Doctors as leaders and governors
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ABSTRACT
Doctors working in healthcare are operating in complex adaptive systems that are unpredictable and have complex problems requiring new and unique skills. The Medical Council of New Zealand has specified a scope of practice for doctors involved in health system leadership, and there are several programs of studies that exist in Aotearoa New Zealand (Aotearoa NZ) to gain skills in this domain. It is crucial at this time of change that we understand why doctors as leaders and governors improve outcomes, the importance of training future medical leaders and how we validate these skills as well as the environment in which they operate. As we begin to reorganise our health system, the question we ask is when will we organise our system to recognise, develop and value these skills?

The health system in Aotearoa New Zealand (Aotearoa NZ) is implementing a significant reform agenda derived from the Health and Disability System Review.1 Unique to the Aotearoa NZ context, a key challenge facing the system and central to the reform agenda is a drive to achieve equitable outcomes, particularly related to Māori, Pasifika, and disabled populations. The opportunity these reforms present is significant. In our previous editorial, we argued for a different approach to leadership and governance to ensure we make progress toward various goals.2 Central to this is the requirement for diversity in leadership and leadership teams to support the drive toward equity and equitable outcomes.2 The requirement for strong leadership and governance has never been more acute.

If the current reforms are to realise intended benefits, clinicians will need to contribute to the design and implementation of whatever flows from decisions made by Health New Zealand and/or the Māori Health Authority. Clinicians are also likely to play a role in leadership and governance of the system as the reform agenda continues to roll-out. In this article, our focus is on doctors as leaders and/or governors (medical leaders).

Various commentators have highlighted the importance of including doctors on design and development of future models of care.3 This commentary highlights that there are compelling reasons to support the inclusion of medical leaders and governors in system design and operation, including improved patient outcomes.1–3 Nonetheless, many questions arise, and these questions may include which doctors could or should be involved in this work, and how do we identify these doctors?

In recognition of the challenging environment ahead, in June 2021 the Medical Council of New Zealand issued the following advice with respect to the responsibilities of doctors in leadership and governance: “If you make decisions about resource allocation or services in an area outside your experience or expertise, or there are disagreements about whose needs should be prioritised, you should seek advice from colleagues with the relevant expertise”.4

This advice, supported by an admonishment that the Council’s standards on professional conduct would apply to doctors who take part, identifies two issues. The first is a degree of self-regulation, relying on doctors to recognise when they have left their field of expertise. The second relates to the ability to identify a colleague with relevant expertise.

Other jurisdictions such as the United Kingdom have also identified the importance of specific leadership and governance knowledge and skills for doctors in clinical director and head of department roles.5 Here again, there is support for investment in and use of medical leaders to enhance system performance.3,5

In this article, we identify: (i) why leader and governor roles for doctors are important, and the environment in which doctors who want to lead or govern at a system level will need to operate within; (ii) how we train and develop doctors to perform in these roles; and (iii) how we validate the skills and knowledge required to perform these roles.

Doctors as leaders or governors

In any industry, effective leadership and governance requires some understanding of the technical content of the industry, a sound understanding of the skill set and discipline that is leadership and governance, and the ability to navigate through the
informal authority relationships of that industry. Assessment against these criteria further supports the role doctors may play as leaders or governors within the health context. It also provides an opportunity to highlight that simply being of an industry—whether doctor, nurse allied health or any other—does not obviate the need to acquire, by some recognised means, a sound knowledge of management, leadership and governance. It is necessary, but not sufficient, to know how the clinical world functions.

In healthcare, matters are, however, further complicated by a peculiar privilege, namely the ability of doctors to direct the diagnostic and treatment course for any of their patients. For this reason, change without medical buy in often results in little-to-no change. This paradigm is increasingly challenged through empowerment of the consumer; however, the role of the doctor in any health system remains influential.

For decades, the challenge of how to engage doctors and get them to lead has occupied many commentators. At the end of the last century, Scally and Donaldson coined the term “clinical governance” as a way in which some core part of the larger industry could be identified and used to drive improvement. Though well intentioned, this also created problems. First, it set apart some part of the system as clinical and some as non-clinical, creating a division that has endured. Second, it allowed specific consideration of medical leadership to be conflated with clinical leadership, where the word “clinical” contracts or expands depending on the audience. Finally, it potentially widened and continues to reinforce the perceived gap between clinicians and managers, as well as contributing to the notion that leadership operates in isolation from the “shopfloor”. Here again, we believe that medical leaders play a crucial role in bridging any perceived gaps, and in demonstrating that leadership must operate across all levels of and indeed, through the system. As a symptom of ongoing failure to appreciate the importance and visibility of this skill in practice, the word “clinical” contracts or expands depending on the audience. Finally, it potentially widened and continues to reinforce the perceived gap between clinicians and managers, as well as contributing to the notion that leadership operates in isolation from the “shopfloor”.

Increasingly, healthcare systems and organisations are recognised as complex adaptive systems (CAS). Effective leaders and leadership approaches at this level embrace complexity. The behaviours and actions characterising effective leadership in these environments are markedly different to simple or complicated domain leadership that are typically more familiar to doctors in leadership positions.

In health systems where doctors play active roles in governance and leadership at a whole of system level, as previously outlined, there is good evidence that system outcomes are enhanced. An example of the interface of how this skill set and equity interface plays out almost every day is in deciding which health services are to be delivered and where. The passion and strength of argument employed by medical staff for their own patient’s interests and their practice, often at incremental cost, are formidable. At times this demand almost overwhelms the system, and decisions are made using models such as garbage decision making. It will be almost impossible to build a system that identifies and assesses the rela-
Doctors as leaders or governors—how do we develop them?

Broadly, doctors may engage in leadership or governance at three levels: within their own specialty (e.g., Head of Department or Clinical Lead); at a sub-organisational or organisational level in their professional sphere (e.g., Chief Medical Officer or Medical Director); and at an inter-organisational or system level (e.g., Regional Lead). As we have previously outlined, the knowledge, content and capabilities required at each of these levels differ. If we accept that when doctors lead or govern at system or organisational levels they require different skill sets and knowledge to operate effectively, then it is important to understand how we train and develop doctors for these roles.3,10

For many doctors, progression in leadership does not necessarily follow a linear or structured pathway. It is important to acknowledge, however, the requirement for acquisition of practice capability whether the progression is linear through different levels or whether the path to leader or governor roles is more ad hoc.

Within the Aotearoa NZ context, in the absence of opportunities for a structured approach, a vacuum has developed. Within this vacuum, less structured approaches to entraining doctors into leadership have flourished. These approaches are sometimes more reflective of personality traits than a demonstrable body of knowledge and capability suited to the requirements of the role and the desired outcomes. Whilst there are examples where this less structured approach has worked well, this is inconsistent with standards across other specialities that have structured training requirements, and not consistent with the Medical Council of New Zealand's advice.

There is an existing pathway to expert medical practice in the field of medical leadership and management and an associated scope of practice set out in the regulatory framework that corresponds with this skill set across Australia and New Zealand. The Royal Australasian College of Medical Administrators (RACMA) is the College that manages this pathway and associated continuing professional development within this scope of practice.

Additionally, many opportunities outside of this formal pathway exist for training and experiential learning in leadership, management and governance. For example, clinicians have opportunities to develop skills through military environments, formal directorships where Institute of Directors requirements are in place, university or academic leadership environments, and/or increasingly commercial and industry environments. There are also a range of formal qualifications that offer learning in this domain for clinicians, including Masters in Business Administration, Masters in Health Management, and Masters in Leadership across a range of universities locally and internationally. Furthermore, the formal pathways that exist within leadership and management often have flexibility to recognise and accredit these training and experiential opportunities.

There are certain domains including financial management, system design and co-design; and operations management to name three, that are not explicitly taught in other medical specialty curricula. Some competencies in domains such as these are required in any leadership or governance function. We acknowledge that within many organisations and systems, partnership models where clinical leaders are paired with operations or general managers do exist and go some way to potentially cover for explicit knowledge in domains like this. However, it is not uncommon for leaders or governors to have stand-alone mandates that require competence in these domains.

Whilst there are specific domains or objects that can be called out explicitly, the key principle is that the training and experience doctors have as they work to become specialist practitioners require and reinforce skills, knowledge, and patterns of practice that rely on simple or complicated paradigms for problem solving.12 This is problematic when doctors are then called on to lead or govern in a CAS environment, where we know different skill sets and knowledge are required to perform. In the absence of a structured approach or formal pathway as offered by RACMA, some thought must be given to how doctors acquire the skills they need at the different levels of leadership or governance, either as a part of their clinical career, or in developing a career in leadership. A useful output to sup-
port this process would be a framework to aid and guide development.

The framework below identifies buckets of skills and/or knowledge that doctors may need in leadership or governance capacities as they progress through their careers, or that would be beneficial in specific leadership or governance roles.\(^{13}\) While a detailed review of specific knowledge and skills within these buckets is beyond the scope of this article, we see development and training across the relational (e.g., communication, meetings); operational (e.g., resource planning, contingency planning); and strategic (e.g., planning, needs assessments) as critical to enable progression through roles and functions.

**Verifying doctors as leaders and governors**

The professional services a doctor can perform in Aotearoa NZ are defined by the scope of practice they are registered in.\(^{14}\) Within these scopes, the Medical Council identifies what each scope of practice entails and the qualifications required for a doctor to attain registration in that particular scope.

At a clinical and departmental level, audit, quality assurance and quality improvement, are very often inherent within a scope of practice for multiple specialties. Leading these activities at a clinical or departmental level would fall within a defined scope of practice.

Within the context of a CAS, and when doctors operate as leaders or governors at a system or organisational level, the scope of these roles broadens. There is a strong argument that a clinical scope of practice does not adequately encapsulate the breadth of the leadership and administration tasks and knowledge required.\(^2\) Additionally, there is arguably limited active management of the scope of practice where doctors are operating in a leadership or governance role at an organisational or system level. This approach is clearly at odds with the majority of specialty practices.

**Figure 1:** Doctors as leaders / governors: skills framework.
for credentialing, and for managing specific scopes of practice. It is important to acknowledge the different standards that exist where doctors working at one-to-one patient level operate within tightly regulated guard-rails, whereas some operating at the system level do not have a similar level of regulation.

Given the inconsistencies and issues highlighted above, we see an opportunity to introduce a requirement for some form of credentialing for doctors to work within this domain. We believe this would again assist with further enhancing medical leader performance and consistency of performance across the system.

**Strengthening and supporting pathways for doctors as leaders and governors**

Doctors as leaders and governors can have a positive impact on overall health system performance. We must recognise this value and commit to measuring value and outcomes from these leadership approaches.

There are multiple pathways that exist today for doctors to build knowledge and skill in relation to complexity leadership. We need to enhance the flexibility and visibility of these pathways to ensure that individuals see them as viable, supported options to pursue. It is also critical that we increase competition for these pathways so that we can select the best candidates for these roles and positions. Many would argue that selection by default does not drive improved performance or outcomes. We have an opportunity to shift our thinking, our behaviours and actions to value these roles and opportunities which will lead to better outcomes for doctors in these roles, and also for the systems and organisations they serve.

**Conclusion**

The challenges and opportunities the health reforms present will require highly capable leadership and governance, at multiple levels. There is no doubt that a medical lens across these domains adds value and could ensure that we make advancements in key areas such as equity. Similarly, health systems anywhere, but particularly those that set out to deliver full coverage for their populations, have grappled for decades with rising costs and variation. Many have transitioned through several structures, and some have returned to previous structures in search of elusive solutions.

Doctors operating effectively as leaders or governors at a system level are part of the solution. We believe there are some key actions that can enhance the role doctors play as leaders and governors:

- Recognition that doctors leading or governing at different levels requires different skill sets and knowledge.
- Structured, supported and tested approaches to equip doctors with the skills and knowledge to perform in system level leader or governor roles.
- A framework that informs semi- or un-structured approaches for doctors whose careers evolve in such a way that a formal or structured award is not viable.
- A regulatory and credentialing framework that documents the capability and credentials of expert practitioners in the medical leadership or medical administration field.
- Measurement and monitoring of outcomes from practitioners that work in system level roles.

Leadership and governance are sometimes reduced to homilies that are as illuminating as they can be elusive. One of these is that leadership and governance can be summarised by the idea that we should work out what we are trying to do and then organise to do that. The steps that follow are then planning the work, working the plan, and managing the variations. Using this approach, it becomes obvious that if we are to assure ourselves and the public that we can supply doctors adequately trained in leadership and governance at all levels of endeavour, then there is a fair bit of organising to be done.
COMPETING INTERESTS
Nil.

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