The new clinical leader

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Abstract: The complexity and cost of health care, along with a greater need for accountability calls for a new style of clinical leadership. The new clinical leader will lead reform by putting the needs of the patient first and foremost, looking at current and planned services from the patient’s point of view as well as the clinician’s. Excellent clinical skills will remain essential but will be supplemented by a focus on team work and mentoring, patient safety, clear communication and reduction in waste and inefficiency, leading to better financial outcomes. The new clinical leaders will understand the importance of consulting widely and engaging colleagues in creating change to improve patient care. They will develop trusting and mutually respectful relationships with health service management and be able to negotiate the delicate balance between clinical judgement, resource constraints and personal loyalties by keeping the best outcome for the patient at the forefront of their thinking.

Key words: clinical leadership; communication; patient safety; team leadership.

Leader A is an excellent clinician, intelligent, astute and much respected. He is proud of his clinical autonomy, comfortable with his clinical decisions and, like many clinicians in our health system, is not really responsible to anyone for his work. As well as being respected for his clinical skills, he is feared and grudgingly admired (as long as one isn’t the butt of his wrath) for his inability to tolerate fools, even if at times ‘fools’ are those who don’t see things in quite the same light as he sees them.

He leads his team fearlessly, shoulders most of the responsibility himself and has such a strong influence on junior staff that some unconsciously adopt his behaviours. He leaves administrative tasks to those he calls the ‘bean counters’ and doesn’t worry much about costs, proudly declaring that ‘the patient’s needs always come first’ although, curiously, the care he delivers is largely based around when his own busy schedule allows him to deliver it.

Although aspects of this leadership style are well known, it is a style that is becoming obsolete. A new generation of clinical leaders is appearing.

Traditionally, medical care has been based around what doctors do, not primarily around what patients need. The new generation of clinical leaders will, as their first priority, ensure that the unit, department or division they lead will first and foremost want to make a difference for good in the lives of the patients they care for. While acknowledging the importance of what clinicians do, the new clinical leaders know that while they must work to a high clinical standard, they also need to work differently.

In addition to honing their clinical skills, they will focus on efficiency, reduction of waste and better value. Value is not a bad word. Although some clinicians may suspect it is management code for cutting costs, value means much more. It is about achieving good outcomes for all patients as efficiently as possible. Value encompasses preventing waste and inefficiency, which are both bad for patient care. Working efficiently means less time is wasted for patients as well as for clinicians. It avoids duplication, gets rid of rules that make little sense, ensures that services are coordinated around what patients need and reduces error.

Error reduction is essential. It has been estimated that up to 22% of health care expenditure is related to potentially avoidable complications. The Quality in Australian Health Care Study found that at least 8% of admissions to Australian hospitals are associated with a reportable adverse event which could have been prevented. This figure is consistent across a range of international studies of error in sophisticated health services. Error reduction significantly reduces costs and improves safety, leading to better outcomes.

Berwick suggests several areas where we could reduce waste, three of which stand out. These are over-treatment, subjecting people to care that cannot possibly help them and which is often rooted in outmoded habits and ignorance of the best recent research; failure of co-ordination when patients and families,
The new clinical leader

Table 1  The top 10 questions about value (After JA Muir Gray) (Gray 2011)7

<table>
<thead>
<tr>
<th>1</th>
<th>How much money should be spent on healthcare?</th>
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<tbody>
<tr>
<td>2</td>
<td>Is the money allocated for the infrastructure which supports clinical care at a level which will maximise value?</td>
</tr>
<tr>
<td>3</td>
<td>Has the money for clinical care been distributed by a method that recognises variation in need and maximises value for the whole population?</td>
</tr>
<tr>
<td>4</td>
<td>Has the money been distributed to different patient groups by decision making that is equitable and maximises value for the whole population?</td>
</tr>
<tr>
<td>5</td>
<td>Are the interventions offered likely to confer a good balance of benefit and harm, at an affordable cost, for this group of patients?</td>
</tr>
<tr>
<td>6</td>
<td>Have the patients most likely to benefit from the interventions, and least likely to be harmed by them, clearly defined?</td>
</tr>
<tr>
<td>7</td>
<td>Is effectiveness being maximised?</td>
</tr>
<tr>
<td>8</td>
<td>Are the risks of care being minimised?</td>
</tr>
<tr>
<td>9</td>
<td>Can costs be reduced without further increasing harm or reducing benefit?</td>
</tr>
<tr>
<td>10</td>
<td>Could each patient’s experience be improved?</td>
</tr>
</tbody>
</table>

Table 2  Five domains of medical leadership (NHS Institute for Innovation and Improvement 2009)8

<table>
<thead>
<tr>
<th>1</th>
<th>Setting direction</th>
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<tbody>
<tr>
<td>2</td>
<td>Improving services</td>
</tr>
<tr>
<td>3</td>
<td>Managing services</td>
</tr>
<tr>
<td>4</td>
<td>Working with others</td>
</tr>
<tr>
<td>5</td>
<td>Personal qualities</td>
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ecesses of care to eliminate unnecessary steps and tackle bottlenecks which prevent the clinical teams delivering the standard of care to which they aspire.3

In addition to providing excellent clinical care, the new clinical leader should set the safety agenda to reduce error and improve quality. To do this effectively means encouraging a culture of honesty and openness with both colleagues and patients and seeing errors as opportunities for improvement.

The new leader should be a champion for improving patient care by gathering data to produce evidence-based challenges to some current practices.

Putting the patient first in a wider sense means there will also be a commitment to the broader, equally important aspects of health: preventive medicine, public health, community education and advocacy.

2 Create a culture of safety

Health professionals can be reluctant to admit errors because of embarrassment or fear of reprisal. The new clinical leader understands the balance between individual and system accountability and knows the knee jerk reaction of blaming the individual is short sighted as most errors are due to problems in the system. The task is to set the safety agenda to reduce error and improve quality. To do this effectively means encouraging a culture of honesty and openness with both patients and colleagues. Errors are always seen as opportunities for improvement.

3 Motivator, mentor and facilitator

Good leaders motivate and inspire others, stimulate their team, develop the skills of others and give credit where it is due. They show integrity in all dealings and encourage others instead of wanting to control. They delegate widely and wisely and think about succession planning from an early time in their leadership. This type of role modelling helps build future leaders.

4 Communicator

Communication does not just mean telling people and expecting action to happen. A single presentation, discussion or email has little chance of getting through the ‘noise’ of busy lives. Good communication means giving a consistent message through a variety of methods, repeated over time.

Good leaders know how to communicate upwards to senior management and administrators as well as to patients,
team members and staff at all levels. Communication should be respectful. It involves publically acknowledging the strengths and ideas of others.

A major part of communication is having good negotiation skills. New policies and practices cannot be imposed, particularly on clinicians who have a significant degree of autonomy. They have to be negotiated and based on sound evidence that the change will result in improved patient care.

5 Team leader, team player

Leading a team involves leading it towards a vision, seeking team members’ views on developing that vision and being a team player as well as team leader. Good team leaders value the opinions of others; they teach, coach and mentor. The best team leaders regard the patient as an integral part of the team, knowing that patients and family members can be good observers with valuable insights.

One of the most difficult tasks for a team leader is to resolve conflict in a way which respects the views and abilities of the parties involved. They also have the responsibility to manage their staff, hold them accountable and do regular performance appraisal as part of the mentoring process.

6 Demonstrate high level clinical skills and research

Although the amount of administrative work may make it difficult to maintain high-level clinical skills, many leaders find it essential to maintain a significant amount of clinical work to remain in touch with reality and retain credibility with clinical peers.

The new clinical leader may or may not have time for research but will always be able to critically evaluate it, acknowledge the value of research and encourage others in research. New clinical leaders will have a clear understanding of the importance of collecting data to measure improvement if they wish to develop arguments to improve patient care. To produce change based on data, it must be accurately and openly collected so that there will be respect for its integrity.

7 Manage finances

This involves managing the budget and being innovative in reducing waste and inefficiency to improve patient care. Clinician leaders are not expected to be accountants and should seek help for some financial tasks. However, they do need to have a broad overview of a budget to be able to allocate resources fairly in a way that will provide the greatest benefit for patients. Good financial management includes reviewing then reducing variation in clinical practice to reduce costs and provide more money for clinical care.

Additional Skills

In addition to these seven tasks, there are personal qualities. The new clinic leader requires the ability to think critically; to monitor his or her own performance; to behave in an honest, open and ethical manner; to display integrity; to see the big picture; to be able to learn from experience; and most importantly to put the patient, rather than him- or herself, at centre stage. A sense of humour also helps. Goleman has found that the best leaders all have a high degree of emotional intelligence, defined as a combination of self-awareness, self-regulation, motivation, empathy and social skills.

Useful Things for Clinical Leaders to Know

Clinicians do not respond well to changes that result in tighter control over their actions. They do respond to change designed to improve the experience of patients. The new clinical leader will be aware of the importance of engaging colleagues in change, rather than decreeing change. Unlike many organisations, hospitals and other health services have an inverted power structure with clinicians and others often having more influence over decision-making than those nominally in control. This means that the leader needs to negotiate rather than impose new policies and practices.

There is a deep-seated belief that autonomy of the clinician is crucial to providing good quality health care. Doctors have historically seen themselves as a patient’s sole advocate, with the rest of the world divided into those who are helping and those who are in the way. Many have their own turf to defend. Threatening someone’s turf is a sure way to start a conflict. For peer pressure to work, clinicians need to be convinced that a change in their way of practice will improve patient care.

A key task of leadership is knowing which of the range of leadership skills are appropriate in any particular situation. If a new staff car park is being planned, wide consultation is wise, but if a fire breaks out in a hospital, immediate action is needed.

Clinical leadership can be lonely. Medical practitioners working in leadership roles occupy a ‘no man’s land’ between the managerial and clinical communities. Leadership is a delicate balancing act where clinical judgements, policy, resource constraint and personal loyalties all need to be considered. Ensuring that the best outcome for the patient is the focus of all decisions will often help clarify some of these conflicting issues.

Although our professional training has equipped us for action, patience is often required. The ‘big bang’ rarely works. Enduring change is best achieved by bottom-up improvements introduced in small, incremental steps. These changes won’t occur without the co-operation and support of clinicians.

Clinical leadership alone is unlikely to deliver major change as the process is complex, requiring the interaction and support of clinicians, managers of health services and bureaucrats in Health Departments. But it is an essential component which can often initiate change and have significant influence. This is why the new clinical leader will develop trusting and respectful relationships with management. Antagonism between clinicians and managers is destructive and not good for improving patient care.

Currently, there is a minimum of available leadership training which allows clear career paths for clinicians. The new clinical leader will work with management to help develop career paths for clinicians which recognise the managerial responsibilities of clinical leaders and which allow clinicians to move in and out of these leadership roles.

Similarly, there is very little leadership training in medical school curricula in Australia and internationally and very little
in early postgraduate training. While such training is needed, it is not sufficient in itself. The role modelling of the new clinical leader is an important component of developing the next generation of leaders.

**Conclusion**

The climate has changed. The complexity and cost of health care means that there is and will be more scrutiny than in the past. The new clinical leader, while understanding the balance between autonomy and accountability, will not fear this new climate but will embrace it. Why? Because it provides a stimulus to review the way we work with a focus on efficient, effective care which will improve patient outcomes.

We started with leader A. What about leader B, the new clinical leader? He or she will be very different, retaining similar clinical skills, but having a much broader, patient-centred leadership role. Leader B is here already in varying degrees. There will soon be many more. The future belongs to leader B. That will be good for patient care.

**References**