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Impact of the doctors' and non-doctors' leadership on patient-care

Iftikhar Ali Kakar
Assitant Professor, Director Department of Medical Education, Bolan Medical College Quetta

Jibran Umar Ayub Khan
Department of Medicine MMC General Hospital Kabir Medical College Peshawar

Usman Mahboob
Associate Professor, Institute of Health Professions Education & Research, Khyber Medical University, Peshawar, Pakistan
Corresponding author email: usman.mahboob@kmu.edu.pk

***Abstract*---**Background: There has been little attention to how organizational structure and leadership contribute to value in health care organizations, although general strategies for promoting value in health care organizations have been described. Objective: The current study aimed to assess the impact of doctors and non-doctor's leadership on patient care in Pakistan. Methodology: In-depth interview were conducted in different hospitals of the Pakistan and a single instrumental case study approach was selected. For sample selection, a non-probability sampling technique called purposive or selective sampling technique was used. All extracted data was subjected to thematic analysis. Results: Participants were interviewed from all the provinces. Majority of the hospitals were managed by non-doctors. Adequate infrastructure, no appropriate laws, communication gap was observed in the current study. Conclusion: The current study shows that in Pakistan health care system upper-level management is comprised of non-technical professionals (non-doctors), and most of Pakistan's hospitals do not have adequate infrastructure, are not governed by appropriate laws, have a communication gap, are not adequately providing health care or doing so inadequately, have shortage of leadership, and upper level and lower level are interdependent. Further due to lack of interest and basic knowledge there is generally communication gaps in between technical and non-technical management staff**.** It is recommended that doctors (technical staff) should be trained enough as leaders for the upper-level management. This can enhance the system output.

Keywords---health care system, communication gap, leadership.

Introduction

Despite the fact that healthcare systems differ in their structure and the resources available to them, it is commonly acknowledged that medical doctors play a critical role in the adaptability and management of different systems [1]. Studies on the effectiveness of health systems and clinical governance have shown that good clinical leadership is essential for driving reform measures and strategies [2-4]. Medical experts' success in hospitals is increasingly linked to their involvement in responsibilities other than direct patient care and their increased collaboration with executive boards [4, 5]. These activities, according to Spurgeon and colleagues (2008), might include engagement of doctors in the management of quality and risk, review of programs or technologies at the organizational level, engagement in organizational panels that impact the evolution of the organization, and engagement of doctors in executive positions [6, 7]. Professionals, notably medical physicians, have been marked as "professional-managerial hybrids" or clinical leaders for their tasks and responsibilities [7, 8]. A number of responsibilities and resources are therefore integrated into clinical leadership to assist front-line doctors in introducing new methods of working and redesigning treatment in order to enhance [2]. On the basis of their professional knowledge and abilities, clinical leaders are required to influence their colleagues in order to promote improvement of treatment within the constraints of available resources. They will also work with managers to build quality improvement-oriented organizational strategies [9]. Clinical leadership for change in health care systems has been proven to be beneficial when clinical experience is coupled with other skills [8].

A number of studies have demonstrated that hospitals with physician board members and several levels of administration had superior performance ratings and reduced morbidity rates [10, 11]. Several studies have shown that hospitals with physician board members and leaders perform better financially, as seen by reduced operational costs and larger profit margins [12]. Limited data is available about the leadership of physician and their effects on patient outcomes. Despite the fact that literature from social sciences indicated that there is a sharp improvement in performance and outcomes due to leadership transformation in healthcare systems [13].

According to Human Poverty Index, Pakistan is a low-income country and ranks 65th among 102 developing countries [14]. In Pakistan, leadership/managerial roles of doctors are poorly addressed and poorly promoted where key positions are being held by individuals with no medical literacy. This study aims to assess impact of doctors and non-doctors' leadership on patient care in Pakistan. The results of this study will prove to be a better source of uplifting healthcare settings in terms of rational recruitment and responsible provision of services by professionals related to health sciences.

Materials and Methods

The current study was a single instrumental case study carried out at different teaching hospitals, universities and colleges of Pakistan. This study was conducted for a period of Six-months after ASRB approval. A non-probability sampling technique called purposive or selective sampling technique was used. The inclusion criteria for our study were all the doctors, and non-doctors who are involved or having experiences in health-related leadership role and willing to participate whereas the exclusion criteria were all those doctors who are not involved in the leadership roles. The data collection process entailed setting the parameters for the study, collecting information through questionnaires, semi-structured interviews on determining protocols for recording data/information. To reflect the complexity of leadership development, we adopt a single instrumental case study approach. Individual semi-structured interviews were used to obtain data. Written consent to participate was taken from all the respondents. Data was acquired initially by observing the leader and other members of the team in their natural environment. Patient care was assessed through clinical reports or self-assessment quality of life tools. The approach provided useful information on the topic in which leadership occurs, and it was then utilized to analyze, corroborate, or challenge the data gathered via focus groups and interviews. Participants in the research were then interviewed. Doctors were interviewed in-depth in semi-structured interviews. Interviews lasted 20-40 minutes, were audio recorded with the consent of the participants, and were transcribed for assessment. Data in our study was systematically analyzed by using thematic analysis. The analysis process begins with reading the responses and listening to the audiotapes. The data was categorized and conceptualized and finally organized into leadership impact on the care-giving process.

Result and analysis

In the current study, participants were included from Punjab, Sindh, Khyber Pakhtunkha and Baluchistan province. The participants included were doctors, non-doctors and patients. Interviews were taken from both the patients and doctors and non-doctors of all provinces. The interviews were transcribed into patient's codes and doctor's codes and non-doctor codes. Themes were finally generated from doctors codes, non-doctor codes and patient's codes from all province (Table 1, 2 and 3)

Table 1: Themes generated from non-doctor's codes from all province

Coding	Themes
• Leaders at upper level are non-technical (non-doctors) • Low budget for the whole system • No specific line of action • Weak infrastructure • Incapability of nontechnical leaders • Lack of knowledge and interest by upper-level management	Weak infrastructure
• Rapid transfers	No appropriate law

• Lack of policies • No legal support to the doctor's opinion	
• No proper representation of doctors • No proper participation of doctors in policies making • Communication gap • No representative of doctors • No affective voice of doctors in parliament and other corridors	Communication gap
• During pandemic non-technical leaders were dependent on the medical staff • Technical leader ship was there who advice all of the non-technical leadership	Team work Dependency
• Doctors need leadership training. • Public leadership can be incorporated to the curriculum of the MBBS program. • Exposure trips to various civil secretariat offices and deputy commissioner • Offices visits • Conducting Demos • Brief training in different institute	Ways of training

Table 2: Themes generated from doctor's codes from all province

Coding	Themes
• Non-technical leaders • Unsatisfactory hospital outcomes	Weak infrastructure
• Technical staff can increase hospital output.	Health system needs technicality
• Training of medical staff • Public leadership can be incorporated to the curriculum of the MBBS program.	Ways of training
• Non-technical staff depends on technical staff.	Dependency Team work
• No proper representation of doctors • No proper participation of doctors in policies making • Communication gap	Communication gap

Table 3: Themes generated from patient's codes from all province

Coding	Themes
• Health care system needs improvement • Hospitals in Baluchistan needs more concentration	Insufficient health facilities
• Non-technical policies maker • Lack knowledge about patient basic needs • They need basic medical training • Needs proper rules and regulation • Care to the patient should provide in time	Weak infrastructure
Doctors' needs	Training required

• procurements training • managerial skills • Doctors needs political support. • Their opinion needs legal cover	Practical implementation
• Communication gap • Lack of interest • Flow of information should be facilitated.	Communication gap

Discussion

Despite the fact that non-physicians presently hold the majority of hospital and health-care leadership posts [15], there is a notion that doctors' clinical perspective and operational grasp of medicine would better prepare them to operate a hospital or health-care system in the value-based health-care era [16]. According to Human Poverty Index, Pakistan is a low-income country and ranks 65th among 102 developing countries [14]. In Pakistan, leadership/managerial roles of doctors are poorly addressed and poorly promoted where key leadership positions are being held by individuals with no medical literacy. Therefore, this study was carried out with the aim to assess impact of doctors and non-doctors' leadership on patient care in Pakistan.

Our study shows that most of the hospitals upper-level managements are non-technical professionals (non-doctors), and most of the hospitals of the Pakistan have weak infrastructure, lack appropriate law, have communication gap, insufficient health care or inadequate care, leadership trainings, and upper level and lower level depends on each other. In accordance with our study, another study also reported non-doctors in management of majority of hospitals [17]. In contrary to our findings other findings shows that in US and UK, majority of hospitals are managed by physicians [16, 18]. Bottom-up leadership, stronger political power, and enhanced contacts between physicians and senior management are some of the advantages of hiring doctors in healthcare management positions [19]. The current emphasis on including physicians in leadership is on attempting to integrate clinical judgments with strategic management decisions, and it has expanded to include essential accountability for both quality of care and resource management [20]. Overarching health system executives develop the policies and governance framework that hospitals operate under, while hospital administrators are more intimately engaged with the day-to-day operations that effect care delivery. Clinically qualified leaders, according to some researchers, may lead to superior quality via better communication with employees, medically aware and patient-centered choices than non-clinician leaders [21]. Others argue clinical executives are better equipped to assess performance, design optimum strategic ideas and put them into effect, and establish an optimal work environment [22].

In current research work it was found that there were serious communication gaps in between the upper and lower managerial staff. The main effects of poor communication in healthcare are a "reduction in the quality of care, poor patient outcomes, wastage of resources, and high healthcare costs" [23]. Communication failures often have a negative effect on patient and staff satisfaction A successful

business depends on effective communication, but even more so in the healthcare industry [24]. The consequences of poor communication in healthcare can be very serious. Poor communication negatively impacts profits in other businesses as well as in healthcare [25].

In current research work most of the participant observed that health care system of the Pakistan has very weak infrastructure due to lack of polices, insufficient care, lack of basic supply, and low funds [26]. Studies suggested that system with low infrastructure cannot flourish and will negatively affect the out of any organization or system. Infrastructure should facilitate the integration of the hospital, as the primary provider of acute care and inpatient treatment, into a broader system of health care, as well as the administration of seven quality domains [27], such as "patient experience, effectiveness, efficiency, timeliness, safety, equity, and sustainability. In addition to buildings, infrastructure includes supporting elements, such as equipment, access, information technology, systems and processes, sustainability initiatives, and individuals" [28]. In summary, these interwoven concepts should allow patients to move seamlessly, while maintaining their dignity and privacy, from initial referral through local hospitals to tertiary centers, and then on to appropriate care ("home, care home, community hospital with intermediate care"), regardless of the patient's age, condition, or social circumstances. The architecture of the health care system is an important element that supports the fundamental aim of promoting improved standards of care and wellbeing for all patients [29]. The major limitation of our study was small sample size therefore a study based on large sample size is recommended. According to the literature, our study is the first to be conducted in Pakistan which is the major strength of our study.

Conclusion and recommendation

The current study shows that in Pakistan health care system upper-level management is comprised of non-technical professionals (non-doctors), and most of Pakistan's hospitals do not have adequate infrastructure, are not governed by appropriate laws, have a communication gap, are not adequately providing health care or doing so inadequately, have shortage of leadership, and upper level and lower level are interdependent. Further due to lack of interest and basic knowledge there is generally communication gaps in between technical and non-technical management staff**.** It is recommended that doctors (technical staff) should be trained enough as leaders for the upper-level management. This can enhance the system output.

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