

# Transforming rural health systems through clinical academic leadership: lessons from South Africa

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Presentation to Prince Mahidol Award Conference 2014 – Transformative Learning for Health Equity  
Pattaya, Thailand, January 27-31 2014

# Why ‘clinical academic leadership’?

- **Why ‘leadership’?**

- related to, but distinct from, management
- transformational
- lack of leadership major challenge in LMICs, especially rural/remote areas
- can be learned
- can be exercised by many staff, not just managers

- **Why ‘clinical’?**

- high degree of discretion of front-line staff
- authority derives not from formal position but knowledge, networks/collegiality, ability to persuade
- complexity and uncertainty of health care requires responsive decision-making

- **Why ‘academic’?**

- good rural training programmes effective in retaining students, producing better-adapted graduates, motivating and retaining rural training staff
- universities bring resources/accreditation/quality improvement strategies to poorly resourced rural services

# Some definitions

**Clinical staff** are people from any disciplinary background who are directly involved in diagnosing a patient's health problem, deciding upon the treatment required, overseeing the care of the patient and participating in the care of the patient, including conducting procedures

**Clinical leadership** is the transformational leadership provided by practising clinical staff who drive improvements in the quality of care through innovation, either through formal participation in clinical governance activities or through informal role modelling and mentorship

# Some definitions (contd.)

**Rural clinical academic leadership** is the guidance and role modelling provided by rural academics with respect to improving the quality of health service delivery, achieving clinical governance and protecting patient safety, providing good quality training, conducting relevant research and, more generally, contributing to the social accountability of health services and universities.

# Methodology

- qualitative, exploratory research
- tapped experiential or ‘tacit’ knowledge of experts (clinical leaders, senior health system managers, academics involved in health system development)
- thematic content analysis of interview transcripts, notes etc.
  
- Study 1 (Doherty *et al* 2013):
  - two-day workshop of 28 participants from Australia, Canada and South Africa
  - focus on developing rural academic clinical leadership
  - small group discussions, feedback to plenary, plenary debates
  - rapporteur took detailed notes which were circulated
- Study 2 (Doherty 2013 and 2014):
  - literature review
  - 17 key informant interviewed telephonically/e-mail
  - focus on roles of clinical staff in district hospitals

# Some challenges to ...

- developing rural academic leadership:
  - lack of policy coherence
  - failing public health systems
  - urban bias in health sciences training
  - lack of leadership training
  - under-developed training roles for public health services
  - little support for rural trainers
- strengthening clinical leadership (in district hospitals):
  - district and provincial offices do not provide enabling environment
  - slow recruitment and poor human resource management
  - insufficiently skilled clinical staff appointed into leadership positions
  - a disjuncture between the identification of problems affecting clinical care and action by the management team

*“Despite having often that passion and that drive, it means you have some success but sometimes that success is only limited to keeping that team together and you’re still putting out fires but some of the more high quality issues, or some of the more deeper issues of clinical governance, you’re not necessarily getting to those even though you’ve got a good team.”*

# To aid transformation, it is imperative to:

- recognise, and advocate for, the importance of clinical leadership
- place a high value on rural academic clinical leadership, including:
  - promoting generalism and rural practice
- support and develop existing rural academic clinical leaders
- grow the next generation of leaders

# Recommendations: universities

- Introduce/strengthen leadership training for all health professionals:
  - a continuum across UG/PG/on-the-job
  - responsive to the needs/experience of students
  - address informal and hidden curriculum
  - draw on experience of business schools but adapt to values of health system – leadership style promoted must be:
    - values-based
    - transformational rather than directive
    - distributed
    - multi-disciplinary
  - clearly identified competencies that include, amongst many things,:
    - problem-solving skills and personal agency
    - public health principles and the nature of the health system
  - must be taught and modelled

# Recommendations: universities (contd.)

- Support rural clinical academic leaders:
  - provide training for leadership, curriculum development, assessment, student support
  - develop career pathways, including joint appointments, time off for diplomas etc.drt
- Establish rural research units in partnership with local clinicians:
  - extend and deepen evidence
  - develop credible research output for local clinical staff
  - improve relevance and policy-into-practice

# Recommendations: Ministry of Health

- Acknowledge clinical leadership as a key driver of health system performance:
  - support clinical leadership development strategies, including new career pathways
  - develop partnerships with universities
- Galvanise human resource management systems, especially with respect to timely recruitment of clinical staff

# Recommendations: facility/programme managers

- appoint credible staff into clinical leadership positions
- clarify the leadership roles of different clinical staff
- encourage clinical leaders to remain highly visible/accessible
- lighten the administrative loads of senior clinical leaders

# Recommendations: senior clinical leaders (academic and non-academic)

- Implement a clinical leadership development strategy e.g.:
  - strengthen the multi-disciplinary clinical team
  - explore/strengthen the roles non-medical clinical staff could play
  - provide supportive clinical supervision and on-the-job leadership training and mentorship for clinical leaders throughout their careers
  - find a mechanism (such as a clinical committee) to take structured action on issues affecting clinical care; and
  - balance collegial leadership with measures to ensure that clinical staff are fulfilling their roles adequately and remain accountable
- Develop clear, frequent and multi-faceted strategies for communication within and between clinical groups, between clinical and administrative staff, and between academic and non-academic staff

# Conclusions

- Clinical leadership is essential for improving:
  - the quality of care
  - general health system performance and sustainability
  - expanding rural training programmes
- Academic clinical leaders can act as a spur to transformation
- There are exciting opportunities for collaboration between universities and health services
- Developing rural clinical academic leadership is complex and takes time, and it is intertwined with health system development

# Sources

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# Acknowledgments

Thanks to:

- the participants in the two studies for contributing their time and expertise
- the funders of the studies on which this presentation is based:
  - Study 1: University of the Witwatersrand, South Africa, as part of its joint agreement with Monash University, South Africa
  - Study 2: The Municipal Services Project which is located at the School of Government, University of the Western Cape, Republic of South Africa, and funded by the International Development Research Centre of Canada.
- the conference organisers