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Erwin Loh Jennifer Morris Laura Thomas Marie Magdaleen Bismark Grant Phelps Helen Dickinson

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Shining the light on the dark side of medical leadership – a qualitative study in Australia

Erwin Loh
Monash Health, Clayton, Australia and Monash University, Clayton, Australia
Jennifer Morris and Laura Thomas
Melbourne School of Population and Global Health, University of Melbourne, Melbourne, Australia
Marie Magdaleen Bismark
Centre for Health Policy, University of Melbourne, Melbourne, Australia
Grant Phelps
School of Medicine, Deakin University, Victoria, Australia, and
Helen Dickinson
University of Melbourne, Melbourne, Australia

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Abstract

Purpose – The paper aims to explore the beliefs of doctors in leadership roles of the concept of "the dark side", using data collected from interviews carried out with 45 doctors in medical leadership roles across Australia. The paper looks at the beliefs from the perspectives of doctors who are already in leadership roles themselves; to identify potential barriers they might have encountered and to arrive at better-informed strategies to engage more doctors in the leadership of the Australian health system. The research question is: "What are the beliefs of medical leaders that form the key themes or dimensions of the negative perception of the 'dark side'?".

Design/methodology/approach – The paper analysed data from two similar qualitative studies examining medical leadership and engagement in Australia by the same author, in collaboration with other researchers, which used in-depth semi-structured interviews with 45 purposively sampled senior medical leaders in leadership roles across Australia in health services, private and public hospitals, professional associations and health departments. The data were analysed using deductive and inductive approaches through a coding framework based on the interview data and literature review, with all sections of coded data grouped into themes.

Findings – Medical leaders had four key beliefs about the "dark side" as perceived through the eyes of their own past clinical experience and/or their clinical colleagues. These four beliefs or dimensions of the negative perception colloquially known as "the dark side" are the belief that they lack both managerial and clinical credibility, they have confused identities, they may be in conflict with clinicians, their clinical colleagues lack insight into the complexities of medical leadership and, as a result, doctors are actively discouraged from making the transition from clinical practice to medical leadership roles in the first place.

Research limitations/implications – This research was conducted within the Western developed-nation setting of Australia and only involved interviews with doctors in medical leadership roles. The findings are therefore limited to the doctors' own perceptions of themselves based on their

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past experiences and beliefs. Future research involving doctors who have not chosen to transition to leadership roles, or other health practitioners in other settings, may provide a broader perspective. Also, this research was exploratory and descriptive in nature using qualitative methods, and quantitative research can be carried out in the future to extend this research for statistical generalisation.

Practical implications – The paper includes implications for health organisations, training providers, medical employers and health departments and describes a multi-prong strategy to address this important issue.

Originality/value – This paper fulfils an identified need to study the concept of "moving to the dark side" as a negative perception of medical leadership and contributes to the evidence in this under-researched area. This paper has used data from two similar studies, combined together for the first time, with new analysis and coding, looking at the concept of the "dark side" to discover new emergent findings.

Keywords Doctors, Dark side, Medical leadership, Medical management

Paper type Research paper

Introduction

"It takes strength to resist the dark side. Only the weak embrace it!"

Obi-Wan Kenobi, Jedi Master, Episode IV – A New Hope, Star Wars

The Force is a metaphysical, ubiquitous power in the popular science fictional universe of the Star Wars galaxy created by George Lucas, and the Dark Side of the Force is a concept which represents the corruptive aspect of the Force that is considered evil (Decker and Eberl, 2005). As portrayed in Star Wars, the Dark Side provides its practitioners with special powers similar to those used by the Jedi, who are the good practitioners of the Force, but draws their power from negative emotion, such as hate. The phenomenon, where those who take on formal medical leadership roles are perceived as having gone to the "dark side", has been well documented (Spurgeon *et al.*, 2011) but is still an under-researched area.

There are two possible implications of the use of the term "dark side". First, clinical practice, which focuses on people and on reducing human suffering, is intuitively perceived by doctors as an innately good thing, whereas the traditional, old-fashioned view of management, with the belief that it focuses only on processes and finances (Drucker, 1973), potentially at the expense of people, can be perceived as intrinsically bad, despite its known importance in ensuring the effective functioning of complex systems, such as health care In other words, clinicians do the right things by their patients, whereas managers bean count and balance the books. Therefore, getting involved in leadership and management is moving away from the perceived altruistic activity of clinical practice. Second, there may be the perception that doctors are attracted to leadership roles that are perceived to be powerful and those who take them on are seen to be using their clinical skills and positions for "evil" instead of "good". The question is whether this implication creates a barrier for doctors who are considering a move from clinical practice into medical leadership roles.

This association between medical leadership and patient outcomes can be attributed to health services being professional bureaucracies, where front-line staff, such as doctors, have increased power and influence because they have specialist training and knowledge that gives them more control of their normal day-to-day duties compared to those in formal positions of authority, leading to an inverted power structure

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(Mintzberg, 1979). Consequently, doctors play an important role as clinical champions and key opinion leaders within health services, and they can act as either an enabler or a barrier to change (Ham and Dickinson, 2008). Furthermore, in professional bureaucracies like health services, front-line staff, such as doctors, are influenced more by the credibility of their professional peers than by the power of people in formal positions of authority (Braithwaite, 2010). Therefore, health leaders have to gain credibility and trust, which may come easier for those who have entered from the front-line ranks and negotiate agreement for change rather than merely impose new policies and procedure (Ham *et al.*, 2011).

Indeed, doctors have been promoted into medical leadership roles as clinical directors of clinical service units in various countries after initial trials in the USA and UK (Buchanan *et al.*, 1997; Cragg *et al.*, 2007; McKee *et al.*, 1999), and more recently in Australia (Braithwaite and Westbrook, 2004; 2005). In addition, doctors have also been appointed as medical leaders in senior management and executive roles of health services in an effort to improve medical engagement (Fitzgerald, 1994; Fitzgerald and Stuart, 1992; Llewellyn, 2001). These medical leaders may maintain a part-time clinical practice and function as hybrid clinician managers, although many who move into more senior management roles give up clinical practice altogether to become full-time medical leaders (Spurgeon *et al.*, 2011). For the purposes of this paper, therefore, medical leaders are doctors who have defined leadership roles in their health organisations. With recent increasing focus on medical leadership in health, a more professionalised cadre of doctors has emerged, leading to formalised specialists training in medical management (Dickinson *et al.*, 2013; 2014). Recent research found two categories of such clinician managers – the "incidental hybrid", who is temporarily in the leadership role and the "willing hybrid", who purposefully form an authentic identity as a permanent medical leader (McGivern *et al.*, 2015).

However, besides the barrier of the perception of joining the "dark side", there are other significant professional disincentives that discourage doctors from pursuing medical leadership roles (Loh, 2012). One major disincentive is the difference in potential income between doctors in senior medical leadership roles and those in senior clinical roles (Ham *et al.*, 2010). Other barriers include: lack of management and leadership training for doctors (Coile, 1999) and fear that they will lose professional autonomy (Degeling *et al.*, 2003). In addition, doctors in clinical practice tend to remain in health services for a long time, and because they have witnessed a high turnover of senior managers over their tenure, they are concerned about the apparent lack of job security compared with clinical practice (Ham *et al.*, 2010).

Be as it may, there is an increasing recognition for the need for doctors to step up into leadership roles in health services (Fielden, 2015), and recent developments have shown an increase in the involvement of doctors in the leadership of health systems (Kyratsis *et al.*, 2016). Research looking at health services in the UK and Australia have shown that the main benefit of improved medical leadership is medical engagement (Spurgeon *et al.*, 2015; Dickinson *et al.*, 2015a). To this end, there is a push to ensure that doctors are not just clinical experts but are provided with management and leadership skills as well (Clark, 2015; Till *et al.*, 2015). Investment in improving medical leadership to improve emotional intelligence, financial acumen and change management skills has been encouraged (Sacks and Margolis, 2015). Very interestingly, there remains a lack of evidence that widespread, non-targeted medical leadership training for all doctors

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provide a return of investment (Jorm and Parker, 2015). Despite this, recent research has shown the importance of mentoring, coaching and developing medical leaders for improvements in quality of care (Wolter *et al.*, 2015). Nevertheless, doctors with leadership positions continue to struggle because of the different characteristics of the social identities of doctors and managers (Andersson, 2015).

Despite calls to drop references about "going over to the dark side" (Lees, 2016, p. 6), this concept remains a recurrent and prominent theme when doctors in leadership roles are asked about how they see themselves. This article explores the concept of the "dark side" using data collected from interviews carried out with 45 doctors in medical leadership roles across Australia. Those interviews did not specifically ask about the "dark side" but provided rich data that allowed the authors to consider the key research question of:

RQ1. "What are the beliefs of medical leaders that form the key themes or dimensions of the negative perception of the 'dark side'?".

Through the analysis of the findings, it is hoped that this paper can better inform strategies to engage more doctors in the leadership of the Australian health system.

Methodology

This paper derives its data from two sources – a qualitative study on medical leadership in a single Australian state in 2011 involving 20 doctors (Loh, 2012) and a subsequent study carried out three years later by the same author in collaboration with other researchers looking at the same topic in five Australian states involving 30 doctors (Dickinson *et al.*, 2015b). The initial research was approved by the Ethics Committee of the Australian Institute of Business and subsequent research by the University of Melbourne Human Research Ethics Committee, with both research studies examining similar research questions through essentially the same qualitative methodologies.

Both studies used in-depth semi-structured interviews with purposively sampled senior medical leaders in leadership roles in health services; that is, the sampling method was purposeful rather than random (Patton, 1987). These interviewees were doctors who had roles leading health services, hospitals (private and public), professional associations and health departments and were chosen for their medical leadership roles through the researchers' own networks and medical leadership associations and groups. The five interviews carried out as part of the convergent interview stage of the initial study to develop the interview guide have not been included in the analysis or results, even though two of the five interviewees in that cohort were doctors. Interviewees were purposefully sampled to ensure diversity in gender, age, tenure, leadership role, organisation type and geographical location, as outlined in Table I.

The researchers contacted potential interviewees via phone or email, with no subsequent drop-outs and a 100 per cent participation rate. Initial interviews occurred in Victoria in 2011, and further interviews were conducted nationwide to include interviewees from New South Wales, Queensland, Western Australia and Tasmania in 2014. Interviewees were given a choice of face-to-face or telephone interviews, with no third party present during the interviews. There were a total number of 45 interviewees from around Australia contributing to the data analysed for this paper, providing the researchers with views from an array of perspectives related to the subject which formed a rich body of data.

Characteristic	No. (n = 45)
Gender	
Male	29
Female	16
Organisation	
Public hospital or health service	24
Private hospital	6
Government department or public sector agency	6
Professional College or Association	9
Leadership role	
CEO/President/Dean	18
Second- or third-tier management	18
Medical director or clinical leader	9

Table I. Interviewee characteristics

The researchers used semi-structured interviews to elicit the interviewees' beliefs and experiences. The purpose of the interviews was explained to the interviewees by the researchers at the beginning of each interview as an attempt to better understand the drivers and barriers relating to the engagement of doctors in medical roles in health organisations. Both studies used a formal interview schedule of questions which was developed based on a comprehensive literature review relating to the research issues and through an initial convergent interviewing stage. The length of interviews ranged from 25 to 90 min. Written consent was obtained to audio record the interviews, which were subsequently transcribed verbatim. The researchers also took field notes during interviews to record initial ideas. There were 42 questions in the first study and 20 questions in the second study, which were grouped according to similar themes, designed to explore general issues relating to doctors in leadership roles. It should be noted that a specific question about the "dark side" was not included in the interview schedules, but the phrase was raised independently around discussions relating to barriers in the engagement of doctors. This paper is a result of additional analysis and coding of the specific theme of the "dark side" that independently arose from those two studies.

As such, this paper combines the dataset from the two previous studies into a single dataset, and analysis was performed on the complete data set for the first time for this paper. Content analysis in this research was based on the "scissor-and-sort" technique, the most common technique for analysing data in focus group research (Crabtree *et al.*, 1993; Stewart and Shamdasani, 1990), where the data collected are closely organised and examined, with any clear patterns initially "cut" or picked out (the scissor) before they are themed (the sort) into clusters of similar data with meaningful relationships to facilitate the drawing of conclusions. Such a straightforward content analysis method was deemed appropriate because this research sought to carry out an in-depth exploration of an under-researched area using interview data (Stewart and Shamdasani, 1990). The researchers developed a coding framework using deductive and inductive approaches based on the interview data and literature review (Gibbs and Taylor, 2010). All sections of coded data were grouped into themes by combining different codes that were connected through key concepts and repeated patterns into groupings (Creswell,

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2002; Neuman, 2006). The whole data set was then re-examined as a whole to ensure that important themes were not missed during earlier stages of coding (Clarke and Gibbs, 2009). For the purpose of this paper, interviewee statements that referred to the phrase "dark side" and other concepts were coded and grouped into themes to form the findings discussed later.

Findings

The "thick" picture usually expected in qualitative research (Eisenhardt and Graebner, 2007) has been provided to flesh out the findings; that is, verbatim quotations, which have been anonymised, are provided below. Each interviewee has been identified via a specific code starting with a single letter and number (e.g. A1) for interviewees from the first Victorian study (e.g. A1) or ML and number (e.g. ML07) for those from the subsequent national study.

A clear and recurrent theme emergent from the content analysis of the interview data collected is the main finding that doctors in medical leadership roles consider the negative perception by other doctors in clinical practice to be a major barrier in their decision to transition into such roles. The negative perception of medical leaders who move into management from clinical practice has been expressed as "*going over to the dark side*". As interviewee C2 put it: "*Probably the most common comment […] was you had moved over to the dark side*". Interviewee A3 explained this concept in terms of scepticism: "*there's a lot of, particularly amongst your medical peers, that there's a lot of scepticism about it. I think people really still talk about it as the dark side […]* " This perceived lack of respect from the clinical colleagues of medical leaders is a significant finding and will now be examined further.

The following four themes were not pre-determined or predicted but arose independently out of the analysis and coding of the accumulated data. In brief, as shown in Table II below, the data analysis suggests medical leaders perceive that they have "moved to the dark side" because of the belief they lack both managerial and clinical credibility; have confused identities; are in conflict with clinicians and clinicians lack insight into what they do.

Table II. Four key beliefs representing the four dimensions of the perception of the "dark side"

Beliefs	Example quote
Medical leaders believe they lack credibility	"*I was a clinician for a long time and I also hated medical administrators. Because I think that from the perspective of the clinician, they're really not doctors. They're frauds*"
Medical leaders are confused about their identity	"*So I've always had this little saying that when I speak to my non-clinical colleagues, I wear a clinician's hat. When I speak to the clinicians, I wear a manager's hat. The interesting thing is I think that makes us hybrids or half-casts*"
Medical leaders are concerned their roles lead to conflict	"*Because at times you're put in direct conflict with your colleagues who you've worked with for many years*"
Medical leaders believe their peers lack insight into their work	"*The tendency is for doctors and other clinicians to simply to underestimate what's required in management and overestimate their own abilities to do it*"

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An issue of credibility – medical leaders believe they lack credibility
Medical leaders feel that they lack credibility in their eyes of their clinical colleagues, which on closer investigation takes a number of different dimensions. On the one hand, this may manifest as a lack of managerial credibility by clinicians. As interviewee ML07 explained:

> I think that doctors are very critical about the credibility. They're very suspicious of administrators and why they would want to step out of clinical […] Why else don't we like them? Because we don't like them because they have really gone over to the dark side […] Clinicians have no appreciation of cash. They don't even know how hospitals run. Clinicians actually have no idea how hospitals run, so they're […] it's extraordinary that people who spend six years training to be a doctor actually don't get the health system. It'd be like a banker not really understanding how money works.

Although many doctors are critical of managerial capacity, it appears that they are even more critical of medical leaders because they may not have the same training or background as their managerial colleagues have.

On the other hand, medical leaders believe they may also lack clinical credibility in the eyes of their clinical colleagues. For example, interviewee ML15 stated:

> I spent the 12 years in clinical medicine […] I do think that is an advantage because I know very well how hospitals are run from both sides of the fence. I know enough about the clinical, patients, the whole lot and I worked in hospitals for six years and I worked in general practice for six years, rural general practice […] I used to call myself jack of all trades, master of none and […] in some ways I do get worried about young doctors taking on medical management after two or three years of doing medicine because you're just getting to understand the actual practice of medicine, then you give it up. That's a bit sad.

In addition, this lack of clinical credibility can lead to medical leaders believing that other doctors perceive them as failed clinicians who were clinically incompetent and not "*real*" doctors. For example, interviewee A3 explained:

> […] culturally there's a negative factor that went into making the decision. I think people would pejoratively say it's the type who can't make it clinically […] I think your reputation gets hit a bit when you go across into management.

Likewise, interviewee C3 used the term "failed clinicians": "*That's the perception, that FRACMA's [specialist medical administrators] are failed clinicians*". Lastly, interviewee E2 used the term "failed doctors": "*There's a lot of clichés around that I've heard […] Things like failed doctors*". The term "fraud" was even used by interviewee ML07 who stated:

> I was a clinician for a long time and I also hated medical administrators. Because I think that from the perspective of the clinician, they're really not doctors. They're frauds. They happen to have a medical degree, but they actually haven't practiced. Some are shifting because they couldn't quite cut the mustard clinically. And I think that's very much it and I think that people will follow a very bad administrator who's a great clinician, right, and they'll forgive them their poor administration but they will not follow a great administrator who is a bad clinician.

An issue of identity – medical leaders are confused about their identity
Doctors in leadership roles may end up being confused by their identity, being perceived as not quite a clinician by their clinical colleagues and not quite a manager by their professional executive peers. Interviewee ML15 explained:

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> So I've always had this little saying that when I speak to my non-clinical colleagues, I wear a clinician's hat. When I speak to the clinicians, I wear a manager's hat. The interesting thing is I think that makes us hybrids or half-casts. I've also joked we're the lepers of the medical world because the doctors don't trust us because we're management. Managers don't trust us because we're doctors and that […] that […] that shouldn't be the case and […] and the real difficulty is navigating that somewhat rocky path and trying to bring both sides to a commonality and that's why I do see senior clinical leaders as critical because they are the glue that can pull a whole system together.

As this quote illustrates, it is not just medical leaders who experience this confusion over identity, but their colleagues may not always know which "box" they sit in.

The apparent negative perception at doctors who transition away from clinical practice to leadership roles may stem from the sense that clinical work is an embedded part of a doctor's professional identity and casting it away leads to a perception that they have lost their identity as "*real*" doctors. For example, interviewee B2 explained:

> I kept doing some clinical work […] I made the decision that was it. I would close the door clinically […] I had this feeling that I'd lost something I'd really worked hard to achieve […].

Similarly, interviewee E2 noted:

> I think it's always gradual because you've got to be honest with yourself that the professional craft that you trained for and has formed your identity is no longer where you want necessarily to be. And doctors have a lot invested in that in who they are, and then to become a manager.

Indeed, some interviewees such as interviewee D1 still had a small clinical session stating, "*I still actually do a clinical session a month, because I can't quite let it go*". Similarly, interviewee ML25 explained:

> […] clinical practices is one of the most important things that I must confess when I looked at the possibility of other roles I've always found it very difficult to […] to consider something that would clearly involve relinquishing clinical practice.

An issue of conflict – medical leaders are concerned their roles lead to conflict

Doctors are also concerned about leadership roles, putting them in conflict with their clinical colleagues when they transition from clinical practice to leadership roles. For example, interviewee A1 stated that:

> […] the only negative things that you think about was, being in this role, what it would do to your relationships with your colleagues, and whether or not there would be some sort of potential for those relationships to deteriorate.

Similarly, interviewee B2 explained that:

> […] sometimes the risk there is that that puts us at odds with our colleagues. Again, as you're aware, medical management is not always seen as a highly desirable professional career path, which is sad […].

Interviewee ML28 described that:

> When I switched over, I was clearly going to the dark side. They banned me from the junior doctors' common room. I think that's probably less so now. I guess, because at times you're put in direct conflict with your colleagues who you've worked with for many years. It's a very, very lonely place to be. There's no doubt about that. Doctors don't like being told what to do, I think.

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> And because we're only trained as clinicians, we're only used to seeing the patient in front of us, the concept of having to think beyond your own department is foreign for most doctors.

As interviewee ML06 put it:

> I think the dark side is a medical frame for having a doctor who has moved beyond just reflecting or representing doctors; who represents the interests of the system, and all the components of it. And so you move from being an agent provocateur to somehow influencing the system on behalf […] a proxy for the interests of, whatever those interests are, to someone who has a broader and a more holistic view of health services management.

Furthermore, there is a perception by doctors in leadership roles that they are not respected by their clinical colleagues. For example, interviewee C1 stated that: " I was conscious that administrators aren't always respected or liked by clinicians […] we live in an egalitarian society where clinicians in particular don't value bureaucracy and management". Similarly, interviewee C2 stated that "*you'd moved over to the dark side […] mean that there is a lack of respect, or even from a negative point of view an arrogance of doctors about the value that management adds*". Similarly, interviewee E1 believed that medical administrators are not seen as leaders: "*I suspect they're not perceived or seen as leaders by the vast bulk of, let's say medical workforce and perhaps broader workforce either. They're just people in the background[…]*".

Doctors contemplating a transition from clinical practice to leadership roles are actively discouraged from doing so by their clinical peers. For example, interviewee ML01 stated that "*people criticised me and said, 'Look, you're losing the plot. You're making a big mistake. You know, do you realise what a silly thing you're just doing?'*". The decision to transition from clinical practice to non-clinical leadership roles has even been considered illogical or insane. For example, interviewee D3 discussed how her colleagues called her "mad": "*People were literally saying, 'Why would you want to do that? You're mad.' There would be comments, they could not get it. They thought you're mad*". As interviewee ML11 explained:

> […] my clinical colleagues may not seek leadership roles; often they don't, like, there would be opportunities for them, say to be department heads or things that often they're very hard to fill because no one wants to do them, because they're regarded as the poisoned chalice, and you know, so whoever gets it is the person who didn't move quick enough, sort of thing.

An issue of insight – medical leaders believe their peers lack insight into their work

The medical leaders interviewed also believed that their clinical colleagues lack insight into their own limited understanding of the complexity and skills involved in medical leadership. The interviewees perceived that their clinical peers may focus too much on the one-to-one relationship they have with their individual patients and not take on a wider population health view that values the role of systems and populations in achieving good health. Interviewee A1 explained:

> Clinicians deal with patients one on one, a small populations or subsets of populations. Whereas, clinician managers have the ability to influence the care that's provided to a much greater group of people.

Likewise interviewee C3 stated:

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> It made me realize that almost more important - and definitely as important as giving one to one good care to a person - was the need to change the system so that it impacted on a whole lot of people.

In the same way, interviewee D3 explained:

> What interested me was being respectful to a large cohort of patients rather than one on one. Being a doctor, doctor-doctor, is you, the patient, you, the patient […] And so the bigger picture […] I decided that I would like to be part of trying to deliver that.

In addition, interviewee ML02 stated:

> I just felt that I didn't really get the satisfaction from seeing a lot of people with, sort of, a lot of amorphous symptoms that at the end of the day, I would think, "Gosh, did I do any good for anyone?" and I wasn't, sort of, a 100 per cent convinced that I actually made a difference to people. I just felt that it wasn't a satisfying thing for me.

Similarly, interviewee ML28 said:

> I didn't think that I could actually give the commitment to the patients as individuals, all of the patients, that I thought they should have […] that I could help an individual patient but in a different role, once they've got to see that [inaudible] a much bigger difference to health care sitting on the other side, than I could working with individual patients.

Second, the interviewees believed that doctors in clinical practice may not have enough exposure to or understanding of the health system outside of their clinical practice to full appreciate the complexities of the health organisation or the health system as a whole. For example, interviewee C2 stated: "*A clinical qualification is certainly not enough to get you there. It does help, however it needs to be balanced by understanding how organisations work, how you communicate*". In the same way, interviewee C3 emphasised the fact that clinicians operate on a smaller scale (often contextualised by their relationship with a single patient or groups of patients) and that does not translate to an ability to manage hospitals:

> They also don't have that much knowledge about things on a bigger scale […] It's all on a very minute scale. It's a very small business, really. You wouldn't ask somebody who runs a milk bar whether they can run Myers.

Likewise, interviewee D2 stated that:

> […] probably not unless they get training, and training means understanding of what's involved. I note that younger registrars and fellows really are incredibly naive about the way a hospital is running, or how the management of the place is run, and junior consultants, and for that matter senior consultants.

Similarly, interviewee E3 provided a good summary of this point when he expressed the belief that clinicians underestimate the skills required for management and overestimate their own abilities:

> I'm a bit of a skeptic about clinicians occupying management positions without proper management training, that the tendency is for doctors and other clinicians to simply to underestimate what's required in management and overestimate their own abilities to do it.

Lastly, interviewee ML28 stated:

> You can't put people in senior leadership roles when you're running something with a budget of $800m to $1bn, with no training; it's crazy. Come in with some background with some vague understanding of governance in a clinical setting but have no idea about budget or finance and all of those things. Maybe that's going to change, because heads of departments are going to have to learn more about budgets and activity based funding, and that the higher-order governance structures. I don't think you can put people in senior health positions without training. If you were running a private organisation, that kind of person wouldn't even get an interview.

Third, the medical leaders interviewed believed that their clinical colleagues felt that their clinical experience is enough to equip them sufficiently as effective medical leaders. For example, interviewee A2 stated that:

> […] there are very, very few people who have had enough exposure in the clinical world to really understand what management is […] interpersonal skills are a really important component of management and leadership. But they aren't the entirety.

Similarly, interviewee A3 stated that clinical experience "*doesn't, in itself, create a competency in management. It probably creates some level of competency of decision making, which is good, but management is a much broader set of skills than that*". Indeed, interviewee D1 described:

> Just your experience of years of dealing with clinical scenarios and patients and families, and other health professionals, actually teaches you probably 70 per cent of the skills that you need to be an effective clinical manager/leader.

Likewise, interviewee D3 agreed and stated that "*because you're a good clinician, will you be a good manager? No. But if you're a good clinician, you'll certainly come armed with some skills to make you a good manager, that's for sure*". In the same way, interviewee E1 discussed the clinical skills that are analogous to similar managerial skills:

> People draw parallels between history and examination, investigation, diagnosis and applying similar disciplines to complex problems […] I think they're very different universes […] I don't think they are particularly transferable skills.

Lastly, interviewee E2 stated that doctors in clinical practice:

> […] always think they've got the solution […] They've got to get over that if they're going into management […] If you're a shocking communicator as a doctor and a patient, you'll be a shocking communicator out with a group.

Discussion

The data analysis suggests that the negative perception by doctors in medical leadership roles of their own transition from clinical practice into leadership, colloquially referred to as "moving to the dark side", is multi-faceted and stems from the following beliefs that:

- they lack both managerial and clinical credibility;
- have confused identities;
- are in conflict with clinicians;
- their clinical peers lack insight into the complexities of medical leadership roles; and
- as a result, they are actively discouraged from making the transition in the first place.

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The irony here is that potentially influential actors in the system are collectively acting to prevent doctors moving into precisely the kind of roles that the system so crucially needs. Given that findings set out here, it is apparent that addressing this issue requires a multi-faceted approach.

The existing literature suggests that competent doctors in medical leadership roles within the health system can lead to improved staff management (ACHE, 2003), patient safety outcomes (Reason, 2000; Ojha, 2005) and operational management (Goldstein and Ward, 2004). In the hospital setting, doctors may add value in medical leadership roles because of their credibility with their peers (Simpson and Smith, 1997) and improved ability to manage other doctors (Fairchild *et al.*, 2004), which is important as doctors as a professional group have more power and influence to block organisational change (Dickinson and Ham, 2008). Therefore, there are good reasons for health organisations to engage more doctors to consider medical leadership roles.

Implications for health organisations

However, the findings of this research are consistent with existing literature, which indicates that doctors, like other professionals, are influenced by extrinsic factors that are imposed upon, and experienced by, them when it comes to making decisions relating to their careers (Funkelstein, 1978). The negative perception by their peers is one such strong external factor that can act as a significant barrier in engaging more doctors into medical leadership roles, and this research has contributed to the existing literature. In addition, abstract factors such as status, which can be defined as seeking to be recognised, admired and respected, is an important career driver for professionals, such as doctors (Francis, 1985). This particular career drive may be detrimentally impacted by the fear of loss of admiration and respect of medical peers if the doctor transitions out of clinical practice into a leadership role, as shown by this research. As such, health organisations and professional associations, such as the Royal Australasian College of Medical Administrators, the medical college responsible for specialist medical administration training, need to actively promote the positive aspects of medical leadership roles to counter the negative perception prevalent in medical culture. The transition from clinical practice to medical leadership needs to be seen as a move to the "bright side" rather than the "dark side", and medical administration and leadership need to be respected as a medical discipline that requires clinical expertise and input.

Implications for training providers

Indeed, this research found that doctors in medical leadership roles perceive that they lack clinical credibility, with their clinical colleagues not seeing medical leadership roles as being part of real medicine (Fitzgerald *et al.*, 2006; BAMM, 2004), leading to an issue with their professional identity. In effect, medical leaders risk being no longer seen as peers of clinicians. When combined with a sense of not being a peer of non-clinical managers, it is perhaps not surprising that medical managers and leaders find their work lonely and difficult. Training providers need to consider the need for a minimum period of clinical experience before doctors consider transitioning out of clinical practice to maintain a level of clinical credibility. Such minimum requirements for clinical practice already exists in some training programs, for example, as part of specialist medical administration training with the Royal Australasian College of Medical

Administrators, which prescribes a minimum of three years of full-time clinical experience before medical administration training (RACMA, 2015).

Furthermore, doctors may lack managerial credibility when they move into leadership roles without the necessary leadership training or qualifications, and this is consistent with the existing literature that most doctors move into medical leadership roles without any postgraduate management training (Vera and Hucke, 2009). As a result, training providers, such as universities and the Royal Australasian College of Medical Administrators, should implement systems to identify doctors who are either considering, or have just transitioned to, medical leadership roles, so that training can be provided early on for credible leadership. This training will not only improve the credibility of medical leaders in the eyes of their clinical peers but will also upskill these medical leaders to perform better as leaders and managers and improve the status of medical leadership as a proper medical subspecialty that deserves respect and recognition.

Implication for medical employers

Moreover, the existing literature suggests that there are other disincentives for doctors transitioning from clinical practice into leadership (Francis, 1985; Ham *et al.*, 2010), such as a potential reduction in income. The literature shows that there is a cohort of doctors in leadership roles who are trying it out before committing to it as a career, the early ambivalent clinician manager (Boucher, 2005). Hospitals and other health organisations who wish to recruit and retain doctors in leadership roles need to ensure that such roles are adequately rewarded, actively promoted and supported through training, career development and succession planning. These roles have real value in improving patient care. Organisations and those engaged with training doctors for leadership and management roles have an obligation to promote the positive benefits of such training, and to emphasise the importance of these doctors as peers of both practicing clinicians and practicing managers and, if possible, to assist in establishing support networks to encourage and enable medical managers to be seen as legitimate peers.

In addition, this research confirmed the existence of the conflict between doctors and management that is discussed by the existing literature (Dickinson and Ham, 2008). This conflict likely arises from the negative perception by doctors of some medical leaders perpetuated by the mismanagement and poor performance of under-trained medical leaders who lack clinical credibility and, as a result, cannot engage their clinical peers. The recommendations outlined in this discussion to improve the reputation of medical leadership roles, clinical credibility and management competencies of doctors who transition into leadership roles, should reduce such conflict and increase clinical engagement.

Implications for health departments

Lastly, this research also found that doctors in leadership roles believe that their clinical colleagues lack insight into their own limited understanding of the skills required for medical leadership because of their focus on one-to-one individual interactions rather than whole populations, lack of exposure to organisational and health system issues, and their belief that clinical practice experience alone is sufficient for medical leadership. The literature indicates that doctors can learn some management competencies through experience (Pilling and Slattery, 2004) but this should occur in conjunction with formal

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postgraduate training (Guthrie, 2005; Ham, 2003). Health services, departments of health and other similar organisations need to consider ways to give doctors in clinical practice exposure to the processes and systems that exist within their health organisations and the health system as a whole, so that they gain an understanding of the complexities involved in leading such organisations, even if they do not intend to take on medical leadership roles. This way, their respect and appreciation for their colleagues in medical leadership roles may increase and lead to a change in the perception that these colleagues have "moved to the dark side".

Limitations

This research was conducted within the Western developed-nation setting of Australia, and the findings will be delimited to such a similar developed nation's health system. The findings may be applicable to doctors in medical leadership roles in most Western developed nations that have a similar health-care system. However, other countries may have health systems with different cultures, capabilities, funding frameworks, training pathways and challenges, and factors like salary and community expectations have to be taken into account when the findings of this paper are applied outside Australia. This research also interviewed doctors who have transitioned from clinical practice into leadership roles, so it provides only one point of view. It is necessary to consider the views of doctors who have remained in clinical practice and who have chosen not to make that transition to find out if there is validity to the perception of the "dark side" in that cohort. Nevertheless, the findings of the research will be of interest to those managing all types of health organisations where doctors are involved in leadership roles. In addition, this study can be expanded to include clinicians from other non-medical health professions and non-clinical managers who work in the health system to see if this concept of the "dark side" exists in other contexts and to better understand how a shared approach to dealing with this perception might be achieved.

Furthermore, this research was exploratory and descriptive in nature and conducted using qualitative methods and is therefore limited to analytical generalisation (Yin, 2009). Quantitative research, such as a randomised survey with a larger population, can be carried out in the future to extend this research for statistical generalisation and to test the statistical generalisability of the deep findings of this research. However, theory has been generated from this research which has contributed to this under-researched area.

Conclusion

In conclusion, doctors in medical leadership roles continue to believe that their clinical colleagues view them in a negative light, which is a potential barrier for future doctors wanting to make the same transition from clinical practice. The term "moving to the dark side" is multi-dimensional and from the point of view of the medical leaders themselves, it relates to their belief that they lack credibility with their clinical colleagues, leading to poor performance and conflict, which creates a feedback loop that increases the negative perception of such doctors in the eyes of clinicians. In addition, the perceived lack of insight of doctors in clinical practice of the skills required by medical leaders contributes to this negative perception. Addressing this important issue requires a multi-prong strategy that will improve the quality and reputation of medical leaders, increase medical engagement and lead to a health system with better health outcomes.

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References

ACHE (2003), "Research notes: the role and function of the physician executive", *Healthcare Executive*, Vol. 18 No. 1, pp. 38-39.

Andersson, T. (2015), "The medical leadership challenge in healthcare is an identity challenge", *Leadership in Health Services*, Vol. 28 No. 2, pp. 83-99. doi: 10.1108/LHS-04-2014-0032.

BAMM (2004), *Making Sense – A Career Structure For Medical Management*, British Association of Medical Managers, Stockport.

Boucher, C. (2005), "To be or not to be […] a manager: the career choices of health professionals", *Australian Health Review*, Vol. 29 No. 2, pp. 218-225.

Braithwaite, J. (2010), "Between-group behaviour in health care: gaps, edges, boundaries, disconnections, weak ties, spaces and holes: a systematic review", *BMC Health Services Research*, Vol. 10 No. 1, pp. 330-341.

Braithwaite, J. and Westbrook, M. (2004), "A survey of staff attitudes and comparative managerial and non-managerial views in a clinical directorate", *Health Services Management Research*, Vol. 17 No. 3, pp. 141-166.

Braithwaite, J. and Westbrook, M. (2005), "Rethinking clinical organisational structures: an attitude survey of doctors, nurses and allied health staff in clinical directorates", *Journal of Health Services Research and Policy*, Vol. 10 No. 1, pp. 10-17.

Buchanan, D.A., Jordan, S., Preston, D. and Smith, A. (1997), "Doctor in the process: the engagement of clinical directors in hospital management", *Journal of Management in Medicine*, Vol. 11 No. 3, pp. 132-156.

Clarke, D. and Gibbs, R. (2009), *Constructing the Template*, University of Huddersfield, Huddersfield, available at: http://onlineqda.hud.ac.uk/_REQUALLO/FR/Template_Analysis/The_Template.php (accessed 21 November 2011).

Clark, J. (2015), "Clinical leadership and engagement: no longer an optional extra", in Patole, S. (Ed.), *Management and Leadership – A Guide for Clinical Professionals*, Springer International Publishing, Cham.

Coile, R. (1999), "Physician executives in the 21st century: new realities, roles and responsibilities", *Physician Executive*, Vol. 25 No. 5, pp. 8-13.

Crabtree, B., Yanoshik, M., Miller, W. and O'connor, P. (1993), "Selecting individual or group interviews", in Morgan, D. (Ed.), *Successful Focus Groups*, Sage, London.

Cragg, R., Marsden, N. and Wall, D. (2007), "Identified perceptions of the clinical director role and the implications for organisational development", *British Journal of Healthcare Management*, Vol. 14 No. 3, pp. 58-65.

Creswell, J. (2002), *Research Design: Qualitative, Quantitative and Mixed Method Approaches*, Sage, London.

Decker, K. and Eberl, J. (2005), *Star Wars and Philosophy: More Powerful than You Can Possibly Imagine*, Open Court Publishing, Chicago and La Salle, IL.

Degeling, P., Maxwell, S., Kennedy, J. and Coyle, B. (2003), "Medicine, management and modernization: a danse macabre", *British Medical Journal*, 326 No. 90, pp. 649-652.

Dickinson, H., Bismark, M., Phelps, G. and Loh, E. (2015a), "Future of medical engagement", *Australian Health Review*. doi: http://dx.doi.org/10.1071/AH14204. [Epub ahead of print], available at: www.ncbi.nlm.nih.gov/pubmed/26386780

Dickinson, H., Bismark, M., Phelps, G., Loh, E., Morris, J. and Thomas, L. (2015b), *Engaging Professionals in Organisational Governance: The Case of Doctors and their Role in the Leadership and Management of Health Services*, University of Melbourne, Melbourne.

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Dickinson, H. and Ham, C. (2008), *Engaging Doctors in Leadership: Review of the Literature*, NHS Institute for Innovation and Improvement.

Dickinson, H., Ham, C., Snelling, I. and Spurgeon, P. (2013), "Are we there yet? Models of medical leadership and their effectiveness: an exploratory study", *Final Report*, NIHR Service Delivery and Organisation Programme.

Dickinson, H., Ham, C., Snelling, I. and Spurgeon, P. (2014), "Medical leadership arrangements in english healthcare organisations: findings from a national survey and case studies of NHS trusts", *Health Services Management Research*, Vol. 26, No. 4, pp. 119-125.

Drucker, P. (1973), *Management Tasks, Responsibilities, Practices*, Harper and Row, New York, NY.

Eisenhardt, K. and Graebner, M. (2007), "Theory building from cases: opportunities and challenges", *Academy of Management Journal*, Vol. 50 No. 1, pp. 25-32.

Fairchild, D., Benjamin, E., Gifford, D. and Huot, S. (2004), "Physician leadership: enhancing the career development of academic physician administrators and leaders", *Academic Medicine*, Vol. 79 No. 3, pp. 214-218.

Fielden, J. (2015), "A medical director's perspective on healthcare leadership", *Future Hospital Journal*, Vol. 2 No. 1, pp. 190-193. doi: 10.7861/futurehosp.2-3-190.

Fitzgerald, L. (1994), "Moving clinicians into management: a professional challenge or threat?", *Journal of Management in Medicine*, Vol. 8 No. 6, pp. 32-44.

Fitzgerald, L., Lilley, C., Ferlie, E., Addicott, R., Mcgivern, G. and Buchanan, D. (2006), *Managing Change and Role Enactment in the Professionalised Organisation*, National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO), London.

Fitzgerald, L. and Stuart, J. (1992), "Clinicians into management: on the change agenda or not?", *Health Services Management Research*, Vol. 5 No. 2, pp. 137-146.

Francis, D. (1985), *Managing Your Own Career*, Fontana/Collins, London.

Funkelstein, D. (1978), *Medical Students, Medical Schools, and Society During Five Eras: Factors Affecting the Career Choice of Physicians*, 1958-1976, Balinger, Cambridge, MA.

Gibbs, G. and Taylor, C. (2010), *How and What to Code*, University of Huddersfield, Huddersfield, available at: http://onlineqda.hud.ac.uk/Intro_QDA/how_what_to_code.php (accessed 14 November 2011).

Goldstein, S. and Ward, P. (2004), "Performance effects of physicians involvement in hospital strategic decisions", *Journal of Services Research*, Vol. 6 No. 4, pp. 361-372.

Guthrie, M. (2005), "Engaging physicians in performance improvement", *American Journal of Medical Quality*, Vol. 20 No. 5, pp. 235-238.

Ham, C. (2003), "Improving the performance of health services: the role of clinical leadership", *The Lancet*, Vol. 361 No. 9373, pp. 1978-1980.

Ham, C., Clark, J., Spurgeon, P., Dickinson, H. and Armit, K. (2010), *Medical Chief Executives in the NHS: Facilitators and Barriers to their Career Progress*, University of Birmingham, Birmingham.

Ham, C., Clark, J., Spurgeon, P., Dickinson, H. and Armit, K. (2011), "Doctors who become chief executives in the nhs: from keen amateurs to skilled professionals", *Journa of the Royal Society of Medicine*, Vol. 104 No. 3, pp. 113-119.

Ham, C. and Dickinson, H. (2008), *Engaging Doctors in Leadership: What can we Learn From International Experience and Research Evidence?*, Warwick.

Jorm, C. and Parker, M. (2015), "Medical leadership is the new black: or is it?", *Australian Health Review*, Vol. 39 No. 2, pp. 217-219, available at: http://dx.doi.org/10.1071/AH14013

Kyratsis, Y., Armit, K., Zyada, A. and Lees, P. (2016), "Medical leadership and management in the united kingdom", *Australasian Psychiatry*, Vol. 24 No. 3, pp. 240-242. doi: 10.1177/1039856216635909.

Lees, P. (2016), "Clinical leadership – are clinicians up for it?", *Clinical Medicine*, Vol. 16, Nos 5/6. doi: 10.7861/clinmedicine.16-1-5.

Llewellyn, S. (2001), "Two way windows: clinicians as medical managers", *Organization Studies*, Vol. 22 No. 4, pp. 593-623.

Loh, E. (2012), "How and why doctors transition from clinical practice to senior hospital management: a case research study from Victoria, Australia", *International Journal of Clinical Leadership*, Vol. 17 No. 4, p. 235.

Mcgivern, G., Currie, G., Ferlie, E., Fitzgerald, L. and Waring, J. (2015), "Hybrid manager–professionals' identity work: the maintenance and hybridization of medical professionalism in managerial contexts", *Public Administration*, Vol. 93 No. 2, pp. 412-432. doi: 10.1111/padm.12119.

Mckee, L., Marnoch, G. and Dinnie, N. (1999), "Medical managers: puppetmasters or puppets? Sources of power and influence in clinical directorates", in Mark, A. and Dopson, S. (Eds), *Organisational Behaviour in Health Care: The Research Agenda*, Macmillan Press, Basingstoke.

Mintzberg, H. (1979), *The Structuring of Organisations*, Prentice-Hall, Englewood Cliffs.

Neuman, W. (2006), *Social Research Methods: Qualitative and Quantitative Approaches*, Pearson Education, New York, NY.

Ojha, A. (2005), "High performance organisations: discussion", *IIMB Management Review*, Vol. 17 No. 4, pp. 73-91.

Patton, M. (1987), *How to Use Qualitative Methods in Evaluation*, Sage Publications, Newbury Park, CA.

Pilling, S. and Slattery, J. (2004), "Management competencies: intrinsic or acquired? What competencies are required to move into speech pathology management and beyond?", *Australian Health Review*, Vol. 27 No. 1, pp. 84-92.

RACMA (2015), *College Handbook*, Royal Australasian College of Medical Administrators, Malvern (accessed 8 December 2015).

Reason, J. (2000), "Human error: models and management", *British Medical Journal*, Vol. 320 No. 7237, pp. 768-770.

Sacks, L. and Margolis, R. (2015), "Physician leadership in organizations undergoing major transformation", *Healthcare*, available at: http://dx.doi.org/10.1016/j.hjdsi.2015 08.011

Simpson, J. and Smith, R. (1997), *Why Healthcare Systems Need Medical Managers*, BMJ Publishing Group, London.

Spurgeon, P., Clark, J. and Ham, C. (2011), *Medical Leadership: From the Dark Side to Centre Stage*, Radcliffe Publishing Limited, London.

Spurgeon, P., Long, P., Clark, J. and Daly, F. (2015), "Do we need medical leadership or medical engagement?", *Leadership in Health Services*, Vol. 28 No. 3, pp. 173-184. doi: 10.1108/LHS-03-2014-0029.

Stewart, D. and Shamdasani, P. (1990), *Focus Groups: Theory and Practice*, Sage, Thousand Oaks, CA.

Till, A., Jones, P. and Mckimm, J. (2015), "Medical leadership and management: an international revolution", *Review Article*, Vol. 3 No. 3, pp. 139-143.

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Vera, A. and Hucke, D. (2009), "Managerial orientation and career success of physicians in hospitals", *Journal of Health Organization and Management*, Vol. 23 No. 1, pp. 70-84.

Wolter, N., Tarnoff, S.L. and Leckman, L. (2015), "Recruiting and retaining physician leaders", *Healthcare*, available at: http://dx.doi.org/10.1016/j.hjdsi.2015.08.009 and www.sciencedirect.com/science/article/pii/S2213076415000822

Yin, R. (2009), *Case Study Research, Design and Methods*, Sage Publications, Beverley Hills.

Corresponding author
Erwin Loh can be contacted at: erwin.loh@monash.edu

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