and help the groups or teams within the organisations. Darzi, 2008; Ham, Clark and Spurgeon, 2010; Warren and Carnall, 2011

7. CONCLUSION

There is strong association between hospital performance and effective clinical leadership. Medical leadership is linked with a wide range of hospital actions and therefore, this is an essential element of the health care system. Besides, it is highly important to develop leadership skills among the doctors in different hospitals to provide high quality healthcare services. Nowadays the importance of effective clinical leadership is widely recognised to improve the patient service outcome. However, still there are quite considerable number of barriers to the effective clinical leadership by doctors in hospitals. To overcome those barriers hospitals should train clinical leaders with necessary knowledge of competence and skills either through framework of following different leadership styles. It has been established that there are various kinds of leadership styles among the clinical leaders. However, there is no single style typology in medical leadership. Authoritative, affiliative and democratic leadership styles are commonly used in hospitals. Comparatively, commanding and coaching style are not used regularly. Range of external and internal factors affect the leadership styles in every organisation. These factors affect the organisation within which the leader acts and also affect personal style choices and wisdom of leaders. Besides, the activity being undertaken by the leaders, the team within which the leader work as well as the institutional experiences and expectations of leadership styles that has been used in that settings also influenced by the wide range of factors. However, clinical leaders who can analyse the above-mentioned factors and then adapt their styles based on that analysis can be more effective leader. It has been also demonstrated that due to continuous changing environment in healthcare area, combination of different leadership styles with innovative process in applying them rather than using traditional leadership styles can act more efficiently in

hospital settings. In addition, they can meet the diverse range of needs of both clinical and non-clinical colleagues. Hence, individuals who are much more effective in their work and are better led by the medical leader within organisations will be able to contribute more to deliver the high-quality, safe and compassionate healthcare services through the greatest possible improvements in healthcare provision.

Reference

1. Academy of Medical Royal Colleges (AMRC) and NHS III (NHS Institute for Innovation and Improvement), 2010. *Medical Leadership Competency Framework*. [Online] Available from: <https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-Leadership-Framework-Medical-Leadership-Competency-Framework-3rd-ed.pdf> [Accessed date: 01/05/18]
2. Ackerly, D., Sangvai, D., Udayakumar, K., Shah, B., Kahlman, N., Cho, A., Schulman, K., Fulkerson, W. and Dzau, V., 2011. Training the next generation of physician-executives: an innovative residency pathway in management and leadership. *Academic Medicine*. 86(5). pp. 575-579.
3. Al-Sawai, A., 2013. Leadership of healthcare professionals: where do we stand?. *Oman medical journal*. 28(4), p.285.
4. Andersen, J., 2010. Public Versus Private Managers: How Public and Private Managers Differ in Leadership Behavior. *Public Administration Review*. 70(1). Pp. 131–141.
5. Bolman, L. and Deal, T., 2017. *Reframing organizations: Artistry, choice, and leadership*. 6th ed. John Wiley & Sons: New Jersey.
6. Bysted, R. and Hansen, J., 2015. Comparing public and private sector employees' innovative behaviour: Understanding the role of job and organizational characteristics, job types, and subsectors. *Public Management Review*. 17(5), pp. 698-717.
7. CanMEDS, 2015. *From Manager to Leader*. [Online] Available from: www.royalcollege.ca/rcsite/documents/cbd/canmeds-2015-manager-to-leader-e.pdf [Accessed date: 04/05/18]
8. Chapman, A., Johnson, D. and Kilner, K., 2014. Leadership styles used by senior medical leaders: patterns, influences and implications for leadership development. *Leadership in Health Services*. 27(4). pp. 283-298.
9. Clark, J. and Armit, K., 2010. Leadership competency for doctors: a framework. *Leadership in Health Services*. 23(2), pp. 115-129.
10. Daly, J., Jackson, D., Mannix, J., Davidson, P. and Hutchinson, M., 2014. The importance of clinical leadership in the hospital setting. *Journal of Healthcare Leadership*. 6. Pp. 75—83.
11. Darzi A. 2008. High Quality Care for All-The NHS Next Stage Review Final Report. London: Department of Health.
12. de Vries, M. and Engellau, E., 2004. Are leaders born or are they made?: The case of alexander the great. Karnac Books.
13. Dickinson, H., Ham, C., Snelling, I. and Spurgeon, P., 2013. Medical leadership arrangements in English healthcare organizations: findings from a national survey and case studies of NHS trusts. *Health Services Management*. 26(4). pp. 119-125.
14. Dixon, P., 2014. *Top 3 skills healthcare leaders need now*. [Online] Available from: <http://www.healthcareitnews.com/news/top-3-skills-healthcare-leaders-need-now> [Accessed date: 02/05/18]

15. Dodson, D., 2017. *What's the Best Leadership Style for Healthcare?* [Online] Available from: <https://nchica.org/whats-the-best-leadership-style-for-healthcare/> [Accessed date: 03/05/18]
16. Edmonstone, J., 2009; Clinical leadership: the elephant in the room. *International Journal of Health Planning and Management*. 24(4). Pp. 290–305
17. Faculty of Medical Leadership and Management (FMLM), 2018. *The leadership competency frameworks, Healthcare Leadership Model and FMLM medical leadership standards*. [Online]. Available from: <https://www.fmlm.ac.uk/professional-development/accreditation-and-standards/the-medical-leadership-competency-framework-and> [Accessed on 28/04/18]
18. Fältholm, Y. and Jansson, A., 2008. The implementation of process orientation at a Swedish hospital. *International Journal of Health Planning and Management*. 23(3). pp. 219-233.
19. Francis, J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles, M. and Grimshaw, J., 2010. What is an adequate sample size? Operationalising data saturation for theory-based studies. *Psychology and Health*. 25(10). pp. 1229-1245.
20. Gentry, W., Deal, J., Stawiski, S. and Ruderman, M., 2012. Are leaders born or made. *Center for Creative Leadership*. (2), p.1.
21. Goleman, D., 2000. *Leadership that gets results*. Harvard Business Review, Harvard Business School, Boston, MA.
22. Ham C, Clark J, Spurgeon P, et al. 2010. Medical Chief Executives in the NHS: Facilitators and Barriers to Their Career Progress. Coventry: NHS Institute for Innovation and Improvement.
23. Heres, L., & Lasthuizen, K., 2012. What's the Difference? Ethical Leadership in Public, Hybrid and Private Sector Organizations. *Journal of Change Management*. 12(4). Pp. 441-466.
24. Jowsey, T., Yeh, L., Wells, R., and Leeder, S., 2009. National Health and Hospital Reform Commission and patient-centred suggestions for reform. *Australian Journal Primary Health*. 17(2). pp. 162–166.
25. Kuhlmann, E. and von Knorring, M., 2014. Management and medicine: why we need a new approach to the relationship. *Journal of Health Services Research and Policy*. 19(3). pp. 189-191.
26. Kumar, R., 2013. Leadership in healthcare. *Anaesthesia and Intensive Care Medicine*. 14(1). pp. 39-41.
27. MacPhee, M., Chang, L., Lee, D., Spiri, W., 2013. Global health care leadership development: trends to consider. *Healthcare Leadership*. Pp. 21–29
28. Mannix, J., Wilkes, L. and Daly, J., 2013. Attributes of clinical leadership in contemporary nursing: an integrative review. *Contemporary Nurse*. 45(1), pp. 10-21.
29. McCallin, A.M. and Frankson, C., 2010. The role of the charge nurse manager: a descriptive exploratory study. *Journal of Nursing Management*. 18(3). pp. 319-325.
30. McKee, L., Charles, K., Dixon-Woods, M., Willars, J. and Martin, G., 2013. 'New' and distributed leadership in quality and safety in health care, or 'old' and hierarchical?

- An interview with strategic stakeholders. *Journal of Health Service Research Policy*. 18(2). Pp. 11–19.
31. McKenna, M., Gartland, P. and Pugno, P., 2004. Development of physician leadership competencies: perceptions of physician leaders, physician educators and medical students. *The Journal of Health Administration Education*. 21(3). pp. 343-54.
 32. Palarca, C., Johnson, S., Mangelsdorff, A. and Finstuen, K., 2008. Building from within: identifying leadership competencies for future navy nurse executives. *Nursing Administration Quarterly*. 32(3). pp. 216-225.
 33. Piper, L., 2012. Generation Y in healthcare: leading Millenials in an era of reform. *Frontiers of Health Services Management*. 29(1). pp. 16-28.
 34. Rad, A. and Yarmohammadian, M., 2006. A study of relationship between managers' leadership style and employees' job satisfaction. *Leadership in Health Services*. 19(2), pp.11-28.
 35. Singh, A. and Jampel, G., 2010. Leadership flexibility space. *Journal of Management in Engineering*. 26(4). pp. 176-187.
 36. Stanley, D., 2010. Multigenerational workforce issues and their implications for leadership in nursing. *Journal of Nursing Management*. 18(7). pp. 846-852.
 37. Straus, S., Soobiah, C. and Levinson, W., 2013. The impact of leadership training programs on physicians in academic medical centers: a systematic review. *Academic Medicine*. 88(5). pp. 710-723.
 38. Swanwick, T. and McKimm, J., 2011. What is clinical leadership and why is it important. *The Clinical Teacher*. 8(1). pp. 22-26.
 39. The Royal Australasian College of Medical Administrators, 2006. *RACMA Workforce Report: Factors Affecting Recruitment and Retention of Medical Managers in Australian Hospitals*. RACMA, Malvern.
 40. Taylor, C., Taylor, J. and Stoller, J., 2008. Exploring leadership competencies in established and aspiring physician leaders: an interview-based study. *Journal of General Internal Medicine*. 23(6). pp. 748-754.
 41. Tchouaket, É., Lamarche, P., Goulet, L. and Contandriopoulos, A., 2012. Health care system performance of 27 OECD countries. *The International Journal of Health Planning and Management*. 27(2). pp. 104-129.
 42. Top, M., Akdere, M., and Tarcan, M., 2015. Examining transformational leadership, job satisfaction, organizational commitment and organizational trust in Turkish hospitals: Public servants versus private sector employees. *The International Journal of Human Resource Management*. 26(9). pp. 1259-1282.
 43. Townsend, K., Wilkinson, A., Bamber, G. and Allan, C., 2012. Accidental, unprepared and unsupported: clinical nurses becoming managers., *International Journal of Human Resource Management*. 23(1). pp. 204-220.
 44. Walton, L., Noonan, C., Miley, C., Jacobs, C., Sloan, E. and Harris, E., 2009. Hospitals employing physicians: A practical guide to buying physician practices and compensating employed doctors. *Health Lawyer*. 22 (2). pp. 1–29.
 45. Warren, O. and Carnall, R., 2011. Medical leadership: why it's important, what is required, and how we develop it. *Postgraduate medical journal*. 87(1023), pp.27-32.

46. West, M., Eckert, R., Steward, K. and Pasmore, W., 2014. *Developing collective leadership for health care*. King's Fund. [Online] Available from: <http://www.ctrtraining.co.uk/documents/DevelopingCollectiveLeadership-KingsFundMay2014.pdf> [Accessed date: 27/04/18]
47. Wikström, E. and Dellve, L., 2009. Contemporary leadership in healthcare organizations: fragmented or concurrent leadership. *Journal of health organization and management*. 23(4). pp.411-428.
48. Witzel, M., 2013. Leaders and managers should be one and the same. [Online]. Available from: <https://www.ft.com/content/0f0e0000-9891-11e2-867f-00144feabdc0> [Accessed on 04/05/18].