

Place of Clinical Leadership in Health Services of Sri Lanka

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Journal of the Ceylon College of Physicians, 2023, **54**, 1-3

Leading and managing systems of healthcare on whatever scale – be it a team, unit, department, hospital, or ministry – is a professional obligation of all clinicians.¹ The policy planning unit of the Ministry of Health is expected to implement system-wide changes whereas the ground situation reality is best known to the clinicians working on-site. Therefore, it is imperative to do a needs assessment taking into considerations factors such as patient needs, clinical evidence, current practice, resources already available within the hospital and in neighbouring hospitals, and the available budget, before embarking on resource allocations and this should be done as a team exercise involving the ministry and the clinicians. Clinical leaders often have to deal with the need for accessibility, affordability, equity, and quality of healthcare that is being delivered to the public.

As the delivery of healthcare is done through a multitude of clinical services such as medical, dental, nursing, rehabilitation services, etc., the leadership of healthcare services can be borne by leaders of different disciplines, thereby justifying a wider coverage of the leadership role.² Recognition of nursing and allied health workers who play a key role in healthcare is long overdue in Sri Lanka where only doctors are given recognition as clinical leaders. Hence, the term clinical leadership is more appropriate than the term medical leadership for this role and can be considered for any person who is leading the delivery of frontline healthcare.


In Sri Lanka, clinicians are often appointed to hospitals without resources in an *ad hoc* manner. As a result, without coordination and help from the Ministry of Health newly appointed clinicians have to work hard to get human and physical resources to develop their place of work. Therefore, development takes place in pockets and system-wide implementation of improvement of patient care is prevented. Needs for healthcare

are ever-changing due to changes in demography with an aging population, emergence of new diseases, eradication of certain infections, antibiotic resistance, discovery of new drugs, changes in staffing, and new technological developments. Such changes have to be closely matched with the finances that are already constrained in Sri Lanka. This demands a proactive and strategic approach with innovations and experimentation through collaborative and compassionate leadership within and across organisations.³

Usually, selection to clinical leadership positions is based on academic or clinical achievements rather than competencies needed to lead; although the latter criterion is more important to play a leadership role. Good clinical leaders should also possess an unwavering commitment to producing long-term results, organisational altruism, personal humility, and qualities of servant leadership.⁴ Success in clinical leadership is determined by factors such as mastery in visioning, good communication, application of change management, team building skills, skills in personal management, and good systems thinking.⁵ Clinical leadership can be made more effective by challenging the status quo, good role modelling, inspirational motivation, intellectual stimulation of those who are being led, and helping followers to optimise performance.⁵ Other factors that would play a key role in producing clinical leaders would be networking skills, a high degree of self-confidence, the ability to work amidst uncertainties, developing a culture that is trustworthy, recruitment of physicians who are capable of carrying out leadership roles, providing leadership from top management, succession planning, recognition of talent with appropriate rewards and incorporation of talent management schemes.³ Six domains as defined by Stroller such as technical knowledge (knowledge of human resources, financing, accounting, and information technology); knowledge of healthcare management (quality assessment, strategic planning, legislation,

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and regulation); high emotional intelligence (ability to evaluate self and others and manage oneself in the context of a group); problem-solving prowess (organisational strategy and project management skills); skills in conflict resolution and commitment to lifelong learning are important determinants for effective and efficient clinical leadership.⁵

Although the formal clinical leader has the overall responsibility and accountability of their teams, team members should play an unrelenting role in recognising issues or problems and advising appropriate actions, and providing solutions.⁶ Clinical leaders have the following key responsibilities: a) to see that communications within the team are clear, timely, and appropriate without discrimination, harassment, or bullying, with due recognition and respect to contribution from team members whilst ensuring communication with patients, their family members and carers, as well as the public, happens appropriately, whilst adhering to confidentiality b) to ensure that the team discusses all available options with patients, whilst informing risks and benefits of treatment that is being offered to them and provide opportunities to express concerns, make suggestions or to have a dialogue, as situations demand c) take time to reflect on their performance, their professional values and the contributions of their team d) be prepared to act on feedback from colleagues, findings of audits, appraisals, performance reviews, complaints from patients or public and also identify issues or problems with team members, teams or services early, and take appropriate course of action to protect patients and improve patient care and services⁷ e) be receptive to whistle blowers as it can help to trouble shoot issues or problems concerning patients f) ensure that patients are informed how information about them are collected, stored, used, accessed whilst maintaining privacy and confidentiality g) ensure that their team members are up to date with regards to patients under their care as well as with the knowledge and skills to function effectively and efficiently and h) provide opportunities for continuing professional development.⁸ Showcasing leader journeys, role modelling, providing access to good leaders, stretch assignments, supported trial periods, job shadowing, preceptorships, workload monitoring, clarifying expectations, building peer networks, coaching, and mentoring will help aspiring leaders to assume their future roles.³

Whether good leaders are born or developed is being debated but there is no doubt about the need for leadership training. The following are common leadership models. When leaders are selected by a group in the institution or appointed by the institution, based on their competency in leadership skills, this

model of leadership is called the contingency model.⁹ The situational leadership model described by Hersey and Blanchard states that instead of using just one style, successful leaders should change their leadership styles based on the maturity of the people they are leading and the details of the task.¹⁰ John Adair's '*Three circles model*' emphasises that leader's focus should be flexibly distributed among the task, team, and the individual in achieving the task, managing the team or group, and managing individuals.¹¹ Transformational leadership is another leadership model, where the leaders empower and develop the followers and as a result not only top-level managers need to show their capabilities, but all managers at all levels of the organization also feel the need to cooperate with others to achieve the desired results.¹² Dispersed or distributed leadership enables detachment from organisational hierarchy so that any team member can assume leadership depending on the need or situation as in medical emergencies.¹³ Collaborative, shared or engaging leadership model is a cross-cutting leadership which spans across several clinical disciplines. Encouraging a collaborative environment promotes an ongoing integration of ideas and interdependency among multiple stakeholders throughout an organization.¹⁴

In Sri Lanka; team, unit, and department leaderships lie with the clinicians and the hospital and ministry leadership with medical administrators. The gap between clinical leaders and hospital administrators needs to be bridged. When there are separate designated clinical leaders for teams, units, and departments as at present; the number of leaders and their agendas become too numerous and diverse, making system-wide implementation of improvements difficult. Such numbers can be reduced by the appointment of Clinical Directors who would head different lines of disciplines such as Medicine, Surgery, Paediatrics, etc. based on their competency in leadership skills as in the leadership model called '*Contingency model*'.⁹ Practising the contingency leadership style involves examining the situation first, then adjusting the response as a leader to suit the context of the situation. Clinical Director's main responsibility would be clinical governance. It can be defined as 'the framework through which healthcare organizations are accountable for continuously improving the quality of their services and ensuring high quality of care'. Clinical governance encompasses clinical audit, risk management, clinical effectiveness, quality assurance, staff development, and research and development.¹⁵ Clinical Directors should be appointed with consensus within the institution and be given their terms of reference so that they can work according to the guidelines developed by the professional colleges in concurrence

with the ministry. They should closely liaise with the Hospital Director and work alongside their Clinical Director colleagues in other lines representing different disciplines in the hospital. Such collaboration and shared strategies are more likely to bring about system-wide improvements within and across the hospitals.

As healthcare services are complex and challenging to manage, physicians do not prefer leadership roles in such environments. Physicians prefer to be independent and therefore they don't usually like to take a role of a follower under a leader. Such behaviour by physicians is thought to be contributed by factors such as prolonged and rigorous training, one to one or apprentice type of training they receive, hierarchical carrier structure, priority given to training in academic and clinical skills and expectation of extrapolated leadership like VIP treatment even outside the domain of their influence⁵. Leading or having responsibility for those who share a common training route or set of qualifications like a group of physicians can be a difficult role.

Doctors are entrusted to provide financially sustainable high quality, compassionate, safe care for their patients.¹⁶ All doctors have some responsibility in leading teams and/or supervising colleagues at the team, unit, department, hospital, or ministry level. Junior doctors should be supervised directly by their seniors and the hospital should have a clear reporting structure for senior doctors.³ Most clinicians in Sri Lanka receive little formal training in leadership skills that may be useful for routine practice but are critical for leading clinical change and capacity building. Hence, it is important for the Ministry of Health and professional colleges to collaborate in providing training in leadership for clinicians so that we can emulate practices in well-resourced countries where clinical leadership such as Clinical Directors of different disciplines can navigate us in the right direction in our quest to provide excellence in healthcare.

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