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Transforming health care organizations to improve performance requires effective strategies for engaging doctors and developing medical leadership. Most efforts in the US and UK to develop medical leadership have focused on structural changes that integrate doctors into administrative structures, but these have had limited impact. Recognizing the distributed and collective character of effective leadership, some health care organizations are now attempting to create greater alignment between clinical and managerial goals, focusing on improving quality of care. These initiatives aim to create effective systems at a team and organizational level, not just the development of medical leadership competencies.

Reforms of public administration and services have been high on the agenda of OECD countries for the past 30 years (Joumard *et al.*, 2010). Because health care systems are the largest area of spending on public programmes, there have been major efforts to transform these systems and improve their performance. Yet improvements in quality, and reductions in cost, have been difficult to achieve despite innovations in practice. In part, this paradox of heightened expectations and lagging results stems from the nature of health care organizations as professional bureaucracies (Mintzberg, 1979; Glouberman and Mintzberg, 2001a, 2001b). While knowledge based organizations, including health care organizations, are often seen as the paradigm of the post-bureaucratic age (Quinn, 1992), the structures and cultures of these organizations have often been highly resistant to change, especially changes that derive from policy or managerial directions. Transforming health care organizations requires effective strategies for engaging doctors and developing medical leaders who can overcome the inertia of traditional professional bureaucracies. These issues are salient in a number of health systems, as noted in a recent paper by Ham *et al.* (2010) who underline the importance of adopting a more systematic and proactive approach to developing medical leadership.

In this article, we look at medical leadership from a systemic rather than an individual perspective. Medical leadership is defined as 'the active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organization which itself recognizes this commitment in supporting and encouraging high quality care' (Spurgeon *et al.*, 2008, p. 214). The focus of the article is on the opportunities and constraints within the health care environment and within the profession to further involve doctors in roles that go beyond their clinical practice.

Beyond professional bureaucracy: the evolving nature of health care organizations

Health care organizations have been considered an ideal type of professional bureaucracy (Brock *et al.*, 1999) where professionals control the expertise and determine the organizational arrangements. Such organizations develop a 'culture of professionalism' (Bledstein, 1978) that pervades decision-making and resource allocation, thus having a major impact on organizational strategies and performance.

The medical profession has traditionally been considered a model of individual professionalism, where each practitioner works with his or her own patients in discrete areas of practice and where the defining influence on medical decision-making is based on assessing the needs of the patient. The socialization of doctors has long emphasised their role as advocates for their patients in ensuring that they receive effective care. In order to be patient advocates, doctors believe they must also maintain clinical autonomy to decide what care is needed.

Scholars studying professional bureaucracy also note the limited influence of managers on professionals; managers' key role has been to provide a setting for professional practice while doctors determined the appropriate scope and

G. Ross Baker is a professor in the Department of Health Policy, Management and Evaluation, University of Toronto, Canada.

Jean-Louis Denis is a professor at ENAP (Ecole nationale d'administration publique), Montréal, Canada, Canada Research Chair on Governance and Health System Transformation and a visiting professor at Euromed Management, Marseille, France.

nature of their work (Pauly and Redisch, 1993). Reflecting this view of the profession and the nature of professional organizations, physician leadership rested on the expertise of individual clinicians and the capability of these leaders to reflect the interests of their colleagues in group practices or departments and in professional organizations such as regulatory colleges.

Such professional organizations left power in the hands of doctors (and to some extent nurses) while managers administered the facilities and supported clinicians in their practices. As a result, decision-making in such environments was slow, change was difficult and these organizations relied on consensus rather than choice between strategic directions.

From the 1960s onward, this archetype of professional domination in health care organizations has been challenged as external pressures have emphasised the need for improved performance in health care systems. Doctors made decisions about providing care to patients that committed hospitals to expenditures without accountability for these costs or for the outcomes of care. On the managerial side, health system leaders recognized the need to involve doctors more closely in decision-making and to recruit medical leaders who could help shape the opinions of their colleagues in line with some organizational or system imperatives and not just negotiate the minimum acceptable changes.

Yet these pressures for the increased integration of doctors within health care organizations may not necessarily culminate in the development of medical leaders dedicated to organizational or system improvement. Indeed, sociologists of the professions have widely debated the consequences of such pressures on the evolution of the status and roles of the medical profession. These debates are helpful in understanding the context in which the development of medical leadership may take place. Friedson (1970) popularized the concept of professional dominance to explain why certain professional groups are able to preserve a high level of autonomy and control over their work conditions, even though there are significant forces in the environment that challenge this autonomy. Despite significant economic and technological changes in health care systems during the 1970s and 1980s, Friedson (1985) argued that doctors were able to maintain their relative immunity from external requirements and continued to regard clinical autonomy as an integral component of their professional identities (they did this in the face of growing evidence about the difficulties that such autonomy presents to improving the quality of care and financial

performance). His analysis suggests that the medical profession responds to external pressures by a process of internal differentiation, giving rise to the emergence of a new professional regulatory élite. This élite is involved in the design and implementation of some additional control over medical practice without substantial impact on the overall level of autonomy and status of the profession. According to this scenario, some doctors may take new leadership positions, but their roles do not significantly modify the relationships between the medical profession and health care organizations and systems.

By contrast, other authors have argued that the emergence of corporate medicine (Bazzolli, 2004; Starr, 1992) has greatly reduced the autonomy of the medical profession (McKinlay and Arches, 1985). These authors argued that the growing size of economic interests in health care, coupled with an increased dependence of doctors on organizations and technologies needed to practice medicine, have significantly reduced doctors' control over their working conditions and subjected the medical profession to bureaucratic control. In its more dramatic designation, doctors are seen as being engaged in a process of proletarization or deskilling. The proletarization thesis suggests that the medical profession has lost power, becoming more integrated within health care organizations and systems to a point that medical leadership may no longer be an issue.

While it is clear that the environment of medical practice has changed significantly, many authors would argue that the medical profession was able to maintain a high level of autonomy through these changes (Tuohy, 1999). Light and Levine (1988) have suggested that the peculiar position of the medical profession will in the end exacerbate contradictions in health care systems and culminate in decreasing autonomy and status. In the case of the Canadian health system, recent data published by CIHI (2010) reveals that in a period of economic constraints, the medical profession was able to secure significant gains, keeping a high-status position within the system.

Despite changes in the environment, there have been only limited shifts in the way the medical profession deals with the challenges faced by health care organizations and systems. The search for effective strategies to ensure a better alignment of the medical profession with broader system objectives remains a major issue (Robinson, 1997; Shortell et al., 2000; Burns and Muller, 2008). The growing interest in the development of medical leadership is the result of these issues (Fairchild et al., 2004; Ham et al., 2010). Medical leadership is seen as a resource to

reconcile professional aspirations with health systems objectives. These strategies to develop medical leadership have to take into account the presence of institutional forces within the profession that do not necessarily favour such engagement on the part of the profession.

Leadership in health care organizations and systems

This section looks at the changing views of leadership in contemporary organizations and examines in particular how medical leadership has shifted in England and the US, reflecting both greater institutional pressures to create more effective health care organizations and the historical experiences of efforts to overcome the separation of clinical and administrative leadership.

Early attempts to develop medical leadership: a structural perspective

The need to create collaborative and effective relationships between clinicians and managers to overcome the chasm between professional norms and managerial imperatives has been a long-term theme in both the National Health Service (NHS) and US hospitals and health services. Not surprisingly, this need led to a focus on recruiting medical and other clinical leaders who could not only represent their professional colleagues, but could also assume responsibilities for managing clinical services. Initially this emphasis on leadership focused on the recruitment and development of individual medical leaders and on structural changes that gave doctors formal roles and responsibilities for clinical services, not just individual practices.

By the middle of the last century, many US hospital leaders recognized that traditional hospital structures with dual lines of authority created conflicts between managers responsible for hiring staff and managing budgets, and doctors responsible for organizing and delivering medical care and managing the work arrangements for the doctors who practised within the hospital. In the face of financial pressures and growing demands for services in the 1960s and 1970s, hospitals began to experiment with creating joint management at the divisional level. One of the earliest models was developed at the Johns Hopkins Hospital in Baltimore, where the gap between doctors and managers was bridged by creating a new leadership structure that placed doctors in unit leadership roles in collaboration with nursing and administrative leaders, and which decentralized decisions to the clinical unit level. Many organizations developed similar structures

that were termed 'divisional' or 'programme management organizational structures'. There is little evidence that such structures overcame the cultural divide that often separates medical groups and administrators, but the development of medical director roles led to a variety of programmes aimed at providing doctors with managerial and leadership skills in these new roles

A similar dynamic unfolded in the UK. The Griffiths Report in 1983 underlined the lack of leadership in the NHS and recommended the development of general managers and the introduction of management budgets and greater financial accountability in hospitals. Along with the strengthening of management, Griffiths recognized the need to engage doctors in management and to provide more management training for them. As in the US, a number of reforms were introduced, and different models were tried to involve doctors in management, including the introduction of clinical directorates (service lines) with a medical leader who worked with the unit general manager to manage the service. This initiative was first pioneered in the UK by Guy's Hospital in London and drew upon the earlier experiences of Johns Hopkins. These clinical directors in UK hospitals provided management and leadership, but also continued to practice medicine. The effectiveness of this medical leadership varied: some organizations achieved considerable success while others failed to do so. Research suggests that the explanation for these differences partly lies in the extent to which organizations supported medical leadership and provided resources for development, recognition and rewards (Ham and Dickinson, 2008).

Despite these structural changes, a number of observers saw little undermining of the traditional view of clinical autonomy, with clinical directors having limited abilities to implement sustainable improvements in their services in the NHS (Ferlie *et al*., 1996). Several research studies have highlighted the limited impact of leadership roles in the NHS in the 1980s and 1990s (Marnoch, 1996; Fitzgerald *et al*., 2006), and the importance of medical leadership as a critical ingredient in more successful initiatives (Joss and Kogan, 1995).

Emergence of a more systemic approach to medical leadership

Recent approaches to leadership in public services have shifted the emphasis from a focus on individual leaders toward a view which stresses the importance of distributed and

collective leadership phenomena in contemporary organizations (Denis *et al.*, 2001; Gronn, 2002). 'Collective' here refers to the sharing of leadership roles among a set of actors in a complementary manner. 'Distributed' denotes the degree to which such leadership roles are spread across a system or an organization (Buchanan *et al.*, 2007). Leadership in health care organizations is widely distributed in the sense that it is *de facto* not concentrated in the hands of a few managerial and clinical leaders. Professionals, specifically doctors, at the strategic and operational levels play leadership roles. Moreover, in such organizations, the formulation of strategies has an emergent quality based on initiatives and actions taken by individuals within the operating core of the organization (Mintzberg and Waters, 1985).

Works on distributive and collective leadership suggest that leadership capacity must reflect the complexity of an organization if it is to contribute to adaptation and performance improvement (Raelin, 2005; Alvarez *et al.*, 2007). These works have implications for the development of medical leadership for health system improvement. While individual capabilities and qualities of aspiring leaders certainly contribute to organizational achievements, effective leadership in this view needs to be seen as an organizational or system property. Accordingly, the emphasis should be put on the development of groups of leaders within organizations that combine the diversity of expertise, skills and sources of legitimacy to respond to system challenges. This collective approach to the leadership phenomenon also extends beyond formal positions of authority, which reveal only one aspect of leadership capacity in organizations. Leadership is not concentrated at the top of the organization but, rather, distributed to respond to challenges that appear at various levels of governance. For example, in health care organizations, medical leadership takes place within units that deliver care and services and at the more strategic level of the organization. Because leadership roles and responsibilities are shared among many individuals in the organization, cohesion and co-operation among leaders across the organization is crucial.

Some current trends in the health care sector may militate in favour of a collective and distributed approach to leadership. Economic pressures and growing accountabilities for quality of care are forcing health care systems to adopt a more collective approach to medical leadership and to work in a more integrated fashion with all professionals (Berenson *et al.*, 2006). These forces may help to counter-balance the resistance of the medical profession to organizational and system integration described earlier. Professional norms are also now shifting to require doctors to consider the resources required for care and, even more critically, to participate with doctors and with other professionals in determining what care is needed. Certifying and regulatory bodies for doctors have begun to require the incorporation of organizational and managerial competencies in medical training and continuing certification. These changes underscore growing pressures to move from a guild mentality to a more systemic approach in the development of the medical profession. Recent emphasis on inter-professional collaboration in medical education and in the delivery of care is another indication of changing expectations regarding the role and contribution of the medical profession (Zwarenstein *et al.*, 2009). These changes contribute to a cultural change within the profession by increasing the socialization of doctors to their work environment.

While any significant improvement in health systems requires commitment and involvement of health professionals and personnel, working in a more integrated fashion, the engagement of the medical profession and leadership remains a particular challenge for reasons that are underlined in the previous section. For example, Berwick and Nolan (1998, p. 290) underline the difference between leadership within the profession of medicine and medical leadership for system improvement:

> *Nothing about medical school prepares a physician to take a leadership role with regard to changes in the system of care. Physicians are taught to do their very best within the system and to perfect themselves as individual professionals by advancing their skills and knowledge every day. But being a better physician and making a better system are not the same job. They require analogous, but somewhat different, skills.*

In response to these challenges, efforts to develop medical leadership have been broadened to refer to the mobilization of professional influence and expertise for the improvement of care and services in the context of a wider concern with organizational and system effectiveness. This medical leadership requires a broader range of knowledge and skills than the traditional administrative roles in leading medical groups.

It involves doctors in leading clinical teams and participating with other clinicians and non-clinicians in developing and executing strategy to improve organizational and health system performance. Medical leadership is now focused on the improvement of health care systems, not solely the practice of individual professionals.

Reports in both the US and UK at the turn of the century drew attention to quality and patient safety concerns (Institute of Medicine, 1999; DH, 2000). Studies on quality and safety of care improvement reveal the critical role that professionals and clinical input play in the redesign of care and services. Clinical teams or 'microsystems' need to develop leadership and skills in process improvement and develop routines that foster teamwork and communications to create safer systems (Mohr and Batalden, 2002; Lingard *et al.*, 2008; Nelson *et al.*, 2008). Growing interest in improving the quality, safety and efficiency of health care has fuelled efforts to engage doctors and develop medical leaders who can be champions of improvements in clinical work. A number of studies have shown that little real progress is possible in clinical process redesign without the involvement of doctors and other clinical staff (see Bowns and McNulty, 1999; Ferlie and Shortell, 2001). Doctors work as members of practice groups and specialties, and much of medicine is practised in teams with other clinicians. Improvements in practice rely upon doctors who can work with their colleagues to identify and spread effective practice through peer influence (Soumerai *et al.*, 1998). Formal quality improvement efforts require doctors to support the goal of redesigning care and to participate in the team efforts to test and assess changes that support improved outcomes (Berwick and Nolan, 1998; Berwick, 2003).

While collective and distributed leadership seem a plausible approach to support leadership development in health care organizations and systems, it may not be easily developed. Recent papers by Currie and colleagues (2007, 2009) underline the importance of external factors and institutional forces that may foster a more individual approach to leadership. They observe, in the case of the UK education system, that policy discourses favour a distributed approach to leadership but accountability mechanisms emphasize the concentration of leadership roles in the hands of school principals. Managers in high-level positions, and under strong external pressures to achieve ambitious targets, may be reluctant to cultivate a more distributed approach to leadership. The authors conclude that more attention needs to be paid to the enactment of

distributed leadership in contexts that are not so favourable. These works suggest that any efforts to stimulate a collective and distributed approach to leadership development will have to take into account the impact of policy context on the ability to engage leaders for improvement.

Experience with the implementation of a more systemic approach to medical leadership
Some forms of health care organizations may find collective and distributed leadership that integrates doctors into leadership structure easier than others. Development of new medical leadership may have been easier for organizations that had historically created salaried medical groups with their own leaders, including the Mayo Clinic, Henry Ford Health Care System and Permanente Medical Groups in the US. At the Kaiser Permanente medical groups, for example, doctors and managers jointly manage the organization, and leaders strive to develop a collaborative culture that recognizes the mutual dependency and need for alignment between doctors and managers (Crosson, 2003; Light and Dixon, 2004). The development of medical leadership in these organizations also provided a natural internal constituency for the leadership of quality improvement efforts that accelerated in the late 1980s.

Efforts to reinvigorate medical leadership in the UK began following the launch of the NHS Plan in 1999, which drew heightened attention to quality of care, and the revelations of the inquiry into the paediatric cardiac deaths at the Bristol Royal Infirmary. Other public scandals identifying failures in care emphasised the need for greater accountability and increased focus on quality of care*. The latter focus translated into greater efforts to recruit physicians to leadership posts and to engage them in leading improvement. Clinical governance provides a framework for monitoring and improving quality of care, and was seen as a lynchpin of NHS reforms (Freeman and Walshe, 2004) and a way to better integrate physicians in the organizational processes of NHS organizations. NHS trusts invested substantial time and resources in developing clinical governance structures and processes (DH, 2000; Walshe *et al.*, 2000), but these efforts had only a limited

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*The Kennedy Report on the Bristol Royal Infirmary stated: 'Sadly, a system of separate and virtually independent clinical directorates, combined with a message that problems were not to be brought to the chief executive for discussion and resolution, meant that there was power but no leadership. The environment was one in which problems were neither adequately identified nor addressed' (Kennedy, 2001, p. 5).

impact on front-line staff, and their focus was sometimes diverted in response to performance management pressures from the Department of Health (DH) (Roland *et al.*, 2001; Wallace *et al.*, 2001).

A number of new agencies (for example the National Institute for Health and Clinical Excellence and the National Clinical Assessment Authority) were created in the UK to support efforts to establish quality standards and assist clinicians in improving the quality of care. The growing emphasis on physicians' key role in the transformation of the NHS was paralleled by evolving views on the changing nature of the medical profession. In a 2005 report, the Royal College of Physicians noted that the traditional divide between management and clinical practice did not serve either doctors or their patients: 'An individual doctor's decision has both clinical and managerial elements. There are signs that management skills will gradually be incorporated into fitness to practice requirements'.

While changes in the profession can contribute to the development of medical leaders, initiatives in health care systems have been developed to promote a greater connection between the medical profession and their organizational environment. These initiatives provide fertile ground for the development of a more collective and systemic view on medical leadership. A review of hospital–physician collaboration (Burns and Muller, 2008) suggested that working on clinical integration may be a good starting point to further develop physician integration and leadership, and promote their commitment to improvement initiatives. According to this review, the growing involvement of physicians in the redesign of care and services provides opportunities to create new options with diverse incentives, governance policies and organizational design. This observation suggests that through their development of medical leadership in practice settings, health systems may make significant gains in terms of the level of co-operation and convergence between the objectives of the profession and organizational or system objectives. The focus here emphasises an organic approach rather than a structural one to stimulate the involvement of doctors in leadership roles for improvement.

Recent policy initiatives continue to stress the need for effective medical leadership. The reforms proposed for the NHS would give general practitioners responsibility for commissioning all health services—a radical reorganization that will demand considerable leadership skills (DH, 2010; Devlin and Appleby, 2010; Ham, 2010). The US proposal to develop accountable care organizations responsible for improving quality of care and controlling costs across systems of care similarly stresses the need for strong medical leadership and skills in managing complex systems of care (McClelland *et al.*, 2010). Both the English and US proposals place great demands on primary care leadership and have left many critical implementation details unspecified. Whatever the final form of this restructuring, the need for collective and distributed medical leadership that can articulate professional concerns, promote quality improvement and integrate local work systems into broader system structures will be critical for success.

Overall, a more collective and systemic approach to leadership in health care organizations and systems suggests that initiatives for leadership development that focus only on individual capacities and competencies will have a limited impact. In addition, the creation of formal leadership positions for doctors within the organizational structure does not suffice to guarantee a dynamic of adaptation and improvement. Strategies to develop medical leadership will have to take into account the need for a more global approach informed by existing knowledge on performance improvement in health care system. They will have also to take into account the importance of creating an enabling context for the development of leadership capacity across the system (Ham *et al.*, 2010).

Conclusion

We have identified the pressures and opportunities that promote the development of medical leadership within health care organizations and systems. Medical leadership is seen as a key ingredient bridging the clinical world and the managerial world that structures the day-to-day functioning of health care organizations. Our analysis suggests three core elements of strategy to further develop medical leadership within health care systems:

• The first element deals with the structural basis of medical leadership. The creation of formal leadership positions for doctors is only one element of such a strategy, and would have a limited impact if not coupled with a more active strategy to get doctors involved in improvement efforts.
• A second element is based on a more collective view of organizational leadership where

leadership development occurs at all levels of a system in a concerted manner.

•A third element is based on the lessons learned from the science of improvement in health care systems (Baker *et al.*, 2008) where leadership development is aligned with clear improvement goals at the strategic and operational levels of the organization.

These three components provide a basis for a systemic approach to medical leadership development in health care system. Initiatives to develop medical leadership in the UK and US have evolved from a focus on structural change to a focus on the development of competencies and skills of physician leaders to lead improvement initiatives and to work in collaboration with other professionals and managers. While these initiatives are essential components of medical leadership development, efforts have to be made to further integrate these programmes within a systematic strategy of performance improvement in health care organizations. Substantial challenges remain in developing collective and distributed medical leadership that links doctors and other clinicians to managerial structures. Further shifts are required in professional development and organizational strategy and culture to achieve more effective systems of care. ∎

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