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Review: Medical directors – Is there a need for reform?

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Abstract

Medical leadership remains integral to the health system amidst a growing burden of ill health and disease, rising patient expectations and medical and technological advancements. The study objectives were to (a) provide a perspective through a rapid review of medical director roles and responsibilities in public and private hospital settings across several Organisation for Economic Co-operation and Development (OECD) and Non-Organisation for Economic Co-operation and Development countries, and (b) provide recommendations on how health system performance could be strengthened. A rapid review of Medical Director job descriptions in public and private hospitals was carried out. Medical Directors are influential leaders in organisational decision-making and quality improvement; however, their role has shifted from clinical oversight to several managerial and leadership roles. We report some variation in their role and responsibilities, in the 'intensity of job requirements' and 'complexity of managing resources' dimensions. The changing expectations of medical directors and the variation in their roles and responsibiliteis may contribute to inefficiencies and misalignment within health systems. There may be a need to pursue reform to assure alignment with health system objectives, albeit reform may require different approaches to meet the needs of different health systems. Further research is needed to explore how reform of medical directors' roles and responsibilities can be quantified to demonstrate improvement within health systems.

Keywords

Medical directors, health system, healthcare organisation, job description, leadership, health workforce

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Introduction

Medical leadership remains an important part of the health system amidst medical and technological advancement, the growing burden of ill health and disease and rising patient expectations.[1] Several challenges manifest within health systems globally which can be conceptualised into three categories: medical practice challenges, organisational challenges and health system challenges. Medical practice challenges refer to the ongoing need for the physician to keep up to date with medical knowledge and maintain ethical practice.[2,3] Organisational challenges include managing human resources, clinical privileging, clinical governance and improving cost-efficiency.[4,5] Health system challenges include the triple aim (cost, access and quality) and managing the supply and demand of health professionals and services.[6,7]

Despite the plethora of technology and evidence-based practice, the health system has become increasingly complex, raising questions on how best to address the triple aim.[8,9] Different approaches to tackling the health system challenges mayinclude top-down reform, bottom-up reform, or a mixed approach.[10,11] Arguably, a bottom-up reform is more favourable because it starts with a change in clinical practice followed by managed organisational changes that gradually influence change across the entire health system. Thus, change is best delivered when it incorporates agreement of those affected, can be easily measured and incremental. This approach prevents the need for abrupt investment or decisions that can significantly affect the entire health system. However, it remains unclear which health leaders or actors within the health system have the authority and capacity to spearhead and catalyse change

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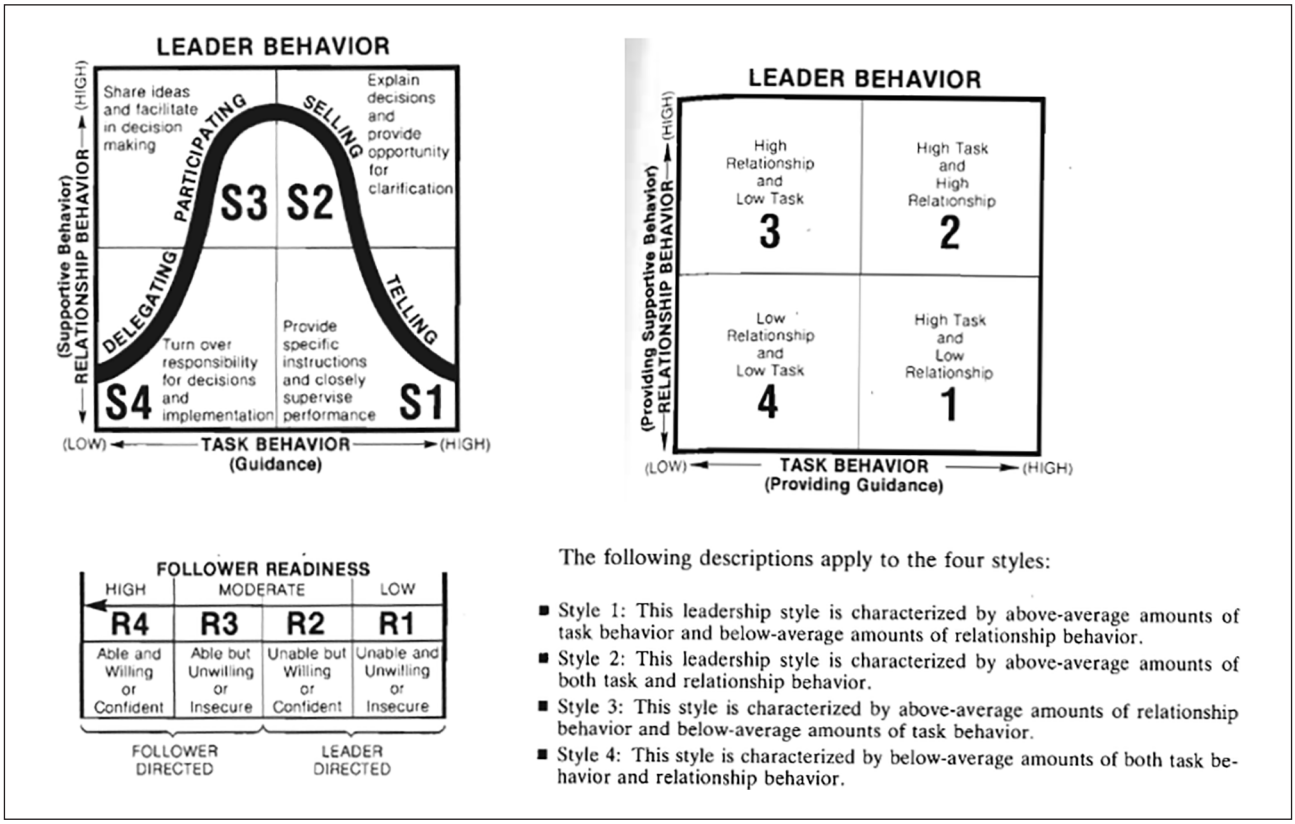

Figure 1. The SLM – Adapted from Hersey and Blanchard.[31]

within an environment where clinical competence, trust, authenticity and integrity play an important role.

Body

The role of Medical Directors (MD)

The role of MD dates to the management of emergency services in the 1960s. MD were essential to provideexpert advice, clinical leadership, staff management and reconcile staff across departments to drive improvements within the healthcare organisation.[12,13] However, the role of the MD has evolved considereably to align with the changing needs of healthcare organisation, which may not necessarily align with clinical practice, or the health system needs.[14,15] The MD may be required to taken on specific clinical work while others may be required to oversee clinical teams or focus on performance management.[16–19] MD may be required to hold qualifications in leadership or management.[20,21] However, formal qualification, career pathway and succession planning remain limited, creating ambiguity in recruitment, competencies, development and roles and responsibilities across the healthcare setting.[22,23] Additionally, the MD may need to be knowledgeable in information and technology, recruitment, budgeting and business continuity, regulatory compliance, management of medical complaints and stakeholder engagement.[24–28] Jones and Fulop[29] suggest inclusion of MD in healthcare institutions improves governance through translational work, diplomatic work and repair work. Some are considered corporate elites and regional political elites within public healthcare systems . These functions may be advantageous for employers in reducing recruitment costs and addressing organisational needs; however, deficiencies and variation in healthcare settings such as hospital settings, for example, can contribute to hierarchy and power struggles between the public and private sector, inconsistent leadership and management and fragmentation in clinical practice, within organisations and across the health system.[30,31]

Theoretical framework

Due to the transient nature of healthcare settings, myriad of complex functions and day to day management and leadership responsibilities and styles, we consider The Situational Leadership Model (SLM) as one approach to understanding leadership.[31] The SLM suggests that leaders should adapt their task behaviour (S1–S4) to accommodate situations and their employee needs (Figure 1).[31] In addition, consider the level of relationship behaviour needed for low to high tasks. Employees (followers) vary in their maturity and readiness (R1–R4) to follow their leaders with varying relationship

behaviours depending on different task behaviours. To achieve optimal performance, the employee must have the ability and willingness to accomplish the specific task issued by the leader. The model suggests there is no uniform way to influence people; however, leadership can be achieved in non-hierarchical settings with the provision that the leader and follower (or group of people) agree to take on their respective roles and responsibilities. On the other hand, Bassi and Russ-Eft suggest competency of a leader could be assessed using different intervals on a behavioural anchored rating scale and competence at work was the significant variation in weight and strength of examples for similar competency.[32] When examples of competency from different jobs were gathered and scaled to more or less competency, competency was found to have scaling properties (low to high) across four dimensions to include the intensity of intention to carry out an intention, complexity in taking on more things, time horizon to seeing further into the future planning and considering future activities and breadth of impact on the number of people and positions affected.[32] These dimensions provide a framework in which competency may be considered as well as complexity of thinking, motivation on managerial performance and impact of achievement. However, there is limited knowledge on how Bassi and Russ-Eft approach might translate with MD and within different health system hospital settings. Additionally, it is important to recognise that MD may be in an opportune position to address healthcare challenges and facilitate engagement to support top-down or bottom-up reform within clinical practice, health organisation and indeed the health system.

Given the importance of MD, we set out to (a) provide a perspective through a rapid review of MD roles and responsibilities in public and private hospital settings across several Organisation for Economic Co-operation and Development (OECD) and Non-OECD countries and (b) provide recommendations on how health system performance could be strengthened.

Methods

In the absence of a tool to specifically assess MD job descriptions, we utilised our expertise in leadership, regulation and health systems and the four competency dimensions from previous research to assess MD job descriptions.[32] For intensity of completeness of actions (dimension 1), we included four variables: medical degree, years of experience, active medical license and leadership training or certification. For complexity in taking on more things (dimension 2), five variables were considered: health facility compliance, quality improvement, performance management of staff, reporting incidents and managing patient grievances. For time horizon (dimension 3), we included two variables: expert clinical opinion, and committee participation and finally for breadth of impact (dimension 4), we included stakeholder engagement. An opportunistic desk research was undertaken between July and August 2022. Information was gathered using LinkedIn and government websites to explore MD job descriptions in public and private hospital settings. Only OECD and Non-OECD countries were considered based on expert knowledge. The following countries were included: France, the United Kingdom, Australia, Singapore, United Arab Emirates and South Africa. Given the breadth of potential providers and job descriptions, we searched for English and French employment adverts with 'Medical Director' and 'Hospital' in October 2022 and selected one private and one public job description for each country. MD job descriptions were excluded if they included organisational arrangements such as secondments, part-time roles and those specific to Covid-19 because they do not reflect the typical role and responsibilities of the MD.

Results

Requirements for MDs

The findings for public and private hospitals in France, the United Kingdom, Australia, Singapore, United Arab Emirates and South Africa. are presented in Table 1.

The intensity of completeness of actions

All employers required a medical degree; however, there were differences in the number of years of experience required; for example, France and Singapore in the public hospital setting required ten or more years of experience, while only France and Singapore and South Africa in the private hospital setting require ten or more years of experience. The remaining countries within the specific public or private hospital settings require 5 years or 8 or more years of experience. The OECD countries in the public hospital setting and Singapore (non-OECD) require the candidate to have an active medical license. On the other hand, neither the UAE nor South Africa do not require an active medical license for the role of MD in the public hospital setting, and all except the UAE require an active license in the private hospital setting. All OECD and non-OECD countries require training in leadership or evidence of certification except for France's (public hospital setting) and the UAE's (private hospital setting).

Complexity in taking on more things

All countries require health facility compliance and quality improvement in public and private hospital settings. However, there were differences in the performance management of staff duties; those countries that excluded this competency included UAE and South Africa within public hospital setting and the UAE private hospital setting. All OECD countries in public and private hospital settings required MD to report incidents and manage patient grievances. Except for South Africa due to the unavailability of information in this category.

Table 1. Requirements for employment and main duties for MDs.

No.	Country/health system	Hospital setting	1. Intensity of completeness of actions				2. Time horizon		3. Complexity in taking more things					4. Breadth of impact
			Medical degree	Ten or more years of experience	Active medical license	Leadership training or certification	Expert clinical opinion	Participation in committees	Health facility compliance	Quality improvement	Performance management of staff	Report incidents	Manage patient grievances	Stakeholder engagement
1.	France (OECD)	Public Hospital Setting	√	√	√	×	√	×	√	√	√	√	√	√
2.	United Kingdom (OECD)		√	×	√	√	√	√	√	√	√	√	√	√
3.	Australia (OECD)		√	×	√	√	√	√	√	√	√	√	√	√
4.	Singapore		√	×	√	√	√	√	√	√	√	√	√	√
5.	United Arab Emirates		√	×	×	√	√	√	√	√	×	√	√	√
6.	South Africa		√	×	×	√	√	√	√	√	×	×	×	√
7.	France (OECD)	Private Hospital Setting	√	√	√	√	√	√	√	√	√	√	√	√
8.	United Kingdom (OECD)		√	×	√	√	√	√	√	√	√	√	√	√
9.	Australia (OECD)		√	×	√	√	√	√	√	√	√	√	√	√
10.	Singapore		√	√	√	√	√	√	√	√	√	√	√	√
11.	United Arab Emirates		√	×	×	×	√	√	√	√	×	√	√	×
12.	South Africa		√	√	√	√	√	√	√	√	√	**	**	√

√: Required; x: Not Required.
*Hospitals can appoint a licensed physician or individual qualified in hospital management.
**Not available.

Time horizon

All countries require MD to provide expert clinical opinions for public and private hospital settings. In addition, all OECD and non-OECD countries (except France public hospital setting) required the MD to participate in committees as part of their role and responsibilities.

Breadth of impact

All countries require stakeholder engagement except for the United Arab Emirates (private hospital setting). Stakeholder engagement entails (a) collaboration and individual engagement, (b) uniting around a common goal and (c) meaningful interactions and discourse all of which are important components for engaging providers, suppliers and policy-makers.

Among the countries included, our findings suggest some variation between OECD countries in the 'intensity of job requirements' and 'complexity of managing resources' dimensions. The greatest variation was observed in the number of years of experience required for the MD role.

Discussion

The importance of MDs

Undoubtedly, the demands upon the health system have meant that employer expectations upon MD have expanded into different roles and responsibilities. MD are increasingly playing an important role in embedding medical professionalism and ethics, interdisciplinary work, instilling a culture of quality improvement and patient safety, assuring that appropriate policies and procedures are developed and implemented, and catalysing change within the organisation.[23,24] Staff often refer to the MD as the mediator when there is a disagreement between clinical teams, thus ensuring harmonious interactions between staff and their respective departments.[33] Also, institutions often hold the MD accountable for underperformance and for staff development.[34] This extends to regulators who may hold clinical staff and the MD accountable for adverse and sentinel events.[25]

It is difficult to associate the findings with other research due to a lack of research in this area. However, the findings suggest some variation across countries in the expectations for MD More importantly, it is unclear how the mentioned dimensions may manifest into the MD job description and how they are performance mananged.

MD, what role can they play?

In light of the varying perspectives across health systems and lack of uniformity on the role and responsibilities of MD, we propose, using our expert knowledge of regulation and health systems, a conceptual framework to align expectations for clinical practice, heatlhcare organisations and health

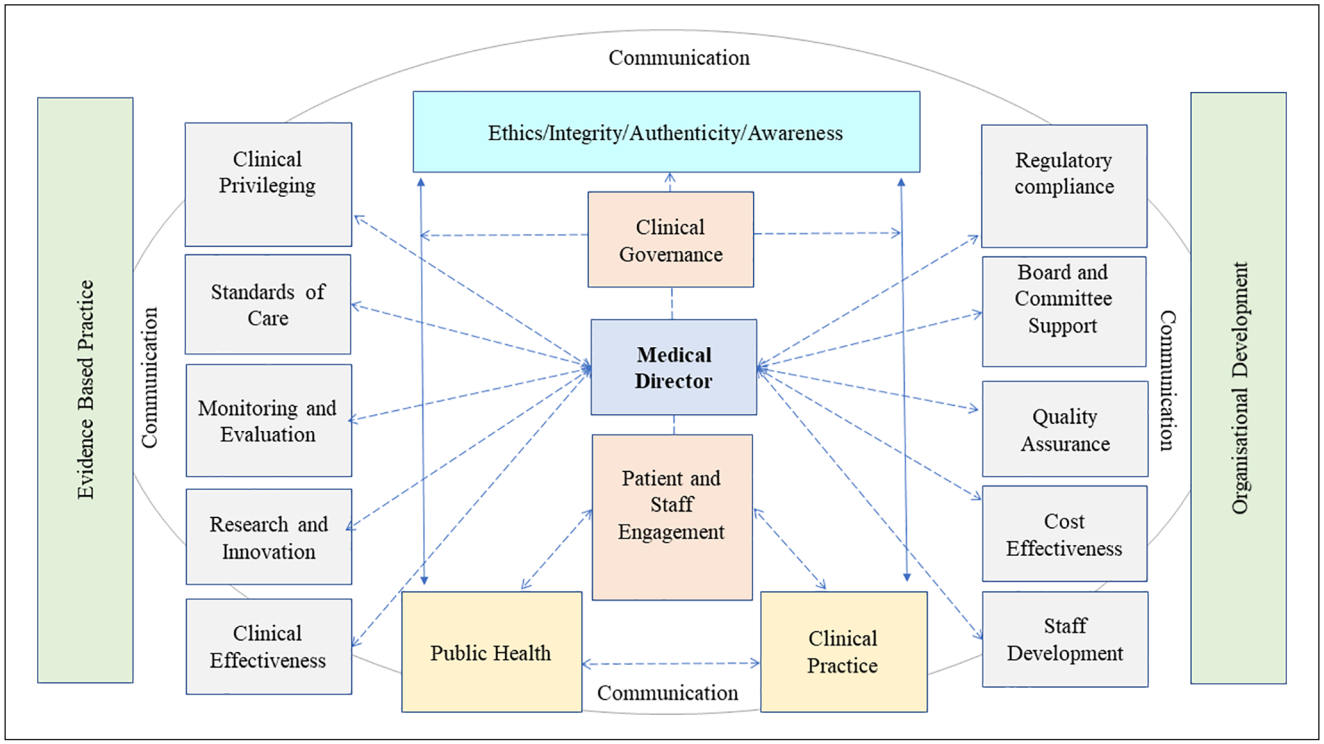

Figure 2. MDs. What role can they play?.

systems(Figure 2). The MD should uphold medical ethics and integrity, be authentic and be astute to personal and professional practice and institutional reform. This is important because it sets the tone and expectations of leaders within the health system. For example, having an ethical policy on the interactions with pharma will prevent distrust among peers, payers and the regulator. The MD should champion clinical governance, staff and patient engagement, public health and clinical practice and support the integration of healthcare services. These facets can also play a crucial role in realising excellence.[35,36] Continuous communication and dialogue across the organisation are vital to assure coordination and alignment of organisational objectives. The MD should actively participate in clinical privileging, standards of care, clinical effectiveness, regulatory compliance, supporting the board and committees, quality assurance, cost-effectiveness and staff development. While some responsibilities within the framework may be delegated, the MD should remain accountable for leadership within the healthcare organisation.[17,37] Regulators should set out the role and responsibilities for MD to ensure that a standardised approach is adopted within a framework of clinical governance, compliance and health system improvement and sustainability.

Limitations and directions for future research

There are limitations. Only six countries were considered based on expert knowledge. Additional countries and recruitment websites could have been included to provide a broader perspective and for generalisability of the findings. In addition, more job descriptions could have been included for each country for both private and public hospitals . Other healthcare settings could have been included, such as primary care or post-acute care settings. Further analysis could be done to capture the role of MDs in low, middle and high-income countries. Qualitative research would be useful to explore how job descriptions affect the MD's ability to lead within the healthcare setting.

Implications

The practice of medicine has evolved considerably over the past century, and along with this the changing role of MD. Different health systems are organised in different ways to address contextual challenges. This may for example include different payment models that incentivise volume versus quality. In this context, it is plausible that MDs, may take on preferences within their health system to actively participate in service improvements, engage in regulatory compliance or in areas where there are health or economic gains. Competencies for leadership and training deemed necessary to drive change may vary across health systems. While our review suggests it is a requirement in most countries, the specific competencies are unknown. The lack of uniformity between public and private healthcare settings may contribute to inefficiencies and misalignment within

the health system. Thus, there may be a need to consider reform to address these challenges which can be conceptualised into three categories: medical practice challenges, organisational challenges and health system challenges. Job descriptions should align within an agreed health framework to assure standardisation of requirements to meet health system needs. Also, it may be useful to adopt leadership frameworks such as the SLM, which sets out the roles and responsibilities of leaders, leadership behaviours and the expected relationships with the followers in a non-hierarchical setting.

Conclusions

The changing expectations of MD and the variation in their roles and responsibilities may contribute to inefficiencies and misalignment within health systems. There may be a need to pursue reform to assure alignment with health system objectives, albeit reform may require different approaches to meet the needs of different health systems. Further research is needed to explore how reform of MD roles and responsibilities can be quantified to demonstrate improvement within health systems.

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Contributorship

KA conceived and designed the perspective and was involved in the literature review, data collection, analysis and write-up. IM was involved in the literature review, data collection, analysis and write-up. All authors reviewed and edited the manuscript and approved the final version of the manuscript.

Declaration of conflicting interests

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Ethics approval

Ethical approval was not required for this review as it does not include a review of patient files or clinical research and utilises secondary information in the public domain.

Informed consent

Not applicable.

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