

**Expert leadership: Doctors versus managers for the executive leadership of
Australian mental health (Viewpoint)**

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Introduction

In a recent Viewpoint, Bhugra (2013) encouraged psychiatrists to assume leadership roles across the mental health system as part of a ‘new professionalism’. He advised, *“Doctors need to take on leadership roles – whether these are small (for the team) or large (for the organisation or professional body)”* (Bhugra, 2013: page 1106). His call is consistent with our College’s continuing emphasis on every psychiatrist developing skills in leadership and management that are appropriate for their organisational and community roles.

The College delivers training and continuing education through the framework outlined by the professional charter produced by the Royal College of Physicians and Surgeons of Canada (CanMEDS), which highlights competency as a Manager as one of six key areas of professional expertise (see Figure 1). This Viewpoint will focus on research investigating the professional model of leadership and management. It asks how physician-leaders with the right combination of CanMEDS management and professional skills can contribute to the performance of health services including psychiatry.

The theory of expert leadership

A research program at Cass Business School, City University London, is investigating professional leadership and management using the ‘theory of expert leadership’ (Goodall, 2009). The theory attempts to explain empirical results showing that expert leaders are associated with better organisational performance in a number of settings

(e.g. universities, hospitals, high-technology industries, sports). The theory proposes the existence of a first-order requirement -- it is that leaders should have expert knowledge in the core-business of the organizations they are to lead, holding constant management and leadership experience. (Expert knowledge is not a proxy for management or leadership skills.)

The theory was first developed in a study examining university leadership and performance (Goodall, 2009). It asked the question: who should lead research universities? Should they essentially be good managers or good scholars? Using a longitudinal dataset, the study demonstrated first, that respected scholars lead the best universities in the world'; and second, that the research quality of a university improved many years later, after appointing an executive leader who was also an accomplished researcher.

The same question about experts versus managers was examined for hospital performance. Goodall (2011) found that the chief executives in the highest rated hospitals in America were more likely to be physician-leaders rather than professional managers. These data included the chief executives in the top-hundred hospitals in three specialty fields (cancer, digestive disorders, and heart surgery) as rated by US News and World Report. The presence of a physician-chief executive was shown to be associated with better hospital quality scores; physician-led hospitals achieved 25% higher quality scores. A related study by the London School of Economics focused on management practices in UK NHS Trusts. They study found that both the best managed hospitals and the best performing hospitals were those with a high

proportion of managers with clinical degrees (Bloom, Propper, Seiler & Van Reenen, 2010).

The US News and World Report's Best Hospitals ranking also includes an honour roll, which lists hospitals that excel across a variety of clinical fields. Amongst these, physicians have outnumbered professional managers as hospital chief executives for a long time. These leading physicians are also outstanding researchers. The ten chief executives in the 2014 honour roll have an average of 18,000 research citations and an average H-Index of 61.

An exemplar, consistently rated among the top four US hospitals, is the Cleveland Clinic. The Cleveland Clinic is physician-led at all levels. It has invested extensively in an academy that educates physicians, nurses, and healthcare administrators in leadership competencies. The academy is led by James Stoller, the chair of the Education Institute and head of respiratory therapy at the Cleveland Clinic. Stoller recognises that physicians are trained in clinical and scientific skills but not in leadership and management, which is why most feel ill-prepared to assume these roles (Stoller, 2014). He has attempted to bridge the gap by studying extensively the leadership capabilities required by clinicians of all disciplines. Stoller highlights competencies such as emotional intelligence, communication, teamwork, and change management; and he believes that leadership training should begin early in clinicians' careers (Stoller, 2014).

Expert leadership in psychiatry

In 2014, US News and World Report also ranked America's top ten psychiatric hospitals. None of the chief executives in these outstanding mental health systems were professional managers. As with the top US hospitals, the psychiatrist executives were leading academics with strong track records in clinical research or neuroscience. This relationship between leadership, clinical practice and research symbolises the integration of mental health services with university research and teaching.

By hiring outstanding psychiatrists into executive roles, prominent US hospitals are demonstrating a belief that expert leadership can translate into quality outcomes. These institutional leaders combine expert psychiatric knowledge with management and leadership skills. Stoller (2014) cites a study of Chairs of departments of psychiatry; it highlights key leadership attributes as strategic acumen, communication skills, administrative and technical skills, motivational capacity, integrity, altruism & tenacity.

In contrast to the elite US model, mental health services in Australia often appoint psychiatrists to clinical/medical director roles that report into executive directors who are mostly non-psychiatrist professional managers. Within the Australian model, the clinical director is usually responsible for medical staff, clinical governance and research. The success of the role depends on the clinical director having the right mix of CanMEDS management and professional skills for the organisation. The executive director and clinical director also need to work closely together to create an effective partnership. There are many examples where this works as an effective leadership

model. However, problems can occur if the clinical director does not have a voice in the appropriate executive forums.

How might the elite US model of physician executives be used to improve the organisational leadership of mainstream Australian mental health? The theory of expert leadership proposes a number of suggestions: first, a psychiatrist executive is viewed as 'first among equals', because he or she originated from among the collegial group; having been 'one of us' signals credibility, which can extend a leader's influence. However, it is important that the psychiatrist executive was a talented clinician, and ideally also a researcher, in their prior career. An unaccomplished clinician who chooses the management route is unlikely to gain sufficient respect from their physician colleagues.

Second, an expert leader, having grown out of the same environment, will be more able to understand the culture, values, incentives and motivations of their psychiatrist colleagues, and other core professionals. A talented clinician-leader who knows what good looks like will be better placed to evaluate individual performance and set realistic goals. Psychiatric experts may also make informed strategic decisions about the long term direction of their mental health organisations.

Third, psychiatrist executives are uniquely placed to link clinical services with academic departments of psychiatry to provide a gateway for translational medicine, which is increasingly recognised as essential if health services are to improve. Psychiatry executive leadership may also have implications for psychiatry teaching and training in Australia. In particular, the College could consider whether psychiatry

executive leadership should become an essential standard for fellowship training placements.

Fourth, it is generally recognised that the success of any organisation relies on the quality of its people. Individuals who have excelled in their field of expertise (in medicine and beyond) can be expected to attract and hire others who are also outstanding in their field. If outstanding core professionals are employed, this is then likely to lead to improved organisational performance. The right leaders can thus help to create spirals of success.

Finally, expert leaders can also signal different messages - about themselves and their organisations - to their staff and also outsiders. An accomplished clinician and researcher commands respect because of his or her proven track record. This 'credibility signal' may be crucial to current and potential employees, and to the wider audience of patients, policy makers and donors. An example is the Nobel Prize winning geneticist Paul Nurse, who has drawn on his scientific reputation to raise considerable funds and create an extensive profile for his new London-based biomedical research institute.

Conclusion

The terms 'best practice' and 'evidence-based' are regularly used by Government ministers and policy advisors; our Viewpoint is interested in the same objectives. If the best psychiatric institutions in the world are led by physicians, then shouldn't we be following in their example? The topic of expert leadership for Australian mental

health will require further scholarly examination. There is evidence from various Australian states of a new activism around psychiatric leadership. Change will require willingness from experienced psychiatrists to become executives and to continue to question the established order.

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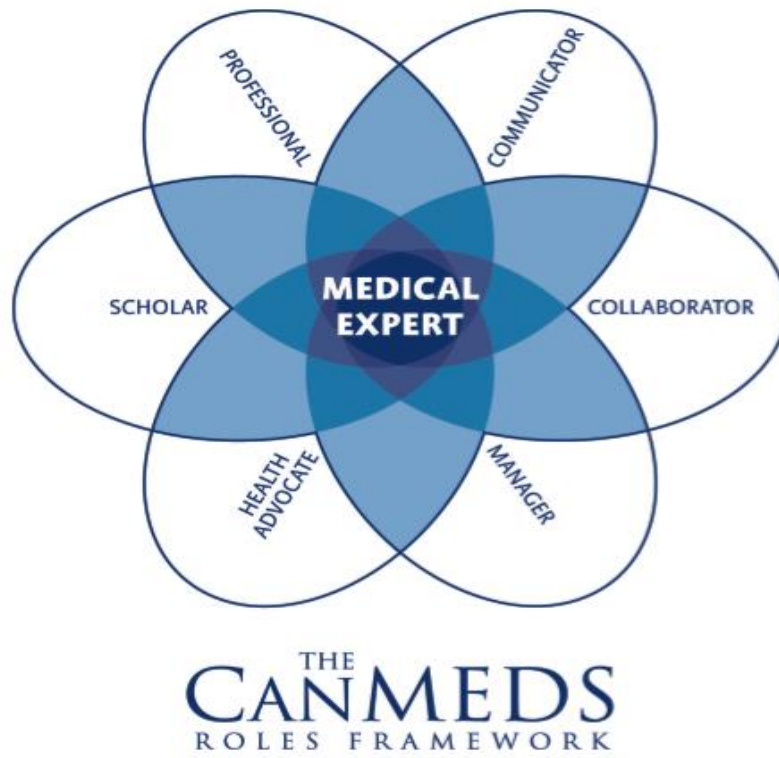


Figure 1: The manager role in relationship with the other key roles of the medical expert within CanMEDS framework.