Clinicians in Management: A Review of Clinical Leadership

Leading management and organisation development for the health services

PREPARED BY

Royal College of Surgeons in Ireland

DISCUSSION PAPER No.4
Mission Statement

We contribute to a better health service by

- supporting people development
- stimulating change in the way things are done
- helping the whole system to improve
Contents

Executive summary 3

1. Introduction 4

2. Methods of information gathering 5

3. Outline of responses 6

4. Discussion 13

5. Conclusions and recommendations 18

References 22
Executive Summary

The Clinicians in Management (CIM) initiative, launched in 1998, is endeavouring to give health professionals a greater say in the planning and management of health services. This is in line with the widely accepted view at home and abroad that clinicians must be closely involved in the management and leadership of healthcare organisations. Our national health strategy, published in Quality and Fairness: a Health System for You (2001), stresses the key role clinicians can play in the planning and delivery of a top quality health service for Ireland.

The Office for Health Management plays a central part in supporting the CIM initiative. It does so through training and development projects designed to assist health agencies to implement the change process. Its Discussion Paper series Clinicians in Management, of which this is No. 4, is a key project in support of CIM.

Discussion Paper No. 4 examines a crucial element in successfully implementing the CIM initiative – the active and wholehearted participation of doctors in the process. It reviews hospital doctors’ attitudes to taking on leadership and management roles in their organisations. This review includes whether they think participation is a good idea in the first place, what would encourage or dissuade them from getting involved, and what it is that organisations can do to facilitate them in taking on the leadership role.

The review was conducted mainly on a one-to-one basis using a semi-structured interview technique featuring questions such as:

- do you support the concept of clinical leadership and, if so, why?
- what leadership tasks do you undertake?
- what skills/attributes/awareness are necessary for clinical leadership?
- what factors act as motivators/de-motivators?

Responses are summarised within six broad topics:

1) is it a good idea overall for doctors to be involved as leaders in the service?

2) levels of clinical leadership

3) leadership tasks at different levels (corporate, department, clinical team)

4) skills/awareness/attributes required of an effective clinical leader

5) motivation for doctors (consultants) to take on leadership roles

6) how can the organisation facilitate doctors who are willing to take on leadership roles/tasks?

The paper discusses the responses in the light of the relevant literature from other health systems, notably in the United States and the United Kingdom. It reaches significant conclusions on the basis of the review and it points to lessons to be learned.
1. Introduction

Health systems worldwide recognise the need for clinicians to be closely involved in leadership and management decisions. The reasons have been well documented. The quality of health care is determined largely by the expert skills and knowledge of clinicians. Clinicians have a high level of professional freedom and discretion in their actions. Their clinical judgments largely determine current and future resource allocation decisions. As a result, health systems recognise the importance of involving clinicians in the management and leadership of health care organisations. Different models for involving clinicians in management/leadership have emerged in different countries, with varying degrees of success (OHM: Clinicians in Management: Discussion Paper No. 2). Research suggests that “one size doesn’t fit all”; the approach must be congruent with the local health service environment, organisational structures and cultures (Rea 1995/1996).

The Irish national health strategy, Quality and Fairness: A Health System for You (2001), highlights the key role clinicians can play in the planning and delivery of a top quality, patient-centred health service, and emphasises the need for transparency and accountability from health service providers throughout the system. This is one of the themes of the Clinicians in Management (CIM) initiative, launched in 1998.

The initiative aimed “to provide for balanced involvement in decision-making between doctors, nurses and allied health professionals, and to decentralise the responsibility for managing resources down to local units with their direct participation”. It suggested that clinicians needed to be involved at both strategic and operational decision levels, while acknowledging that “no single solution (would) suit every organisation” and that “specific structures and management arrangements (were) required to suit local circumstances” (OHM: Clinicians in Management: Discussion Paper No. 1).

One key issue in effective implementation of CIM in its broadest sense is the active commitment of doctors to the principle, and their involvement as clinical leaders. This discussion paper seeks to inform and stimulate discussion on clinical leadership. It explores the views of hospital doctors, their attitudes to participation in the leadership and management of their organisations and how leadership and management processes can be facilitated. The exploration includes whether doctors think CIM is a good idea in the first place, what would encourage or dissuade them from getting involved, and what can organisations do to facilitate them in taking on leadership roles. The paper discusses the responses in the light of relevant literature from other health systems, notably in the USA and the UK, and finishes with conclusions and recommendations based on the responses.
2. Methods of information gathering

The Office for Health Management commissioned the review which is reported in this discussion paper in order to stimulate discussion and debate on clinical leadership issues. The review involved an exploration of the views of doctors on aspects of their leadership roles. The semi-structured interview proved the most practical method of gathering information; the doctors' clinical workloads for example precluded the use of focus groups or group interviews. The same interview format was used consistently with all interviewees. Each interviewee was asked

- do you support the concept of clinical leadership and, if so, why?
- at what level(s) do you observe clinical leadership being practised?
- what leadership tasks do you undertake?
- what skills/attributes/awareness are necessary for clinical leadership?
- what factors act as motivators/de-motivators?
- what would facilitate doctors positively disposed towards involvement in clinical leadership to take on the leadership role?
- what are the critical success factors for effective involvement of doctors as clinical leaders?

Twenty-five doctors in total were interviewed. Eighteen of the interviews were conducted on a one-to-one basis with consultant doctors, and a single interview was conducted at one hospital with a group of seven doctors consisting of a mix of consultants and specialist registrars.

The doctors interviewed were representative of colleagues in managerial roles and were chosen to deliver a comprehensive perspective (Appendix 1). The selection criteria aimed to include doctors

- with different experiences of management/leadership, for example medical executive members, heads of department, members of planning/project groups, those not in formal leadership roles but acting as such
- from across the entire spectrum – from those in long-standing consultant positions to those newly appointed, and a small number of specialist registrars in clinical leadership/managerial positions, for example responsible for organising rotas or engaged in clinical supervision of colleagues.
- working in various types of hospital, for example voluntary, health board urban, regional, county or tertiary referral.

Semi-structured interviews were chosen both to maximise the response rate and to facilitate exploration of the views expressed while securing answers to key questions. The interviews ranged in duration from forty-five to seventy-five minutes and were held on site to accommodate busy clinical schedules. The same two researchers conducted virtually all interviews jointly; two were conducted by one of the researchers working alone. The responses were analysed to reveal minority opinions and to identify common themes and contrasting views.
3. Outline of responses

**Topic No. 1: is it a good idea overall for doctors to be involved as leaders in the service?**

**Quotes**

“Yes, can’t go back to the way it was”

“Yes, need more doctors in administrative roles and in Department of Health and Children”

There was unanimous support for clinical involvement in leadership at all levels, to ensure that the medical viewpoint was heard. Respondents recognised that their clinical practices had a major impact on both the quality and the quantity of service delivery and on resource allocation decisions. They also recognised that they were well placed to contribute to decisions requiring clinical knowledge and experience, and to represent the viewpoint of medical colleagues. There was a strong view that more doctors were required in administrative roles in the service, and also in the Department of Health and Children (DHC).

**Topic No. 2: levels of clinical leadership**

Most respondents suggested that, regardless of the level of operation, the essence of clinical leadership lay in being proactive in seeking and influencing change, with colleagues and throughout the health system. Respondents identified three levels of leadership:

- a) across the organisation as a whole at corporate level (“influencing up”)
- b) as head of a department or service (“influencing across”)
- c) as leader of one’s own clinical team (“influencing down”).

**a) influencing up – contributing “medical expertise” to the corporate decision-making process**

A minority of respondents saw themselves in this category, where they were involved in corporate decision-making with top management and other clinicians. They saw their main role in this area as contributing medical expertise and knowledge, including in-depth knowledge of clinical issues, to the decision-making process. A few had formal corporate roles, such as Medical Director, Clinical Director, Master (Dublin maternity hospitals). More were members of strategic planning groups or ad hoc service planning groups. Typical tasks undertaken included

- engaging in strategic thinking and planning in the hospital
• making a case or negotiating resources at regional or national level (even at the level of the Minister for Health and Children (MHC)) for a particular speciality

• acting as conduits of communication in both directions, top-down and bottom-up, between clinicians and top management.

b) influencing across – influencing as department head
Many respondents were influencing across the organisation as heads of departments or services. Leadership tasks included

• acting as leader in a service area, such as anaesthetics, or as a clinical director across several departments

• negotiating and managing resource allocation

• planning for future needs and development

• promoting/facilitating best practice through evidence-based medicine (EBM), protocols, continuing professional development (CPD)/training.

c) influencing down – leading the clinical team
Most respondents related to this aspect of leadership because of their responsibility for patient care. Examples included

• providing leadership for the multidisciplinary team, including conflict resolution

• setting and improving clinical standards through audit and EBM

• ensuring appropriate training and CPD of staff, especially juniors

• rostering colleagues

Topic No. 3: skills/awareness/attributes required of an effective clinical leader

Quotes

“You need (clinical) credibility, otherwise you'll be seen as a surrogate manager”

“You have to be able to convince people, bring them on side”

“Telling people won't get it done – you have to persuade them”
Respondents identified a common thread in the way effective clinical leaders approached the leadership task across the three levels of leadership outlined in a), b) and c) above. They

- used persuasion rather than hierarchical power to change peoples’ attitudes and behaviour
- produced evidence to back up their case for change (for management and peers)
- provided examples of successful change (to get colleagues on board)
- prepared the ground in advance for major decisions through consultation and clarification with colleagues, anticipating possible problems in advance and providing options for action.

Respondents were conscious that their credibility and acceptability among their peers rested on their ability to act as advocates for patient care and clinical service development, rather than as the clinical arm of executive management.

Respondents identified a consistent set of skills and attributes that they associated with effective clinical leadership. The overriding prerequisites for acceptability of any clinical leader were reported to be professional competence and expertise; without these the clinical leader would not be taken seriously. Other important skills and attributes identified included

- the ability to project a consistent vision for the service that inspires confidence and trust
- a strategic appreciation and environmental awareness of the organisation and the wider health system
- political skills and astuteness, and practical experience of working in the system
- personal integrity as shown by impartiality and a balanced, fair approach
- personal insight into one’s own strengths and weaknesses
- determination, patience and persistence in the face of setbacks and delays
- being able to convince people through persuasion, not coercion
- being able to “go around” problems if the direct approach proves ineffective
- good team leadership skills, especially listening skills, and the capacity to convey credit and encouragement.
Topic No. 4: motivation for doctors (consultants) to take on leadership roles

Quotes

“To see that what we do is in the best interests of patients and the service”

“Managerial work is becoming a more integral part of medical work”

Motivators
Factors motivating Irish doctors to take on clinical leadership roles:

• having the opportunity to realise a vision of effective, high quality patient care through exercising professional values and principles
• being in a position to advocate on behalf of patients in resource allocation and service decisions
• having a measure of control over one’s working circumstances
• being in a position to contribute to corporate decisions
• the assurance that one would not be managed by non-clinicians or the wrong clinician
• being in a position to raise the profile of the department/service generally
• the challenge of taking on a new and very different role (minority view).

The motivation to become involved in clinical leadership stems mainly from professional values and vision for excellence in patient care, service delivery and working conditions. Some were spurred on by the climate for change in the health service. Others were of the opinion that those not involved early on might lose out later. Some reported getting involved in management roles to influence decisions regarding development of their own unit or department or directorate. A minority expressed an interest in dabbling in medical politics. A few also mentioned the attraction of being “part of the decision-making inner circle”.

De-motivators
Factors discouraging Irish doctors from taking on clinical leadership roles:

• a sense that involvement does not produce results
• demands on clinical time
• lack of time to maintain clinical expertise
• a perception of slow decision-making at management level, leading to loss of credibility
• the absence of (speedy) communication between management and clinical leaders
• inadequate support from management – moral and structural
• apprehension at moving into a difficult role: from a familiar role of professional autonomy to one of limited control; isolation that comes from being “neither flesh nor fowl”; colleagues not yet on board – “swimming against the tide”

• loss of income through time foregone in private practice.

Many of the disincentives above stem from shortcomings in organisational structures and functioning, or the absence of pre-existing effective working relationships with senior management. There was a widely shared sense of frustration with the decision-making and implementation processes in healthcare generally. A number of organisational factors were proposed to explain this; the many layers of administration, the cumbersome nature and slow speed of the administrative process, the absence of effective communication channels between administration and clinicians to provide updates/feedback on progress. This lack of effectiveness served to reduce credibility for the process among an already somewhat reluctant peer group.

Many doctors viewed the move into management as leaving a familiar ground where autonomy and effectiveness were largely guaranteed to an area where control was limited. A lack of time, adequate financial compensation, loss of income from private practice and poor administrative support were other major factors. Others feared alienation from peers and also that their clinical skills might be affected by time spent away from practice. Several respondents mentioned the absence of a supportive working relationship with senior management, where mutual respect and trust were apparent. Some expressed scepticism about management’s intentions, and were suspicious about the “real” agenda behind involving them in leadership roles asking, “is it responsibility without any power?”

Some doctors did not welcome having to tackle unpleasant tasks such as acting as spokesperson for the organisation when things went wrong, or being involved in litigation. Other mitigating factors reported were high turnover amongst administrative staff, coupled with inflexible recruitment and selection processes.
Topic No. 5: how can the organisation facilitate doctors who are willing to take on leadership roles/tasks?

Quotes

“Involvement needs to have real meaning; doctors need to be at the table when decisions are made”

“Real functioning of clinical leaders is hampered by the system”

“I’m supposed to have the power, but he (the administrator) can take my secretary away”

Doctors interviewed felt that organisations can encourage clinical leadership by

- “walking the talk”, with managers being seen to take the initiative seriously (from the DHC through to individual organisations), and having the confidence to trust in their medical colleagues
- choosing a structure that suits the organisation – “one size doesn’t fit all”; this requires time and consultation to ensure that staff are aware of the changes, and understand the new ways of working
- clarifying what clinical leaders’ roles and responsibilities are, and consistently adhering to these
- giving doctors real decision-making power, and keeping them informed; otherwise they lose faith in the process and lose the respect and interest of their colleagues
- eliminating some of the layers of administration that can delay decision-making
- devolving authority to allow maximum decision-making at local level
- demonstrating that experience of clinical leadership is valuable for career advancement
- providing a career path (including pension considerations) for clinical leaders
- acknowledging and minimising as much as possible the costs involved for doctors, including loss of income from private practice foregone, loss of clinical experience and time for research pursuits and personal activities
- providing training and development relevant to doctors’ needs and circumstances, with the following characteristics
- unidisciplinary to begin with (majority view)
• incorporating an action learning approach
• delivering knowledge of management terminology
• demonstrating how the system works nationally and internationally
• offering insight into one’s leadership strengths and weaknesses; leadership development
• incorporating training in time management and change management
• providing opportunities for networking with other clinical leaders and with management.
4. Discussion

Many of the respondents’ views are echoed in other systems.

Doctors generally accept that they have a management role to play in their organisations; some are actively interested in being involved (Brazell 1987, Horsley et al 1996). The benefits they see include clearer service objectives for the organisation, better service planning, budgetary control and quality control, as well as faster decision-making (through decentralisation) and flexibility to respond to changing demands (Buchanan et al 1997). As doctors they are often in post for many years, have a greater level of independence than managers, and can “disagree with decisions and keep their jobs” (Saxton 1994), making them powerful advocates for quality patient care. A minority disagree, some believing that they can exercise sufficient power and influence without becoming involved in management (Dopson 1994, Ong and Schepers 1998), others that they are trained to cure the sick, and that they have no other responsibilities (Brazell 1987).

This model of different levels of management and leadership, identified by Irish doctors, finds parallels in several descriptions from other systems (Chantler 1994, Ong and Schepers 1998, Dyson 1994, Allen 1996). These models distinguish between managing self and patients and the clinical team, managing/leading across the organisation, and contributing to corporate decision-making (Figure 1).

![Levels of clinical management/leadership](image.png)

Figure 1: Levels of clinical management/leadership (after Allen)
Irish consultants’ leadership roles seem to approximate most closely to the Allen model in NHS Trusts: Level 1, i.e. management of self, patients and support staff (practised by all consultants); Level 2, contributing to management decisions beyond the firm (practised by most); Level 3, clinical directors managing other consultants (practised by a few); and Level 4, medical directors contributing to strategic decisions (very few). In the Irish system, all consultants are involved at Level 1 (self and patients), many are involved at Level 2 (beyond the firm) through projects and development committees, a small (but increasing) number at operational Level 3 (clinical directors), and a very small number at strategic Level 4 (medical directors (MDs)).

In a survey of Irish hospital consultants in one large teaching hospital, Callanan et al (2002a) identified two distinct roles in which clinicians were performing, i.e. either as members of the board of management or as heads of a clinical speciality. The hospital structure effectively precluded a clinician from having both roles concurrently, creating a barrier to effective collaboration.

Buchanan et al (ref) identify three models of managerial authority within the clinical directorate structure, popular in the UK and the US: the Johns Hopkins model, where each directorate is an independent cost centre and the director has line authority, reporting to the hospital’s chief of staff; the Guy’s Hospital model, where support services are decentralised to each directorate, with the clinical director responsible for budgets and reporting to the medical director; and the BMA model, where clinical directors (a) are identified as suitable by their peers, (b) have budgetary responsibility, and (c) cannot override the clinical judgments of their colleagues.

The BMA model of managerial authority is the one that respondents to our survey identified with most readily. This suggests that while it might be acceptable for clinical directors in the Irish system to have responsibility for resources, the extension of the role to include direct managerial authority over their colleagues would not be favourably received.

There are very few medical directors MDs in the Irish health system. Respondents generally did not raise the issue of incorporating MDs into hospital structures. A few who were familiar with the issue from previous experience saw the MD role (full-time leader/manager) as a possible solution to the time pressures on doctors straddling both clinical and managerial jobs. They also considered the MD position as an effective way of ensuring that medical expertise was available at corporate level, and as a possible career objective for doctors wanting to become more fully involved in management and leadership. They did not suggest that the MD would have managerial authority over a group of consultants. In time, the Irish health service may extend the managerial role of doctors further to Level 4, and appoint more MDs at corporate level. The UK experience suggests that there is no single, perfect arrangement. It appears that successful approaches are those that attempt to match the role of the MD with the stage of development of clinical leadership in the organisation. The de-motivators identified by Irish doctors, especially the reluctance to alienate colleagues or take on thorny issues, suggest that the development of such a role will require careful consideration.

Many of the personal skills and attributes identified by Irish doctors in our survey as necessary for effective execution of the clinical leadership role are common to other systems. Buchanan et al (1997) identify five categories of qualities as necessary:

- “context factors” such as professional credibility and skill
- “personal stance”, especially willingness to take responsibility for collective corporate decisions
• “core understanding”, especially understanding organisational issues and one's own role
• “behavioural capabilities”, especially general leadership qualities and being a team player
• “specific skills”, for example good political skills, being able to argue a case convincingly etc.

These findings are echoed in other research (Thorn 1997, Ong and Schepers 1998). Palmberg (2002) identifies six characteristics of effective clinical leaders:

• they like to work with others, both as a leader and clinically
• they have extraordinary energy and are “borderline impatient”
• they stay involved in clinical work to maintain their understanding of operations
• they are not dependent on outer confirmation to carry on
• they have strong confidence in other people’s will and capacity
• they are able to prioritise and delegate effectively.

It would be interesting to compare these traits with those of Irish doctors. Survey respondents associated effective leadership with a facilitative interpersonal style, rooted in consensus, and they associated leaders with a clear vision of what was possible within the constraints imposed by the structures they worked in. Of note, Callanan et al (2002a) reported in their survey of consultants in Ireland that seniority rather than genuine interest or aptitude appeared to be a significant feature in the appointment of clinical leaders. Furthermore they reported that clinical leaders were selected exclusively by their peers without any management input, a practice that might well militate against a collaborative management system.

Many of the motivators for doctors to take on management and leadership roles reported in this survey are shared across systems. These include

• the belief that change is coming anyway and it is better to be on board than risk being left behind (Harrison and Pollitt 1994)
• commitment to quality patient care (Cavenagh 2000, Brazell 1987, Callanan et al 2002a)
• having some control over resources
• the desire to be part of the corporate decision-making group, and to be kept informed about events and developments (Dopson 1994, Riordan and Simpson 1994)
• fear of being managed by non-clinicians, or by the “wrong” clinicians
• the belief that one would do a better job than one's medical colleagues (Cavenagh 2000)
• being able to attract high calibre staff

• (for a minority) the challenge of a completely new role and the power of the role (Diskin et al 1990).

Irish doctors both in our survey and elsewhere suggest that an important factor influencing their involvement in management is the personal influence of the chief executive officer/general manager and evidence of a good working relationship between the chief executive officer and clinical leaders (Callanan et al 2002a). Scottish doctors agree (Bruce and Hill 1994). There is also agreement on the need for at least a few enthusiasts - change champions - among senior medical staff (Diskin et al 1990, Callanan et al 2002a).

Many of the factors discouraging doctors from involvement are also shared across systems. These include the absence of quantifiable benefits, especially in quality improvements (Diskin et al 1990, Cavenagh and Dewberry 2000, Cavenagh 2000). This is significant in the Irish situation, where doctors are being encouraged to become more involved in service planning. If they do not see benefits as a result, they may be less enthusiastic about participation (Brady MBA unpublished). Other de-motivators are

• the perceived threat to clinical identity and self-esteem through being viewed more as manager than clinician (Dopson 1994, Bruce and Hill 1994)

• having to manage or confront clinical colleagues (Buchanan 1997, Cavenagh 2000), or alienating them (Riordan and Simpson 1994)


• lack of administrative support (Cavenagh 2000) and lack of preparation, adequate knowledge, general awareness and managerial language for the new role.

There is a general agreement in the Irish context that clinicians would benefit from a better understanding of management, financial systems and strategic decision-making before adopting managerial roles (Department of Health and Children 1996).

Doctors in the UK cite pressures on personal and clinical time, and lack of administrative support as major disincentives (Cavenagh 2000). Callanan et al (2002b) have also identified a concern amongst Irish doctors of losing out on clinical skills as a result of the increased time spent on managerial duties. Respondents in our survey identified potential loss of private practice as another disincentive. This may reflect the difference in doctors’ employment contracts in the UK and Irish systems. In Ireland there is potential for substantial earnings from private practice. Callanan et al (2002b) identified loss of private income as a disincentive due to the unique nature of the Irish consultants’ contract. Irish doctors devoting significant time to the clinical leadership role stand to lose out financially. Current arrangements do not compensate for potential loss of private practice. While finance is by no means the only disincentive to involvement in clinical leadership, it could be a significant factor for some doctors with high earning potential outside their public commitments (Callanan et al 2002b).
This is a complex issue that may require a flexible approach on a case-by-case basis. In some Canadian hospitals, clinical leaders’ remuneration is negotiated on an individual basis, and takes account of potential earnings foregone (Dr D McCutcheon, personal communication). It might be possible to build such an arrangement into the system here, with doctors compensated for potential losses for private practice foregone, in addition to the remuneration for the clinical leadership post. On the other hand, if general managers and chief executive officers are seen to be earning significantly less than their medical counterparts, their credibility may suffer. Callanan et al (2002b) recommend further research to determine adequate/appropriate compensation for doctors engaged in managerial duties so as not to block the progress of clinical involvement in management roles.

It is generally recognised that appropriate management and support structures will facilitate clinical leadership. Doctors agree that organisations should experiment with organisational design; however, it is crucial that the achievements of medical and managerial objectives are not seen as separate endeavours (Buchanan 1997, Ong and Schepers 1998). UK doctors are explicit about the need for business managers (Saxton et al 1994). Survey respondents referred more generally to the need for administrative and information support, possibly reflecting the relative stages of development of clinical directorates in both systems. Efficient paperwork, meetings and committee work are also essential (Saxton et al 1994). Getting other doctors to take on some management responsibility is also recommended. Managers need to appreciate doctors’ time schedules, and be accessible “out of hours” if necessary (Thorne 1997).

Survey respondents set great store on the need to streamline administrative and decision-making procedures. It may be that they will view progress on this front as a proxy for the organisation’s “real” intentions about involving them in management and leadership in the most appropriate way.
5. Conclusions and recommendations

There is evidence among those interviewed of the involvement of doctors in clinical leadership in the Irish health system.

There is also strong support for the principle of clinical leadership, and a very keen, shared motivator in the form of improvements to the quality of care.

There are several critical success factors for developing shared decision-making processes (see Table 1 below).

Those interviewed identified a consistent skill-set associated with clinical leadership, encompassing a proactive approach and the adoption of a persuasive, rather than coercive, approach.

The views of respondents are shared by doctors from other health systems; there is potential for learning and transfer of experience from these systems.

Evidence of results – in other words demonstrable benefits to patients – is required to maintain clinicians’ continuing commitment and motivation. Further consideration should also be given to the reward system for doctors who take on substantial clinical leadership roles.

The principal de-motivators are related to poor relationships between doctors and general managers resulting in an absence of trust, lack of clarity about clinical leaders’ roles, especially the boundaries of decision-making, and cumbersome administrative processes that slow things down and leach away clinical leaders’ credibility among their peers.

This exploratory research suggests that there is a challenge to health agencies to ensure that they possess the right tools, structures and organisational cultures to sustain clinical leadership. Successful participation of clinicians in management requires ongoing commitment at a practical level through, for example

- appointing clinical leaders with the necessary skills and attributes, the respect and confidence of their peers, and the ability to work effectively with management
- clarifying the respective roles and responsibilities of clinical leaders and managers
- devolving decision-making to the lowest appropriate level
- streamlining the decision-making process by eliminating unnecessary layers of bureaucracy
- providing accurate and timely information to aid decision-making
- providing locum support, administrative backup and targeted training and development for doctors undertaking the role
- establishing clear decision-making structures that are used consistently, and that enjoy the support of all involved.
Some of the structural and system disincentives identified above can be tackled successfully with drive and determination, and appropriate resources. Removing other disincentives will require changes in values and attitudes, to foster trusting relationships that will help realise the shared vision of improvements to the quality of patient care. Such changes will require education, training and other purposeful strategies.

**Table 1: critical success factors in advancing clinical leadership in the Irish context: composite of survey findings and analysis**

- commitment at both managerial and clinical levels
- the “right” person for the job of clinical leader
- clear roles and responsibilities for clinical leaders and managers
- objective evidence of success
- structures and decision-making processes to support and facilitate shared decision-making
- access to support functions, for example finance, information systems
- adequate time and compensation for clinicians taking on the job
- organisation development to facilitate change, and training and development to enhance personal capacity.
Appendix 1

Table A1: location of respondents

<table>
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<th>Where working</th>
<th>Number</th>
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<td>Voluntary</td>
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Table A2: years as consultant

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</tr>
<tr>
<td>20 +</td>
<td>6</td>
</tr>
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</tr>
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<td><strong>Total</strong></td>
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</tr>
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<td><strong>Male 20</strong></td>
<td><strong>20</strong></td>
</tr>
<tr>
<td><strong>Female 5</strong></td>
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Table A3: management/leadership position

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<td>Clinical Director</td>
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<td>Clinical Co-ordinator</td>
<td>1</td>
</tr>
<tr>
<td>Project/planning team member</td>
<td>1</td>
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<tr>
<td>Chair of Medical Executive</td>
<td>1</td>
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<td>Head of Department</td>
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<td>Senior Registrar</td>
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<td><strong>Total</strong></td>
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**Table A4: management training of respondents**

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References


Cavenagh P., “Buggin’s turn or Buggins’ choice”, Clinician in Management, Vol. 9, pp 146-159.


