Leadership in medicine: where are the leaders?

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ABSTRACT

- Despite leadership roles being critical, we persist with outmoded models of organisations and pay inadequate attention to developing individual leaders and new models of leadership within the medical profession.
- New forms of leadership are required. Among many important roles, leaders are called on:
  - to enhance the meaningful identity of a profession;
  - to create effective linkages with other healthcare professionals and stakeholders, as well as with healthcare system managers;
  - to interpret complexity so that their institutions and followers can operate successfully in uncertain times; and
  - to consistently model ethical behaviour.

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In recent decades, the nature of the profession of medicine has changed. The profession has been defined through long-standing legislative canons coupled with the status accorded to individual doctors by society through societal contracts,[1] and deeply entrenched cultural systems arising principally from the influence of professional craft groups. Before the advent of the Internet, restricted access to medical information also protected and contributed to defining the profession. It has been within these frameworks that leadership roles in medicine evolved. A number of external influences have now altered doctors' autonomy and the hierarchies within which they practise. These include funding constraints, demand for greater accountability for the safety, quality and efficacy of healthcare, and public access to medical information. The aggregation of hospitals into large systems has moved management from local clinical control to distant bodies. Hospital-based clinicians now often feel lonely and isolated in coping with increasingly devolved responsibility for the actual delivery of care. Among many challenges facing Australian medicine is developing leadership within the profession.

Leadership has received little attention in Australian peer-reviewed medical literature. In my survey of articles indexed over more than 30 years in five Australian journals (*The Medical Journal of Australia*, *Australian and New Zealand Journal of Surgery*, *Australian and New Zealand Journal of Psychiatry*, *Australian Family Physician* and the *Journal of Internal Medicine* and its predecessor), I could barely find 50 articles dealing with leadership. Over the same time, there are at least 500 and, in some instances, thousands of articles dealing with each of the national health priority areas[2] as currently defined by the Australian Department of Health and Ageing. Furthermore, very few of the 50 articles, editorials or letters dealing with leadership provide substantial information or commentary on the makings of leadership. One regionally relevant and accessible electronic archive of medical interest, the *e*MJA,[3] does not index "leadership", and in over 3800 entries has but three items with "leadership", "lead" or "leader" in the title. None of these, or of the 95 or so items in which leadership is mentioned in the actual text, deal with the subject in a substantive manner. I can only surmise the subject of leadership is either unimportant, uninteresting, or perhaps just too difficult, to warrant more attention in Australian medical literature. Alternatively, the dearth of discourse on medical leadership may be the result of outmoded assumptions about leadership operating in concert with obsolete organisational models.

Capable leaders are needed in medicine to shepherd and influence continued evolution of dynamic healthcare systems. The changes we face are profound and have crept up on doctors and many professional bodies. The "professional bureaucracy", characterised by disseminated power, individual autonomy and inflexible structures,[4] has difficulty in responding nimbly to external forces. For individual doctors, the model of professional work has moved from control by individuals to constraint by systems, from flexibility to rigidity of practice, from primacy of an individual blend of art with science to management by multiprofessional teams, and, most importantly for many in the profession, stability has been replaced by uncertainty and ambiguity. Increasingly, formal recognition of status is being replaced by greater attendance to informal and personal rewards by doctors. This, coupled with frustration about not being able to deliver care the way they want to and a desire for a more balanced personal life, is leading to an exodus from lifetime commitment to clinical practice.

While the changed dimensions of medical practice and professional life demand and deserve respect, a campaign is needed to develop doctors as leaders. Clinical mastery or eminence in discipline-specific research does not necessarily translate into an ability to lead. Society needs doctors to learn about new ways to serve the ailing healthcare system as leaders in roles that are personally meaningful and systemically effective. Doctors and their professional organisations (especially the Colleges) must be open to the reinvention of their relevance to medicine's future. Our colleagues in the United Kingdom suggest that the profession needs to give more explicit attention to patients' rights, public responsibilities, partnerships, enhanced accountability and advocacy for sufficient resources.[5]

Leadership is ultimately a social function within an organisation or a group. Any consideration of leadership which begins with aphorisms about influence, control, motivation, inspiration, leading by example, and so forth, avoids the need to consider the nature of organisations of the modern world. Regrettably, the role of leaders in modern professional and service organisations often continues to focus on a hierarchical view of leadership as a part of a mechanical view of organisations (ie, thinking of an organisation as a machine in which all parts can be understood in detail). In such a view, power, control and outcomes arise through division of labour and differentiation of functions — the command and

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control model. Significant parts of healthcare systems in Australia remain locked in this paradigm.

Meanwhile, many doctors wonder where they fit into the professional calling they entered with altruism, and still yearn to serve. An all-too-frequent side effect of such a system is that junior colleagues and medical students are exposed to the apparent despair of leaders. Should we be surprised that disenchantment is infecting the next generation of doctors?

Many metaphors beyond that of "machine" have been promulgated to describe modern organisations.[6] For example, healthcare systems may be regarded as "political systems" with all the connotations of factional interest, conflict, power struggle, influence and compromise. In some ways, our healthcare systems also resemble "psychic prisons". In those confines, trapped doctors see their work through a traditional lens which leaves deep dichotomies between rational and irrational responses to the real changes brought by external forces. The metaphor of organisational "psychic prisons" cautions us against assuming that all aspects of an organisation will be understood, and reminds us that dynamic leadership in healthcare requires exploration of the unconscious concerns of staff, which, if not addressed, thwart change.

Another metaphor for organisations is a living organism capable of internal self-organisation.[6,7] Such living entities use many sophisticated and varied repertoires to respond to shifts in their environments. This image has multiple derivative levels when applied to complex systems such as healthcare (eg, a state health service can be viewed as a very complex organism within which a multitude of elements — ranging from hospitals and clinics to large diagnostic laboratories right down to small trauma teams in emergency departments) co-exist. Within such an organic system, leadership roles are not defined in hierarchical management of reporting lines, but rather as overseeing components within a complex of related subsystems forming the wider healthcare business and social ecology.

In new models of organising healthcare, medical leaders must help design and supervise the complicated networks within such systems. The work of leaders should be purposeful, authentic and professionally meaningful. Explicit strengthening of governance within our hospitals and healthcare systems will permit leaders to operate more effectively. The safety and quality movement has significant potential in this area. However, in many settings, implementation of sound policy appears to be in danger of falling into a morass of hierarchically driven bureaucratese, involving blame-prone audit driven by paper-based compliance. The value within the profession and healthcare system delivered by education and training responsibilities is another area that needs explicit attention in terms of the leadership of coordinated governance and oversight.

We as a profession must decide which sort of organisation is desirable — a machine under the illusion of control or a living, evolving entity requiring appropriately skilled leadership and relevant models of governance. The answer should be clear — if we are planning for further gradual disenfranchisement of the professional workforces and more public outcries about medical error, we should rigidly aspire to have mechanistic organisations. If we want sustainability and capacity to meet the challenging demands of providing healthcare and promoting health and innovation in an unpredictable world, we will want to be part of an endeavour built around new organisational models truly valuing our purpose. From studies in other settings, the evidence about sustainability is clear[8] — organisations which survive well have attributes that include:

- sensitivity to their environmental context (ie, the ability to learn and adapt);
- a sense of cohesion and identity (ie, the ability to build a community and "persona" for the organisation);
- tolerance and decentralisation (ie, the ability to build constructive relationships with other entities); and
- fiscal conservatism (ie, ability to govern growth and evolution).

None of these are easy for current healthcare organisations to master, and, in this context, the implications for developing a new generation of medical leaders and programs for reinventing the current leaders are profound. Leaders in professional settings such as healthcare have, I believe, several important roles, described below.

Championing identity

Eminent Harvard opinion-leader, Howard Gardner, in reflecting on the power of narrative and stories, writes "... leaders fashion stories: principally stories of identity".[9] As external influences have supervened and the relevance of professional bodies has waned, doctors struggle for an identity within complex systems. The role of the leader is to enhance the identity of each individual as someone who adds value, be it by delivering care, promoting health or through research. Gardner also refers to the struggle for new stories to replace or augment older stories. Our profession needs to make more time to hear and consider the success stories from our clinics, hospitals and healthcare systems, often involving those who are not part of traditional power structures.

Creating linkages

A role of new-style or reinvented medical leaders is to demonstrate and engage their followers in creating order, not only in their own work setting, but also through their interdependent work with other people and with other systems. The capacity to promote linkages and connectedness involves designing strategy, building bridges across cultural gaps and empowering action.[10]

Translating complexity

In highly complex systems, we need leaders who have skills resembling those of an accomplished orchestral conductor. Such individuals understand and interpret the score across a wide range of players. Without having extensively read the score or heard the piece before, they can, with minimal rehearsal, lead the performers to great coordinated achievement. Leaders engender comfort in their colleagues when faced with uncertainty and ambiguity, especially early in a decision-making process. They encourage flexible thinking in designing new work practices and intermittently ask their colleagues to contemplate possible futures, making the previously unimaginable less daunting when it arrives. Leaders also play a vital role in advocating an appropriate balance between the professional needs of individuals and their collective responsibilities to the institution, system or society.

Modelling behaviour

Leaders have a responsibility to always show intellectual rigour, honesty, transparency and integrity in all they do. Their values

must be evident, as it is the re-establishment of an explicit set of professional values which will help remedy the current crisis of confidence that swirls around us.[11]

Developing new models of leadership will require sustained emphasis and attention, beginning during medical student and postgraduate training and continuing in established professional circles. Australia needs thoughtful dialogue about the role of medical leadership in healthcare now and in the future. Our colonial style of debate, which seems to drive so much of the hasty setting of health policy through political point-scoring, has no place in such a dialogue. Rather, we need a deeply thoughtful discourse to develop frameworks for new models of leadership in medicine. This important work awaits us — let us begin.

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Competing interests

None identified.

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