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Article information:

To cite this document:
Peter Spurgeon Paul Long John Clark Frank Daly , (2015),"Do we need medical leadership or medical engagement?", Leadership in Health Services, Vol. 28 Iss 3 pp. 173 - 184
Permanent link to this document:
http://dx.doi.org/10.1108/LHS-03-2014-0029

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Do we need medical leadership or medical engagement?

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Received 31 March 2014
Revised 25 September 2014
23 October 2014
Accepted 24 November 2014

Abstract

Purpose – The purpose of this paper is to address issues of medical leadership within health systems and to clarify the associated conceptual issues, for example, leadership versus management and medical versus clinical leadership. However, its principle contribution is to raise the issue of the purpose or outcome of medical leadership, and, in this respect, it argues that it is to promote medical engagement.

Design/methodology/approach – The approach is to provide evidence, both from the literature and empirically, to suggest that enhanced medical engagement leads to improved organisational performance and, in doing so, to review the associated concepts.

Findings – Building on current evidence from the UK and Australia, the authors strengthen previous findings that effective medical leadership underpins the effective organisational performance.

Research limitations/implications – There is a current imbalance between the size of the databases on medical engagement between the UK (very large) and Australia (small but developing).

Practical implications – The authors aim to equip medical leaders with the appropriate skill set to promote and enhance greater medical engagement. The focus of leaders in organisations should be in creating a culture that fosters and supports medical engagement.

Social implications – This paper provides empowerment of medical professionals to have greater influence in the running of the organisation in which they deliver care.

Originality/value – The paper contains, for the first time, linked performance data from the Care Quality Commission in the UK and from Australia with the new set of medical engagement findings.

Keywords Health leadership initiatives, Leadership, Organizational performance

Paper type Conceptual paper

Leadership in Health Services
Vol. 28 No. 3, 2015
pp. 173-184
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1751-1879
DOI 10.1108/LHS-03-2014-0029

Introduction

There appears to be quite widespread international advocacy of increasing the involvement and participation of doctors in the leadership of health-care

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organisations (Darzi, 2009, in the UK; Falcone and Satiani, 2008, in the USA; and Dwyer, 2010a, 2010b; Health Workforce Australia, 2011, in Australia). These are specific examples, but the viewpoint is quite widespread and would, one assumes, stem from a lack of such involvement. In the UK, most hospital chief executives are non-physician managers, whilst in the USA, out of 6,500 hospitals only 235 are led by physicians (Gundesman and Kanter, 2009). In Australia, the number of doctor Chief Executives in hospitals is not known but the lead professional body's workforce plan describes a shortage of doctor managers, known as medical administrators, citing recruitment, retention and lack of training positions as causes.

In Australia, the Royal Australian College of Medical Administrators (RACMA) provides training for specialist medical administrators who move into medical leadership roles. Dwyer (2010a, 2010b), also in Australia, has acknowledged that the roles and skills required by medical leaders are poorly understood by the medical profession. The sense of general agreement and advocacy of enhanced medical leadership can sometimes be based upon rather over-generalised use of terms and assumptions (that when asserted sufficiently, often appear to be factual). In this context, a major assertion is that the involvement of physicians leads to a better organisational performance. It is only recently that Goodall (2011) reported for almost the first time that there was "a strong positive association between ranked quality of a hospital and whether the CEO is a physician" ($p < 0.001$). This was in the USA, and, even here, the report is one of association rather than clear causal attribution. Delivering high quality patient experiences and clinical outcomes within a financially constrained environment is among the highest priorities for healthcare leaders; the exploration of the relationship between the quality of medical leadership, engagement and performance is vital. The authors here also contend that involvement of doctors in organisational leadership can have a positive benefit but that there are many subtleties and confusions of definition, meaning and terminology that need to be dealt with before the critical process – medical engagement – can be discerned. In this paper, we will attempt to address a number of the common misconceptions, or blurred terms, before offering a focus on the nature and role of medical engagement in improving organisational performance.

Clarifying terms and assumptions

There are at least three areas which we suggest would benefit from greater clarity of definition and use. This is not to assert that the view expressed here is unchallengeably correct; rather, it is to be clear how we are using the terms and to recognise the implications and understanding that can occur from less precise usage.

"Leadership" versus "A Leader"

By definition, the study reported by Goodall (2011) is concerned with individual physicians who are appointed to a designated leadership role as the CEO. The traditional and somewhat outmoded approach to leadership is to search for a set of characteristics or qualities possessed by an individual regarded as a leader. The language used to discuss leadership often reflects an underlying implicit model or concept of leadership. Spurgeon and Crag (2007) suggests that there is a tendency to

confuse the question, "who are leaders?" with, "what do leaders do?" The former approach emphasises the notion of leadership as a personal capacity, and enquiry using this model has produced a number of overlapping lists of personal qualities that a leader might be expected to possess. However, those who produce such lists rarely state whether all the characteristics are necessary to undertake leadership roles or just some, and which ones and in what combinations? The potential for confusion in the reader of such lists is considerable and, to some extent, explains the difficulty the learner or trainee has in grasping what is needed to be a leader. A more constructive interpretation is to recognise that many individuals can contribute as leaders but in quite different ways, depending on their own unique set or combination of characteristics.

The search for universal characteristics of a leader has been largely unsuccessful and probably flawed in principle. As Grint (2001) says, the term is so multifaceted and so many constructions exist, that many authors do not say quite what they mean by the term leader or leadership. A similar view is expounded by Edmonstone (2009), who suggests that the current approach sees leadership as existing within individuals rather than in the relationships between them and in the organisational context.

A parallel confusion exists when discussing medical leadership. The position advocated here is leadership as a process defined heavily by the contextual demands of the situation, and via a model of shared or distributed leadership, enabling most individuals to collectively contribute to the process in many varying ways, according to their personal qualities, skill sets, experience and position (Petrie, 2011).

Medical versus clinical leadership

The US health-care system tends to use the term "physician leadership" and, in many ways, overrides the problem within this definitional use. There are two concerns here. Even if a definition of leadership could be agreed, is it the same as clinical leadership, or is this something distinct and different? Some might argue that clinical leadership is just a description of any individual in a clinical role who exercises leadership; others suggest that it is leadership by clinicians for clinicians. The latter would seem a much too narrow formulation, as it would automatically exclude other management or leadership activity, and the point really is to involve clinicians in a wider set of tasks than their immediate clinical context.

The other issue is whether, by using the term clinical leadership, authors are trying to be inclusive of all clinical professions but are not quite saying what they mean. For example, Edmonstone (2009), when discussing clinical leadership, goes on to quote the results of a survey by Nolan about career paths, which actually focussed only on medical directors. Our use of the term medical leadership is not in any way meant to undermine or overlook the contribution of other healthcare professionals to the essential teamwork demanded by modern healthcare provision. By advocating medical leadership as distinct from clinical leadership, it is not to imply that a doctor is always the leader or a better leader in all circumstances. This is far from the case. However, what is suggested is that when leadership is examined within a team, the professional identity, training and perspective of an individual is part of how the leadership role is enacted. There are, of course, other pragmatic

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reasons for making the distinction, not least in respect to training and career pathways. The medical undergraduate course is of a different length and pattern and the junior doctor role is only found in one professional group. Finally, there is, as Spurgeon *et al.* (2011) discuss, the different perspective of doctors within the health system, based notably on a history of individualistic expertise, maintenance of medical autonomy in practice and differential power bases within the professional grouping, and this has an influence on how they (and others) perceive their role and contribution to the leadership process.

Management or leadership

This is a perennial debate, and is largely unproductive and unresolved. Is it possible to draw a clear distinction between the two terms, and does it matter whether or not this is possible? It is certainly true with regard to the latter point that, in the UK health system, the invitation for doctors to become involved has been markedly more successful when use of the term "leadership" emerged to replace that of "management". This was, to some extent, a process of evolution, but it also reflects the relative stereotypes attached to the two terms. On the whole, individuals do not feel positive about being "managed", associating it with bureaucracy and control. In contrast, the charismatic leader articulating a positive vision of a better future is a rather more appealing prospect. We may summarise the argument by suggesting that managers are primarily concerned with making the current system and its procedures operate as efficiently and effectively as possible. Leaders, on the whole, seek to change what currently exists so that the organisation will be better equipped to deal with the future. The latter usually has a rather longer-term perspective and also has a motivational impact upon the people who work in the organisation (Spurgeon and Klaber, 2011).

Any distinction quickly becomes blurred in practice. Major implementation programmes within organisations are typically assigned to a manager using the concept of project management. However, the success of any such implementation will often turn on the manager's ability to communicate and convince staff of the merits of the change. This task in itself sounds very much like the influencing behaviour that is said to be an essential ingredient of leadership.

Similarly, this can operate in the reverse direction. If a young consultant seeks to set up or improve a service, then influencing colleagues, management, patient groups and funders will be a major leadership task. However, in such a setting, the young doctor will very quickly be asked to develop a detailed business plan – and this would normally be described as a classic management task. Most significant tasks in organisation require aspects of management and leadership. It may be more useful to think of management and leadership as processes which interact and support each other, and are both necessary for effective organisations.

Medical engagement

Having clarified our position on some important aspects of terminology, it is possible to turn to the main thrust of our argument in this paper. It is not unreasonable to ask what the current advocacy of medical leadership is for – presumably to improve the performance of the organisation and the delivery of healthcare to patients. It is our contention that medical leadership is in itself a

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mechanism or process to achieve greater medical engagement in the running of the organisation, and that it is this engagement that has the impact upon organisational performance. In this section, we set out the background and development of this proposition, providing conceptual as well as empirical evidence from the UK and Australian health systems.

Engagement has become a widely used term and, perhaps as a consequence, there is some slippage with definition and meaning. It is used beyond the health service and in a range of sectors. McLeod and Clarke (2011) provide a very useful review across a range of sectors. They suggest that there is no universal definition but, despite this, conclude a) that engagement is measurable, although the different tools used account for some of the variability in the concept, and b) that engagement correlates with performance and innovation and, although correlational, that the consistent nature of studies of engagement, coupled with individual company case studies, makes for a "compelling case".

The weight of evidence in the health sector is accruing all the time. Prins *et al.* (2010) found that, in a study of 2,000 Dutch doctors, the more engaged were significantly less likely to make mistakes. Toto (2005) demonstrated that engaged physicians can have a direct day-to-day input on the financial bottom line of hospitals. Without medical engagement at a collective level and the individual alignment of doctors, Taitz *et al.* (2011) found that there is no meaningful way to influence variations in practice or care. The UK Health Think Tank, The King's Fund (2012), devoted its entire 2012 Leadership Commission event to exploring the importance of engagement in the health sector.

Schaufeli and Bekker (2003) describe engagement as "a persistent, positive, effective, motivational state of fulfilment in employees that is characterised by vigour, dedication and absorption". It is not always the case that the term is used with an associated definition. It is often used rather generally to imply that a communication process is in place – engaged in a debate. This is rather loose, feels rather one-way (from management to employee) and, worryingly, in the context of doctors, might suggest communication for compliance, a proposition unlikely to be too well-received.

The term "engagement" is also sometimes used as an action verb – to engage in a task or do something. However, if the task changes or even disappears, does it therefore mean that the individual is not engaged? This, in our view, externalises the process of engagement too much, so that it is associated with a singular task or activity. The view adopted here is that engagement is an intra-individual concept, involving a motivational state or level of commitment that exists within the individual and can be applied to a range of tasks or settings. It is a perspective on engagement that serves to explain its linkage to a range of organisational performance motives. An individual's reservoir of motivation/commitment can increase and, if this is extended to a collective workforce, then one can see why an organisation, by increasing its overall level of engagement, has effectively increased its potential "power" to perform.

It was just this conceptualisation that led to the development of the Medical Engagement Scale (MES) within a national project in the UK, called Enhancing Engagement in Medical Leadership, run jointly by the Institute of Innovation and

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Improvement, and the Academy of Royal Medical Colleges. The focus on the medical profession in particular was a recognition of the power and influence of this professional group, their critical position in the promotion and implementation of medical improvement sought by the government and the need to move them collectively from a somewhat negative, alienated group to one much more engaged, driving through important improvements.

So the MES was developed around three conceptual premises:

(1) Medical engagement is critical to implementing important changes and improvements in the health system.

(2) A definition of medical engagement includes: "the active and positive contribution of doctors, within their normal working roles, to maintaining and enhancing the performance of the organisation, which itself recognises this commitment, in supporting and encouraging high quality care" (Spurgeon *et al.*, 2011) – which means the measure simultaneously requires the reciprocal nature of engagement, by assessing an individual's propensity to engage, and the organisational system, in terms of its role in creating the cultural conditions for engagement to flourish.

(3) A distinction is made between competence and performance in the context of work behaviour. Competence may be thought of as what an individual can do, but this is not the same as what they will do, with the two together equating performance.

A full account of the development of MES is to be found by Spurgeon *et al.* (2011). The scale was developed with a very large sample of NHS staff (over 20,000), good reliability (0.7 to 0.93) established for the sub-scales (Working in an Open Culture, Having Purpose and Direction, Feeling Valued and Empowered) and validity. Following the pilot work, MES was applied to a further 30 secondary care trusts in the UK health system, to:

- establish normative data for patterns of engagement; and
- assess the underlying challenge – does medical engagement relate to organisational performance?

MES consists of 30 items and is administered as a survey of all medical staff in a health care organisation. It is typically offered via a website link and also includes organisational identifiers such as Directorate/Division or Specialty Group, role in the organisation and length of time working in the organisation. The resulting analysis provides an overall index of Medical Engagement levels as well as scores on the sub-scales that make up the index. These sub-scales act as a diagnostic tool identifying areas where the organisation might focus efforts to enhance levels of measured medical engagement. The data are collected from each participating organisation and then combined to provide a cumulative normative dataset.

In the next section, we present some findings on these two issues, from the UK (where the relevant database is now approaching 80 UK Trusts and well over 8,000 doctors on the database) and a smaller subset of early findings from the Australian work.

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Results

UK findings

The initial UK normative group of 30 trusts was examined in terms of the association between the level of medical engagement and performance on a number of externally and independently collected performance indicators. A very large number of significant correlations were observed (Table I).

The relationships included a wide range of types of indicator, from clinical performance, financial management, safety indicators, patient experience and overall quality standards. The relationships are, of course, by association, and do not, in themselves, indicate conclusively directionality. However, the results are congruent with the wider systematic association between levels of engagement and organisational performance.

As data collection has continued, it was decided to reassess the new set of medical engagement data against the most recent and evolved set of performance measures used by the Care Quality Commission (CQC) (2013) in the UK (Table II). Once again, a large number of significant correlations were observed – between a new set of medical engagement data and a new set of performance measures. So again, this strong association is found, suggesting that the common unit here (medical engagement) has a sustained and continuing probable causal link to organisational performance.

Australian results

An initial pilot project using MES has been conducted in Australia and New Zealand. Four sites have so far completed and currently all have been compared on the existing UK normative database. However, as more Australian and New Zealand sites participate, it will be appropriate to develop localised norms for future use and comparison. However, even within the constraints of using UK norms, there is a clear distribution and relativity of MES results. Two sites are in the high range overall, and two in the low range. Broadly speaking, the results at the Australian sites compare to the UK results in so much as the two ranking high on the MES index perform well using nationally agreed risk-adjusted performance data.

Implications for medical leadership

The linkage of medical engagement to a range of health organisational performance measures has two important implications:

1. that it is important to understand how organisations may best promote medical engagement; and
2. an imperative for medical leaders to develop or utilise the appropriate skills to enhance levels of medical engagement.

A recent study by Atkinson *et al.* (2011) looked at organisations with high levels of medical engagement, seeking to identify common features in these organisations that might explain their levels of achieved engagement. They report the following key elements:

- Leadership is a stable, top level leadership team that promotes and fosters relationships, sets expectations and leads by example. We know that engagement requires good interpersonal relationships and that, without

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Table I.
Relationship between initial MES cohort (30 Trusts) and independent performance data

The care quality commission – NHS performance ratings 2008/2009	Medical engagement index	Meta 1: working in a collaborative culture	Meta 2: having purpose and direction	Meta 3: being valued and empowered	Sub 1: climate for positive learning	Sub 2: good interpersonal relationships	Sub 3: appraisal and rewards effectively aligned	Sub 4: participation in decision making and change	Sub 5: development orientation	Sub 6: work satisfaction	*n* trusts
The care quality commission – NHS performance ratings 2008/2009											
Overall quality score	0.68***[a]	0.63***	0.70***	0.65***	0.68***	0.46**	0.73***	0.49**	0.62***	0.62***	30
08/09 financial management score	0.47**[a]	0.48**	0.44**	0.46**	0.50**	0.37*	0.52**	0.24	0.47**	0.41**	30
08/09 core standards score (as a provider of services)	0.34*[a]	0.37*	0.25	0.36*	0.37*	0.31*	0.31*	0.12	0.41*	0.28	30
08/09 existing commitments score (as a provider of services)	0.64***[a]	0.59***	0.67***	0.60***	0.64***	0.45*	0.69***	0.53**	0.61***	0.55**	25
2008/2009 NHS performance ratings existing commitments and national priorities indicator scores (frequency of "achieved")	0.69***[a]	0.54**	0.75***	0.70***	0.56**	0.44*	0.76***	0.62***	0.66***	0.68***	25
Total time in A&E: four hours or less (% level "achievement")	0.55**	0.55**	0.47*	0.59***	0.52**	0.53**	0.52**	0.33	0.70***	0.46*	24
Inpatients waiting longer than the 26 week standard (% level "underachievement")	−0.57***[a]	−0.59***	−0.41*	−0.64***	−0.52**	−0.62***	−0.44*	−0.30	−0.72***	−0.52*	25
All cancers: two month urgent referral to treatment (% level "achievement")	0.54**[a]	0.52**	0.42*	0.61***	0.49**	0.50**	0.35*	0.46*	0.60***	0.57**	24

Notes: [a] Attentuated range of performance ratings; levels of significance; $^{*}p < 0.05$, $^{**}p < 0.01$, $^{***}p < 0.001$

MES scales	Examples of CQC indicators			
	Patient survey		Key indicators	
	IPSurfConfDoc	IPSurfInvDeci	SINAP15	NHFD01
Index of medical engagement	0.67		0.59	
Meta 1 – Working in a collaborative culture	0.60		0.62	
Meta 2 – Having purpose and direction				0.55
Meta 3 – Being valued and empowered	0.69	0.57	0.58	
Sub 1 – Climate for positive learning			0.59	0.55
Sub 2 – Good interpersonal relationships	0.66		0.66	
Sub 3 – Appraisal and rewards effectively aligned			0.64	
Sub 4 – Participation in decision-making and change				0.62
Sub 5 – Development orientation	0.72	0.61		
Sub 6 – Work satisfaction	0.64		0.62	

Notes: IPSurConfDoc = Inpatient Survey 2012 Q25 "Did you have confidence and trust in the doctors treating you?"; IPSurInvDeci = Inpatient Survey 2012 Q32 "Were you involved as much as you wanted to be in decisions about your care and treatment?"; SINAP15 = Key Indicator 8: Number of potentially eligible patients thrombolysed; NHFD01 = National Hip Fracture Database: measure of cases assessed as achieving compliance with all nine Best Practice Tariff standards of care

Table II. Example of new MES data and new care quality commission data (2014)

stability, particularly in the executive, it is hard for these relationships to form.

- Selecting and appointing the right doctors to leadership and management roles. There has been a history of appointing the most senior doctors irrespective of competence for the post. Highly engaged organisations make the right appointment an important principle by using open competition and ensuring a choice of candidates, and then selecting based on ability, leadership aptitude and potential. This has the vital ingredient of signalling that medical leadership roles are really important and can have a major influence upon the functioning of the organisation.
- Promoting understanding, trust and respect between doctors and executive leaders. This recognises that professional groups may have different perspectives but that they can work together for a common goal of delivering improved patient care.
- Effective communication, so that information is shared openly and honestly without hidden agendas.
- Setting clear expectations about acceptable professional behaviour and being willing to enforce this, whoever is involved, if behaviour occurs outside of these guidelines.
- Providing continuous support, development and leadership-skills-training for doctors at all levels. This is not simply about sending individuals on external courses, but offering mentorship, coaching, identifying potential and having a culture, whereby improvement programmes and personal development are built together so that the whole organisation can benefit.

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If these factors represent overall ways in which organisations can operate to enhance engagement, what are the implications for individuals in medical leadership roles? On the evidence that enhanced levels of medical engagement improve organisational performance, it is vital that medical leaders acquire the requisite skills that will enable them to foster this engagement.

There is evidence from the NHS in the UK that the pursuit of improvement, and especially meeting centrally imposed targets, has led to a forceful, hectoring, possibly bullying style which has been described as "pace-setting" (Hodgetts, 2012). Short-term gain has been achieved, whilst the more constructive long-term relationships described above have been sacrificed.

There is a recognition that this style needs to change, or at the very least be developed so that other approaches can exist. Perhaps, the point was most powerfully made by the Francis Report (2011), following the failings at Mid-Staffordshire Hospital, who said that the failure in clinical governance at the Trust was caused by:

> […] a lack of clinical engagement – whatever then gets turned out by the Department of Healthcare, whatever initiatives are started at the top, unless the clinical soil is fertile, the seeds will inevitably fall on stony ground at Trust level (Francis Report, 2011).

The challenge for medical leaders is that a style that builds upon the views of a range of stakeholders, and explores this diversity of perspective, is more difficult, more demanding of quite high level skills (Alimo-Metcalfe and Alban-Metcalf, 2008). Brook (2010) argues that physicians need to go beyond the immediate concerns of their individual professional practice and to engage in the improvement of healthcare outcomes for entire communities and populations – that is, leadership is about improving health, reducing variation, and doing so in an affordable way.

A subtle shift in the role of medical leaders is required, moving from individual doctor excellence, which is insufficient to overall health systems improvement (Bohmer, 2012). In conclusion then, we move through a process of encouraging more doctors into medical leadership roles, but equipping them with the necessary skills to ensure that, through their leadership, individual engagement is enhanced and thus organisational performance improved.

The view that medical leaders are crucial to supporting the development of such engaged cultures is recognised in both the UK through inclusion of leadership skills in the undergraduate and post-graduate curricula, as well as in Australia – Scott *et al.* (2012) suggesting that physician training be widened to encompass behaviours beyond technical skills.

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