

## Guest editorial

# Leadership, medical education and the quality of care

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One common theme at the moment in health professional newsletters, particularly those in the medical profession, is a debate about the premise that the healthcare system is in a mess because of a lack of leadership. If only somebody could show us the way we could transform the healthcare system, reduce errors, improve access to the needy, spend money more wisely and make people healthier! This is not a new concept,<sup>1</sup> but rather one that regularly attracts attention as health care struggles to adapt to changing times amidst financial pressures and complaints about poor outcomes. A commonly proposed strategy is more leadership training, ideally beginning at undergraduate level in medical schools, so that doctors can become the focus of profession-lead reforms.<sup>2,3</sup> As with many complex issues, this may be an appropriate answer to a question about health professional education, but it is not clear whether we have yet heard all of the right questions that have to be answered in order to address the broader issues surrounding healthcare reform.<sup>4</sup> Further, the supposition that someone will come along and lead us to salvation belongs to a relatively dependent and reactive culture, which suggests that change will occur through only external, not internal, forces – a ‘top down’ view of management. Is that really what is needed?

So, what are the broader issues? It would appear that vast armies of health professionals are working hard to provide the best they can, but possibly without either a clear idea of what we should be achieving or a sense of belonging, achievement and appreciation. Healthcare systems are inevitably large, complex bureaucracies, where different groups can easily find themselves in ‘silos’, not necessarily working well with other groups, even those that may be functionally and geographically close. Clinical care is often fragmented, and both patients and the workforce are often confused about how to access necessary care. Resources are consuming an increasing, probably unsustainable, proportion of national productivity, but tend to be allocated according to historical budget processes, not knowing how to either reduce waste or respond to the conflicts of evidence and emotion that surround ‘rationing’

controversies.<sup>5</sup> As the population ages and more evidence emerges about how best to investigate, diagnose and manage health problems, different kinds of services are required, perhaps by different kinds of providers, and the debate about quality has broadened to embrace patient safety.<sup>6</sup> In summary, healthcare systems tend to be past-oriented, difficult to adapt to emerging challenges, beholden to discipline or professional boundaries, inefficient and inflexible. Effective leadership is certainly one important strategy, through developing a clear vision of what we should be doing, what values we should share, what structures and practices need to change, and ensuring that these changes can take place.

This is however, no easy task, as it requires a substantial change of systems and culture,<sup>7,8</sup> which will be more effective if a different model of leadership is developed. In this model, leadership is less about telling people what to do, and more about effecting change through the actions of others. Core attributes include: understanding the business and its core values; having a clear vision of the future; effective communication; humble confidence; knowing when to be different and learn from other businesses and models; and emotional intelligence.<sup>9–11</sup> Effective leaders can influence the development of organisational culture, but can directly influence the actions of only those relatively close to them, and so need to devolve leadership to others for specific tasks. Leadership is therefore required at several levels, ideally throughout the entire healthcare system. The first level is that of national politics, because there should be a clear, shared, national understanding of what kind of healthcare system we want. The sharing at this level should include the views of all stakeholders in health care: funders, providers and recipients. This understanding should be identifiable as a vision that can be sold by politicians and accepted by both healthcare professionals and the wider population. The second level is that of the health professional organisations, which must be able to accept that individual and group aspirations can be met by being part of solutions rather than defenders of past structures. A poor result of leadership training would be to develop strong leaders for each profession and then find that

they did not work well together. The third level is that of individual health professionals, who should all share a leadership role, with both their colleagues and their patients, in order to make change happen at the 'frontline'. Leadership at all levels should be moving the organisation in the same direction. This model of shared, democratic leadership is different from the more common hierarchical model in which workers wait to be told what to do.

What is the role of primary care in this leadership and healthcare reform debate? While hospitals are also changing, much of the reform appears to be focused on primary care: primary care increasingly commissions/purchases health care across all levels; inpatient services are being moved to ambulatory settings; new health professional roles are developing; and the imperative is growing to increase interprofessional care as a quality enhancement strategy. In many respects the secondary care level is being absorbed on both sides by primary and tertiary care services, and the location of a service (hospital or community based clinic) is becoming less relevant to the definition of primary, secondary or tertiary care. Primary care may therefore be where leadership is needed most.

Primary care is also an ideal context in which to develop clinical leadership within the more contemporary model of interprofessional teamwork. Here healthcare teams are regarded as teams of experts who are leaders in their own right, and who together provide better care than individual members could achieve alone. In primary care, individuals from so many different health professions have to work well together to provide good care for their shared patients. Students can be placed in several different healthcare teams, each with a particular clinical care focus, role model (hopefully sound) interprofessional practice, and observe clear benefits to patients and be better prepared for the workplace.<sup>12,13</sup> Evidence is emerging that learners can learn more from participation in genuine interprofessional care than from lectures and simulations.<sup>14</sup>

This does not mean that everybody can or even should be strong leaders, but rather that all health professionals should understand leadership and be able to work out their own personal roles in healthcare reform. The minimum role for all is engagement in the reform process, so that any changes reflect sound practice, can improve patient care and are feasible. Without this very basic level of acceptance, leadership will not influence how we work at the frontline, effective change will not happen, and the lament about leadership will continue. Are we ready for the challenge?

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