



**Engaging professionals in organisational governance:**  
The case of doctors and their role in the leadership  
and management of health services

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## Executive Summary

MEDICAL ENGAGEMENT IS A TOPIC THAT HAS STARTED TO RECEIVE SIGNIFICANT INTERNATIONAL ATTENTION OVER THE LAST TWENTY YEARS AND IS THOUGHT TO BE A HELPFUL MECHANISM THROUGH WHICH HEALTH SYSTEMS CAN DRIVE THE EFFICIENCY OF HEALTH ORGANISATIONS, PATIENT EXPERIENCE, AND CLINICAL OUTCOMES.

In Australia, engagement of the medical workforce is recognised as a crucial factor in responding to changes in the context of health services and the broader environment.

Current pathways for doctors into management and leadership roles are relatively *ad hoc* and poorly understood. Australia currently lags behind other countries in its heedfulness to, and evidence-base for, effective medical engagement.

This research project sought to investigate issues of medical engagement in the context of Australian health services. Specifically we investigated: What are the formal and informal opportunities for doctors to engage in leadership and management?; What are the intrinsic and extrinsic factors that encourage doctors to engage with these opportunities?; What are the barriers that stop doctors from engaging in leadership and management roles?; How might doctors be better supported and developed to engage

in leadership and management roles?; and, What does this tell us about the design and management of highly professionalised organisations?

This project adopted a qualitative research methodology, purposively sampling 30 medical practitioners who work in medical leadership roles in Australia to take part in semi-structured interviews. Interviews focused on three broad areas: intrinsic and extrinsic factors that encourage medical practitioners to take on leadership roles, barriers to such involvement, and opportunities for improved support and development.

The research found that there is no single route into leadership and management opportunities and no clear or consistent career pathway across healthcare organisations for doctors interested in becoming engaged in formalised governance roles.

Those we interviewed described having taken on roles often with little preparation or training and experiencing a significant learning curve. A range of different training and development opportunities had been accessed by those we spoke to, resulting in very different experiences and levels of preparedness for medical management and leadership roles.

In terms of why doctors seek out opportunities to engage with leadership and management roles, we found that there are far more intrinsic than extrinsic motivators – meaning that doctors sought out these roles due to a desire to make a difference, rather than because they are supported by the system or are a way of achieving significant recognition. In fact the opposite was often true, with these roles being associated with lower earning potential and being perceived as of low status by medical colleagues. Doctors also reported being attracted to these roles due to the changing nature of the medical profession and the fact that they are expected to work for far longer periods than has been the case in the past.

By and large medical management and leadership roles were described as difficult and often lonely as individuals fall between medical and management communities. The demands on time and abilities are significant and roles often lack the necessary levers to bring about desired changes or influence on

colleagues and their practice. What seems clear from the data is that if we are to encourage more effective medical engagement in leadership and management roles there needs to be some significant changes to the practices and process that underpin these.

While there has arguably been little recognition of these roles in the past we argue that the Australian health system is currently at a time of transition. There is more interest in these roles being expressed by doctors and greater attention to these from health organisations. We may be on the precipice of change, which means that important decisions about the preparation, recruitment and support of doctors who seek to take on management and leadership roles are all the more crucial.

We suggest the time is ripe for a broad national discussion about the role of medical engagement as an enabler of change within the health system, and how this might be best supported. The response to this conversation could require significant changes to the roles, expectations, education and development of doctors and other professionals but the pay-off of a more engaged workforce potentially offers a significant reward.

# 1. Introduction

Although it has long been recognised that doctors play a crucial role in the effectiveness and efficiency of health organisations, patient experience, and clinical outcomes, only over the last twenty years has the topic of medical engagement started to garner significant international attention as an enabler of organisational performance. Given the challenges of burgeoning costs and demand for health care within a context of an ageing population and increased prevalence of chronic illness and disability, the current approach to service delivery within the Australian health system is arguably unsustainable, and will therefore need to undergo significant changes in the years ahead. These changes will require meaningful engagement of the workforce and, in particular, of doctors who will continue to play a significant role in determining the success of change initiatives. The leadership of doctors in promoting and supporting change initiatives is thus crucial to the future of the Australian healthcare system. Yet current pathways for doctors into management and leadership roles are relatively ad hoc and poorly understood.

Australia currently lags behind other countries in its heedfulness to, and evidence-base for, effective medical engagement. This situation is problematic because a lack of medical engagement in other settings has been shown to have serious consequences in terms of patient safety (1-3). Much of the literature generated about medical engagement to date comes from UK and US contexts. The evidence shows that there are no easy answers when it comes to issues of medical engagement, and those who lead health systems need to think carefully about how to respond to and shape this agenda.

This research project undertook an exploratory investigation of issues of medical engagement within the context of health services, focusing on the role that doctors play in the governance of these organisations. The project aimed to gain a better understanding of why doctors engage in formal and informal processes of leadership and management, and how we might better support those who have an interest in pursuing such a career path.

The research questions that underpin this project are as follows:

- What are the formal and informal opportunities for doctors to engage in leadership and management?
- What are the intrinsic and extrinsic factors that encourage doctors to engage with these opportunities?
- What are the barriers that stop doctors from engaging in leadership and management roles?
- How might doctors be better supported and developed to engage in leadership and management roles?
- What does this tell us about the design and management of highly professionalised organisations?

One of the challenges in speaking about medical engagement is that different terminology is used in this field of study. As we explain in the following section, it is often unclear precisely what is meant by the notion of medical engagement, and it can be used to refer to involvement in both formal and informal governance processes. In relation to formal governance, leadership and management structures and processes, a range of terms have been used such as medical administration, medical management and medical leadership.

Often these terms are used interchangeably to refer to the same phenomena, whilst at others they are used to distinguish between different types of actions and interactions. The term clinical governance is also sometimes used in an interchangeable way with medical governance to distinguish a different set of factors and issues related to medical clinical practice in particular. In drawing on the words of those we interviewed, a variety of different terms are used. We do, however, think that language is important, and will return to this issue again in thinking about the future of medical governance.

This report sets out the findings of our research and provides an account of the tensions and questions that arise from our observations. We conclude by setting out our thoughts regarding the required next steps in taking the medical engagement agenda forward alongside the engagement of the broader health care workforce.

## 2. What the literature says

Previous research in organisational theory and human resources has found that more engaged employees tend to be happier and more productive in their work (4). Within this context engagement is generally seen as an indication that individuals feel some sort of connection with the organisation that they work for and the sorts of tasks associated with their role. In research from the UK National Health Service, West and Dawson (5) found that organisations with highly engaged employees have significantly lower rates of absenteeism; an increase of one standard deviation in engagement equates to an average saving of £150,000 from lower staff absence. In the same research West and Dawson found engagement is also linked to lower patient mortality rates, fewer accidents, and organisations overall make better use of resources and demonstrate better financial performance.

In recent years, discussions of engagement have particularly focused on one group of professionals; medical doctors. Engaging doctors is thought to be crucial because of the important role that these professionals play within health organisations and their role in providing high quality patient care.

In addition, the power of the profession as both an enabler and a barrier to change is well recognised (6)

The engagement of doctors also has another dimension of importance given the nature of health organisations as professional bureaucracies (7). In professional bureaucracies, front line staff have a significant measure of control over the content of work by virtue of their specialist training and knowledge. Consequently, hierarchical directives issued by those nominally in control often have limited impact, and indeed may be resisted by front line staff. Professional bureaucracies have an inverted power structure in which staff at the bottom of organisations generally have greater influence over decision-making on a day-to-day basis than those in formal positions of authority. Control of the business process is often driven by professionals who use collegial influences to secure co-ordination of work. Collegial influences depend critically on the credibility of the professionals at their core, rather than simply the power of people in formal positions of authority (8). Organisational leaders therefore have to negotiate, rather than impose, new policies and practices, working in a way that is sensitive to the culture of these organisations (9).

Evidence suggests that organisational leaders have typically struggled with the task of negotiating, and this lack of medical engagement has meant that hospitals have failed to achieve acceptable levels of patient care (10). Whilst organisational leaders are important in facilitating the engagement of the workforce, arguably senior professionals (such as doctors) also have a role to play in these processes.

A burgeoning medical engagement evidence base has developed over the last twenty years in response to the identification of the importance of this function in high quality health systems. Australia has yet to develop the same sort of evidence base, although it is typically assumed that similar relationships exist. Indeed, a range of recent enquiries, commissions and reports identify a critical need to engage all health professionals as a way to improve healthcare (11). Medical engagement has been defined as the 'active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high-quality care' (12: pg. 214). Whilst this is a laudable aim, which is based in a need to embed continuous improvement in care delivery, one of the challenges is how to identify and measure engagement.

In examining the link between medical engagement and performance a proxy measure of the number of physicians on a hospital's board of management has been used as an indication of engagement (13). Yet, such a measure does not necessarily measure actual levels of engagement in improvement either at the organisational management/governance level or in terms of front-line clinicians. In addition, in some settings, the number of doctors is limited by legislation (e.g. Victoria). In the UK, Spurgeon and colleagues (12) have developed a Medical Engagement Scale which is a validated measurement tool to assess levels of engagement of doctors in health organisations. Tools of this type can be helpful in giving organisations a clear sense of levels of engagement within their organisations, and can identify areas where additional work may be required to achieve engagement.

In recognising the link between medical engagement and improved performance, health organisations have implemented a number of different mechanisms to increase medical engagement. Many health organisations have introduced clinical directorate models; a form of organisational structure that typically involves doctors assuming middle-management roles heading clinical service units.

These sorts of structures have been implemented in a range of countries following their initial experimentation in the US and UK (14-16). There is some evidence demonstrating the efficacy and effectiveness of these within an Australian context (17, 18). The role of the medical administrator (also known as medical manager, medical leader, physician manager) has also come into focus as health organisations have sought to appoint doctors to clinician-manager roles as a way of securing medical engagement (19-21). In many cases those taking on these roles maintain a foot in both camps acting as 'hybrid' doctor-managers, although in others doctors give up their clinical practice altogether (22). In the US, for example, most chief executive officers of health organisations are doctors by background, giving up their clinical practice at some point in their journey to positional leadership.

Much of the literature notes the challenges inherent in hybrid roles, particularly given the common perception of managerial duties as 'going over to the dark side' (22) and the significant professional cultural disincentives to engage with these roles (23).

In Australia, a number of the challenges that other health systems face in relation to medical engagement are further exacerbated by key features of the medical profession in this country such as the oversupply of domestic medical graduates and the significant numbers doctors who are based largely in their own private practices who have part time appointments in public hospitals (11, 24). Australia does, however, uniquely have a medical specialty college – The Royal Australasian College of Medical Administrators – with a Fellowship training programme for those interested in becoming medical administrators. Other specialty colleges have to this time provided limited formal training in medical leadership and management for system improvement, despite the importance of management and leadership as critical attributes of professionalism (25-27).

Other suggestions for the improvement of medical engagement focus on performance metrics and either financially incentivise higher levels of performance or penalise those with poorer levels of performance (2). However, there are a range of challenges with identifying acceptable levels of performance, and then being able to measure these in practice.

Other attempts have drawn on new technologies and are closely linked to aspects of medical professionalism (28). What is clear is that no health system to date has designed a way in which to define, measure and improve medical engagement across the board.

Overall, many of the mechanisms used to encourage medical engagement have a structural flavour to them, with a strong emphasis on formalised roles within healthcare organisations. Writing from a Canadian perspective, Baker and Denis (29) are critical of this type of approach, arguing that 'transforming health care organizations to improve performance requires effective strategies for engaging doctors and developing medical leadership. Most efforts in the US and UK to develop medical leadership have focused on structural changes that integrate doctors into administrative structures, but these have had limited impact. Recognizing the distributed and collective character of effective leadership, some health care organizations are attempting to create greater alignment between clinical and managerial goals, focusing on improving quality of care' (pg. 355).

Such a perspective argues that it is not simply having doctors engaged in formalised leadership roles that leads to improvement, but the focus should be on how teams operate within healthcare organisations. Leadership is recognised in this context as not necessarily residing in the activities of individuals but is a collective manifestation of groups in relation to a set of particular goals. Yet many attempts aimed at bringing about greater medical engagement have focused on individuals, and not their teams.

This finding is reflected in the fact that most training and programs aimed at developing medical leaders involve individuals learning alongside other doctors, and away from those they work with on an every-day basis (30).

In her examination of the literature on Medical Managers and its applicability to the Australian context, Dwyer (31) notes that in light of falling Medical Management trainee numbers there is an 'urgent need to encourage more medical practitioners into management and for organisations to further embrace Medical Managers in key leadership roles'. Certainly the evidence would support this position, but other issues are also important if we are to take issues of medical engagement seriously.

Recent research from the UK found that sustained attention to issues of medical leadership in recent years have created a more professionalised cadre of medical leaders, leading to better trained individuals and increased competition for these sorts of roles (30, 32). Yet, this research also found that often little had changed for other doctors who were not in these formalised roles; the team noted an 'engagement gap' between medical leaders and the 'rank and file' doctor.

Rather than viewing this group of professionalised doctor-managers as an illustration of the acceptance of this sort of career path to the medical profession, Dickinson et al (30) conclude that what we have seen is a splitting of the medical profession where the 'administrative elite' of doctors in leadership roles has resulted in increasing differentiation between these doctors and the 'rank and file' whose main focus is their direct patient care.

What this study shows is that medical managers may be a necessary, but insufficient, mechanism for generating widespread engagement of doctors in organisations and health systems. This study illustrates that effective medical engagement requires a multi-pronged approach involving the individual, interpersonal relations, and the system.

### 3 Methodology

In this research project we sought to explore the different views and perspectives of individuals working within a range of different medical engagement roles. As such we adopted a qualitative research methodology. A purposive sampling approach was used to select doctors who work in medical leadership roles in Australia, as defined above.

For the purposes of this paper, we defined medical leadership as the practice of trained medical practitioners occupying formal leadership roles relevant to the health and medicine, at the level of managing and administering health-related services (such as hospitals), organisations

(such as professional organisations) and government departments. Interviewees were identified through researchers' personal networks and professional associations, including the Royal Australasian College of Medical Administrators. Additional interviewees were also identified via recommendations from other interviewees, via a snowballing recruitment strategy.

We aimed to identify interviewees representing diversity in gender, age, tenure, leadership position, service/organisation type and geographical location (see Table 1).

**TABLE 1: CHARACTERISTICS OF INTERVIEWEES**

CHARACTERISTIC		NUMBER (N=30)
<b>Sex</b>	Male	22
	Female	8
<b>Organisation</b>	Public hospital or health service	12
	Private hospital	3
	Government department or public sector agency	6
	Professional College or Association	9
<b>Level of leadership</b>	CEO / President / Dean	11
	Second or third tier management	10
	Medical director or clinical leader	9

Interviewees came from five Australian states: Victoria, New South Wales, Queensland, Western Australia and Tasmania.

Potential interviewees were approached by phone or email, and all who were approached agreed to participate with no subsequent drop-outs. Interviews were conducted between June and September 2014. We gave interviewees a choice of conducting the interview by telephone or face-to-face. Where interviewees elected for face-to-face interviews, the setting was a combination of public and private hospitals in Australia. No-one else was present beside the interviewer and the researcher. Recruitment of interviewees continued until we reached data saturation.

To elicit interviewees' beliefs and experiences, we used semi-structured interviews. Interviewees were told that the purpose of the interview was to better understand the drivers and barriers impacting the involvement of medical practitioners in the leadership of healthcare organisations.

Interviews lasted between 25 and 60 minutes. Interviews were recorded with interviewee consent and transcribed verbatim. The interview schedule was informed by an in-depth search of the literature pertaining to involvement of medical practitioners in medical leadership roles. Questions in the schedule focused on three broad areas: intrinsic and extrinsic factors that encourage medical practitioners to take on leadership roles, barriers to such involvement, and opportunities for improved support and development.

Following each interview, interviewers noted initial thoughts and ideas. Field notes and transcribed interviews were read and re-read by three researchers (HD, MB, LT) to achieve a close immersion in the data. Data were managed using N-Vivo software. A coding framework was developed using an approach that was both deductive and inductive, arising from the content of the interviews and informed by our review of the literature. Frequent discussions within the team ensured thorough and consistent coding.

Coding differences were resolved by consensus. The coding framework is available on request to the authors. All sections of coded data were grouped into themes. These themes explained larger sections of the data by combining different codes that were connected through key concepts and repeated patterns. Themes were then reconsidered in relation to the data set as a whole to ensure that no important themes had been missed during the earlier stages of coding. The final stage involved choosing examples of transcript to illustrate major themes and the diversity of responses. The research was approved by the University of Melbourne Human Research Ethics Committee.

Having provided an account of the literature and the methodology adopted in this project we now set out the findings of this research. Findings are illustrated by the use of verbatim quotations which we have anonymised. To illustrate that these quotations have come from different individuals, each interviewee is identified via a specific code starting ML (e.g. ML07).

## 4 What opportunities are there to engage in leadership and management?

Our data suggests that there is no one single route through which doctors become engaged in the leadership and management of health organisations, but rather a **diverse array of opportunities**. In this section we explore some of those which interviewees spoke of, and categorise these broadly into formal and informal opportunities. By “formal opportunities”, we mean those opportunities that have been specifically established in order to encourage doctors into leadership and management activities. Those which we term informal are not necessarily oriented towards taking on formalised leadership and management roles, but they may lead to these opportunities over the longer term.

In talking about the routes from clinical practice into formalised management and leadership roles, what was clear is that there is no one journey that doctors take. As one interviewee explained,

*“I didn’t make the jump from clinical practice to executive... There was a long journey in-between.”* (ML02).

Many interviewees explained that they had not planned their career paths and had not necessarily intended to become doctors who occupied leadership or management roles, but had moved into these in a more organic or opportunistic way. The following quote is one example of such a journey;

*“I think basically I fell into the role. So head of medicine, and when the new CEO... joined the health service there was a vacancy in the chief medical officer role, so he suggested I fill it temporarily while they looked for a chief medical officer. And then as it evolved he then asked me to take the position permanently, after a few months... Yup, it wasn’t a deliberate thing, it just kinda happened that way.”* (ML29).

Often interviewees explained that they had happened into these roles as a result of opportunities that had arisen, rather than as a planned route;

*“My career pathway is very organic, there’s nothing planned, designed; that’s not the approach, so it’s just evolved as it were, through a fairly organic process, but one of the things in working in a department of health, which some of my public health work was based in, that led*

*to further working in more clinical policy, and working in a health department environment where it’s basically, you know, supporting that public health function”* (ML11).

Individuals were able to take these opportunities as there was limited, or often no, competition for these roles. As we explained in the methodology, the majority of those we interviewed were established medical leaders who had been in these roles for a significant period of time. Only a small proportion of those that we interviewed had come into formalised management and leadership roles within the last few years. We mention this observation as it is apparent that this field may currently be going through a time of transition.

While traditionally there has not been a high degree of interest in, and competition for, these roles, this may be changing. Larger numbers of doctors are graduating from Australian medical school than ever before and it appears as though there may be an oversupply of doctors within the next decade (33). An implication of this is that there will be greater competition for specialty training than ever before. This supply-side factor may mean that we start to see greater interest in these roles over the next few years as doctors face fiercer competition for roles and specialty training opportunities.

### 4.1 FORMAL OPPORTUNITIES

For many of those we interviewed, their first engagement with leadership and management was when they took on a position that included **formalised leadership and/or management responsibilities**. Interviewees explained that doctors are assumed to have capacities in terms of leadership and management as a result of their training, the kinds of work that they take on and their status within clinical teams. As such, many explained that they had received little formal training before entering into their first management or leadership role;

*“[Leadership roles] was something that was thrust upon you. And that was the model. If you are good clinically, then you have to run something... before I got my ticket, I was a registrar in emergency medicine. I think, effectively I was de facto running the emergency department at [place] from in about my fourth graduate year”* (ML03).

In terms of the kinds of administration, management or leadership roles available, there are a **wide range of different job titles** including chief executive, chief medical officer, clinical director, medical director, chief health officer, director medical services, clinical lead, and others still.

For those operating within the system there may be clear and very different roles for chief executive, chief medical director and clinical director, but this may not be clear for all and there is some variation in practice across organisations. One observation that we would make from the data is that there is often little consistency in terms of these job titles and the everyday activities that role holders enter into. Whilst some (chief executive, medical director) have a degree of consistency across organisations, others significantly vary in terms of the description of these roles and what individuals are asked to do on a day-to-day basis. Some of these roles involve maintaining clinical practice alongside management and leadership roles, whilst others involve giving up clinical practice all-together and transitioning into a purely managerial role. It is therefore difficult to compare these roles across institutions and there is certainly no consistent career path or development role into these.

Not everyone who takes on management and leadership roles does so either willingly or in the full knowledge that there are these kinds of expectations on them.

As one interviewee explained,

*"I'm a, a reluctant leader. I guess I don't see myself as a, as a clinical leader as such, but more an enthusiast to go with the team... I was thrown, post PhD, into a transplant role where everybody else disappeared around me. I found myself as head of transplantation and that was good but realised yourself too junior at that stage and not supported clinically by other people around you because of there's no experience there, um, nor having the leadership skills, um, at that point and I think looking back naively you think, yeah, that's one of the reasons you really do flounder in that role"*

(ML18).

A number of interviewees explained to us that they got their first exposure to management and leadership in **acting or temporary roles**, filling in whilst a colleague was away ill or on leave. After this first experience they either got a taste for this sort of role or were judged by colleagues to have performed well, and invited to take on new expanded responsibilities. Many of those who entered through such a route explained that medical leadership roles sometimes lack visibility and they had not known what was involved in this type of role before actually taking on such responsibilities.

Many of those we spoke to explained that leadership and management learning is now starting to be recognised as a more important activity for doctors, and so it is being increasingly recognised through medical school and **formalised education processes**.

As one interviewee explained,

*"...there's some really good stuff happening across some of the universities now getting medical students more engaged with that sort of educational of thinking" (ML01). Others expressed the belief that even if individuals do not go on to assume leadership or management roles, being exposed to this sort of learning is helpful in terms of the day to day activity of health organisations; "even though you don't go into a management position, it does help you think logically through issues, think logically about decision-making and how to relate to your colleagues if... so, I think that would be useful"*

(ML02).

Although there was some debate in terms of what is the best time to expose doctors to these kinds of issues.

Another interviewee believes that,

*"it probably would be good to do it as early as registrar-type level. I think any lower than that would be a waste of time. I think, yeah, medical school wouldn't be the right place but probably registrar-level would be the right level for it"* (ML02).

After initial training a number of doctors choose to return to education at a later point to do some form of **postgraduate education** which in some cases results in a move into the management and leadership space. As one interviewee explains,

*"when you think of it there are quite a few of those people around who are interested in the broader health system and they do come out of the 100% clinical role, actively to pursue that, and often, not uncommon now for doctors to do MBAs and management training, or you know, post medical education, increasingly people are interested in more formal training in that as well"* (ML11).

Interviewees explained that at one time it might not have been expected that doctors have a formalised educational qualification to go into leadership and management roles but that this is becoming increasingly expected now.

As one interviewee explains,

*“It’s pretty unusual to find a manager in a hospital that isn’t either done some kind of Master’s degree or... Not necessarily MBA, it can be the... Master of Public Health...so pretty unusual to find anybody from ... kind of middle to senior management that hasn’t got some kind of Master’s, you know” (ML22).*

As the previous quote suggests, while those thinking of moving into leadership and management roles may benefit from postgraduate study, which degree is an open question. In our interviews we uncovered a broad range of possible courses and interviewees told us that each have their different strengths and weaknesses.

We consider some of these here, but given our limited sample it is unlikely that we have been exhaustive in terms of options and perspectives on their relative merits.

A number of those we interviewed had at some point undertaken a **Master of Business Administration (MBA)**. An MBA typically introduces students to commercial management techniques, and as such, includes a number of the more practical skills around budget management, human resources, finance etc.

Often those who chose to do the MBA explained that they felt this was more valued than some other qualifications at postgraduate level, and also provides some perspective on issues from a broad position, rather than simply focusing on health. As one interviewee explained,

*“I chose to do an MBA rather than a Masters in health administration... the masters of health administration is no necessarily the right one. It is too internally focused. An MBA give a broader picture. It showed me that health isn’t special; it isn’t different, it’s the same as any mammoth, huge organisation and we should be running as such, rather than running it as a special health-type focus...I knew that a Masters in health administration in the private sectors carries far less value than an MBA” (ML28).*

Often interviewees suggested that one of the attractive things about the MBA is that it is perceived to offer more opportunities to move into new roles in the private sector in the future;

*“I thought an MBA was more generic because I thought there is a possibility maybe I’ll go out of health. You never know” (ML24).*

Other interviewees concurred with this position explaining,

*“I did the MBA ... I think I started off in the MBA almost idealistically thinking there might be opportunity in Big Pharma ... and with the secondary thought of hospital administration. And I guess part of it was being naïve. But I don’t know what the correct career path should be before this type of position. I think you do have to have clinical credibility though, and you can have three hundred degrees behind your name, but if you haven’t actually been dealing and managing patients, and in some respects still managing patients, you just ... you don’t have that direct insight as far as I’m concerned” (ML13).*

Others chose not to undertake MBAs, but do postgraduate courses that focused more specifically on a health context. A variety of options are available such as the **Master of Public Health (MPH)**, **Master of Hospital Administration (MHA)**, **Master of Health Services Management (MHSM)** and slightly broader courses such as the **Master of Public Policy and Management (MPPM)** or **Master Public Administration (MPA)**. While the kind of curriculum that underpins MBA programmes tends to be fairly consistent, there is far more variation in these other programmes.

Often interviewees explained that they had chosen courses not necessarily because they had been able to weigh up the pros and cons of a range of different opportunities, but due to the fact that they were available in their locality. Whilst there may be a broader array of opportunities in urban or metropolitan areas, there are far fewer available opportunities in more rural or remote areas. In these situations the selection of course may have related more to the availability of options, rather than the appropriateness of the postgraduate course for the individual’s development.

Australia benefits from having a recognised specialty specifically for doctors who want to move into administrative roles; the Fellowship of the **Royal Australasian College of Medical Administrators (FRACMA)**. A significant proportion of those we interviewed had undertaken the specialty training offered by RACMA and spoke highly of this experience.

As one interviewee described,

*“I think RACMA helped immensely. You couldn’t have done this job, at least I couldn’t have done this job, without the training that I had”* (ML12).

Most of those we interviewed had embarked on their RACMA training as a second specialty area following initial training in one or more other areas. However, some we interviewed who bucked this trend had undertaken it earlier in their career. As one interviewee explained,

*“I chose that as my first postgraduate fellowship, which is fairly unusual. There are a few of us around, and there is a growing number who do it as their first job. We have a few in [place] who have gone down that path. In fact some of our most senior executives are now in that position. But...I think, often, the way I’ve seen senior clinicians land...is that you get a gap in your director of clinical services, and you can’t find someone or can’t recruit them, and you put your wise senior clinician in the job, because people will respect them and hopefully they’ll do a reasonable job. We’ve seen many health administrators in [place] take this as their last job before retirement”* (ML28).

The previous quote again illustrates the fact that there is often limited competition for medical leadership roles – either due to lack of interest or levels of competence in management. In metropolitan areas there is the potential for greater competition but in more rural or remote areas there is less, meaning that medical leadership roles are often simply circulated amongst a limited group of individuals. Many of those we spoke to believed that there is also a lack of transparency in recruitment and appointment processes. Medical leadership roles often therefore fall to long-serving individuals, rather than those who have opted to move into leadership or management positions.

In terms of the value that RACMA provides, whilst many talked about this in terms of specific training and being exposed to a range of different activities as part of placement or project work, others spoke about value in terms of belonging to a group;

*“as a trainee, or as a consultant, or as a fellow, I didn’t belong to that program. And then when I joined RACMA there was a feeling of belonging to a college...the first thing that the training does give you is a belonging and a rightful place you’re part of a specialist training college as a candidate and then as a fellow...I couldn’t have just been plonked into this job and started from day one if you didn’t have the training”* (ML12).

This quote illustrates a sentiment that many echoed about the need for those entering management and leadership roles to not simply access training to make this transition, but to also have the support of a peer group. As we will illustrate further below, medical management and leadership roles were often described as being incredibly demanding and can often be a lonely experience.

Not everyone that we spoke to was positive about RACMA, or they viewed the training as a useful starting point but insufficient in terms of becoming a fully developed leader. As one interviewee explains,

*“RACMA’s OK, but it’s for people who want to become pure managers more than people who want to be clinician managers”* (ML20).

Some of those we spoke to agreed that RACMA training is more appropriate for those who are seeking to give up their clinical practice entirely, rather than working in a hybrid clinician-administration role.

A number of the organisations that interviewees worked for run their own **in-house training** and development programmes aimed at encouraging doctors into management and leadership roles.

As the following quote illustrates, there are no end of possible options for doctors looking to gain development in management and leadership - the difficulty that many reported was in how to choose between these various different options. The value of the in-house programmes is at least, in part, that it is likely to be specific to the local organisational context and can work to accord the values and culture of that locality;

*“we do in-house... And I think that, I mean there are lots of providers now... I know the university do these sorts of things... A lot of the colleges will, sort of certify or accredit ah, the programs or subjects that are provided by universities. The attraction of in-house is that, it’s sort of the bespoke I suppose to the needs of that organisation and um ah so we are attracted to in-house because we have sort of a strong commitment to um, you know, values and those sorts of things in the way we deliver our leadership and management courses. Ah so may... I think that would... the argument for doing it in-house might be that you see that as a way of reinforcing and building a particular culture. And of course, increasingly there is lots of stuff that’s on line now. So, I think that in a way, for the sort of entry level diploma type you can’t do this job as department head unless you get a, like a diploma of*

*Institute of Company Directors or a diploma from somewhere else. That stuff is, you know, management 101 and you do a bit of budgeting and you do a bit of people management and you do a bit of, probably a bit of IT and make sure they're familiar with systems. I don't know that you'd be looking to turn them into MBA type people but you'd need to give them enough to ensure that they are um supported to do the job not thrown to the dogs"* (ML23).

Again there was significant variation reported in the sort of in-house training opportunities offered, and whether these are simply short (day or half day) training opportunities around specific topics (e.g. managing teams, budgeting) or more substantial and on-going programmes seeking to develop the organisation's future medical leaders.

## 4.2 INFORMAL OPPORTUNITIES

In addition to formal opportunities to become engaged in the leadership and management of health care organisations, interviewees also described a number of informal routes. These typically give individuals experience of issues relating to leadership and management that either encourage them to seek out a pathway into these types of opportunities in the future, or afford them the requisite experience to take on more formalised opportunities in the future.

Several interviewees described **mentoring** arrangements that seek to identify those who may be interested in leadership or management positions, and offer them experiences that assist their progression into this space. As one interviewee explained,

*"I think it's really, really important to make sure that people that want to—well, firstly, the people are encouraged to step into leadership roles. So, I'm a very, very strong believer in mentorship and having mentoring roles for my peers and people are coming to the system. So, mentoring is just a fundamental thing... One of the offshoots of good quality mentoring is that you can actually direct people towards things that they might not otherwise think about"* (ML01).

Mentoring is a fundamental component of practice in many organisations and

also in some of the programmes for developing medical leaders;

*"the mentoring process I think, is very very important and I think that's something that's a challenge in relation to those sorts of things... I mean there's always, the good things, with RACMA having to have preceptors and things of that nature so that you can get the diversity in relation to exposure to different fellows and help them along the way"* (ML05).

Within health organisations there are a variety of ways that individuals can gain leadership experience in departments and also through **committees** that operate on a cross-organisational basis (e.g. quality and safety). These sorts of opportunities expose individuals to the working of health organisations and systems, which is important to leadership and management. Some reported that doctors often work in a narrow part of health organisations and do not always feel as though they are part of a larger system. Committees and other informal opportunities expose individuals to this, which can give doctors a desire to do more work on a system basis.

**Experience** is a factor that features prominently within the data we collected. Many interviewees spoke of the importance of the learning that they had developed over their career, and that they regularly drew on this in informing their management and leadership practice. One interviewee explained,

*"I found the background in hospitals, which was my career path prior to this, incredibly useful, particularly around the medico-political interface; you don't run a public hospital without having politics beating upon your door, and...be it big-p politics in the sense of the Minister of Health asking you why you're making his life unpleasant, through to the small-p politics just going on in the workplace every day of the week"* (ML08).

Many interviewees spoke specifically about the importance of experience in clinical practice in preparing them for leadership and management roles. As we will discuss in more detail below, a substantial proportion of interviewees argued that clinical experience is a crucial factor in preparing for doctors for leadership and management roles. As such, many felt that doctors should not seek to enter management or leadership roles until they gained substantial clinical practice.

One interviewee explained the sort of advice that they give to potential medical leaders,

*“look at some experience in clinical practice is better to come into this speciality and in that time, I guess, work around... know what your organisation is doing and try and see if you can do some bigger projects, which, sort of improvement projects and things which involve larger part of the organisation rather than just working within your clinical place. Do some audits, see how quality works and all that stuff, so... And then of course I do tell them “do a masters,” so that at least that’s one thing that’ll be done” (ML12).*

## 5. What factors encourage doctors to engage with leadership and management opportunities?

Having set out what opportunities there are to engage with management and leadership roles, in this section we consider the kinds of factors that encourage doctors to do this. We consider these factors in terms of their status as intrinsic and extrinsic drivers. We consider factors to be intrinsic where they arise from some sort of inner drive to take on a role because individuals find it to be personally rewarding in a way. Extrinsic factors derive from the external world and typically relate to some sort of positive reward or sanction for engaging in particular behaviours.

What is apparent from the data presented below is there **is a far broader range of intrinsic factors than there are extrinsic motivators**. Many of those we interviewed described taking on management or leadership roles as a result of some inner personal drive, and did so despite the system, rather than because of it. As we have already explained all of this could potentially change in the future as greater numbers of doctors enter the workforce and there is more fierce competition for specialty training. Given this set of circumstances we may find that in the near future a far

greater number of extrinsic motivators take hold within the system. Although of course this raises the question about whether these are the ‘right’ sort of drivers for these roles.

### 5.1 INTRINSIC MOTIVATING FACTORS

Without fail, interviewees typically reported that they had been attracted to engaging in leadership and management roles because they felt this offered an opportunity to **have a greater impact** over a population, rather than one patient at a time. Interviewees were often at great pains to explain that this did not mean that they were not interested in patient care, simply that they could make a greater impact through management and leadership roles;

*“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% convinced that I actually made a difference to people. I just felt that it wasn’t a satisfying thing for me” (ML02).*

Such a perspective was concurred by other interviewees,

*“I like patients, it wasn’t that I didn’t like patients or anything like that, but when I went into the job I thought you could actually change a system and actually have bigger effect on the whole patient population rather than just individual patients and that to me something that I really enjoyed sort of thing so um and I’m just... it’s my nature, I like to fix things and um I can’t stand it when you see inefficiencies or you see things that are not right and nobody is doing anything about it sort of thing, so... to use that... I suppose it is a power type thing but it’s the ability to try and change things when things aren’t right” (ML05).*

*“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. I always knew there was a group that I couldn’t ever relate to emotionally. So it was more about what I could do as...a bigger picture thing really, the recognition...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” (ML28).*

Interviewees often spoke about being motivated by a desire to **solve problems** and to make a difference,

*“I describe myself as someone who has an overdeveloped sense of responsibility, too, but also an optimistic problem solver. So, I can’t help but see problems and then I can’t help but see solutions... And then I can’t help thinking I have to help try and fix that, and that’s partly because my parents were like that, I’m sure. I don’t know about the rest of it but I think as clinicians we ... you know, what I was going to say is that we get doctors to stand at the end of the day and then see the problem with the patient and fix the problem with the patient. It didn’t take me long before I was standing at the end of the day thinking, “Well, this is a problem the patient has, but actually there’s a problem with the system.” We could fix the system, then we might be able to prevent the problem the patient has... And so I’ve got that slightly bigger picture view and started to think about what we could do to improve the system which then led me to doing, well, basically to quality improvement which is any improvement change, and leadership, I guess” (ML27).*

A number of interviewees described being attracted to **systems thinking**, and that taking on management and leadership roles allows them to engage in these sorts of processes;

*“For me, I think if you ... if you think about your role as an emergency physician, then you immediately think about health systems. Because you know our health systems are under strain. You see it in emergency department, whether it’s primary care, hospital care, aged care, whatever. They are all built up there. And so that’s where you get a sense of maybe there’s some things that can be done with the system” (ML03).*

Interviewees explained that they are intrinsically drawn to the bigger picture, rather than the micro focus of the majority of their colleagues,

*“I need a bigger picture than that sort of tiny, tiny level of...it’s not that I have a problem with doing molecular work. It’s that I have a problem with...problem with an absolutely single minded focus and... you know...I again had colleagues whose...you know...mono-maniacal focus...you know... really just ultimately drives you nuts because you can never actually get them to contribute in anything other... unless it actually is aligned with what their interests are and I guess I’m completely the opposite” (ML25).*

Again the issue of time and generational change featured in descriptions of these issues.

A number of interviewees explained they perceived that younger generations of doctors are more interested in systems thinking that previous generations have been;

*“I’m seeing a bit of a quantum... change in that the youth or the younger doctors are much more systematic in their thinking than the older doctors are. I think that they’re more team-based, and by team I don’t just mean just co-located, but cooperative and working together and not so much power-driven as the past” (ML06).*

It is certainly true that systems thinking is now present in the teaching curriculum for doctors, in a way that it tended not to be in the past.

We have already mentioned that the medical profession is going through a change to the extent that there are more doctors than ever before, but there are also other significant **shifts in the profession** and the **nature of work** that mean leadership and management roles are starting to become more attractive. Across the board people are living for longer and we are starting to see an elongation of our working lives. Doctors reported engaging with leadership and management roles as a result of these factors, either so they were not, for example, carrying out surgical procedures at 70 years of age, or in search of a new challenge.

One interviewee explains that,

*“you certainly get to a stage, and I’ve got to a stage in my medical career where clinical work, serious clinical work became less of an option”*

(ML03).

Traditionally doctors have reached the peak of their profession as they near retirement age, but in many cases now doctors may reach this point and still have a further twenty years left in the profession. As one interviewee explains,

*“So you’ve got really intelligent people who in my experience, sometime between the age of forty and fifty, have become ‘this is not enough for me’. Now, some of them do ratbaggy money things, some of them get into industrial politics, some of them go into politics, some of them said they want to make a difference to the system. It’s the latter group that I think have stepped up into the... you know, they’re fifty, sixty, they’ve already got their... they’re independent financially, they want to put something back, and this is an avenue, a safe avenue for doing it”* (ML06).

Another concurred suggesting,

*“I think it’s one of the sorts of later-career options. ...And the College does say, you’re going to be better at your job if you go and get some clinical experience, and get involved, know exactly how the system works clinically, rather than go straight into administration, because then otherwise you may as well just be a manager”* (ML04).

*“I actually thought, “I don’t think I want to do what I am currently doing for the next 20 years. At the end of my career I really discovered I had a bit of a talent for organising and bringing people together. I’m actually shocking at detail of it. You know, I can get stuff done and people seem willing to follow or to help me. I think that’s better than follow, to help me get to that outcome ... And I saw it as a challenge, something I could do. And, you know, I was not altruistic particularly. If I can find this ... I really felt as though this was an opportunity for me, to go a different direction in life”* (ML07).

Others still were interested in **having an influence** on the health organisations that they worked for,

*“I found myself wanting to have some influence, which was a key thing. And, I thought was a big opportunity to have influence in that role”* (ML01).

According to such a perspective, individuals saw this as an opportunity to allow doctors to have a significant influence on the health system.

One interviewee explained,

*“I sat there and thought, “Geez, if...if we as doctors don’t take an active role in how the health system is shaped and...and developed, it’s going to happen anyway, but it’s going to happen without us.” So when...when they first made that move from, you know, the medical superintendent to CEOs and to business footing”* (ML15).

Leadership and management roles were seen as a way in which doctors can have a significant influence on the operation of organisations and health systems more broadly.

One interviewee presented a rather cynical view on engagement, although many of those we spoke to shared such a sentiment;

*“Let me tell you my theory on engagement... two types of engagement. Those people who are after the kudos of just having a title and you’ll get them engaged. It’s important for them to put it on their CV “I was clinical director, I was program director, I was associate professor” you know? It suits for their own glory box. But there’s a limited number of positions like*

*that and if the competition isn’t big for that position then you get a less than engaged person, you get somebody there with the title and the glory box. For the rest of the consultants—and this is my cynical attitude—the only time you’re going to get engagement, is if you pay for it, it’s as simple as that. These are people who have private practices elsewhere, and unless you’re gonna pay them to come and engage on a clinical level, they can earn more in private and that’s where they will be. And it’s as simple as that: it comes down to dollar The dollar. I hate to say it, it’s the dollar. And predominantly those clinicians who have the capacity for private practice ... so you have clinicians who don’t have in their craft the capacity for private practice, who will probably be more engaging. For example emergency physicians, because you can’t go and open up your rooms anywhere”* (ML13).

## 5.2 EXTRINSIC MOTIVATING FACTORS

As we suggested above, far fewer extrinsic motivating factors were suggested to be important in terms of decisions to move in to management and leadership roles. As we will discuss in more detail below when we consider the barriers to engaging in management and leadership roles, a great many aspects of the extrinsic context tend to act as a disincentive to taking on these roles rather than acting as an enticement.

As we explained above, many of our interviewees had undertaken the RACMA programme at some point in their career. The fact that Australia has a recognised specialty in this area was seen by many as a motivating factor to the extent that this signals that management and leadership are a legitimate career choice for doctors. The **availability of training and development opportunities** were also seen to have been important factors in determining a move into this space. Many interviewees told us that having a **mentor** had been an important factor in encouraging them into a management or leadership role.

## 6. What are the barriers to doctors engaging with leadership and management opportunities?

As we have already described, by and large medical leadership and management roles are largely perceived to be difficult in practice and draw on different skills and abilities to those that doctors are typically trained for. Moreover, interviewees described a wide range of different barriers that pose challenges for individuals in assuming these roles. In this section, we outline those that were most frequently cited in interviews.

### 6.1 TRAINING

As we explained in the previous section, one major barrier to doctors taking on these kinds of leadership and management roles is that they are **not necessarily equipped to do so through training or medical school;**

*“even in just management roles, you know, lots of assumptions get made of people who are good at their technical jobs, but they sort of get promoted. And, as soon as they get promoted to whatever it is level, they suddenly evolved into a management job, because that’s what the management jobs are. And, then I think, “Hang on. But, now I’ve got to look after people and how do*

*I do that?” So, they need training”*  
(ML01).

These sentiments were echoed by another interviewee who explained,

*“I really strongly believe that we have to get across to people in the system that it is wrong and highly risky to ask clinicians to do management jobs, for which they have no training”*  
(ML23).

Given that we have noted above that for many doctors their first experience of leadership and management is when they assume one of these roles, this lack of training around management is a significant barrier to engaging effectively with these roles.

### 6.2 CAREER PATH

Interviewees also reported that there is a **lack of a consistent or clear career path** for those interested in medical leadership and management roles. As we described above, those we interviewed had very different trajectories into their roles and this lack of clear progression was seen as a barrier for some;

*“There’s no such thing as a prescribed career path for a chief*

executive. There's no course you do: at the end of it, there you are. There's a lot of attributes and experience training, of which, it all has to come together. And there's obviously something about capability, but experience and qualifications allow you to do that. And the biggest... what I hoped to do was at some point give up my medical practice" (ML06).

### 6.3 CULTURE

A further barrier to engaging with medical management and leadership roles is the perception of colleagues and others that this is expressed as 'going over to the dark side'. Nearly all of those we interviewed reported that they had been advised against taking on leadership or management responsibilities, and that this was seen as turning their back on both clinical practice and clinical colleagues. One interviewee described 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?""* (ML01).

Another interviewee adds to this experience explaining,

*"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"* (ML06).

Interviewees often described that doctors who move into these roles are not liked by clinical colleagues;

*"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"* (ML07).

### 6.4 WORKLOAD

Those in leadership and management roles typically reported that their **workload** is substantial and often more than their other clinical colleagues. Often this is because individuals are trying to operate both clinical and managerial practice alongside one another. As one interviewee explained,

*"This is a full-time job, and more, you know... maybe it's just me, but you worry about it all the time, you know. And, you know ... you know, so, I think, it's difficult, you know, to be that and also run a clinical load. But, the time is the biggest thing, and also, you know, and ... I think it's suddenly certain people that can be really really good at two things, you know. But, that being said, at the levels below us, divisional director level, and even my director of medical governance level, they ... they are about half and half"* (ML22).

### 6.5 LOSING DIRECT PATIENT CARE

Often doctors have to make difficult decisions about cutting back on clinical practice in order to allow time for administrative duties;

*"I'm going to cut back a little bit on the clinical work because the admin work's becoming increasingly demanding. But I don't want to give it up altogether and we're looking at, sort of, you know, medium term strategies of how to do that. So, I'll*

*probably do a little less patient clinics and possibly this time next year may come off the after-hours ward service roster, or perhaps do the odd night on call if somebody's on leave or something like that"* (ML16).

**Giving up direct patient care all together** is a decision that some doctors make in assuming a more full time management or leadership role. For some this is an incredibly difficult decision in the sense that this is not just their job or what they spend their days doing, but being a doctor is an intrinsic part of their **identity**. As one interviewee explains,

*"clinical practice 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"* (ML25).

Others reported being less concerned about taking the decision not to practice medicine any more. As one interviewee describes,

*"as soon as I made that decision to say, "Right, I'm not going to be practicing clinically" it was actually as though a weight had been lifted. Now, I still miss the clinical side and I think that's true for any doctor"* (ML15).

This decision is often not made quickly or easily but comes as a result of a long and agonising thought process.

*“So, I think the hardest job is to be a good clinician manager and...and by that...you know...if you look at these guys that are heads of units, we will give them an admin allocation, which may be half a day a week. It may be as much as two days a week, but they’re still expected to uphold their clinical load and uphold at a consultant level...achieve a consultant level and that’s hard. That is hard. So you start to see a few of them reach that issue too and they think geez I can’t do both so...so which is going to give?” (ML15).*

## 6.6 JOB DESIGN

Job design is another issue that a number of interviewees raised, with many being concerned that medical management jobs are not well conceived and do not give the appropriate levers or tools to be able to make changes but do afford a high degree of accountability to individuals. As one interviewee explains,

*“...the job description, the position description I was given, when I read it it was just phenomenally huge, and at my interview I basically said there is no way possible that one could undertake all these activities on a .5 EFT. And I was told “oh no that’s fine we just put them down, this is what we’d like, this is the ideal, but obviously we don’t expect all that.” Well I’ve been having to do almost all of that on a .5 EFT. But the*

*challenges have been big.”(ML13).*

These sentiments were echoed by another colleague who told us that,

*“the problem is that for a lot of doctors even if they’re interested in engaging with management, they’re often left impotent because they’re given no authority... Um and I think when I look back at the... my initial experience and amongst other problems is that that I was given some degree of accountability but no authority to do anything to, to actually influence outcomes, so... I think it’s certainly something I’ve learnt that you need to, you need to match the two pretty closely, don’t hold someone accountable for something that they’re very powerless to change but um similarly, once you give them the authority, yep, that’s, that’s the accountability and they can’t just pass it off and blame, blame management because they are management” (ML17).*

## 6.7 LOSING INFLUENCE

One implication of poor job design is that medical leaders and managers may find that despite having a formalised role **they lack the ability to influence and direct change**. As one interviewee explains,

*“I always liken the executive medical director’s job to an ambassador. That they are powerless. They have very little actual power and they are the*

*representative of the medical staff to executive and the interpreter of the madness of the organisation back to the medical staff” (ML07).*

A number of interviewees described that their organisations do not always support medical leaders and allow them to exercise leadership and management;

*“barriers can be presented by administration, I mean hospitals can be barriers for people to take up leadership, and that’s a cultural thing, I mean, and an organisation has to be prepared to support leadership, and if it’s like me where you’re learning on the job that means an element of tolerance when errors are made, that means the provision of opportunities to take up leadership learning, and it also means that support when trying to be a leader I suppose, you know, when trying to engage in change and support your unit, if it happened to be a Unit Head, but if in fact you—you’re always going to—that support’s not there, I can’t imagine anybody staying in those leadership roles if they feel that whatever they do they’re not going to get supported by their organisation.” (ML14)*

Medical leadership roles do not always benefit from **being well regarded** by doctors and are therefore not sought after. As one interviewee explains,

*“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” (ML11).*

Those who assume these sorts of roles explain that they end up trapped in a sort of ‘no-man’s land’ where they are neither full clinicians or full managers but a hybrid of both;

*“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” (ML15).*

Another interviewee 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. 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" (ML28).

Many interviewees expressed the belief that it is not just doctors who are dismissive of medical leaders, but also the broader community.

## 6.8 LACK OF SUPPORT

Overall many felt there is a **lack of support** for these sorts of roles; "

*...It doesn't matter how good you are, the community is there to get you and politicians are there to get you. It's just hell" (ML01).*

Others concurred arguing,

*"I don't see the health department or health services actively teaching doctors how to manage, actively creating career paths for them, actively including them in the system in a meaningful way. And I think that applies to this organisation that I work in as well. A lot of this is lip service. It's not actually empowering the doctors and saying, "Here's the*

*problem. Help us solve it. What are your solutions?" You know, we can argue bargy about this" (ML07).*

## 6.9 CREDIBILITY

The issue of **credibility** features prominently in discussions about barriers to these roles, with medical leadership roles generally lacking credibility in the wider system. As one interviewee explains,

*"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 work because that is the nirvana that everyone, you know, that is what you should be doing. Why else don't we like them? Because we don't like them because they have really gone over to the dark side and we don't have, as clinicians... 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" (ML07).*

Aside from issues of credibility, identity and clinical practice, financial barriers were also an issue that many interviewees raised. As one interviewee explains,

*"there's no doubt that the pay, particularly in the Victorian Public Sector system, is sort of significantly less than you can earn in the private sector but, you know, I've been fortunate enough to sort of not really have to worry about differentials in pay. I do the job because I really like it, not because it's the most high-paying job. But that might be an issue for some people" (ML02).*

In giving up clinical practice it is likely that doctors in leadership and management roles are paid less than before. Moreover, there are fewer opportunities to engage in private practice within a busy schedule;

*"the only ones on ground level who don't really have the capacity for private practice are the ones who will be involved and contributing and engaging to the organisation. You find me a specialty who has the capacity for private practice and tell me how much capacity for involvement you've got. The only incentive is if you've paid them enough that they don't have to go to their rooms, they will be involved." (ML13).*

Many we spoke to were at pains to point out that this did not mean that they were necessarily poorly paid in the scheme of the broader community but they are in comparison to their clinical peers,

*"I'm well-paid by community standards... I'm not well-paid*

*by medical standards. Not even remotely. But ... so, I ... adjusted long ago. You know, it's just the way it is" (ML30).*

For some reduced earning potential was even more significant given that they also were required to pay for additional education.

*"I think the other thing that went through my mind is now with the expense of extra education. I now know that there's a lot of motivated people who will go into it anyway, but it's a barrier, particularly talking about engaging younger people, people who've got young families, you know, spending \$10,000 to courses, not something they're going to be able to do easily" (ML27).*

## 6.10 GENDER

Interviewees agreed that men are over-represented in medical leadership roles. In the words of one senior woman:

*"the majority of that world is older men" (female, government department).*

There were differing views on the causes of this gender disparity. Several interviewees believed that men and women had equal opportunities to take up leadership roles, and women chose to prioritise their families rather than taking on "a lot of other demands and responsibilities." These different

social roles were seen as “something that you just can’t change” other than waiting for more women to slowly come through the leadership pipeline as the number of women entering the medical workforce increased.

This view that gender disparities are “natural” and inevitable was a minority view. Most interviewees believed that gender-related barriers were impeding women’s ability to achieve and thrive in medical leadership roles. At a personal level, lack of self-confidence led to doubt among some women that they were suited to leadership roles. The following quotes illustrate this type of perspective:

*“I suppose when I was thinking and talking about this role here, you know, I had to think, ‘Oh, can I do that?’ or, ‘Would I be able to do that?’ I wasn’t sure”* (female, professional organisation)

At an organisational level, informal processes for appointing leaders were seen as disadvantaging women and perpetuating the status quo. A number of interviewees argued for more transparent processes for identifying and growing medical leaders, with an explicit focus on gender equity.

*“I think we should be identifying people, easing them into it and not just tapping someone on the shoulder and saying how would you like to be medical director?”* (male, hospital)

At a structural level, providing appropriate maternity leave, childcare, part-time training, and flexible workplace policies were seen as useful strategies for supporting women to transition into leadership roles, when the time was right for them.

*“We can either accept that and say, ‘Oh you know, that’s a disaster,’ or ‘it’s terrible and can’t do anything about it,’ or I think we say to women, ‘Look, you know, we’re going to support you and provide you with education and leadership skills because when your kids are no longer, you know, at school or young school levels, you may want to take on some of these roles, and we will actually come to you and speak to you about that.”* (male, hospital)

These findings are consistent with international evidence that a complex interplay of factors inhibit women from assuming medical leadership roles. Redressing this imbalance will require us to move beyond “fixing the women” to a systemic, institutional approach that acknowledges and addresses the impact of unconscious, gender-linked biases.

## 7. How can doctors be better supported and developed so that they can engage in leadership and management roles?

As we have previously suggested, there have been some significant shifts in doctors’ willingness to take on more formalised management and leadership roles over time. As one doctor explained,

*“to be honest, I cannot recall ever having any training in leadership or management. And I don’t say that with any pride. It would have made life a lot easier if I did have that... of course, has been a real problem with the health system. And doctors in particular felt that inherent in their being is in leadership. Then it became trial and error and hopefully not too much error along the way”* (ML03).

Although there have been some significant changes to practices since the 1980s this does not mean that all is well in terms of the support and development of doctors. Within interviews there were a broad range of different mechanisms suggested that might help doctors be better prepared to take on management and leadership roles, and we outline these in this section.

Many of those we spoke to saw a need for **more structured and developed pathways** into medical management and leadership roles.

*“So one of the things that I think we need to do is, first of all, recognise that senior clinician management actually does need a career pathway for a Director of Medical Services type of person”* (ML08).

In the context of health care there are more prescribed pathways for nursing and allied health leaders and yet these have continued to be lacking in the context of medical careers. As we have already explained, there is little in the way of systematic preparation for these roles, and this poses significant barriers for doctors who may wish to move into management and leadership roles. As one interviewee explained,

*“I think that my gut feeling about health care, in my experience—and you know, I guess I’ve been around it now for 25 odd years—is that the system doesn’t grow leadership, it just takes people who have ideas, and if those ideas are sort of deliverable then they sort of get asked to do other things. And I’m not sure—I mean my view about*

*that is that it would be good if we weren't just using percolation as a methodology to find leadership"*

(ML14).

Some interviewees pointed out that the entire approach to the training of doctors does not encourage engaging in leadership and management, and make taking on these roles a challenge;

*"The training of doctors is anti-systematic. So their starting position is negative. They enter, and are respected for being individualistic, autonomous, and take some joy in being about anti-management or anti-administration: they're just the soft target, you know, they're just something that gets in the road"*

(ML06).

In better supporting medical leadership, one of the issues that a number of interviewees raised relates to the point in a doctor's career when they should learn about issues of management and leadership. This was a keenly contested topic with some individuals arguing that there should be more about this covered in medical school than there presently is, and others seeing no place for this discussion at medical school. Others viewed this decision not as either or in terms of the point at which doctors should receive training about these issues, but that this should be a process of lifelong process of education;

*"I did anatomy in my second year at medical school and I may as well have done geography because, you know, I've retained some of it, but its relevance is just not there so I think teaching people about management at medical school until they actually become... Like, really, when you become a registrar, we should be saying to people, "You know what, you're a manager now. You have staff beneath you and we need to take you away and teach you, even if it's just for a few days, about what management is about for your level." And then when you become a consultant, you're a bigger manager now. You're actually managing a unit here with people. So, we don't do that"* (ML07).

Some suggested that the fact that learning about management and leadership tends to be more self-directed than guided may mean that individuals are not necessarily encouraged to explore these kinds of roles.

Most of those we interviewed believe that if we are to improve the quality of medical leadership and management then there is a need to invest in a **more structured career path and a clearer sense of what competencies are abilities are required** for these roles. In essence, what many of those we spoke to are arguing for is a **broader acceptance** of the need for medical leadership roles and more

consistency in terms of how individuals are developed and trained to take on these roles. One interviewee explains that,

*"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"*

(ML28).

The UK was cited as an example of how more formalised and explicit approaches might be taken to the development of medical leaders. The Faculty of Medical Leadership and Management articulates the requirements of doctors in relation to leadership and management from the start of medical school through to consultant level.

Alongside more **formalised roles and career paths**, many also believe that there should be a more **structured**

**approach to career development** than is often taken at the moment. This would involve identifying individuals who might demonstrate some kind of capacity for leadership roles and cultivating their experience.

*"I think we should be identifying people, easing them into it and not just tapping someone on the shoulder and saying how would you like to be medical director?"; 'Well there you can start next week'"*

(ML17).

Another interviewee described how this is done in their organisation,

*"I would have started some low level management training in advance. I had an opportunity there for two and half years sitting on the board of representatives and I think what we should do is, if we're looking at potential leaders, as a hospital we'd be saying, 'Look, you clearly show interest, you put your hand up to be a representative of this or that, could we offer you a bit of training?' So, one of the things that I've done is with our organisational development person we, we run a series of seminars on issues like budgeting, leadership... Um performance management, strategy, um we get in a speaker and I invite a few of the senior doctors, some of whom are in management positions... But some of whom are representatives and who seem to show in interest that*

way. I think it's just a, it's a bit of a toe in the water... But it's introducing them to the language, we... as soon as someone gets into any leadership position or management position as part of their performance agreement, it's well 'How can we help you?', it's, it'll generally be to start doing Harvard ManageMentor but saying, 'Look, do you understand finances? Generally, you find, 'No, not really'. Um so, what'll happen is we'll send you off on a two day intensive financial, um literacy workshop. Um, there was a, another person who, um, had a, whose problem really was trying to get... a bit like me in my first job... was trying to get traction with more senior staff and we sent her and a nursing counterpart off to a Leadership Victoria..." (ML17).

**Individual mentoring** was seen as an important mechanism to aid the development process by identifying and working with individuals who may go into leadership roles in the future. **Leadership coaching** was also talked about in positive terms by many of our interviewees;

*"The other thing that I've found useful in this current role was executive coaching. I have to say that has been quite helpful, and I think that, particularly if you're in a more senior role, that's a good tool as well"* (ML11).

We heard that a number of health organisations are investing in leadership coaching to help them develop future leaders. This approach was often situated within a context of **succession planning** where opportunities have been sought out and developed for those doctors who show potential for leadership and management. One interviewee explained about the approach in their organisation,

*"so there's two elements we are grooming a group of younger fellows to come up through these ranks by being on training committees and actually being on the board and the councils and things like that so they're getting some experience at that level, which is really good and getting young and enthusiastic people before they've actually had the management experience in the, in the work environment and see what their junior fellows that are actually doing so I think, suppose practicing for them in some ways"* (ML05).

Another interviewee speculated on the future and what we will see in relation to processes of development for leadership and management;

*"So in ten years' time, people will have done leadership courses tailored to their level of training and where they are in the system and learn from that and they want to*

*go back for more. They will have progressively taken on leadership roles and be applauded for that"* (ML03).

Around ideas of coaching and developing individuals was often a sense that there is a need to separate out those who really have a desire to go into medical leadership roles, and those who select this as an option because they do not like clinical practice or struggle to get into a different area of specialty training. As one interviewee explained,

*"in my experience the potential trainees fall into two camps, the one who really want to do it and the one who's found they don't much like clinical medicine and sees this as the sort of, 'if you can't do well, administrate'. And so I've seen a few sort of cynical, um, you know chair warming types who ah, who get into this role but there's still other really um, keen, ah motivated, ah quite idealistic people, the challenge is to help them stay that way. Whether it's a senior clinician in um public or even more an independent doctor who also sees themselves as a costumer in private, it's a huge challenge because they tend to cut their teeth on managing junior medical staff and arranging rosters and then have to move into managing people who have no expectations of being managed, resent being managed and where your sort of tactics for*

*influence are much more limited"* (ML17).

Much of the focus in terms of development relates to the idea of being able to **practice management and leadership skills** within an organisational setting, rather than just simply attending a training programme or a university course away from the organisational setting. One interviewee described their organisation's approach to this:

*"because we're a big organisation and, and we do try and support people, we allow them to make mistakes, and ... and, you know, say, you know, we support them through organisational structure, that's the first thing. So, I've got people who report to me, I, you know, I try and get them to do as much as they can, and I allow them to make mistakes and, you know, sometimes I then retrieve the mistakes if I can. So, there's that, but we also have training programs for, for aspiring managers, so, so, we've got didactic progress, but we've also got group educational and group experience programs, we support people"* (ML22).

Others were seeking to develop opportunities for doctors to engage with their organisation so that they get a better understanding of the operation of this and the broader system;

*"We've created a medical council in the organisation I'm working in; that has formalised... this is not radical, but... cos we're an evolving, a growing health service, we've just been able to put clinical heads across most of the organisation, about forty-eight of them or something. And so those positions have now been formalised into a clinical council that includes junior doctor representation, so it's not just... sometimes we talk about organisations just for senior doctors; this is for the whole organisation. We are trying actively to develop a broader sense of the organisation"* (ML06).

The issue of **clinical credibility** came up a number of times in discussions about training and development of medical leaders. Although medical leadership positions have traditionally been occupied by individuals who have been in these roles for some time, this is starting to change and there are a group of younger doctors that are relatively recently out of medical school who see this as a legitimate career choice.

As one interviewee explained,

*"There are some young people who just gravitate to that area. You know, I've said to a group of doctors of training in Canberra, I think last year, "The fact that you're all here to go to a leadership course, you've self-selected because you're interested and that's a very good thing.*

*But the rest of your class, who haven't self-selected, who haven't thought it was worthwhile coming along, are still going to have to be leaders in their own area," and I think that's our problem"* (ML09).

Others viewed this development as problematic and believe that doctors require a significant amount of clinical experience before they are able to operate effectively as leaders. Doctors who have less clinical experience are seen to lack the knowledge of the system and how it operates, but may also lack legitimacy in the eyes of their colleagues.

One interviewee described this situation as follows,

*"I spent the 12 years in clinical medicine, I...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. So, I...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.*

*On the other side, I see people who dally with the management side and never want to give up the clinical side and that's...that a tension"*(ML15).

As suggested above, ultimately many of the sorts of factors that are presented as barriers to doctors engaging with management or leadership roles are not just simple issues, but relate to fundamental factors relating to the **culture** of health and health organisations. Many of the barriers relate to the lack of respect that is afforded to doctors in leadership roles and a perception that this involves 'going over to the dark side'. Issues of culture and perceptions of how different roles are valued are much more difficult to change than setting up a career path or designing a new development programme.

## 8. The future of medical leadership

From an examination of the international literature on medical leadership, there is little in our findings that are significantly different to the trends experienced in other countries. Although there will be some variation due to factors such as the structure and history of health systems, the literature suggests that the transition to management and leadership roles is not easy, that these roles are often challenging and lack reward. However, several other countries have often adopted more systematic approaches to the training and development of doctors for management and leadership roles than Australia has done to date. Despite RACMA being formed in 1963, it appears that the Australian health system still faces a number of challenges when it comes to effectively preparing, attracting and recruiting effective medical leaders and managers. Moreover, these findings have a high degree of resonance with those from Loh's research (23), undertaken a number of years prior to this and suggesting little has changed in the short term in relation to the medical leadership agenda. That the same issues are being faced in a number of different systems suggests that there are no easy answers, but this should not make the task any less urgent.

Ultimately the evidence set out in this

report raises a range of questions that we need to consider carefully if we are to drive more effective medical engagement in Australia. Although the issue of medical engagement has received significant attention at the local level, there has not been concerted effort focused on thinking about this issue in a more collective way. If we do wish to take this agenda to the next level then it is important that we consider what is medical engagement and what do we hope it will deliver in practice. We suggest the time is ripe for a broad national discussion about the role of medical engagement as an enabler of change within the health system, and how this might be best supported. The response to this conversation could require significant changes to the roles, expectations, education and development of doctors and other professionals but the pay-off of a more engaged workforce potentially offers a significant reward. We finish by setting out what we believe are some of the major tensions and issues that dominate this area.

The first issue in which we need some clarity is in respect to **what we think medical engagement should achieve**. If medical engagement is fundamental to the operation of the health system and reform in line with future challenges and issues, then it is crucial

that we articulate this and invest in these roles and career paths. Related to this issue is the fundamental notion of **what medical engagement is** and how organisations know when they have this. Is this an issue that should be the concern of the entire medical workforce or is this limited to a few doctors who inhabit formalised roles in the governance systems of organisations? What research from the UK (30) has demonstrated is that, although helpful, producing a cadre of more qualified and better prepared medical leaders does not in itself deliver medical engagement. Indeed, by focusing just on one group of doctors (those in leadership roles) we may find that this produces even more of a gap between the general medical community and those in leadership and management roles. Careful consideration needs to be given in engaging all doctors and not just those who occupy these specialty roles. Recent research speaks to the importance of distributed or collective leadership, where all those within organisations take responsibility for its success and not just their own jobs or work areas (34).

One issue that interviewees did agree upon is the idea that more work needs to be done at a national level to articulate **the kinds of competencies required of doctors in respect to leadership and management**. This would involve setting out the

expectations of all doctors, both those who seek to formally engage with leadership and management roles, and those who do not. For formalised medical leadership roles more of a shared sense of what roles are, their responsibilities and requirements in terms of training and development would also be a helpful initiative. This is not to codify these roles and force all organisations to use the same sort of model. However, in professionalising this area further and having a sense of the scope of these roles and the experiences that candidates are expected to have, we may find that these become better respected roles and more attractive to individuals, rather than simply those that people fall into accidentally. Examples of this exist around the world such as the Medical Leadership Competency Framework in the UK or the LEADS framework in Canada (35). Combining this with a sense of the type of career trajectory that is anticipated for these roles would also help to clarify issues.

As we have noted on a number of occasions, **the medical profession is currently going through some profound changes within the context of a rapidly changing health system**, and this looks set to continue. As the system has more doctors than ever before due to increasing numbers of graduates from medical schools and retirement ages potentially extend, it is likely that we will see different sorts

of career structures emerge. It is likely that we will see greater competition for these roles, where in the past this has been more limited. To date, those who have gone into these roles have typically been highly motivated to take these on and have done so despite the system and the concerns of their colleagues. If these roles become more attractive then we need to ensure that we are able to select the best individuals for these roles, that they are clear about how they give effect to their accountabilities and that they are clear about what is asked of them. In setting out these expectations, one issue that seems to be important particularly in the context of a highly professionalised environment, is **the degree to which clinical experience is important** in an individual's ability to take on a medical leadership role. If one of the major roles for medical leaders is to influence peers then this may be an important component and would benefit from greater clarity. Do medical leaders need credibility as clinicians or managers or both and how can these be enhanced through training and development processes.

As we have noted a number of times in

this report, the most significant barriers to engagement are cultural, and relate to the sorts of values and interests inherent within the system. These take time to address, and interventions are often gradual and incremental rather than big bang. The addition of more extrinsic motivators may help to add a degree of balance to the factors that encourage or discourage individuals into these roles. In addressing these issues, it is important that change is driven from multiple different sources. With issues as important as this they will not simply be the responsibility of governments or health organisations; doctors also need to play an important role in these processes.

There is also an important role for **different levels of government** in framing and shaping these issues. Whilst Australia has a specialist College that focuses specifically on medical administration in the form of RACMA, if medical engagement is not just confined to those in formalised leadership and management roles then there is a question about **the role of other medical speciality colleges** in driving and supporting this agenda. In addition there are a range

of other important stakeholders such as universities, health care regulators, jurisdictions, consumers and others who have a role or interest in this agenda.

Much of the literature on medical engagement derives from US or UK settings. We lack good quality evidence about these issues specifically in the context of Australian health services. If we are to have more clarity over **the sorts of levers that are available to drive medical engagement** then we need some **urgent research** exploring the Australian experience and what works in this setting. Experience in other systems demonstrates that health systems are difficult to change and they take a long period to reform. If we are to embrace medical engagement within health services there is an urgent need to address many of these issues if we want to see changes happen over the next decade.

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