STRENGTHENING CLINICAL LEADERSHIP IN HOSPITALS:

A REVIEW OF
THE INTERNATIONAL AND SOUTH AFRICAN LITERATURE

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In memory of

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who inspired this research

Acknowledgements

Policy brief

The debate around public hospital management reform in South Africa tends to focus on the extent to which authority should be decentralised to the senior management team and how to strengthen general management processes. These interventions are seen as key to improving hospital performance.

However, the international literature emphasizes that, in the hospital setting, decision-making that directly affects the quality of care largely occurs at lower levels of the management hierarchy. Equally importantly, it is largely clinicians, and not general managers, who make these decisions.

For this and related reasons, decentralised clinical leadership may be a good strategy for achieving the level of quality (and efficiency) that is required to ready public hospitals for National Health Insurance.

Clinical leadership is the transformational leadership provided by practising clinicians who drive improvements in the quality of care through innovation, either through formal participation in clinical governance activities or through informal role modelling and mentorship.

One of the most common mechanisms for strengthening clinical leadership is the creation of clinical directorates headed by a clinician who is usually supported by a general manager. The clinical director oversees clinical processes and also puts in place appropriate management systems so that he/she can manage the budget, human resources and procurement effectively.

Clinical leaders can be any type of health professional, although they are most commonly doctors and nurses. Importantly, they continue their clinical work on a part-time basis: this is what allows them to keep patient care at the heart of management, understand what is needed to protect the quality of care and retain the respect of the clinicians and other staff that they lead.

Successful examples of clinical leadership are based on open and inclusive communication as well as collaborative leadership styles that rely on influence and mediation (sometimes called "influence-ship") rather than "command and control". They allow clinical input into decision-making at all levels, facilitate clinical leaders' understanding of the strategic direction of the health service and reconcile professional aspirations with resource availability.

The few local studies on this topic suggest that the concept of clinical leadership as it is expressed in the international literature - as central to clinical governance and improving hospital performance - may be productive for the transformation of South African public sector hospitals, many of which are experiencing a management crisis.

Further debate and research is required to understand how the local context may affect the relevance and implementation of the clinical leadership concept. Particular questions to explore in future work on the role of clinicians in leadership in South Africa are:

1. Can other clinicians fulfil the same clinical leadership roles as doctors?
2. Do clinical leaders need to be practising clinicians?
3. Do clinical leaders need to be the head of a management team to effect change?
4. Do clinicians have the skills to be leaders and managers?
5. Will clinician leadership lead to "medical dominance"?
6. What is the role of the professional health care manager in relation to clinical leaders?
7. Can the private for-profit sector provide lessons for improved clinical leadership?

Finally, clinicians already play a pivotal role in sustaining hospital services in South Africa. This is especially so in poorly-resourced areas: thus, in rural district hospitals, clinicians shoulder enormous responsibility, not just for managing the care of individual patients, but also developing staff and services at primary and hospital level, and contributing to wider decision-making around health care priorities and resource allocation.

This may make the district hospital a good candidate for exploring mechanisms to harness the leadership potential of clinicians.

Extended executive summary

Background

The debate around public hospital management reform in South Africa tends to focus on the extent to which authority should be decentralised to the senior management team and how to strengthen general management processes. These interventions are seen as key to improving hospital performance. However, as this review shows, the international literature emphasizes that, in the hospital setting, decision-making that directly affects the quality of care largely occurs at lower levels of the management hierarchy. Equally importantly, it is largely clinicians, and not general managers, who make these decisions.

This literature review is the first part of an exploratory research project titled "The role of district hospital clinicians in improving clinical governance in the public health sector in South Africa: possibilities and challenges." The project forms part of The Municipal Services Project which is located at the School of Government, University of the Western Cape, Republic of South Africa, and funded by the International Development Research Centre of Canada.

The review explores what the international and South African literature on clinical governance has to say about the role of clinicians – doctors, nurses, allied health professionals and mid-level workers who are involved directly in seeing and treating patients – in helping to transform public hospitals to provide better quality of care. It suggests that decentralised clinical leadership may be a strong candidate for achieving the level of quality and efficiency that is required to ready public hospitals for the implementation of the proposed National Health Insurance policy.

Definitions of key terms

Clinician: any health professional who is directly involved in diagnosing a patient's health problem, deciding upon the treatment required, overseeing the care of the patient and participating in the care of the patient, including conducting procedures

Clinical governance: the creation of an integrated system for leading, managing and monitoring the clinical process that promotes a productive culture in which clinical excellence can thrive, whilst ensuring transparency and accountability on behalf of leaders, managers and clinicians

Clinical leadership: the transformational leadership provided by practising clinicians who drive improvements in the quality of care through innovation, either through formal participation in clinical governance activities or through informal role modelling and mentorship

Is clinical leadership absolutely necessary for improved hospital performance?: the international perspective

The international literature explains that health care institutions are "professional bureaucracies" where a clinician's authority does not derive from his/her position in the formal management hierarchy but from his/her specialist knowledge and linkage to professional networks. In hospitals, this means that most decision-making that affects clinical care (and even some aspects of organisational efficiency) is actually out of the hands of hospital managers: it occurs in a completely different setting from the boardroom or office, namely, in the ward and operating theatre.

In addition, the clinical process is extraordinarily complex and unpredictable in nature. No one patient entering the health system is the same as another, conditions progress from day to day, and treatments vary according to an array of individual, family and contextual features. This means that it is difficult to standardise the approach to care, while the management of resources – at the ward, theatre, unit and departmental level - needs to adapt to changing circumstances. A high degree of discretion is required of health professionals, and clinical decision-making needs to be individualised and responsive.

The conventional approach to managing a government bureaucracy through hierarchical, rule-governed relationships is therefore not entirely applicable to public hospitals, at least with respect to the clinical process. In order to be effective managers of change (or even to meet regular financial and other targets), hospital managers have to bring clinical leaders into management processes, actively facilitating clinical leadership and encouraging managers and clinicians to understand one another's viewpoints and experiences.

Leadership also has to penetrate into all parts of the organisation: this need for "distributed" leadership means that a large number of clinical leaders need to be involved, organised into teams working on specific clinical areas or "clinical micro-systems." This must happen together with a new approach to leadership that is shared and collaborative, extending across both organisational and professional boundaries.

The international literature also shows that effective clinicians have specific attributes, apart from their expert knowledge, to contribute to this new approach to clinical governance. Because of the nature of their training, their roles within the clinical setting and their socialisation within their professional groupings, they tend to deploy a different leadership style to general managers. They have a "micro-level" viewpoint and use persuasion and evidence to bring about change, often acting as "opinion formers" who shape the tone of the hospital in an integral way. Good clinicians are trained to take responsibility for decision-making and to prioritise patient care. Because material incentives to become clinical leaders are poor, clinical leaders tend to take up leadership positions not so much for personal advancement as to advance their clinical area.

In combination, these characteristics make clinicians good candidates for bringing about organisational change in support of patient care, and recent international research evidence is strong for clinician engagement as an essential strategy for improving clinical governance. However, the literature emphasises that an increased influence for clinicians needs to be balanced by greater accountability, recognition of funding constraints and adherence to national norms and standards.

Developing new roles and structures for engaging clinical leaders

Historically, the assumption has been that doctors and nurses simply look after patients, while administrators simply look after the organisations that treat them. There have also been poor relationships between clinicians (especially doctors) and managers. This is due to different backgrounds, training, social status and perspectives.

Internationally, management reforms since the 1980s have sometimes aggravated these poor relationships by elevating concerns of efficiency and financial soundness over the demands of patient care. Clinicians have resented managers and "managerialism" for compromising the quality of their clinical practice. Managers, on the other hand, have been frustrated by clinicians' insistence on the primacy of their individual clinical autonomy, sometimes at the expense of the wider hospital community.

An understanding of the critical role clinical leadership could play in clinical governance has given rise to attempts to develop more productive relations between clinicians and management, with most formally documented examples emanating from Australia, the European continent, the United Kingdom and the United States. Some of these initiatives are happening within public hospitals still subject to the New Public Management approach, some are happening in public hospitals where the public sector ethos that prevailed prior to the 1980s is still strong, and some are happening in private hospitals.

Even in South Africa, where public hospital management is generally in crisis, there are examples of well-functioning hospitals, even in resource-poor areas: these examples are not well-documented, but from the limited information available it appears that good clinical leadership is a contributing factor.

The international and local examples show that, in order to restore mutual respect and a sense of shared purpose between clinicians and managers, a "crossing over" of perspectives is required: clinicians must contribute to organisational transformation, traditionally the preserve of general managers, while managers, in turn, must shift their focus to achieving the main purpose of hospitals, good quality clinical care. This leads to a greater willingness on the part of both clinicians and managers to share responsibility for change, re-alignment of priorities, a dove-tailing of clinical and resource management decision-making, and a greater likelihood for innovation in service delivery.

This requires not only a "mind-shift" on the part of clinicians and managers, and changes in their respective behaviours and training, but also the incorporation of clinicians into management teams at different levels within the organisation, as well as greater recognition of their informal leadership contributions as role models and mentors. An important change from traditional approaches is that clinical leaders assume much greater responsibility for overseeing all the functions falling under their team, including managing the budget, human resources and procurement, as well as taking responsibility for meeting targets.

Over the past decade there has been considerable progress in moving towards this form of distributed clinical leadership in the countries mentioned above, especially through the creation of clinical directorates where, with the assistance of a general

manager, a clinical leader takes responsibility for the running of a clinical unit or a department. Clinical leaders can also be involved in a range of other leadership roles, both formal and informal, ranging from participation in district management teams to mentoring other health professionals at the bedside.

Successful examples of clinical leadership are based on open and inclusive communication as well as collaborative leadership styles that rely on influence and mediation (sometimes called "influence-ship") rather than "command and control". They allow clinical input into decision-making at all levels and facilitate clinical leaders' understanding of the strategic direction of the health service. They reconcile professional aspirations with resource availability, facilitate and support clinical self-management, achieve change through motivating clinicians, and promote a move away from a custodial role for clinicians – where they focus on protecting their clinical practice - to creating a greater alignment between the managerial and clinical objectives of the organisation.

Almost all of the literature emphasises that successful clinical leaders continue with part-time clinical work. Clinical work is the source of clinicians' strength as leaders because it provides them with in-depth knowledge of the needs of the health service and, if done well, generates the respect that encourages other health workers to follow their lead. Once they take up formal leadership positions, continuing clinical work preserves clinical leaders' credibility with other clinicians.

Strengthening clinical leadership

There are many barriers to strong clinical leadership. Clinicians are often poorly prepared for leadership and there are few financial incentives to take up leadership positions, as well as limited career pathways. Organisational support is often weak and clinical leaders may encounter resistance from their clinical colleagues who sometimes judge them for having gone over to "the dark side" by participating in management processes. Clinical leaders' attempts to institute effective clinical governance may also be stymied by persistent management hierarchies that do not recognise clinicians' contributions or maintain "silos" that fragment the efforts of doctors, nurses and general managers or administrators.

To counteract these problems, clinicians need leadership training and mentorship, starting at the undergraduate level and persisting late into their careers. Importantly, this training should break from conventional business management approaches to respond to the unique features of the public health system and reflect a philosophy of shared, multi-disciplinary and transformational leadership.

The support of top-level hospital management is critical to the development of clinical leadership: hospital CEOs need to be willing to delegate power and responsibility to clinical leaders and nurture productive relations between clinicians and management, creating an enabling environment for clinical leaders to function well and to assist the hospital in achieving its objectives. For this to happen adequately, CEOs themselves need to receive appropriate delegations.

Further, clinical leaders should be valued by the organisation, including receiving adequate financial rewards and being offered career paths that allow them to

combine management with clinical work, as well as to move in and out of leadership positions. The support of their colleagues is important, as is administrative back-up.

Lastly, placing clinicians in leadership positions is not a "magic bullet": it is very important to ensure that appropriate people fill these positions – with the necessary leadership traits and skills, and the ability to adapt their leadership styles and focus to the contingencies of local circumstances.

The need for more debate and research

The limited local evidence on this topic suggests that the concept of clinical leadership as it is expressed in the international literature - as central to clinical governance and improving hospital performance - may be productive for the transformation of South African public sector hospitals, many of which are experiencing a management crisis.

Clinical leadership has the potential to address the structural cause of inefficient and poor quality care, namely, overly centralised, bureaucratic and unresponsive decision-making and organisational cultures. It has the potential to transform underlying values and management processes by placing the provision of good quality care at the heart of an organisation's management efforts, creating an organisation-wide shift in management culture, building management systems that support the clinical process actively, drawing on the leadership potential of clinicians, releasing potential innovation through unifying the efforts of managers and clinicians, and strengthening the accountability of the whole organisation to delivering good quality care.

Yet South African hospitals may have important differences from the high-income countries which generate most of the clinical leadership literature. Obviously there are fewer resources and staff shortages are particularly bad, but there are more subtle factors – such as differences in the level of decentralisation and organisational culture – that might be equally important considerations. District hospitals in particular may have much more extensive roles than their high-income counterparts, responsible as they often are for developing and supporting the surrounding primary care services.

Further debate and research is required to understand how these differences may affect the relevance of the clinical leadership concept. Some important questions that need to be debated are:

8. *Can other clinicians fulfil the same clinical leadership roles as doctors?*

In South Africa there is a shortage of doctors and other health professionals, especially nurses, already play an enormous clinical leadership role at the primary care level and inpatient setting. Further, different types of health professionals may be better placed to take on leadership roles at different levels within the clinical governance process and parts of the hospital. Yet doctors enjoy significant status and are very influential in determining the allocation of resources within hospitals.

It would be useful for further South African research to identify what the peculiar strengths are of different types of health professionals and where and when these might be most useful in providing clinical leadership.

9. Do clinical leaders need to be practising clinicians?

Many CEOs and even clinical directors in South Africa are clinicians who no longer undertake clinical work, especially in the larger hospitals. While these people may play important roles in facilitating clinical practice, they belong to the administrative structures of the hospital and, as the literature suggests, have a fundamentally different perspective from clinicians. Nurses who manage wards are in a different position, however, as they are in close daily contact with the needs of patients and patient care, including through participation with doctors in daily rounds.

These differences highlight the need to develop a more detailed understanding of how current involvement in clinical practice affects leadership ability and status.

10. Do clinical leaders need to be the head of a management team to effect change?

Clearly clinicians can effect change through many mechanisms, some of which are informal. Some formal mechanisms may be limited to participation on management committees or leadership of elements of quality improvement programmes, such as clinical audits. However, some of the literature suggests that, in order to achieve a fundamental shift in the clinical process and marshal other hospital functions in support of this process, clinicians need to head decentralised management teams (at the level of departments and units). This implies that nursing managers and administrators would report to their departmental or unit clinical head, rather than to the senior nursing manager or administrator at the level of the hospital executive.

Further investigation is required to assess which model is most practicable and effective, keeping in mind that greater decentralisation may be needed in larger hospitals in order to "flatten" the management hierarchy, whereas in small hospitals it may be easier to create direct communication between all members of the health care management team, and instil a collaborative culture, without formally breaking the management silos that presently exist.

11. Do clinicians have the skills to be leaders and managers?

Over the decades there have been many hospital managers who have not performed well, highlighting the fact that training and management experience, as well as leadership qualities, are required for anyone fulfilling a leadership role. However, there are examples, even in poorly-resourced hospitals, where clinicians are very effective managers, performing complex managerial tasks on a daily basis, especially with respect to managing limited resources.

Research should therefore focus on identifying the characteristics of, and the formal and informal requirements for, good clinical leaders, differentiated by their professional background, place in the organisational and professional hierarchy and the specific demands of their job.

One of the reasons that decentralisation efforts are often stymied is a fear that lower levels in the system do not have sufficient capacity, opening up government to the

risk of under-performance, including financial mismanagement: therefore appropriate capacity-building for leadership needs to be developed, including mentorship in the workplace. Strategies also need to be developed to incentivise good clinicians to become involved in leadership roles.

12. Will clinician leadership lead to "medical dominance"?

One of the difficulties of discussing who should lead decentralised hospital management teams is that it provokes professional rivalries. This is particularly so when suggesting an elevated role for doctors, given that other professions – particularly nurse and career managers – have long struggled to have their critical contributions to health care properly acknowledged. The nursing and administrative professions also have a stake in promoting "managerialism," however, which means that they are not entirely disinterested participants in the debate.

It will be critical to disentangle arguments for and against clinical leadership that are based on narrow professional interests from those based on the best interests of patients and the health system. It will also be important to understand how the skills and aspirations of different professional groupings can be satisfied by transformed management structures and processes.

13. What is the role of the professional health care manager in relation to clinical leaders?

If clinicians take on more leadership and management roles – such as running decentralised units where all staff within the unit report to them – the question then arises as to what the role of the health care manager would be, both at the level of the CEO and within the clinical unit, as well as the leadership style that such managers should adopt. This needs further exploration but it is already clear that senior managers have special skills in providing overall strategic direction, ensuring standards are met and providing support to clinical teams. Re-conceiving this support – at both a senior and middle-management level - as facilitating clinical decision-making is necessary to achieve the full potential of clinical leadership: how to do this effectively needs to be investigated. Traditional management training programmes and mentorship approaches would need to acknowledge, and respond to, this shift.

14. Can the private for-profit sector provide lessons for improved clinical leadership?

In South Africa, for-profit private hospitals are generally perceived to provide better quality care than their public sector counterparts, while remaining financially viable. The question therefore arises whether, under these potentially more favourable circumstances, good models for effective clinical leadership have evolved. This is certainly worth investigating, although researching the for-profit private sector is difficult given that very little information is in the public domain.

It should be remembered, though, that there are contextual factors that may constrain the usefulness of the for-profit experience, particularly the financial incentives that affect treatment patterns and the focus on the individual patient as opposed to the hospital catchment population. Indeed, problems with the quality of care at some private hospitals are also reported in the press. This means that the

differences in the ethos that prevails at public and private hospitals in South Africa need to be well-understood before comparisons can be drawn.

Conclusions

This review suggests, on the basis of the international literature, that decentralised clinical leadership may be a good strategy for achieving the level of quality and efficiency that is required to realise the objectives of the South African government's policy on National Health Insurance. Importantly, this does not simply mean putting in place a set of structures, standards and activities to oversee quality of care: it is about a new way of conceptualising hospital management, at least at levels below the senior management team.

Exactly how clinical leadership should be effected in the South African context needs further investigation and debate. The international literature on this subject has only emerged in the last decade and the degree to which useful comparisons can be drawn with South Africa are not known, given the different circumstances that prevail. The local evidence for successful reform of clinical governance in hospitals is very thin and, where it exists, sometimes controversial.

However, hospital management systems in South Africa are weak. The political sustainability of National Health Insurance rests on the delivery of good quality care in the public sector: while national standards and more competent hospital CEOs are vital to guide change in public hospitals, it is at the level of the ward and clinical section that quality improvements will be generated on a daily basis. Clinicians already play a pivotal role in sustaining hospital services. This is especially so in poorly-resourced areas: thus, in rural district hospitals, clinicians shoulder enormous responsibility, not just for managing the care of individual patients, but also developing staff and services at primary and hospital level, and contributing to wider decision-making around health care priorities and resource allocation.

This may make the district hospital a good candidate for exploring mechanisms to harness the leadership potential of clinicians. Historically these hospitals have been under-developed, yet they form an integral part of the district health system and will be a key mechanism for extending hospital coverage. Some district hospitals are able to draw on a long-standing tradition of commitment to the community they serve, enjoy the services of long-serving clinicians and close-knit clinical teams, and demonstrate quality improvements in the face of enormous challenges. All in all, it may be easier to integrate clinical, leadership and managerial roles and staff in district hospitals than in larger hospitals with more complex hierarchies and, especially in rural hospitals, the organisational culture may be more conducive to teamwork.

The literature is unequivocal in stating that health care organisations – especially those in the public sector - have to be managed on a different basis from commercial enterprises and government departments. Significant improvements are impossible without unifying the efforts of clinical, clinical support and non-clinical services in the interests of patient care, decentralising authority and responsibility for both managerial and clinical decision-making to the appropriate levels, and transforming the organisational culture. Exactly how this should be done needs to be explored

whilst at the same time managing the sensitivities of different professional groupings, as well as policy-makers' concerns about decentralisation in the context of weak capacity.

List of abbreviations

CEO	Chief Executive Officer
NHS	National Health Service
UK	United Kingdom
US	United States

Contents

PART A: INTRODUCTION TO PURPOSE AND KEY CONCEPTS

A1. Background to the review

The debate around public hospital management reform in South Africa tends to focus on whether, and how, to decentralise authority to the hospital Chief Executive Officer (CEO), the ideal characteristics of a CEO, and how to strengthen the capacity and leadership style of the senior management team as a whole. These interventions are seen as key to improving hospital performance. However, as will be shown by this review, the international literature emphasizes that, in the hospital setting, decision-making that directly affects the quality and efficiency of care, as well as resource allocation patterns, largely occurs at lower levels of the management hierarchy. Equally importantly, it is largely clinicians, and not general managers, who make these decisions.

This review is the first part of an exploratory research project titled "The role of district hospital clinicians in improving clinical governance in the public health sector in South Africa: possibilities and challenges." The project hypothesizes that one of the reasons for the lack of progress in public hospital management transformation is the limited degree of decentralization of appropriate authority (and responsibility) to levels *below* senior management, poor management structures at these levels which effectively sideline the leadership contributions clinicians could make, and limited capacity development for clinical leadership.   While skilled and supportive senior managers and well-functioning general management systems are of course vital, it might be that it is only at the level of the clinical department and ward that substantial improvements in clinical care – and even some aspects of organisational efficiency - can be made.

A2. Aim and objectives of the review

The aim of this review is to inform the next, interview-based phase of the project through summarising what the international and South African literature has to say on the role of clinician leaders in improving clinical governance in public hospitals.

The objectives are to:

    a. explore whether clinician engagement in managerial decision-making is necessary for improved public hospital performance;
    b. describe the historical formal and informal leadership roles of clinicians and their historical relationships with managers;
    c. describe appropriate contemporary roles for clinicians in leadership and management;
    d. identify the structures, mechanisms and processes that are useful in strengthening clinical leadership; and
    e. reflect on the relevance of the international experience to the South African context.

The review focuses on findings that are relevant to the public hospital sector, as this is the sector that is responsible for serving the bulk of the South African population. The new draft policy on National Health Insurance sees the public sector as the main vehicle for expanding the coverage of health care and identifies strengthening this sector as an immediate priority (National Department of Health 2011a). This does not mean that lessons from the for-profit private sector cannot be applied to the public sector, and the review does indeed draw on private sector examples reported in the international literature. It also reflects briefly on the differences between the public and for-profit private sectors that might affect the role and impact of clinical leaders.

A3. Approach to the review

PUBMED and Google Scholar were searched using the following terms: "clinical governance," "clinical leadership/management," "medical leadership/management" and "doctors in management." Websites that were identified through the Google Scholar search were also explored for additional publications. The reference lists of key articles or reports identified through the first round of searching were scanned for additional publications. As resources for the review were constrained, preference was given to retrieving recent publications that reviewed other studies or presented cross-country comparisons. Only articles that were relevant to hospital management were retained. The search was stopped once significant new information no longer appeared.

Limitations of the review are those associated with a rapid, desk-based review: some important articles may have been overlooked and it has not been possible to tap the experiential knowledge of those practitioners who do not publish in academic journals. Further, research in this area is relatively recent, only English-language sources were accessed and the vast majority of sources derive from high-income countries. With a few exceptions, very little literature describes the for-profit private sector experience, probably because information on this sector is seldom in the public domain.

A4. Structure of the report

The findings of the review are summarised under headings that respond to the objectives listed above, including an early assessment of how the South African context may differ from that reflected in high-income countries (in Part C). A planned set of key informant interview will supplement this section at a later date.

The main body of the text (Part B) is prefaced by a fairly lengthy discussion of the key terms used in the report (in Part A). This is because there appears to be a lack of conceptual clarity, in both the international literature and the South African discourse, on what is meant by commonly used terms, such as "clinician," "clinical governance" and "clinical leadership." This lack of clarity contributes to difficulties in structuring constructive debate around the role of clinical leaders in contexts where

there are professional and organisational rivalries between different categories of health professional, or between health professionals and managers.

A5. Definitions of key terms used in the review

A5.1 Clinician

There is no standard definition of "a clinician," not least because of the complexity of health care and the size and multi-disciplinary nature of the health care team. This review applies the term to a person directly involved in diagnosing a patient's health problem, deciding upon the treatment required, overseeing the care of the patient and participating in the care of the patient, including conducting procedures. While many individuals may play a role in clinical patient care, this is to varying degrees: the emphasis of this review is on those who have some responsibility for clinical decision-making.

Originally the use of the term in the UK literature on clinicians was synonymous with doctors, although more recently the term has come to be used more inclusively, and there is a growing literature on clinical nurse leaders in particular (see, for example, Stanley 2006b). This review uses the broadest interpretation, thereby including nurse clinicians, allied health professionals and mid-level health care workers.

Strictly speaking, in South Africa a nurse clinician is someone who has received specialised, post-basic training in history-taking, physical examination, differential diagnosis and decision-making around treatment (Strasser, London et al. 2005). Traditionally known as primary health care nurses, these clinicians are trained for the primary care setting but may also be found working in casualty or inpatient wards. Because of staff shortages in hospitals, some of these nurses, as well as many others who have not received any clinical training at all, also provide clinical care as described in the definition above, although this is outside their official scope of practice. For the meantime, all these nurses are included within the term "clinician," because the purpose of this project is to investigate how best to tap the untapped leadership potential of all those involved in clinical patient care (regardless of their formal training), although this review does reflect on how different disciplinary backgrounds may affect clinical leadership roles.

Nurses and other health workers who tend to patients but are not involved in decision-making around diagnosis and treatment are <u>not</u> included in this definition: although their skills and behaviour impact directly on the quality of care experienced by a patient, they do not have responsibility for deciding on the course patient care should take. People in purely managerial positions are also <u>not</u> included in the definition, even if they have had clinical training, because of their fundamentally different roles, perspectives and experiences, especially when their clinical experience has been quite limited or when several years have intervened since their last clinical experience. An exception is nurses who act as ward managers and are closely involved with ward rounds as well as monitoring patient care: this is because, even though they have managerial and administrative responsibilities, they work at the "coalface" of patient care. This mirrors the experience of a senior doctor who is responsible for running a clinical department whilst also tending to his or her own patients, and who is therefore also included in the term "clinician" in this review.

While this application of the term "clinician" attempts to draw some boundaries around the term, this review acknowledges that there may be other competent individuals who, because of a prior history of appropriate clinical experience, or because of their unique personality and skills, may also be suited for clinical leadership roles.

A5.2 Clinical governance

"Clinical governance" is a term that gained currency in the United Kingdom (UK) during the late 1990s, inspiring a major health policy of the Labour government to improve the quality of care provided by the National Health Service (NHS). The policy emerged in response to a growing awareness that in many NHS facilities patients still experienced poor quality care, and was spurred on by some high-profile incidents where patient safety was severely compromised (Freedman 2002). This was despite a relatively well-resourced health system and at least a decade's worth of experience with "quality assessment," "quality assurance," "clinical audit" and "continuous quality improvement," all strategies aimed at strengthening the quality of care. Similar problems were apparent in other high-income countries.

The characteristics of supposedly sophisticated health care facilities experiencing the paradox of poor quality care were investigated in the United Kingdom and elsewhere, and are summarised in **Box 1**. They reveal fundamentally weak management of the clinical process and an absence of clinical leadership (Balding 2008). In these organisations, traditional quality improvement strategies are fragmented, some driven by clinicians through a process of self-regulation under which it is assumed that they have the skills and will to improve standards of care on their own, while others are driven by managers through top-down processes that fail to motivate and support clinicians (Buetow and Roland 1999). Ensuring that clinical care is of good quality is not recognised as a "corporate" responsibility, like financial soundness, accountability and the efficient use of tax funds (Freedman 2002): the clinical process is consequently de-linked from the managerial processes of the organisation.

Box 1: The characteristics of health care organisations with persistently poor quality of care

- Quality of care problems are known about for many years without being addressed
- Mistakes are frequently repeated because lessons from prior experience have not been incorporated into new ways of working
- There are major barriers to disclosing quality problems and investigating adverse incidents fully
- There is a culture of 'blame and shame' where individuals, rather than clinical or managerial systems, are penalised for making mistakes
- There is a lack of systematic performance monitoring and reporting
- There are poor or absent systems for staff training and accreditation
- The lines of accountability for patient care are unclear and diffuse

Source: Adapted from (Balding 2008)

The concept of clinical governance was developed to address these underlying, systemic problems and provide greater impetus to quality and safety improvement initiatives. For the first time, the UK's new Labour policy made the quality of care a direct, statutory responsibility of the CEO and hospital board, placing it on a par with corporate governance. As the Australian Council on Healthcare Standards puts it, this creates a "system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care" (Balding 2005a, 2). Clinical governance is a concept that now enjoys widespread usage in many high-income countries.

One misconception of the term is that it aims to achieve governance by clinicians (especially doctors) and therefore "medical dominance." Rather, it is about the governance of clinical practice through re-aligning and unifying the efforts of general managers and clinical leaders (Starey 1999; Gray 2004; Phillips, Pearce et al. 2010). It "introduces increased responsibility and transparency around safety and quality into all staff roles" (Balding 2005b, 353) and "aims to bring together managerial, organisational and clinical approaches to improving quality of care" (Buetow and Roland 1999, 184).

Another misconception arises from this formulation, namely, that clinical governance strategies are simply an attempt by managers to rein in the professional autonomy of clinicians. A later section explains why such an approach would in any case be unlikely to succeed but, for the meantime, it is important to emphasize that this review uses the term in an expanded and more positive, collaborative sense. Here, the key to clinical governance is "[c]reating an environment in which clinical excellence can flourish" (Hackett, Lilford et al. 1999, 98) and "the promotion of a productive culture and climate within which care can thrive" (Braithwaite and Travaglia 2008, 11).

In its widest sense, then, clinical governance is about much more than implementing quality improvement programmes: it is about transformation of the management ethos of health care organisations. In contrast with **Box 1**, organisations with good clinical governance should display the features summarised in **Box 2**. Clinicians have a special role within clinical governance as it empowers them to "lead a comprehensive strategy to improve quality ... although with an expectation of greatly increased external accountability" (Buetow and Roland 1999, 184).

In the NHS, both managers and doctors appear to have accepted the need for clinical governance and an increasing number of best practice sites are emerging (Kirkpatrick, Malby et al. 2007). However, the impact of clinical governance strategies is still to be fully assessed and there is some division in the literature about whether clinical governance is achieving its full potential (Braithwaite and Westbrook 2005). Much of the current literature draws on key informant interviews, often with subsets of professionals, rather than more comprehensive evaluations. The opinions expressed in these interviews themselves yield contradictory assessments and it is sometimes difficult to untangle objective views from those that reflect inter-professional prejudices and stereotypes, or to differentiate between flaws in the concept and problems with implementation.

Box 2: The characteristics of health care organisations with good clinical governance

- There is an organisational and management framework for improving the quality of care
- There is a "duty of quality" relating to the organisation as a whole, not just to the individuals within it
- There is a comprehensive organisational strategy for improving the quality of care
- There are named individuals within the organisation who have the responsibility to improve quality of care
- There is a focus on clinical leadership although it is understood that this must be accountable to the CEO as well as national clinical guidelines and standards
- There is a focus on the processes of care, including clinical decision-making and the appropriateness of care in an holistic sense

Source: Adapted from (Buetow and Roland 1999)

It may well be that clinical governance in some facilities exacerbates "managerialism" and undermines the clinical process; in other cases, it may undermine the role of managers in participating in ensuring sound resource management and cost-effectiveness. Further research is required to establish when this is so and what the explanatory factors might be. Further research is also required to investigate how clinical governance can promote more dimensions of quality than simply clinical effectiveness. Nonetheless, a body of international literature has built up over the last decade that strongly affirms the importance of clinical governance – and clinical leaders – in addressing long-standing quality of care problems in hospitals.

A5.3 Clinical leadership

The terms "leadership" and "management" are often used together. Thus, the World Health Organisation states that "[g]ood leadership and management are about providing direction to, and gaining commitment from, partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other health resources" (World Health Organisation 2007, 1).

This definition acknowledges that leaders often perform management tasks, and vice versa: the boundaries between leadership and management are not always that clear (Bohmer 2012). Nonetheless, it is possible to discern differences between the prime functions of leaders and managers, as well as differences in the skills required to execute them (McKimm 2004; Swanwick and McKimm 2011; Bohmer 2012). Leadership – especially transformational leadership - is about developing a values-based vision and direction for an organisation, motivating and inspiring members of that organisation to implement the vision, aligning the efforts of various members, guiding the organisation through periods of change and instability, and developing and empowering followers (Kotter 1996; Stanley 2012; Ross, Edmonstone et al. date

unknown). Management, on the other hand, is more about achieving stability through planning and operational problem-solving, including developing concrete plans and budgets, setting targets, and marshalling and organising resources.

This review focuses on individuals at the leadership end of the leadership-management continuum and also recognises that leadership can be provided by people who are not in formal leadership positions. To perform as successful leaders these individuals need a mixture of analytic and interpersonal skills, as well as the ability to balance competing needs and conflicts of interest (The King's Fund 2011).

As should already be apparent, good leadership is essential to realising the potential of the clinical governance approach. As Balding states,

> leadership is a fundamental component of effective safety and quality improvement with senior and line managers, informal and opinion leaders all required to contribute through translating clinical governance policy into practice … Clinical leadership, in particular, has been found to be a key success factor for [quality] improvement programmes, but is rarely formally established without senior leaders endorsing and shaping organizational roles and processes to facilitate their involvement (2005b, 355).

In this quote, the term "clinical leadership" refers to the leadership provided by clinicians, which distinguishes it from the term "clinical governance." This is how the term is used in this review. To reiterate, clinical leaders are health professionals who lead change in practice and suggest innovations that improve the quality of clinical care (Stanley 2012).

PART B: THE INTERNATIONAL CASE FOR CLINICAL LEADERSHIP

B1. Is clinician involvement in managerial decision-making necessary for improved hospital performance?

The discussion so far has implied that, in order to improve hospital performance, clinicians have to play leadership roles and, in some cases, take up management positions. But is this absolutely necessary? Would clinicians' time not be better spent on simply seeing and treating patients (and, at most, overseeing the work of other clinicians), especially in settings where there is a shortage of skilled clinical staff? Career managers – people who used to be clinicians but have gone full-time into management, or people who have general, human resource or financial management training and experience - would then be the ones running all the other aspects of the hospital, including clinical governance systems.

The literature is unequivocal in categorising health care institutions as "professional bureaucracies." This means that authority does not derive from a person's position in the formal management hierarchy (their "position power"), as in a company or a government department (Ross, Edmonstone et al. date unknown). Instead, "frontline staff have a large measure of control by virtue of their training and specialist knowledge and through professional networks and collegial processes, rather than involvement in the organisation's bureaucracy" (Hamilton, Spurgeon et al. 2008, 5). As Ham (2003, 1) puts it, "hospitals and other healthcare organisations have an inverted power structure, in which people at the bottom generally have greater influence over decision-making on a day-to-day basis than do those who are normally in control at the top."

This means that most decision-making that affects clinical care (and even some aspects of organisational efficiency) is actually out of the hands of hospital managers. It occurs in a completely different setting from the boardroom or office, namely, in the ward and operating theatre. Decisions are made through collegial mechanisms rather than through line management structures. This tendency has persisted despite management reforms in the UK and United States (US) which, since the 1980s, have tried to strengthen managerial control over clinical decision-making as part of cost containment measures (Ham and Dickinson 2008).

Strengthening managerial control over clinical decision-making is, in any case, very difficult given the extraordinarily complex and unpredictable nature of the clinical process. No one patient entering the health system is the same as another, conditions progress from day to day, and treatments vary according to an array of individual, family and contextual features. This requires highly individualised and responsive decision-making, as explained by Lipsky's (1980) theory of "street-level bureaucrats."

In the case of the health sector, "street-level bureaucrats" are the clinicians and other health workers who work directly with patients and their families, and have to decide between different care options and deploy resources accordingly. As Edmonstone (2009, 293) summarises, under Lipsky's theory "[d]iscretion rather than prescription was seen to be a key feature of their work, partly because they operated in complex

situations which could not easily be reduced to programmatic formats, partly because the situations they encountered might require compassionate treatment, and partly because the exercise of initiative in itself could inspire the trust of clients both in the individual professional and in the agency he or she represented."

Because of the role of these sorts of "street-level bureaucrats" in these sorts of "professional bureaucracies," conventional approaches to administering a government bureaucracy (or even a commercial company) are not applicable. "In these disconnected hierarchies [of professional bureaucracies]," says Ham (2003: 1-2), "organisational leaders have to negotiate rather than impose new policies and practice." In order to be effective managers of change (or even to meet regular financial and other targets), senior hospital managers have to bring clinical leaders into management processes, actively facilitating clinical leadership and nurturing the common ground between managers and clinicians (Balding 2008; Kirkpatrick, Shelly et al. 2008; Mountford and Webb 2009). In fact, recognising the considerable skills and experience of senior professionals in supporting management systems is a feature of other "high-risk industries" (Balding 2008).

The complexity of hospital care also requires leadership to penetrate into all parts of the organisation: this need for "dispersed" or "distributed" leadership means that a large number of clinical leaders need to be involved, organised into teams working on specific clinical areas or "clinical micro-systems" (Dickinson and Ham 2008). This re-distribution of leadership responsibility throughout the organisation must occur in tandem with the development of new leadership practices that are shared and collaborative, extending across both organisational and professional boundaries (The King's Fund 2011).

This implies a much greater level of involvement on the part of clinicians and Swanwick and McKimm (2011, 22) go so far as to state that "engaging in leading and managing systems of health care, on whatever scale – team, department, unit, hospital or health authority – is therefore a professional obligation of all clinicians."

What clinical leadership adds to health care management is not just expert knowledge of clinical processes. Because of the nature of their training, their roles within the clinical setting and their socialisation within their professional groupings, effective clinicians tend to deploy a different leadership style to general managers. As Edmonstone notes, they have a more "micro-level" viewpoint and, when leading well,

> use persuasion, rather than hierarchical power to manage the tension between the hierarchical management system and the clinical 'expert system;' prefer an approach to change which [is] evidence-based and planned, using consultation, clarification and a choice between options; and feel more comfortable with a reflective practice/professional artistry approach to health care than a technical-rational one (2009, 291).

Further, clinicians (and especially doctors) tend to be "opinion formers," seeking opportunities to shape their organisation's goals and policies, playing a pivotal role in the tone of the organisation and in bringing about change (Ham 2008; Mountford and Webb 2009). At their best, clinical leaders are able to act as the "umbrella" shielding clinicians from the bureaucratic demands of the organisation, and as "un-blocker[s]"

of change, removing bureaucratic obstacles and convincing clinicians to engage in new initiatives (Dickinson and Ham 2008).

Good clinicians are trained to have the courage to make the decisions needed to progress care and feel personally responsible for their patients: for example, a study of clinical nurse leaders found that "their approach to clinical leadership was based upon a foundation of care that was fundamental to their values and beliefs or view of nursing" (Stanley 2006a, 20). Because material incentives to become clinical leaders are poor (see later), clinical leaders tend to take up leadership positions not so much for personal advancement as to advance their clinical area. Medical consultants, in particular, are able to take a long-term view of health systems development as they typically remain part of the health service for much longer than managers (Balding 2005a).

In combination, these characteristics make clinicians good candidates for bringing about organisational change in support of patient care, and the research evidence that clinician engagement is essential for improving hospital performance is strong and consistent (Ham 2003; Ovretveit 2005; Ham 2008; von Knorring, de Rijk et al. 2010). Thus, for example, quality improvement strategies in the UK have had more success when "done in a way that made sense to staff and that engaged doctors fully in its implementation" (Ham and Dickinson 2008), with one study finding that "hospitals with the greatest clinician participation in management scored about 50 percent higher on important drivers of performance" (Mountford and Webb 2009, 3). Looking at primary care practice in Australia, Phillips, Pearce et al. (2010, 606) also found that "the evidence is strongest for improvements that are driven by health professionals at the practice level." Bohmer (2012, 7) concludes that "[l]eaders at the lowest levels of delivery organisations, where clinicians and patients interact, have control over a set of organisational levers that have been shown to have a meaningful impact on both intermediate medical outcomes (e.g. error rates) and terminal outcomes (e.g. readmission and mortality rates)."

Other research shows that, because the desire to help their patients and provide a high standard of care remains clinicians' main motivation, strategies that engage clinicians and improve clinical practice appeal to this commitment are more likely to succeed than strategies that try to control their behaviour (Ham 2003; Balding 2008; Swanwick and McKimm 2011). For the UK this means that, in contrast to the 1980s when there was a high degree of centralism in the NHS, and a disproportionate focus on meeting efficiency targets, "the [more recent] conceptualisation of reform as having a service quality and improvement agenda has offered a more attractive approach for bringing clinicians into leadership roles than previous rather resource-oriented initiatives"(Ham 2008).

All of these sources recognise that increased influence for clinicians needs to be balanced by greater accountability, recognition of funding constraints and adherence to national norms and standards. Clinicians clearly cannot act outside the priorities and constraints of the health system yet, on the other hand, "exclusive or excessive use of these top-down mechanisms [such as performance indicators, clinical standards and guidelines] can result in opportunity costs for the service, disruption of teamwork ... and constructing clinical activities around indicators rather than need" (Phillips, Pearce et al. 2010, 606). Further, one of the tasks of clinical leaders should be to help improve the relationship between clinical staff and management, through

engaging constructively with managers to develop innovative patient care within the context of organisational constraints (Lunn, MacCurtain et al. 2008).

In conclusion, the literature arguing for an increased role for clinicians is relatively new and not well-accepted everywhere. As explained by Edmonstone (2009, 291), "the notion of clinical leadership is a 'contested' one, which can be seen from a purely managerialist perspective as an illegitimate, deviant and elitist activity... A milder variant of this perspective would regard clinical leadership as simply an instrumental means of achieving managerial ends."

B2. Historical relationships between clinicians and management

In contrast to contemporary notions of the value of clinical leadership, historically "the conventional view of health care management divides treatment from administration – doctors and nurses look after patients, while administrators look after the organisations that treat them" (Mountford and Webb 2009).

Historically there have also been poor relationships between clinicians (especially doctors) and managers. Kirkpatrick, Shelley and others (2008) ascribe this to the fact that clinicians and managers have different backgrounds, training and social status and, as groups, have their own distinctive cultures, characterised, for example, by the use of specific (and sometimes alienating) jargon. They have different perspectives, represented, for example, by their different approach to, and use of, evidence: doctors tend to rely on "complex hierarchies of quantitative evidence" while managers are skilled in the "pragmatic use of qualitative, experiential and anecdotal evidence" (Kirkpatrick, Shelly et al. 2008, 28). Doctors exist in independent hierarchies, and their loyalties and aspirations lie mainly outside organisational structures, whereas those of other clinical groups and managers tend to correspond directly with their organisational roles. All these factors can make it difficult for clinicians and managers to understand each other's points of view.

Negative attitudes are aggravated by professional rivalries as well as the "silos" of traditional management hierarchies, where different health professionals and administrative functions (such as human resources and financing) report in separate, parallel structures to senior management. Sometimes the elevation of individuals with insufficient skills or inappropriate leadership styles to leadership positions can also entrench prejudices (Powell and Davies 2012).

The management reforms in the UK and US in the 1980s exacerbated these tendencies. As mentioned earlier, these reforms arose partly in response to relentlessly rising costs. They were also the result of a new management philosophy, "The New Public Management," which sought to introduce market-based mechanisms and performance-related incentives as a remedy to the inefficiencies of the public sector.

In the NHS, doctors grew embattled and sidelined as a result of these reforms (Ham 2008) and there is still "a sense that, even after 20 years of reform, new structures of governance, guidance and cost control are not synchronised with clinical practice" (Kirkpatrick, Shelly et al. 2008, 28). Over the same period in the US, a series of

serious and ongoing disagreements between the governing bodies and medical staff of hospitals have been highlighted in the media (Schyve 2009). Many doctors resent the surge in regulation and the shift of power to managers: the perception is that managers focus on meeting financial and performance targets rather than clinical priorities and patient-centred care.

These feelings have persisted even into the era of clinical governance as it is sometimes perceived as a top-down managerial approach (Hackett, Lilford et al. 1999; Som 2005). As one hospital CEO put it, management "invents work for us instead of doing odd jobs for us" (Witman, Smid et al. 2010, 490).

Professional hospital managers, on the other hand, feel that doctors in particular have unassailable clinical status and expertise, whilst at the same time knowing little about the health system as a whole and tending to do what they please within the organisation (von Knorring, de Rijk et al. 2010). Doctors are seen as "troublesome," making it difficult for CEOs to manage them as they would other elements of the hospital. As the CEO of a Swedish hospital put it, "[i]t's hard to manage physicians ... to stick to rules and strict criteria and things like that, because physicians always try to understand why, and if they're not completely convinced about the motives, they kind of do what they want to" (von Knorring, de Rijk et al. 2010: 8).

To exert influence managers have to resort to separating doctors from the rest of the organisation (for example, by meeting with them separately), influencing them through cajoling and nagging, and appealing to clinician leaders to convince their clinician colleagues to engage in change efforts. These strategies, whilst pragmatic, weaken the role of senior managers and, at the same time, leave clinicians feeling over-managed. Importantly, the "managerial and leadership resource contained in the clinical body" remains largely untapped (Spurgeon 2008).

B3. Contemporary roles and structures for engaging clinical leaders

An understanding of the critical role clinical leadership could play in clinical governance has given rise to attempts to develop more productive relations between clinicians and management as opposed to the historical "oppositional stalemate" (Kirkpatrick, Shelly et al. 2008). Hamilton, Spurgeon and others have argued that a culture needs to develop where mutual respect is restored, as well as a sense of shared purpose, so that "doctors are much more engaged in the health system in which they work" (2008, 3). This would ensure that clinicians start to help achieve organisational transformation, traditionally the preserve of general managers, while managers, in turn, shift their focus to the core business of hospitals which is, after all, clinical care and the patient experience, rather than simply financial soundness (Kirkpatrick, Shelly et al. 2008).

This "crossing over" of perspectives would lead to a greater willingness on the part of both clinicians and managers to share responsibility for change, re-alignment of priorities, a dove-tailing of clinical and resource management decision-making, and a greater likelihood for innovation in service delivery (Kirkpatrick, Shelly et al. 2008).

This would not only require a mind shift on the part of clinicians and managers, and changes in their respective behaviours and training, but also the incorporation of clinicians into management teams at different levels within the organisation, and the awarding of formal leadership positions to clinicians on some of these teams. An important change from traditional approaches would be that clinical leaders would assume much greater responsibility for overseeing all the functions falling under their team, including managing the budget, human resources and procurement, as well as taking responsibility for meeting targets.

As Hamilton, Spurgeon et al. (2008, 4) write, "[m]edical engagement is not only about the appointment of a small group of leaders to roles such as medical or clinical director ...Enhanced medical engagement should work towards a model of diffused leadership, where influence is exercised across relationships, systems and culture. It should apply to all rather than a few." Top managers need to create the expectation of clinical excellence and involvement amongst all their clinical staff (Ham 2008): as Hamilton, Spurgeon et al. (2008, 7) explain, "[c]hief executives from high performing trusts understand that only 20 per cent of doctors want to be involved in strategic planning, but expect all doctors to be engaged in improving services for patients." This is what Mountford and Webb (2009) call "distributed leadership," categorising three distinct types and levels of clinical leader (see **Table 1**).

Over the past decade there has been some progress in moving towards distributed clinical leadership. In the UK and the rest of Europe it is not very common for CEOs - what **Table 1** calls "institutional leaders" – to be clinicians, although it is likely in the UK that increasing numbers of clinicians will be appointed to this position in future (Malby, Edmonstone et al. 2011).

However, with the implementation of the clinical governance policy in the UK, quality care was made a statutory responsibility of CEOs and their boards. The board constitutes a clinical governance sub-committee and sometimes a governance directorate, and the CEO and other executive staff are expected to give priority to clinical governance, actively support these activities within the organisation, and facilitate collaboration between clinical and non-clinical managers and their teams. In theory, these provisions should ensure a strong link between corporate and clinical governance.

The "medical director" forms part of this institutional leadership, sitting on the board or senior management team where he or she answers directly to the CEO. It is not only doctors who play this role and a UK study found that in 27 percent of cases the position was filled by the nursing director (Walshe, Cortvriend et al. 2003), while there are indications that nurse clinicians are generally becoming more involved in the management of clinical and operational affairs (Freedman 2002; Bretschneider, Eckhardt et al. 2010).

The medical director typically devotes half of his or her time to leadership and management tasks which include leading the development and implementation of a clinical strategy, providing clinical advice to the Board, setting clinical standards, ensuring alignment between clinical staff and the organisation, ensuring training of clinical staff, planning clinical staff requirements and overseeing disciplinary procedures for clinical staff (The NHS Confederation 2009; Dickinson 2012; The King's Fund 2012).

Table 1: Three types and levels of clinical leader

	Overall identity	Sources of power	Selected leadership skills and knowledge required
Institutional leader	• Clinician executive acting as steward of whole organisation • Little direct contact with patients	• Highly credible to colleagues as clinician and leader, able to communicate vision	• Corporate-level strategic thinking, talent management, succession planning • Political savvy, strong skills in negotiation and influence
Service leader	• Passionate advocate for own service, feels responsible for this clinical and financial performance	• Highly credible to colleagues, primarily as clinician, well connected, can tap into centres of excellence • Innovative, willing to take risks	• Fluent service-management skills e.g. strategy/people development, budgeting • Detailed knowledge of evidence-based medicine in own clinical area
Frontline leader	• Great frontline clinician who focuses on delivering and improving excellent patient care • High level of direct contact with patients	• Passionate about clinical work, credible to colleagues • Close to patients and frontline realities, can see opportunities for improvement	• Understanding of systems- and quality-improvement techniques e.g. process mapping, operational improvement • Self-starter, able to work well in teams

Source: (Mountford and Webb 2009)

Clinical directors, or what **Table 1** calls "service leaders," exist to varying degrees in high-income countries (see **Box 3**). In the UK, clinical directorates were created to engage doctors directly in management, and to balance corporate and front-line expectations for service delivery as part of "service-line reporting" (Cragg, Marsden et al. 2008).

Clinical directors are senior doctors who retain clinical responsibilities but also manage a unit on a part-time basis (in the NHS, usually for around 20 percent of their time) (Dickinson 2012; The King's Fund 2012). In the NHS they were usually part of a management "triumvirate" that included a nurse manager and a business manager although more recently clinical directors tend to form part of a management "duality," together with a business manager (Dickinson 2012). In the Netherlands, it is only a clinical leader and general manager who run the equivalent of clinical directorates, each with different tasks but both remaining equally accountable (Ham 2008). The general manager can either be a nurse or someone with administrative training. In this way, the organisation moves "towards structures where doctors lead

whole areas of the business with support from general managers and specialists such as human resources and finance" (Hamilton, Spurgeon et al. 2008, 7).

Box 3: A comparison of the formal leadership roles of clinicians in some high-income countries

- In **Australia**, the medical and clinical directors are doctors, and doctors also lead each clinical area (such as surgery and medicine) through tightly-managed "clinical networks" which are the most popular institutional mechanism for increasing doctor engagement.
- **Denmark** is more advanced than the other European countries in the formal development of management roles and responsibilities for doctors, with consultants managing clinical directorates, sometimes together with a nurse.
- The **Italian** situation is similar level to that in Denmark in large trust hospitals, but often the clinician manager is sidelined into a 'public health' role.
- The **UK** is less advanced because despite having clinical directorate structures in place at the operational level, many key decisions are taken by general managers.
- The formal set-up of the **French** system is a similar to the UK, although medical participation in management is more recent and less well embedded
- The **Netherlands** presents a mixed picture. Since the 1990s some hospitals are experimenting with divisional-style structures managed by doctors. Other hospitals retain traditional contractual arrangements that keep doctors arms-length from hospital governance.
- The **German** system is again mixed with some hospitals using clinician managers and others not. The representation of doctors at strategic level tends to function through a separate medical board which is less integrated with the executive. However, performance is mostly determined at the departmental level under the leadership of a medical head with strong authority, but within the constraints of set conditions.

Source: (Ham 2008; Neogy and Kirkpatrick 2009)

Clinical directors are expected to participate actively in organisation-wide planning processes as well as re-designing the work of their units, including prioritising activities, ensuring staff training and allocating budgets (Balding 2005a; Dickinson and Ham 2008). They are required to assemble an effective clinical team and work with managers to remove organisational barriers to effective clinical care.

Quality improvements are executed by what **Table 1** calls "frontline leaders." These are clinicians working in integrated health care teams linked closely to clinical support services as well as responsive human resource, financial, administrative and supply chain management systems. Team leadership of these "clinical micro-systems" has been shown by research to be key to achieving high levels of performance (Dickinson and Ham 2008).

Box 4 summarises the clinical leadership structures that resulted from implementing clinical leadership at various levels in a Dutch academic hospital. An important feature of the Dutch example is that the divisional head, who is a clinician, has a

leadership role and is not expected to have personal expertise in all the dimensions of general management. Instead, he or she is provided with adequate support in the form of a non-medical manager to whom financial and other management functions are delegated (Witman, Smid et al. 2010).

Box 4: Clinical leadership management structures in a Dutch academic hospital

- Board of directors oversees hospital.
- Hospital is divided into 10 divisions.
- Each division contains 2-7 clinical departments representing different specialties plus, in some cases, some non-clinical departments.
- Each division is managed by a 2-person management team reporting to the board:
    - A divisional head who is the chairing medical manager (and who also heads one or more departments)
    - A nurse
- A non-medical manager is positioned below this management team.
- Departments have heads who are usually medical professors of a specialty.
- Each department has 4-30 medical specialists.
- Larger departments have sub-departments for sub-specialties.
- Registrars, junior doctors and interns are also part of departments.

Source: (Witman, Smid et al. 2010)

Kaiser Permanente, a large private provider in the US, is held up by several authors as a good example of how clinical leadership has been harnessed and supported (Kirkpatrick, Malby et al. 2007; Ham 2008; Ham and Dickinson 2008). It has invested heavily in developing clinical leadership, reconfigured the management system to align with the needs of management in a professional bureaucracy, appointed up to a quarter of doctors to leadership roles, involved a lot more n quality improvement through developing drug formularies and clinical guidelines, emphasized horizontal or collegial processes of control and coordination, and developed a culture where autonomous professionals accept the need to work in partnership with their peers and managers (Ham and Dickinson 2008).

The Veterans Affairs Administration in the US is also recognised for turning around its quality of care problems through deploying clinical leadership: here, "doctors collaborated with administrators on important clinical decisions – such as how to expand or reconfigure services – in full knowledge of the trade-offs and resource implications" (Mountford and Webb 2009, 3).

Reid, Mash et al. (2011) is the only source identified by this review that comments on the situation in low-income countries. The authors interviewed sixteen generalist doctors who had worked in public or non-profit district hospitals in eight sub-Saharan African countries. They confirmed that clinically doctors working in these settings needed to be competent in a wide range of disciplines and procedural skills, ranging

from emergency through to chronic care. They also provide supervision, training and mentoring to other staff working in the district hospital as well as the surrounding clinics. Further, they act as managers, both in terms of organising quality improvement and continuous professional development activities, as well as more general human resource management, including conflict management. They have to provide leadership with respect to immediate clinical problem-solving as well as strategic guidance around how to implement plans emanating from the district office at the hospital level. One interviewee described the leadership role thus: "It's like a sort of puppet master: you pull strings and make sure that everybody is in the right place at the right time" (Reid, Mash et al. 2011, 6)

Overall, successful clinical leadership models appear to be based on open and inclusive communication as well as collaborative leadership styles that rely on influence and mediation (sometimes called "influence-ship") rather than "command and control" (Walshe, Cortvriend et al. 2003; Ross, Edmonstone et al. date unknown). They allow clinical input into decision-making at all levels and facilitate clinical leaders' understanding of the strategic direction of the health service "so that they can contextualise their clinical governance role and that of their department or unit" (Balding 2005b, 355). They reconcile professional aspirations with resource availability, facilitate and support clinical self-management, achieve change through motivating clinicians and encourage clinicians to shift from focusing only on their own clinical practice, creating a greater alignment between the managerial and clinical objectives of the organisation. This is done "by making sense of the clinician's agenda for managers" (Kirkpatrick, Shelly et al. 2008, 31). It is these cultural and behavioural changes to leadership and management that are probably more important than the creation of formal clinical leadership structures (The NHS Confederation 2009).

Almost all of the literature emphasises that successful clinical leaders continue with part-time clinical work, certainly up to clinical director level and even at medical director level, although this is the level at which clinicians find it difficult to balance both the clinical and leadership demands of their position. Even CEOs may retain some clinical interest, although a study of the NHS found marked differences in the amount of clinical work done by different CEOs, ranging from none to two days per week (Ham, Clark et al. 2010). As explained earlier, clinical work is the source of clinicians' strength as leaders and acts as a reality check with regard to what is happening in the health system. Clinical work also provides them with "personal" or "expert" power and helps to preserve their credibility with the clinicians they lead. Clinical work provides clinical leaders with the stimulation of seeing patients and maintains their clinical careers as a safety-net in the event of their not being able to continue pursuing a leadership career (Ham, Clark et al. 2010).

B4. Barriers to clinical leadership

While one can make the case for clinical leadership, in reality clinicians wishing to take on formal leadership roles face many obstacles. They are usually poorly prepared for their leadership roles and have little time to undertake leadership

training as they still do clinical work: when they are able to set aside time for training, they prioritise clinical training (Kirkpatrick, Shelly et al. 2008).

There are few material incentives to become a clinician-leader: doctors with management functions may suffer financially as they are less well paid than those that achieve seniority through the clinical route, and suffer professionally as they have more restricted career pathways and options (Ham 2008; Mountford and Webb 2009). Organisational support is often weak and clinical governance processes under-resourced (Walshe, Cortvriend et al. 2003; Kirkpatrick, Malby et al. 2007; Cragg, Marsden et al. 2008) and other doctors do not recognise clinical management as a specialty (Ham and Dickinson 2008). This is partly as a result of a medical culture that does not value clinical leadership and management roles but also because it is relatively difficult to describe leadership functions and activities coherently (Ham and Dickinson 2008; Kirkpatrick, Shelly et al. 2008).

Further, clinical leaders often battle to reconcile the competing pressures of their dual allegiances to other clinicians and to the management hierarchy (Witman, Smid et al. 2010): this applies to doctors just as much as it does to nurses (Firth 2002). The former allegiance requires clinicians to prioritise the immediate needs of individual patients, engage in a collegial fashion with other clinicians and remain loyal to the group, while the latter allegiance requires them to exercise financial discipline, monitor the standard of care and censure inappropriate behaviour (Edmonstone 2009). The less they engage in clinical work, the harder it is for clinical leaders to maintain the respect of their clinician colleagues because, as explained earlier, this respect is based on their clinical knowledge and contributions, not on their formal position of authority (Witman, Smid et al. 2010). Other clinicians can also treat clinical leaders as if they have "gone over to the dark side" by enlisting in the ranks of management even though these leaders themselves experience persistent tensions with managers (Hamilton, Spurgeon et al. 2008; Ham, Clark et al. 2011).

Finally, clinicians can feel reluctant to participate wholeheartedly in leadership activities because of confusion regarding the meaning and implications of the concept of clinical governance (Som 2009) or they do not trust the concept and strategy of clinical governance (see **Box 5**).

The literature does not say much about how career managers react to clinicians assuming greater leadership roles, or about how nurses and doctors in particular accept one another as leaders, but presumably changing power relations between different stakeholders within the hospital, and the long-standing problem of "silos" in the management hierarchy – with different health professionals and administrative functions (such as human resources and financing) reporting in separate, parallel structures to senior management – can also act as barriers to achieving successful clinical leadership (Hackett, Lilford et al. 1999).

All these obstacles mean that clinical leaders can become disenchanted with their formal leadership roles and it is sometimes difficult to attract them to positions such as Clinical Director (Cragg, Marsden et al. 2008; Dickinson and Ham 2008; Ham and Dickinson 2008). In addition, clinicians "are [not] always willing to perform as managers in the ways anticipated by policy makers" (Neogy and Kirkpatrick 2009) and, at worst, are able to confound the efforts of managers who try to transform their hospitals through top-down approaches (Swanwick and McKimm 2011).

Box 5: Clinician attitudes that act as barriers to engaging in clinical governance efforts in the NHS

- Reluctance to engage in change given the enormous changes the health professions experienced in the 1980s and 1990s
- Suspicions that scarce clinical time will be invested in the bureaucratic dimensions of clinical governance systems at the expense of direct patient care
- A concern that clinical governance systems strictly based on evidence, guidelines and protocols will discourage individualized clinical judgments and stifle innovation
- Frustration with unsuitable guidelines and poor management, together with a lack of time, leading to a "why bother?" attitude
- Perception of clinical governance systems as a vehicle for "managerialism" with "performance" reduced to simply controlling costs
- Ambivalence towards self-regulation being replaced by a management culture of accountability, hierarchy and control

Source: (Hackett, Lilford et al. 1999)

B5. Strengthening clinical leadership

The leadership and management strengthening framework of the World Health Organisation talks about the need for adequate numbers of managers, managers with appropriate competencies, functional support systems for managers, and an enabling working environment (World Health Organisation 2007). All these elements apply to the development of clinical leadership, especially as leadership is acknowledged as a core competency for health professionals in an increasing number of countries (Stoller 2013).

Aspirant clinical leaders will need training and mentorship (Swanwick and McKimm 2011; Ross, Edmonstone et al. date unknown). The leadership and management training already offered to clinicians at postgraduate level in several countries, notably Denmark and the UK (Malby, Edmonstone et al. 2011), will increasingly need to be incorporated in undergraduate training. While partnering with Business Schools can be useful, "the substantial differences between leadership for [public] health systems need to be acknowledged and addressed ... Consequently, the predominant models of leadership education for rural clinicians are shared, distributed, multi-disciplinary and transformational rather than directive" (Doherty, Couper et al. submitted 2013).

Ongoing mentoring of aspirant leaders in the workplace also needs to be provided, including mid-career support (Ham, Clark et al. 2010). Innovative training methods and curricula need to be deployed, given the nature of leadership requirements in health care organisations, and inter-professional communication and learning in the workplace also needs to be nurtured (McKimm 2004; Swanwick and McKimm 2011). Likewise, clinical leaders need to develop an understanding of health systems and

their functioning, "and must be comfortable working both within, and with, these systems for the benefit of their patients" (Swanwick and McKimm 2011, 22).

The support of top-level hospital management is critical to the development of clinical leadership but Balding (2005b, 353) emphasises that it only works "if it is enacted in a way which empowers clinical and non-clinical managers to build accountability for safety and quality improvement more effectively into their organizational structures and routines." CEOs need to be willing to delegate power and responsibility to clinical leaders and nurture productive relations between clinicians and management, creating an enabling environment for clinical leaders to function well and to assist the hospital in achieving its objectives. As one United Kingdom CEO said when interviewed, "I view my role as managing the culture, as opposed to managing the business ... clinical change must be led by clinicians ...the top team, whoever they are in an organisation, have to give the influence and the power away in order to get it back" (Kirkpatrick, Shelly et al. 2008, 32).

Further, clinical leaders should be valued by the organisation, including receiving adequate financial rewards and being offered career paths that allow them to combine management with clinical work, as well as to move in and out of leadership roles (Ham 2008). The support of their colleagues is important, as they "may require the input and encouragement of their peers both from within and outside the organization, and are likely to be influenced by the example of their colleagues when deciding their level of involvement" (Balding 2005b, 355). Administrative back-up is also vital to enable clinicians to fulfil both their leadership and clinical responsibilities (The NHS Confederation 2009).

Lastly, placing clinicians in leadership positions is not a "magic bullet": it is very important to ensure that appropriate people fill these positions – with the necessary leadership traits and skills, and the ability to adapt their leadership styles and focus to the contingencies of local circumstances (Ham, Clark et al. 2010).

PART C: RELEVANCE OF CLINICAL LEADERSHIP TO SOUTH AFRICA

C1. Background to the public hospital sector in South Africa

South Africa is an upper-middle income country characterised by severe inequities that persist between socio-economic groups and geographic regions, even beyond the apartheid era (McIntyre, Doherty et al. 2012). Under apartheid, hospitals were racially segregated and concentrated in urban areas, and lower levels of the hospital system were particularly under-developed (Doherty, Thomas et al. 2002).

Since the demise of apartheid, the National Department of Health has placed emphasis on equitable resource re-allocation and on developing the district health system. There have also been attempts to expand hospital infrastructure and revitalise referral hospitals. While there have been successes in extending primary health care coverage and achieving more equitable inter-provincial resource allocation, considerable inequity remains and there are significant quality of care problems in both primary care services and the public hospital sector (Doherty, McIntyre et al. 2000; Doherty 2008; Heunis and Janse van Rensburg 2012; McIntyre, Doherty et al. 2012).

Enormous funding, staffing and management challenges persist for public hospitals (Heunis and Janse van Rensburg 2012). In addition, until relatively recently, district hospitals remained somewhat sidelined as the process of district health systems development tended to concentrate on the expansion of primary care services and the setting up of district management teams (McCoy 1998; Strachan 2000). However, as discussed later, there are examples of well-functioning district hospitals, even in some poorly resourced rural areas, which poses the question of how such institutions are able to succeed while others remain crisis-ridden.

A new draft policy on National Health Insurance envisages a major role for public hospitals in extending health care coverage and points to the need for significant upgrading of public sector hospital services, especially at district level (Department of Health 2011). As discussed further below, the improvement of hospital management is seen as one of the main strategies for turning around public hospital performance.

A large for-profit private hospital sector exists alongside the public sector but serves less than a fifth of the population (McIntyre, Doherty et al. 2012). While these hospitals are perceived to be better managed and provide better quality of care, they are very expensive and are unaffordable for the majority of the population.

C2. Problems with public hospital management in South Africa

Extensive problems with public hospital management in South Africa were identified in 1996 by the Hospital Strategy Project, a national initiative of the first post-apartheid National Department of Health that involved all nine provincial departments

of health as well as other experts (Monitor Company, Health Partners International et al. 1996c). The main problems identified by the Project are summarised in **Box 6**.

The wide-ranging management transformation strategies suggested by the Project have since only been implemented piecemeal by national and provincial departments of health (Heunis and Janse van Rensburg 2012). Despite localised initiatives to improve management, such as several projects by the non-profit Health Systems Trust, the Lean Institute Africa of the University of Cape Graduate School of Business and the Council for Health Services Accreditation of Southern Africa, many hospitals continue to be under-resourced and poorly managed (Stack and Hlela 2001; Salmon, Heavens et al. 2003; von Holdt and Murphy 2005; Pillay 2008; Pillay 2008; Versteeg, du Toit et al. 2013).

While there have been instances of greater authority being delegated to CEOs, especially in the largest hospitals, centralisation of authority at the level of the provincial departments of health or district management team remains an obstacle to achieving more dynamic leadership and management at many hospitals (Couper and Hugo 2002; Harrison 2009; Doherty 2011; Reid, Mash et al. 2011; Heunis and Janse van Rensburg 2012). This is compounded by the fact that there is a high turnover of hospital CEOs resulting in many hospitals being led by inexperienced senior managers. In addition, administrative systems remain weak, a persistent feature of much of the public sector (Gilson, Doherty et al. 1999).

Box 6: Key management problems identified by the Hospital Strategy Project

- Hospital managers have inadequate authority to actively manage their institutions
- Budgets are often so unrealistic that they are not taken seriously by hospital managers
- Personnel management systems are slow and unresponsive
- Training, career paths, remuneration and job satisfaction are inadequate to attract, retain and motivate good hospital managers
- There is systematic underdevelopment of management skills and operational systems
- Existing management structures, which separate the accountability structures of nurses, medical staff and general workers, prevent appropriate and efficient general management by a single management team
- Several of the key hospital management functions, such as procurement, maintenance and transport are located entirely outside of the health sector
- The lack of legitimacy and authority of hospital boards eliminates accountability to patients and communities

Source: (Monitor Company, Health Partners International et al. 1996c)

Under-resourcing, poor management and other problems have led to a widespread perception that public hospitals often provide poor quality care, especially in rural areas, as evidenced by sustained media attention to this issue. The problem is not confined to rural and under-resourced settings, however: public dissatisfaction with the quality of patient care at public hospitals led to a public inquiry in the province of Gauteng in 1999 (Commission of Inquiry into Hospital Care Practices 1999) and

2013 sees another concerted drive for public debate around the reasons for poor hospital performance, especially poor quality of care (Section 27 and Treatment Action Campaign 2013; The Editor 2013).

The current climate has seen a renewal of efforts by government and others to address the management problems in public hospitals and shift the attention of CEOs and other managers towards quality of care issues (Doherty, McIntyre et al. 2000). These include sharing the lessons learned at successful sites (Couper and Hugo 2002; Doherty 2011; Doherty and Gilson 2011), assessments of the management skills of hospital CEOs (Development Bank of Southern Africa 2011) and district hospital performance (Health Systems Trust 2012) commissioned by the National Department of Health, the publication of a new hospital management policy that creates new designations for hospitals and outlines skills requirements for CEOs (National Department of Health 2012a), the publication of national standards for health care organisations (National Department of Health 2011), the setting up of an Office for Health Standards compliance (Republic of South Africa 2011), and the recent launch of an Academy for Leadership and Management in Health Care (National Department of Health 2012b).

However, most of the efforts since the Hospital Strategy Project have focused on improving the general management of hospitals, especially at the level of the senior management team. Where there are systematic efforts to address quality of care issues, such as through the Council for Health Services Accreditation of Southern Africa and the activities of the nascent Office of Health Standards Compliance, these tend to focus on identifying standards and setting up structures and procedures that tackle problematic elements of care (such as record-keeping, waiting times for collection of pharmaceuticals or turn-around times in theatre, and hygiene control). While these may have an impact on elements of care (Mayhew, Doherty et al. 2008; Doherty and Gilson 2011), there do not seem to have been concerted attempts to address the clinical process as a whole, including configuring comprehensive clinical governance systems and developing integrated clinical teams.

Neither has there been much progress with the decentralisation of management authority and responsibility *within* the hospital. In larger hospitals a number of "medical managers" may report to the senior "clinical manager:" this has achieved deconcentration of management tasks but does not represent a shift of real management authority to lower levels in the hospital. Some would also contend that these management tasks remain largely administrative in nature, given that even CEOs do not have the authority to make important decisions, such as "hiring and firing." As Bennett, Corluka et al. (2010) put it, CEOs in the South African public sector are not CEOs in the way that the term is ordinarily understood in the private sector, but rather departmental functionaries in an administrative hierarchy (Bennett, Corluka et al. 2010).

A documented exception is the Chris Hani Baragwanath Hospital Transformation Project (Doherty 2011) which is described in more detail later but was able to achieve both real decentralisation of management authority and set up improved clinical governance systems: however, this project was discontinued in 2010. There are also some examples of the creation of cost centres, especially at larger hospitals (such as Universitas in the Free State (Gilson and McIntyre 2008)), which have sought to introduce decentralised management of clinical departments, but the

nature, impacts and sustainability of these efforts have not been documented. Of course, there are other individual hospitals where dynamic leaders are managing to improve the quality of care, as discussed later, but these are highly dependent on the individuals concerned and their achievements remain fragile in the face of a high turnover of staff (Couper and Hugo 2002).

The recently published national standards around quality of care have, as one of the indicators of success, that "[h]ealth professionals are appointed as heads of department/sections, with clear job descriptions and lines of accountability" (National Department of Health 2011, 22). However, this document does not clarify the level of autonomy these heads would enjoy or whether doctors, nurses and administrative managers within clinical departments would report to the departmental head instead through traditional line-management structures. Under the silo system, doctors, nurses and administrators report in separate lines to the CEO, and then wait for decisions to travel and up down these hierarchies before change can be implemented (Doherty 2011). There is also no single "locus of control" that integrates decision-making and authority at the level of the department, unit or ward. As the international literature suggests, both these problems make it difficult to find sustainable solutions to quality of care problems.

One reason for the seeming reluctance to tackle the clinical process head-on may be that, at least in the inpatient setting, it is seen as the preserve of doctors and that, additionally, the medical profession is perceived to be resistant to behaviour change. Thus, in speculating as to why clinical outcomes had not been demonstrably improved at hospitals in the province of KwaZulu-Natal that were undergoing the accreditation process, Salmon, Heavens et al. (2003, 17) state that "it is more likely that those standards that hospital staff found 'easier' to implement because they did not require doctors' involvement or ongoing attention – such as writing job descriptions, posting procedures, and so on – were the ones that changed first," as opposed to those that impacted in an integral way on the quality of care.

This explanation does not consider the option that doctors feel alienated by the accreditation approach and process, especially where it focuses on the presence of checklists and procedures, rather than on measuring actual changes in patient outcome. Indeed, Harrison (2009) notes that many senior clinicians feel excluded from decision-making in public hospitals and identifies this as one of the problems that need to be rectified before hospital performance can improve.

It might also be that the silo system is so ingrained and unwieldy that it is difficult to contemplate addressing the clinical process in a holistic fashion, particularly as it innately requires decentralised decision-making by integrated teams (Strachan, Davids et al. 2001; Doherty 2011).

In truth, the obstacles to quality improvement are many and varied, and it is indeed very difficult to measure the impact of any intervention on the quality of care. However, the examples below show that where there is strong clinical leadership, and where clinical and managerial objectives and activities are well-integrated, prospects for improving clinical governance seem better, even in poorly-resourced South African settings.

C3. Local examples of the positive effects of clinical leadership

Some examples of successful clinical leadership in public sector hospitals in South Africa exist even in poor, rural communities. Some of these cases are district hospitals where "the commitment of the staff is often passionate and dedicated, and the integration of the hospital into the community complete" (Clarke 1998, 6).

These examples show that such hospitals rely on dynamic leaders that operate at all levels of the facility, mobilising and co-ordinating clinical and non-clinical functions on a daily basis through strong interpersonal relationships and communication systems, and with a clear focus on patient care (Strachan, Davids et al. 2001; Couper and Hugo 2002; Puoane, Cuming et al. 2008; Doherty 2011; Doherty and Gilson 2011). The contributions of clinical leaders are often identified as important, even transformative, although cultivating clinical leadership is seldom identified as a specific strategy for improving hospital performance.

For example, Strachan, Davids et al. (2001) found in interviews with fifteen hospital superintendents who felt they had successfully implemented change, that they had made it their business to support their clinical staff actively, including attending ward rounds on a regular basis. This was despite the constant struggle they faced in balancing their administrative duties with their own clinical duties.

Focussing on four successful district hospitals in KwaZulu-Natal and North West Province, Couper and Hugo (2002) found forms of non-hierarchical leadership that tended to develop an ethos of teamwork, collegiality, good interpersonal relationships, continuous inter-professional and intra-professional communication, problem-solving, staff development and commitment. In some of these hospitals, the senior management team included clinical heads, and there was an emphasis on trying to solve problems at the level of the unit or ward so that they did not need to be taken to a higher level. One hospital developed quality improvement teams for different units: their job was to identify aspects that needed to be improved and to work with staff to implement change. Couper and Hugo (2002, 29) note that "[t]he success of these projects encourage staff and build them up, because they own them – they are not imposed from outside."

Doctors in these hospitals played a vital role as leaders, not only as members of management committees at the hospital and even district level, but also as role models and mentors. As one interviewee noted (Couper and Hugo 2002, 47):

> I think the attitude of the medical staff actually helps a lot with the whole hospital as well, in that they are in a leadership position even when they don't want to be. A lot of the [medical] staff don't see themselves directly as leaders, but the way they behave, the way they treat patients and their attitudes to their work, does set the tone.

The importance of clinical prowess in gaining and maintaining respect as a leader is highlighted by the same study in the following quote by the head of a successful district hospital who was asked by his predecessor to take over the leadership of the hospital (Couper and Hugo 2002, 47):

My immediate thought was: I'm very happy as a doctor in the wards and looking after a clinic and doing my normal chores. And I'll never forget [his] words. He said that your success as superintendent and as a leader in a hospital like this is not measured by your qualification as an administrator, but your qualification as a clinician - you are accepted as a good superintendent by the staff ... I didn't have any problems with being accepted as a superintendent, young as I was … the staff support you because of your clinical style or your clinical success, therefore they'll support you as an administrator.

In studying the reasons why four rural hospitals in the Eastern Cape performed differently in the care of malnourished children, despite ostensibly similar resources and training around malnutrition, Puoane, Cuming et al. (2008) concluded that there were clear differences in institutional culture explained by differences in leadership, teamwork and managerial supervision and support. These differences meant that the presence of clear clinical guidelines and external training were insufficient to protect the quality of care. Interestingly, nurse clinicians played an important role in guiding young or inexperienced doctors and senior nurse managers were instrumental in providing strong leadership that motivated staff and created a sense of belonging to a team. Important steps in monitoring the quality of care – such as case reviews – included the whole clinical team, while mutually respectful relationships were maintained between different health professionals.

Lastly, an evaluation of the Chris Hani Baragwanath Hospital Transformation Project in Gauteng records an experiment to decentralise management authority to the clinical head of the surgery division, and to strengthen the integrated leadership of wards by nurse managers (Doherty 2011). **Box 7** summarises the strategies that contributed to the successes of this experiment which its implementers claim led to an array of improvements in the quality of care, as well as improved efficiency and staff morale. An unusual aspect of this project was the integral part played by unions in designing and implementing the project.

As all this local evidence makes clear, in successful hospitals clinical leaders are able to play transformative roles, both in terms of their contributions to clinical governance as well as to the wider development of hospital staff and systems. In these settings, collaboration between different sorts of health professional, as well as between health professionals and administrators, is the norm (Doherty and Gilson 2011).

Box 7: Lessons from the Chris Hani Baragwanath Transformation Project

Decentralisation:
- Authority was decentralised first to the hospital CEO and then to the Head of the Surgery Division.
- Under the divisional head, the management hierarchy was flattened to one or two levels (for the nursing, medical and administrative functions).
- Each level was given decentralised authority and accountability for a set of operational matters (up to a pre-defined limit).
- This resulted in rapid decision-making that was responsive to needs on the ground.
- For the Surgery Division, the central hospital management relinquished control of operational matters in order to focus on policy, strategy, resource allocation, support and monitoring and evaluation (although this was contested by some senior managers).

Clinical leadership:
- The divisional head was a practising surgeon with an international clinical reputation who took on the leadership function in a part-time capacity.
- The head assumed accountability for running the division, including the ability to hire and fire.
- Administrative competency for the division was provided by a strong, integrated management team that supported the head.
- A divisional manager was responsible for coordinating the daily activities of the division, under the leadership of the head.

Integration:
- Each manager (nursing, medical and administrative) reported to the head of the division, rather than their counterparts in central hospital management.
- These managers worked cooperatively in join committees.
- This broke the pattern of working in silos and integrated all functions under the leadership of one person, the head, who then reported to the CEO.
- Likewise, in the wards, ward managers assumed full responsibility for coordinating activities within the wards, from those carried out by cleaners to those carried out by doctors.
- The management team of the division worked closely with the trade unions represented in the hospital to improve human resource policy and management.

Reorientation of management towards patient care:
- Decentralisation, clinical leadership and integration together re-oriented decision-making in the service of patient care.
- This was aided by the fact that senior divisional administrative staff were brought into close contact with the process of health care delivery, through participation in committees that include health professionals, by locating administrative offices right next to wards and by sending administrators out to the wards on a regular basis to assess needs.

Increased leadership and management resources and skills:
- The Project argued that the hospital was under-staffed not only in terms of clinical staff but also in terms of skilled managers, and therefore expanded the number of managers (but not the levels of management).

Source: (Doherty 2011)

C4. Exploring clinical leadership in the South African context

The limited local evidence on this topic suggests that the concept of clinical leadership as it is expressed in the international literature - as central to clinical governance and improving hospital performance - may be productive for the transformation of South African public sector hospitals. It has the potential to address the structural cause of inefficient and poor quality care, namely, overly centralised, bureaucratic and unresponsive decision-making, and an organisational culture that is focused on administrative concerns.

Clinical leadership has the potential to transform underlying values and management processes by placing the provision of good quality care at the heart of an organisation's management efforts, creating an organisation-wide shift in management culture, building management systems that support the clinical process actively, drawing on the leadership potential of clinicians, releasing potential innovation through unifying the efforts of managers and clinicians, and strengthening the accountability of the whole organisation to delivering good quality care.

Yet South African hospitals may have important differences from the facilities in high-income countries which generate most of the clinical leadership literature. Obviously there are fewer resources in South Africa, and staff shortages and skills deficits are particularly problematic, but there are more subtle factors – such as differences in organisational culture and the level of decentralisation – that might be equally important considerations. The role of district hospitals in particular may be much more extensive than that of their high-income counterparts, responsible as they often are for developing and supporting the surrounding primary care services.

Further debate and research is required to understand how these differences may affect the relevance of the clinical leadership concept. Some important issues to consider in this debate are identified below.

C4.1 Can other clinicians fulfil the same clinical leadership roles as doctors?

The large majority of the literature explores the role of doctor clinician and much less is said about other categories of health professional, although the role of clinical nurse leaders is growing. In South Africa there is a shortage of doctors and other health professionals, especially nurses, already play an enormous clinical leadership role at the primary care level and inpatient setting.

Further, different types of health professionals may be better placed to take on leadership roles at different levels within the clinical governance process and parts of the hospital. For example, in the Chris Hani Baragwanath Transformation Project, nurses were given the authority to manage all aspects of the ward, including cleaning and clerical services, with doctors expected to report to them before conducting ward rounds: this empowered nurses at the ward level to have a direct impact on efficiency and quality of care, even though the head of the management team for the surgery division (where the project took place) was a doctor (Doherty 2011).

It needs to be remembered, though, that doctors tend to have more professional status and "clout" within a hospital which might make it easier for them to negotiate

change with certain stakeholders, especially in larger hospitals. They may also have more appropriate clinical knowledge for leading certain units or departments and research suggests that "doctors have the most influence when it comes to implementing operational changes that can lead to improved performance" (Hamilton, Spurgeon et al. 2008, 5).

In addition, there is some evidence – both from South Africa and the UK – that the former strength of the ward-based clinical team may be waning. Doctors are increasingly responsible for a range of patients and interns or registrars across different wards while ward nurse managers are often spending too little time on clinical care, consumed as they are by administrative concerns (Strachan, Davids et al. 2001; Olsen and Neale 2005).

It would be useful for further South African research to identify what the peculiar strengths are of different types of health professionals and where and when these might be most useful in providing clinical leadership.

C4.2 Do clinical leaders need to be practising clinicians?

Many CEOs and clinical directors in South Africa are clinicians who no longer undertake clinical work, especially in the larger hospitals. While these people may play important roles in facilitating clinical practice, they belong to the administrative structures of the hospital and, as the literature suggests, have a fundamentally different perspective from clinicians.

As discussed earlier, the literature suggests that those professionals leading the clinical process should be practising, at least for part of their working week, because this keeps them answerable to patient care even whilst they attend to the administrative needs of their line manager. Clinical practice is also the source of their authority in the professional hierarchy: if they become divorced from clinical realities they risk being seen as a defector to management and losing their influence with clinicians (Witman, Smid et al. 2010).

These assertions need to be tested but in the case of the Chris Hani Baragwanath Transformation Project it was clear that doctors in purely managerial roles were not able to exert their authority over the senior doctors obliged to report to them because of their limited clinical experience and effectively junior position in the clinical hierarchy: this meant that senior doctors went "over their heads" to lobby the CEO directly (Doherty 2011).

Nurses who manage wards are in a different position, however, as they are in close daily contact with the needs of patients and patient care, including through participation with doctors in daily rounds. Their suitability as clinical leaders may depend more on their personal characteristics, experience, integration with the rest of the health care team and formal authority, than on a clinical role of their own.

These differences highlight the need to develop a more detailed understanding of how current involvement in clinical practice affects leadership ability and status. However, whilst making room for excellent leaders who are not clinicians (or who are no longer clinicians), the concept of clinical leadership remains focused on maximising the leadership potential of clinicians, for the reasons described earlier.

C4.3 Do clinical leaders need to be the head of a management team to effect change?

Clearly clinicians can effect change through many mechanisms, some of which are informal. Some formal mechanisms may be limited to participation on management committees or leadership of elements of quality improvement programmes, such as clinical audits. However, some of the literature suggests that, in order to achieve a fundamental shift in the clinical process and marshal other hospital functions in support of this process, clinicians need to head decentralised management teams (at the level of departments and units). This implies that nursing managers and administrators would report to their departmental or unit clinical head, rather than to the senior nursing manager or administrator at the level of the hospital executive. This was what was implemented at Chris Hani Baragwanath Hospital (Doherty 2011) but there are other success stories where teamwork between different elements of the hospital hierarchies was able to overcome the disadvantages of a silo structure without having to formally dismantle it (Couper and Hugo 2002; Doherty and Gilson 2011).

Further investigation is required to assess which model is most practicable and effective, keeping in mind that greater decentralisation may be needed in larger hospitals in order to "flatten" the management hierarchy, whereas in small hospitals it may be easier to create direct communication between all members of the health care management team, and instil a collaborative culture, without formally breaking the management silos that presently exist. As one district hospital clinician reported when interviewed, "in a small hospital one needs each other more and more, or more than one would in a bigger community, and the number of choices for friends and relationships are so much smaller and the resources are stretched, so you rely on each other heavily, so relationships run deep" (Couper and Hugo 2002, 13).

A principle to remember, though, is that it is possible for a doctor "at least theoretically, [to] amass knowledge of the management world, but a non-medical manager cannot amass medical knowledge" which makes it inherently difficult for a professional manager to manage the clinical process (Witman, Smid et al. 2010, 478). This lies behind the argument by Witman, Smid et al. (2010, 491) for "bring[ing] the formal hierarchy of the hospital organisation more in line with the informal professional hierarchy, for instance in the appointment of doctors in the lead as medical managers." However, the literature does not explore adequately whether transformation of management training approaches, and the institutionalisation of teamwork in hospitals, would not substitute for this shift.

C4.4 Do clinicians have the skills to be leaders and managers?

During apartheid, the heads of hospitals had to be doctors. Almost no training was available for these doctors and they were sometimes very indifferent managers: this was partly responsible for changes to the legislation in the late 1990s which opened up CEO positions to other professional backgrounds, including non-clinicians. Many of these new CEOs have also not performed well, highlighting the fact that training and management experience, as well as leadership qualities, are required for

anyone fulfilling a leadership role. This informs recent moves by the National Department of Health to ensure that all CEOs receive formal training.

However, in poorly-resourced hospitals it has already been shown how central clinicians are to effective management of the clinical micro-systems within the hospital. Already, many public sector doctors, especially those at a senior level, are in fact performing complex managerial tasks on a daily basis, especially with respect to managing limited resources. While many may not be suitable for, or interested in, more formal roles, there are other highly credible professionals who may already be able to take on management positions at various levels of the hospital, or be ideal for other leadership roles in the clinical governance process.

The debate should therefore perhaps focus on identifying the characteristics of, and the formal and informal requirements for, good clinical leaders, differentiated by their professional background, place in the organisational and professional hierarchy and the specific demands of their job.

One of the reasons that decentralisation efforts are often stymied is a fear that lower levels in the system do not have sufficient capacity, opening up government to the risk of under-performance, including financial mismanagement: therefore appropriate capacity-building for leadership needs to be developed, including mentorship in the workplace. Fortunately, postgraduate training in management is now becoming more widely available in South Africa but it remains to be seen whether this is also able to support on-the-job training.

C4.5 Will clinician leadership lead to "medical dominance"?

One of the difficulties of discussing who should lead decentralised hospital management teams is that it provokes professional rivalries. This is particularly so when suggesting an elevated role for doctors, given that other professions – particularly nurse and career managers – have long struggled to have their critical contributions to health care properly acknowledged. The nursing and administrative professions also have a stake in promoting "managerialism," however, which means that they are not entirely disinterested participants in the debate.

It will be critical to disentangle arguments for and against clinical leadership that are based on narrow professional interests from those based on the best interests of patients and the health system. It will also be important to understand how the skills and aspirations of different professional groupings can be satisfied by transformed management structures and processes, and to highlight the fact that well-functioning management systems are likely to benefit the majority of health workers and administrative staff, even while they may challenge the power of a few individuals, especially those currently on the senior executive management teams. It may be useful to advertise how senior executive management teams could themselves benefit from clinical leadership through bein relieved of many of the day-to-day operational concerns, including dealing with multiple lines of reporting, and freed to focus on their core strengths.

C4.6 What is the role of the professional health care manager in relation to clinical leaders?

If clinicians take on more leadership and management roles – such as running decentralised units where all staff within the unit report to them – the question then arises as to what the role of the health care manager would be, both at the level of the CEO and within the clinical unit, as well as the leadership style that such managers should adopt.

There is very little literature on the role of managers under a system of strong clinical leadership, but there is a growing interest in this issue (Hackett, Lilford et al. 1999; Ovretveit 2005; Ham, Clark et al. 2011). Further investigation is required but senior management teams have special skills in providing overall strategic direction, ensuring standards are met and providing support to clinical teams. Re-conceiving this support – at both a senior and middle-management level - as facilitating clinical decision-making, rather than controlling the behaviour of clinicians, is necessary to achieve the full potential of clinical leadership. Witman, Smid et al. (2010, 492) note that, in adjusting their priorities to include not only concerns of efficiency and financial soundness but also the quality of clinical care, it is essential for hospital managers to actively create an "institutional ethic" that ensures that "the professional conscience of the medical world plays a significant role in the organisation to protect the trust in doctors and hospitals." A critical issue to explore in the South African context is how supply chains can be developed in support of the clinical process (Doherty, McIntyre et al. 2000).

Traditional management training programmes and mentorship would need to acknowledge, and respond to, this shift. Under a changed conceptualisation of general management, it could well be possible to integrate clinical and managerial concerns more easily, and to develop a management style that is oriented more to facilitating the clinical process. While managers are often criticised, recent research on the NHS emphasises that, as a result of reforms over the past two decades, it is not so much over-managed as over-administered: the research cautions against demonising managers in the process of trying to raise the level of participation of clinical leaders, as both cadres need to be developed (The King's Fund 2012). In South Africa, the Chris Hani Baragwanath Transformation Project also argued that the number of management posts was woefully inadequate and spent considerable funding on strengthening these echelons, even whilst at the same time positioning them under the leadership of a clinician (Doherty 2011).

C4.7 Can the private for-profit sector provide lessons for improved clinical leadership?

In South Africa, for-profit private hospitals are generally perceived to provide better quality care than their public sector counterparts, while remaining financially viable. Private sector CEOs have full autonomy, unlike in the public sector, which gives them more flexibility to manage their institutions efficiently. Doctors working in these hospitals are independent practitioners with considerable autonomy over the care of their patients. The question therefore arises whether, under these potentially more favourable circumstances, good models for effective clinical leadership have

evolved. This is certainly worth investigating, although researching the for-profit private sector is difficult given that very little information is in the public domain.

It should be remembered, though, that there are other contextual factors that may constrain the usefulness of the for-profit experience. The private hospital focuses on the needs of individual paying patients rather than the wider catchment population, and is not involved in the development of other parts of the health system. This changes the leadership roles that clinicians need to play. There are also financial incentives for over-servicing that could affect the integrity of clinical leadership. Indeed, problems with the quality of care at some private hospitals are also reported in the press. This means that the differences in the ethos that prevails at public and private hospitals in South Africa need to be well-understood before comparisons can be drawn.

Unfortunately, the international literature on good clinical leadership does not tease out these differences between public and for-profit private settings. However, it is apparent that good clinical leadership can exist in both settings, as testified by the example of Kaiser Permanente quoted earlier. When examining these examples, if should be remembered that, in countries like the US and the Netherlands which are well-known for their strong private sectors, these sectors are much more closely regulated than in South Africa (Doherty, Gilson et al. 2002).

PART D: CONCLUSIONS

This review suggests, on the basis of the international literature, that decentralised clinical leadership may be a good strategy for galvanising quality and efficiency improvements that are required to ready public hospitals for National Health Insurance. Importantly, this does not simply mean putting in place a set of structures, standards and activities to oversee quality improvement: it is about a new ethos for organising and leading the clinical process.

Exactly how clinical leadership should be effected in the South African context needs further investigation and debate. The international literature on this subject has only emerged in the last decade and is incomplete. Further, how the development of good clinical leadership acts in unison with other decentralisation initiatives, or as a counterpoint to some of the commercialising tendencies of the New Public Management, is not well documented.

The degree to which useful comparisons can be drawn with South Africa are not known, given the different circumstances that prevail. The local evidence for successful reform of clinical governance in hospitals is very thin and, where it exists, sometimes controversial.

However, hospital management systems in South Africa are weak. The political sustainability of National Health Insurance rests on the delivery of good quality care in the public sector: while national standards and more competent hospital CEOs are vital to guide change in public hospitals, it is at the level of the ward and clinical section that quality improvements will be generated on a daily basis. Clinicians

already play a pivotal role in sustaining hospital services. This is especially so in poorly-resourced areas: thus, in rural district hospitals, clinicians shoulder enormous responsibility, not just for managing the care of individual patients, but also developing staff and services at primary and hospital level, and contributing to wider decision-making around health care priorities and resource allocation.

This may make the district hospital a good candidate for exploring mechanisms to harness the leadership potential of clinicians. Historically these hospitals have been under-developed, yet they form an integral part of the district health system and will be a key mechanism for extending hospital coverage. Some district hospitals are able to draw on a long-standing tradition of commitment to the community they serve, enjoy the services of long-serving clinicians and close-knit clinical teams, and demonstrate quality improvements in the face of enormous challenges. All in all, it may be easier to integrate clinical, leadership and managerial roles and staff in district hospitals than in larger hospitals with more complex hierarchies and, especially in rural hospitals, the organisational culture may be more conducive to teamwork.

The literature is unequivocal in stating that health care organisations – especially those in the public sector - have to be managed on a different basis from commercial enterprises and government departments. Significant improvements are impossible without unifying the efforts of clinical, clinical support and non-clinical services in the interests of patient care, decentralising authority and responsibility for both managerial and clinical decision-making to the appropriate levels, and transforming the organisational culture. Exactly how this should be done needs to be explored whilst at the same time managing the sensitivities of different professional groupings, as well as policy-makers' concerns about decentralisation in the context of weak capacity.

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