Research Article

Necessary Skills for Leadership in Healthcare

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Abstract

Clinical leadership and the clinical leader's time have come. It's a new agenda in the health service, which focus on innovation, change and a drive for quality. Health care practices are also changing. It's recognition that greater change needs stronger leadership and that leaders can come from any stratum of the health industry. The main qualities of a healthcare leader are approachability, empowerment and motivation, being visible in practice, clinically competent and clinically knowledgeable, has values and beliefs on show, has effective communication skills, copes well with change, has integrity, is supportive, inspires con idence and is a positive clinical role model. A better outcome is the end in mind. Performance excellence achieves better outcomes. Process improvement leads to performance excellence. Healthcare leadership requires clinicians to consider the needs of the wider patient population; to take decisions that not only make the best of resources but also deliver clinical quality; and implement clinically-led service improvements that are likely to succeed. A scienti ic methodology and change leadership combine to enable teams to improve processes. In current healthcare settings, an effective organization consists of integrated teams in which individuals combine their expertise, abilities, and experience in order to solve difficult challenges and pursue innovative solutions. We need to develop ever more advanced diagnostic and treatment technologies, but we don't need to become mere technicians. The leaders of medicine need to understand how much their success depends on the quality of the science that we support. If the ield stagnates due to lack of resources, funding, or interest, then the advancement of innovative and more productive means of health promotion and disease prevention, diagnosis and treatment will struggle.

Keywords: Healthcare; Operating Room; Health promotion; Disease prevention

Outline

- Clinical leadership and the clinical leader's time have come. There is a new agenda in the health service focusing on innovation, change and a drive for quality.
- Care practices and the context of care provision are changing. There is recognition that greater change needs stronger leadership and that leaders can come from any stratum of the health industry. Indeed, effective change, quality improvements and innovation may be more successful if they are initiated and developed by clinicians who are empowered to lead.
- Leaders come from any stratum of the health industry whether you are your community hospital's chief executive officer preparing for a major change in reimbursement that could bankrupt your organization and leave your community without healthcare, a nurse manager dreading the resistance your nurses will vehemently evoke when yet another new technology hits your unit from the chief information officer, or one of the millions of people in healthcare worldwide who is asked to change when you simply want to care for your patients and want the change to help you help them.
- The main attributes of healthcare leaders are approachability, empowerment and motivation, being visible in practice, clinically competent and clinically knowledgeable, has values and beliefs on show, has effective communication skills, copes well with change, has integrity, is supportive, inspires confidence and is a positive clinical role model.

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- Why is it that some improvement efforts succeed and many fail despite the analytical skills, leadership cheerleading, change management programs, and sometimes a “do-or-die” pressure to improve?
- The three elements that come in a “package” that differentiate improvement efforts that succeed from those that fail are called the 3M's (Measure, Manage to the measure, Make it easier).
- A better outcome is the end in mind. Performance excellence achieves better outcomes. Process improvement leads to performance excellence.
- A scientific methodology and change leadership combine to enable teams to improve processes.
- Requirement of healthcare staff who can establish direction and purpose, inspire, motivate and empower teams around common goals, in order to help produce improvements in quality, clinical practice and service.
- Patients can now be treated and cared for in a range of clinical areas and environments by experienced and skilled health professionals, who can prescribe care and implement clinical decisions based on their critical thinking and leadership skills.
- The drive to improve quality and support the integration of quality improvement sits at the heart of a need to generate more effective clinical leadership.
- How to develop a change to help nurses spend more time with patients and less time in charting.
- Functional results oriented healthcare leadership requires clinicians to consider the needs of the wider patient population; to take decisions that not only make the best of resources but also deliver clinical quality; and implement clinically-led service improvements that are likely to succeed.
- There is no one way to define a healthcare team, alluding to the goal of creating greater interprofessional interaction within such a team.
- In current healthcare settings, an effective organization consists of integrated teams in which individuals combine their expertise, abilities, and experience in order to solve difficult challenges and pursue innovative solutions.
- We need to develop ever more advanced diagnostic and treatment technologies, but we don't need to become mere technicians.
- The leaders of medicine need to understand how much their success depends on the quality of the science that we support. If the field stagnates due to lack of resources, funding, or interest, then the advancement of innovative and more productive means of health promotion and disease prevention, diagnosis and treatment will struggle.

Resume

- People like Napoleon and Martin Luther King are frequently cited as fantastic visionaries and leaders. They describe their leadership style as charismatic, aggressive and at times authoritarian. But are those leaders suited to the needs of today's healthcare environments where choices often require empathy and sensitivity beyond purely cost-effectiveness or benefit optimization?
- An organization can be only as adequate and good as its workers. The most effective way to lead an organization is to trust and respect the people who we work with.
- As a result of changes in the societal structure of health care, the dichotomy between management and leadership is increasingly declining.
- Owing to the important positions of health management practitioners and professional expertise in promoting transformation and leading growth of health care institutions, the emphasis on competencies has been driven by the need to build effective and knowledgeable health management and leadership personnel
- In addition to identifying core competencies, it can also be useful to identify the specific skills that certain individuals or members of a professional body require for good performance.
- Laboratory leadership includes cooperation with other health care professionals at the front line to administer, support, and improve clinical laboratory facilities to satisfy the needs. And the knowledge is the key contribution to laboratory medicine to healthcare.
- A significant factor in why very different ways of thinking have led to difficulties in understanding each other is the parallel development of physician education, nursing education, and hospital administrator training.
- The best way to protect any profession's long-term survival is by ensuring it makes meaningful contributions to those it represents. The value of the healthcare professions lies in their capacity to support patient best interests.
- How we get paid will impact profoundly on what we do. It is also important that health care stakeholders give serious consideration to the mechanisms of benefits and rewards.
- The less intrinsically exciting, rewarding and fulfilling we make our work, the more necessary it becomes to bait people to do it by means of extrinsic rewards.
- Academic researchers and medical schools are excellent at exchanging expertise in many ways. Teaching, which inevitably includes the exchange of expertise, constitutes a key interest among many academic doctors.
- Leadership is generally seen in terms of the decision-making capability of the individual, making the big call, deciding a course of action or a plan.

Introduction

Healthcare has developed immensely ever since the dawn of the industrial age. Today's health care programmers are very dynamic and work better among their multiple stakeholders by positive interconnections and interrelationships. According to the World Health Organization, complex health

care services are not fulfilling their primary function because "the health standards in many developed countries are unacceptably low, and the prevalence of significant inequalities in health status is an issue that no country in the world is excluded from" [1]. American medical care was usually given just two hundred years ago by independent doctors who went from home to home to offer their services [2,3]. Western nations continued to transition towards a more concentrated model of health care provision: hospital medicine. Numerous hospital super complexes with complicated bureaucratic structures arose throughout the 20th century as cities grew increasingly larger and more densely populated. Hospitals, hiring hundreds and at times thousands of health care professionals, were increasingly difficult to handle and needed a well-organized leadership team to be present. Many facets of the physician's everyday life have significantly changed in hospitals and clinics over the past decade, bringing another degree of complexity to healthcare system. A major cause of medical practitioner's discontent is that the individual orientation for which they have been educated does not fulfill the demands of modern healthcare systems that require leadership skills to cope up with the challenges of the present-day healthcare [4]. Led with various issues such as "financial limitations and demands for greater transparency for healthcare protection, quality and effectiveness," physicians are increasingly overwhelmed with their everyday workload and may not feel as respected and valued as they may have been in the past. Medical practitioners also receive guidance about these new demands from leaders who either do not have a clinical experience or do not wish to fill their leadership position. The lack of consistent and supportive instructions from reputable and qualified professionals thus affects both the health professionals and the general well-being of the entire medical system. Thus, hospital inefficiency could be eliminated through adequate medical leadership training of healthcare professionals. To face current and future healthcare challenges, we need to develop a new generation of competent healthcare leaders at all levels of their medical service. Many countries around the world are beginning to recognise the numerous benefits of developing leadership skills in their medical students, doctors, CEO's/ CMO's, ministers of health, and nurses [5].

Literature Review

Leadership skills had been researched for over 100 years ago and today the research still goes on and nearly 50 different approaches have been named. But the special authorities and resource persons have not agreed upon a particular approach considering it as a model because all of these approaches are based upon industry set examples. Moreover, the approaches made in these models and the definitions pinpointed overlap to a significant degree. Latest studies emphasize that a leader must be capable of a leadership style that is adaptive to dynamic situational demands [1]. While considering healthcare, clinical leadership is the demand of time. Healthcare has a new catalog focusing on change, freedom, revolution and a drive for quality. A health care system encompasses "all practices aimed specifically at improving, preserving or sustaining health," and health outcomes may include, for example, "changes in perceived health status, changes in the distribution of determinants of health, or causes believed to impact health, well-being and quality of life." As a matter of fact, innovation, quality improvements and a powerful change may be more effective when developed and undertaken by healthcare leaders who are empowered to lead [2]. Care practices and the context of care provision are changing. There is a recognition that greater change needs stronger leadership and that leaders can come from any stratum of the health industry whether you are your community hospital's chief executive officer preparing for a major change in reimbursement that could bankrupt your organization and leave your community without healthcare, a nurse manager dreading the resistance your nurses will vehemently evoke when yet another new technology hits your unit from the chief information officer, or one of the millions of people in healthcare worldwide who is asked to change when you simply want to care for your patients and want the change to help you help them. A healthcare leader must be a pragmatic clinical role model possessing the qualities of head and heart such as accessibility, attainability, authority, motivation, clinically knowledgeable and competent, being visible in practice, copes well with change, has effective communication skills, has values on show, inspires confidence, is supportive and helps his co-workers grow [3]. An organization can be only as adequate and good as its workers. A great dilemma of our system is that healthcare organizations and medical practices spend great sums of their money on the making of their buildings, purchasing equipment, and the establishment of other lavatories but there is little or no concern about the understanding of people who work in it. Healthcare leaders need to understand the nature of their physicians, technologists, nurses, attendants, administrators, and others who work in the organization. While hiring candidates, can we predict who will perform best? Are there any measures to motivate the people who work in our organization? Why some people perform better than others? How to improve the quality of work, giving rewards, such as pay increases and public praise, or using sticks, such as the reduction in salary or the threats of termination? [4]. Medicine and nursing must now invest in the bigger aspect of the health profession and focus on leadership development in their areas. The Healthcare industry in the US needs to be put onto the right path and we have got both a responsibility and a historic opportunity to do so. We see physicians as the traders of science and technology, but we have failed to envision a more comprehensive vision of physicians as the practitioners of leadership. No one is saying that US healthcare organizations must have a health professional as a steer or control, or that having a healthcare leader will cure all the ailments but the need has never been greater for the healthcare professionals to assume a leadership responsibility who know first-hand what it is to care for the sick. During their education, most physicians become adapted to receiving recognition for their performances and regard themselves as

high achievers. Realizing this, only a healthcare leader will have the capability to look for the areas of the organization where every physician could play a constructive part according to his or her abilities and earn themselves an opportunity for recognition. Hence the most effective way to lead an organization is to trust and respect the people who we work with and to work with them, understand their skills and abilities help them polish these skills, make them utilize these for the benefit of the healthcare and achieving the comprehensive objective of the organizational progress and development [4]. Treatment of a patient is a diverse and complex process because it involves more than one person and more than one discipline. Processes inside and outside the hospitals fail and lead to the failure of the discharge process in several ways. For example, if a patient with congestive heart failure is discharged, there are certain rules to maintain the recovery process, *i.e*., he needs to eat healthy food but there are many cases where patients fail to maintain their diet and thus the discharge process that is meant to continue the recovery process fails. Hence, leadership attributes of healthcare professionals demand a process improvement throughout the "value-stream" of the organizations. We desire better performances to achieve better outcomes for our patients and that is possible through process improvements. This process improvement can be achieved by utilizing the 3M's. Measure. Manage to the measure. Make it easier when any one of the 3M's is missing, process improvement suffers, and better outcomes are not achieved. We will understand this with the help of an example where the hospital staff is struggling with the availability of braces needed for orthopedic surgeries. Braces are a crucial part of orthopedic surgeries as they provide support to the limbs and facilitate the surgical team in performing the procedures. The first M was performed when it was measured how many times the correct brace was missing. Now the next step was to manage to the measure and the director of the Operating Room (OR) performed the second M by highlighting the issue in the gathering of the hospital staff daily. This is called managing to the measure. The hospital staff also tried to manage to the measure by viewing daily the chart of missing braces but no improvement in the availability of the correct brace was measured. They were fully aware of the fact that the availability of the correct brace was important for the surgeons. The director also played its part to manage to the measure by asking daily the number of occurrences when the correct brace was missing but no improvement was observed. The first 2M's were happening that is measure was occurring and the staff and the director were managing to the measure by highlighting the issue of missing braces and reviewing the number of cases daily. The next important question was how to move the process improvement in the right direction and make it easier for the surgeons to get the correct brace for the surgeries. A team was formed to resolve the issue using scientific methodology. Scientific methodology is a professional way to analyze the issue, highlight the contributing factors or root causes of the issue, calculate the current performance, use standardized ways to sustain the gains, and develop circumstances to improve the issue. The team members began to work on the issue and soon they discovered that the technicians were aware of the demand of braces by the surgeons and that it was their responsibility to ensure that the correct braces were made available to the surgeons at the time of surgery. The team soon discovered the root causes of the issue. The first cause was the unavailability of braces on those specific days of the week when two of their most busy and highest-volume surgeons were performing surgeries. The second root cause was the lack of coordination between the different ORs in the hospital. Actually, the primary building lacked enough ORs to handle the demand so there was another OR situated at a five-minute walk from the primary building where the braces were stored. This highlighted the issue that the most frequent number of cases when the braces were missing occurred in the other part of the hospital and not in the primary building. Moreover, the team probed further into the issue and found that some braces were off in the corner, needing to get repaired. The team worked their best to highlight the root causes and then informed the orthopedic surgeons about the process to improve performance. They suggested to smooth the demand of braces between the highest-volume surgeons on the busiest days and to get the extra braces repaired to increase the number of braces that were the main issue. The director of the OR allowed the team to get the braces repaired and follow the further methodology for performance excellence to achieve better outcomes for the organization. The team suggested that on the busiest days some members of the primary or staff should contribute to the workload of the other operating room and take the free braces along with them to the remote building where most cases of missing braces occurred. The staff of the remote building was appreciative of the teamwork and efforts made by their fellow staff and the issue of the missing braces was completely resolved. Another benefit ensued by bringing the two staff together. The extra braces and teamwork made it easier to get better outcomes and the number of cases without brace improved as well as staff satisfaction. The $3M^s$ of process improvement using the scientific methodology contributed to better outcomes for the reputation of the organization as well as for the quality of treatment given to the patients in healthcare. The director of OR proved himself as a healthcare leader who can achieve change. To improve is to change, and to be perfect is to change often. Healthcare has many great examples of change, including physicians and staff today who are eliminating infections, improving care, and reducing mistakes. What is common is that changes are led, not just managed. As in the previous example, we talked about the director of OR as a leader who can achieve change. This gives us another definition of leadership called "change leadership". Change leadership is as necessary for process improvement as science in the greatest discoveries of healthcare. Change leadership requires someone to lead but change management is a completely different term. Leadership is the key to achieve change and it is the keyword to differentiate change management and change leadership. The change would not have been achieved if we wanted to

manage only. In healthcare, we see some changes that failed badly, and we see managers as frustrated as the staff. But we also see some changes that made a significant impact and the whole organization worked peacefully under the directions of a leader. Hence, we see that changes happen when there is someone to lead, and change leadership proves itself as important as the science in healthcare. A change that made influence and helped achieve better outcomes was improved customs and values in the Operating Room (OR). An organization led to change the cultures in the operating room to influence the surgeons, nurses, anesthesiologists, surgical techs, and attendants to respect each other's opinions and work as a team. Following this culture, improvement in patient safety as well as a sense of responsibility was observed in the whole staff while working in a peaceful environment. A control chart showed a significant reduction in mistakes, slips, and lapses every day. The medical care improvement champion for a well-being framework and I were brought in to support an emergency clinic's CEO, Chief Financial Officer (CFO), and head nursing official (CNO) discover why a change to assist attendants with investing more energy with patients and less time in charting and outlining failed. Who might contend that such a change seemed well and good? The change was to purchase PC's on wheels so medical caretakers could move the cart into the patient's room and do the required graphing while at the same time investing energy with the patient. Previously, the attendants would leave the patient's room, stroll to the medical caretakers' station, and enter the information on PC's at the work area. What we discovered was a complete inability to accomplish any extra time with patients. It is no big surprise. At the point when we previously went to the floors, we found the PC's on wheels outside the patient rooms, not inside any room. We watched nurses despite everything doing their outlining at the medical caretakers' station or one of the PC's on wheels stopped close to the attendants' stations. Also, half of this costly tablet PC's, which cost much more than a desktop PC found at the attendants' station, were out of order, having been unplugged and their batteries depleted. They were presently occupying a fundamental room in the passageways or buried in a storeroom. What turned out badly with this change? It is not that the PC's on wheels didn't function just as the workstation desktops. They had highlights, for example, bio-metric examining that made marking on as simple as swiping a thumb over the sensor. In any case, not one medical caretaker was utilizing this element, and numerous attendants whined about the numerous keystrokes required just to sign in. They had contact screen capacity and a lash to permit one hand to hold the tablet while the other hand could enter patient information. So, for what reason did we see enormous work area size consoles added to these handheld PC's and hear that attendants found the touch screen baffling? More regrettable, for what reason were the PC's on wheels never under any circumstance, taken into the patient's space to accomplish the essential target of attendants outlining continuously and investing more energy with patients? Technically, the computer systems did work. Much additionally astounding, more than one medical attendant didn't understand the PC had a lash on the back so it could be taken from the mount and held in one hand. Upon the arrival of the computers, not one nurse could recall the tablet designer or supplier coming to illustrate the computer or address their complaints. Supervisors were as upset as the nursing staff about the new devices, and the instigators of the change lacked support. We informed hospital executives and corporate Chief Financial Officer (CFO) and Chief Information Officer (CIO) of our findings and recommendations. Originally the CFO was told the changes would focus on improving the satisfaction of patients and nurses. We shared how the money was wasted 100 percent. The CFO immediately ended the program. He then approached the CNO of the hospital and agreed to help anything she and her team thought they wanted to monitor that expanded patient time, enhanced charting for quality patient treatment and knowledge, and facilitated the daily life of the nurses. What we see contrasting between the unsuccessful changes and the productive changes is not so much the management but how the transition is led. Management typically includes arranging, coordinating, managing, budgeting, execution, and evaluation; ensures that resources are spent effectively to accomplish organizational objectives [6,7]. The philosophy of management has been defined as 'special' in the sense that it has no uniform definition but is determined by context, that is to say, the practices, frameworks, and cultural values under which it is applied [8]. There are various schools of thinking of management; one such school is the 'orthodox' or bureaucratic (scientific) approach to management that stresses a simple management system, focused on a hierarchical chain of command involving worker discipline and performance accountability [9]. Leadership is about vision, ideas, direction and inspiration; it sets the direction and motivates others to achieve the organizational goals, rather than focusing on the day-to-day application of such strategic objectives [10,11]. The dichotomy of management and leadership in the industry is gradually diminishing as a result of developments in the social nature of health care. Thus, managers (generalist qualified administrators, skilled managers of the health service) occupy managerial roles, perform management duties, and provide leadership [12]. In the other side, practitioners (including physicians and nurses) and other professions with no management experience will step into management positions and provide leadership. The growing role of physicians in the preparation, administration, and coordination of treatment in accordance with the idea of clinical leadership is one transition that has dramatically changed the social nature of health treatment. Professional leadership in clinical environments is provided by clinicians to ensure safe, reliable, and high-quality care [13,14]. Typically, these tasks are undertaken in tandem with positions and duties in non-clinical administration or leadership. Thus, a tradition of 'managerialism' in the health care industry, governed by generalist professional administrators, is being replaced by a cohesive (collective) leadership system for the efficient delivery of health care services. Such a management strategy is somewhat analogous

to the idea of 'dispersed' or 'sharing' leadership in which various players partake in activities that are 'spread' or dispersed across the organization [15]. In health policy and leadership literature, the words 'competence' and 'competency' are sometimes used interchangeably and inconsistently. Both words, though, are separate definitions. Competency refers to the expertise, skills, and behaviors that health leaders need to play productive tasks and that can be strengthened by preparation and learning [16-18]. Information was defined as a description of the knowledge or comprehension of the ideas, hypotheses, rules, or principles needed to carry out a task efficiently [19-21]. Skill, on the other hand, refers to the possession of the ability to perform physical or cognitive tasks successfully in order to achieve a specific outcome, whereas attitude refers to 'a relatively enduring organization of beliefs, feelings and behavioral tendencies towards socially significant objects, groups, events or symbols" [22]. Some skills are considered crucial to organizations' successful performance; such skills are known as 'core skills,' a concept first advocated by Prahalad and Hamel [23]. Core competencies have also been defined as common competencies that overlap and complement each other and are shared in a wide variety of roles and settings by health managers. While the idea of core competencies promotes communication and cooperation between individuals, it has been criticized for failing to take into account each manager's unique needs in line with his or her dominant position in management or leadership. Thus, in addition to recognizing core competencies, it can also be helpful to recognize the particular skills needed for successful output by certain individuals or members of a professional body [24]. Competence is the capacity to reliably deliver the outputs (of behavior) necessary to accomplish the organizational objectives efficiently [25]. In other words, a professional health manager or leader has the requisite expertise, skills, and attitudes that allow him or her to successfully manage or lead. The word 'competency' or 'level of competency' refers to the level of competence for a specific skill [26]. A 'competence model' is a structure that includes declarations of competencies in which critical expertise, skills, and attitudes are defined as suitable for particular positions, or a set of competencies needed for good results. Capacity, on the other hand, refers to individuals' strength or ability to maintain or possess the requisite competencies at a degree deemed appropriate for a role [27]. As pointed out earlier, numerous reports on health policy and leadership have been published. Much of these focused on defining and/or assessing critical skills that health administrators and stakeholders need for successful results in management and leadership positions. Owing to the important positions of health management practitioners and professional expertise in promoting transformation and leading growth of health care institutions, the emphasis on competencies has been driven by the need to build effective and knowledgeable health management and leadership personnel. The World Health Organisation, which promoted the need to improve management and leadership skills at all levels of the health system, has also acknowledged as much [28]. Related techniques are used to define and compare the critical competencies needed by health care and workforce leadership. These techniques include peer review, role description study, Delphi methodology, polling, work incumbent interviews, and focus groups. The best methodology suggested for competency recognition and appraisal includes the use of various approaches to boost the reliability of the results [29,30]. In health policy and leadership, a significant point of contention is whether competencies are or not contextually responsive across countries and organizational contexts. While some scholars have argued that certain 'essential' skills are relevant to most health contexts [31,32], others have argued for more context-compatible skills based on the premise that skills can be affected by contextual factors such as staff dynamics and the scale, history, and needs of organizations [33-36]. Despite the claim, some competency domains have been established as important for health care and leadership positions through many surveys, regardless of the contexts in which certain positions are exercised. These fields include teamwork, interpersonal partnerships, company competencies, health care system understanding, expertise, and leadership [37]. A closer look at these areas of expertise reveals that some are people and relationship-based, including communication, interpersonal partnerships, professionalism, and leadership. A close look at these competency domains reveals that these are focused on individuals and partnerships, including connectivity, interpersonal interactions, integrity, and leadership. This is not unexpected given that healthcare institutions consist of human networks in which individuals of varying backgrounds engage with each other in order to operate the healthcare system successfully to deliver healthy, efficient, and high-quality patient care [38,39]. Competency-based training or skill development in health care institutions may be aimed at enhancing individual leaders' skills for effective role performance, a term known as 'leader growth'. On the other hand, in order to promote 'leadership development', such preparation or skill development programs may be directed at improving the mutual skills of the entire management and leadership workforce. However, a more traditional approach is to concentrate preparation and career growth on improving the potential of individual managers and leaders to be successful in leadership roles [40].

Thus, a leadership modeling strategy that emphasizes on leaders as complete individuals (as opposed to the existing method of focusing on particular behaviors) has been proposed to ensure the creation of comprehensive leadership. This model of leadership growth in health care institutions is worth investigating [41]. A noteworthy development in health management and leadership literature is the growing emphasis on defining and evaluating critical competencies required for effective performance in leadership positions by practitioners from both health care and clinical perspectives. In most cases, the aim of defining and evaluating competencies is to guide the development of competency structures that are used to evaluate the competence, identify ability deficiencies and prioritize relevant training and

growth opportunities. Laboratory leadership includes cooperation with other health care professionals at the front line to administer, support, and improve clinical laboratory facilities to satisfy the needs. And the knowledge is the key contribution to laboratory medicine to healthcare. Laboratory leadership often includes supervision to ensure that information is delivered in a way that is acceptable and legible, exploiting ways to bring value to programs where possible. Most notably, laboratory leadership needs successful relationships with laboratory staff, vendors and manufacturers, senior management, and others who depend on the services given. Laboratory leaders therefore also need to concentrate their attention on the right individuals and engage in improving strategic capabilities that can strategically strengthen a leader's capacity to create good working relationships [42]. Leaders, as we all agree, are not formed overnight. Instead, the leaders build skills and competencies over time over a spectrum. Indeed, leaders grow along a curve based on the interactions they develop along the way and the expertise and competencies. Organizations like clinical labs that will succeed in the 2020^{s} will be built to continually evolve and respond to evolving conditions, incorporate artificial and human intelligence in different forms, and leverage the advantages of larger market environments. Recognizing the importance of successful leadership to a clinical laboratory's performance, this has become a significant priority field for the IFCC Clinical Laboratory Management Committee (C-CLM). The bottom line is continuous reform will be expected to be competitive within the next decade. Yet organizational reform is particularly challenging to implement effectively. Ultimately, by understanding the complexities of change, welcoming uncertainty, and utilizing research and analytics lessons to find the right resources for implementing change, next-generation executives will ensure their labs are better equipped to succeed in the future. Why do some of our healthcare practitioners lack the basic skills needed to lead their organization rather than just working from 9 to 5 and performing their duties for salary or public praise? How did we get here? Let us find the answer to this question through the life of a chief medical officer. As he went to medical school, the chief medical officer did not expect a career at management. He did not intend to develop formal leadership skills except, possibly, to ensure smooth activity in his medical office. In addition to his medical office practice, he concerned himself with duties that included federal submission of quality paperwork, clinical performance review at the health center (every third weekend), and the sole oversight of a 45-bed hospital facility 30 miles from the office! his responsibilities included emergency medicine, primary care, obstetrics, pediatrics, etc. Circumstances in patient care also made his role as the covering physician essential in various areas of the hospital. Within a matter of weeks of arriving at his new practice location, it became apparent that neither medical school nor residency training curriculum addressed the management and leadership skills needed for properly delegating, developing patient-centered care teams, postponing triage-based treatment, and meeting patient needs by using the expertise and abilities of the staff assembled to care for them. The doctor was appropriately overwhelmed and unable to rely on education or experience to address all of the clinical needs of the patient and the management supervisory responsibilities. The work was only possible with an organized team in which nurses worked at the top of their licenses and administrative staff took responsibility for the operations. Teamwork and separation of labor helped the Community Health Center to thrive and accomplish its mission. Different members of the squad had various talents, and perhaps neither even knew what the others had done. As a consequence, connectivity and behavioral problems have arisen. The team made this system work, but back so, the doctor felt there had to be a smarter way to do it. As a microcosm of the national healthcare system, the unique perspective of this young man prompted him to investigate the dynamics of the parallel but distinct career growth of nurses, doctors, and managers. He recognized that the diverse collection of isolated business relationships could inhibit the performance of all of the participants in their short and long-term roles. He also noticed that there was confusion and disagreement between well-meaning members of the staff, even when everyone felt he or she was doing what was best for patients and the organization. Throughout his practice, the doctor discovered that his experience was presented in his own medical silo through the eyes of a specialist educated. Part of his personal development was recognizing that when working as a group, other team members still had their own lenses as place. In a way, healthcare practitioners have learned to coexist with corporate priorities that don't necessarily fit in a conglomeration of care sites. Hospitals required doctors to provide them to clients (patients). Physicians tend to have a "clinical competence gap" with healthcare managers. For their part, executives also argue that physicians clearly do not grasp the complexities of healthcare as a company. The complexities of today's world require an immediate need for clinical and strategic stakeholders to build better awareness. A significant factor in why very different ways of thinking have led to difficulties in understanding each other is the parallel development of physician education, nursing education, and hospital administrator training [43]. Leaders ought to closely examine who serves in the organization, what the organization provides for working environments, and how these two communicate with motivational influences to improve or hinder the purpose of the organization. Leaders will do a great job at making our companies thrive by knowing what makes us tick. The leaders in medicine need to be scientifically informed and professionally competent but we still need to be people wise. People are the most significant ingredient in the success of an organization [44]. The value of the healthcare professions lies in their capacity to support patient best interests, relating to health providers, and communities. In our best, health providers make choices about finding resources, scheduling testing, administering care, and offering service by putting patient and public’s best interests first. Health care practitioner’s priorities fall in second place. Only if we stay

firm to this ethical mission can medicine and other health care careers remain secure as confucius said, “Those who seek the good of others have already secured their own”. If patients and the public believe that we care more for our own interests than theirs and that we use them merely as a means of getting what we want, then we cease to be true professionals, becoming mere despots. You can't believe people who use others as weapons. Feeling close to those who treat others as stepping blocks to their own prosperity is difficult. The best way to protect any profession's long-term survival is by ensuring it makes meaningful contributions to those it represents. Our moral integrity starts to crumble the moment we begin to think of ourselves as the rulers of all we work to support. When we negotiate deals with hospitals, pharmaceutical providers, and government, we find ourselves putting our own needs first. We cease to be self-regulating people committed to higher ends, being instead what Plato called "merely money-makers," whose public values were subverted by private vice [44]. If healthcare is to thrive in the coming years, we need to make sure we never encourage ourselves to secure our own profits and feel happy trumping the interests of patients and communities. An entitlement attitude is anathema. First we have to worry of what we will give, not what everyone else owes us. Far from strengthening our security, our incarceration, even the entombment, will be a siege mindset. We work to make a difference for those who depend on us in their lives [44]. Over the last few years, some health systems have progressed towards an income-based incentive structure that provides a closer link between producing healthcare revenue and rewards, rewarding individuals who raise more revenue. Such compensation schemes are deserving of close inspection, particularly from an academic viewpoint. Supporters of hiring health care practitioners on the basis of discretionary profits create many rationales. First, if the most income-generating individuals aren't paid for it, we will get unhappy. Second, supplying individuals whose performance standards are somewhat different with the same rewards can create a sense of injustice. Third, once we know that even though we earn less therapeutic income, we'll be paid the same way; our productivity will begin to decrease over time. Finally, presenting us with a financial opportunity to produce more income will drive us to work ever harder, enhancing both the company and its workers' financial bottom line. Yet some critical questions must be posed to us by leaders. The first relates to the relationship between work effort and profits. Is there any clear proof that the individuals who earn the most profits actually work the hardest? The reply to this question is in many cases strongly in doubt. A general pediatrician and a neuroradiology’s can work similar hours with similar intensity levels, but produce very different revenue amounts. Even if we work as hard as peers in other environments, doctors operating in situations with bad payer blends or reduced collection rates may produce less revenue. And there's the consistency problem. Practices that increase income will compromise the standard of treatment by pushing us to work more efficiently than we can. Another question addresses the topic of funding nonclinical operations. If the criterion for measuring payments is medicinal revenue, what will happen to non-clinical operations such as education, testing, and service? A funding scheme that precipitates an elimination of these research projects will be catastrophic in terms of the nation's long-term healthcare needs. Even if priority is to be extended to non-clinical research projects, payments cannot be focused solely on revenue. Teaching medical students creates less money than conducting medical procedures. To address such concerns, a more comprehensive productivity assessment system would need to be built that integrates performance measures other than revenue. But how can we measure teaching in such a way that criteria like student contact hours and teaching quality are commensurable? How could productivity of research be measured: submissions, publications, grant dollars? How could the contribution of each member to the service be measured? It is important that those who will live with the answers to such questions participate in the system’s development. In an effort to capture such disparate variables as commercial income, educational activity, testing activity and service operation in a single compensation scheme a new degree of complexity arises. How many hours of student contact or peer-reviewed publications worth an appendectomy? Such estimates can require several perspectives. At departmental level, an emergency department may represent a weak source of clinical income, and a misallocation of resources could seem to be spending more money into emergency care. But from the point of view of the medical centre, the emergency room can be a crucial component of a wider and financially significant service line that involves neurosurgery and cardiology. Moreover, an emergency department physician who contributes relatively little to a department’s bottom line in terms of clinical revenue may nevertheless make superb contributions in medical student and resident teaching, or through departmental administration. A third issue relates to the context under which compensation programmers work. What would be the longer-term consequence of a decision to raise clinical revenue in the short term? If we cut the amount of time we spent in face-to-face conversation with patients and families, doctors could potentially get more work done and produce more clinical revenue. A hospital could profit financially in the short term from a strategy of reducing such conversations. However, such encounters can be crucial in developing patient-physician relationships, creating word of mouth referrals, and improving physician fulfillment over the long term. A fourth question: What part does compensation play in inspiring and motivating doctors? Is money the only thing we care about, really? If not, where does money rank as a source of motivation compared to others, such as the opportunity to improve patients' lives, the desire to continue to grow and develop personally and professionally, maintaining a high standard of living outside the workplace, the degree of community spirit in the workplace, the dignity in which employees are handled, the ability to play a part in corporate decision-making and our sense of success in our employment. Paying us more clearly won't actually change the standard or quantity of work we do, and cutting pay isn't

a guarantee that people will change the way we work. In attracting more attention to extrinsic incentives such as pay, there are two big drawbacks, which is just what a revenue-based compensation system appears to do. For one thing, people can tend to "cheat" the system, doing things that increase our pay but don't contribute to the organization's wider ends. For instance, physicians can start "cherry pick" work that most increases pay, and shun work that generates little income. Second, we are diverted from the intrinsic benefits of the job itself by concentrating on extrinsic rewards. If extrinsic incentives such as bonuses override inherent rewards, doctors cease to be medical practitioners and become merely money-makers. The less intrinsically exciting, rewarding and fulfilling we make our work, the more necessary it becomes to bait people to do it by means of extrinsic rewards. The more interesting and daunting it is, and the more possibilities it presents for professional discernment and personal development, the more risky it becomes to try and exploit professional conduct by extrinsic recompenses. Is medicine an area of intrinsic reward, or not? Do physicians should advise premedical students to consider joining the profession only if their main concern is income or can we point to other facets of medicine that make it rewarding? The passion for revenue based pay schemes allows university officials, rather than negotiating for them, to do things to our faculty. Such structures tend to accentuate power disparities, build competition and rivalry within an organization rather than promote a sense of team spirit and cooperation. If we really want our companies to increase the quality of service, we should look for ways to help our colleagues become better physicians. There is no doubt that unequal pay schemes pose a challenge to organizations involved in health care. Few circumstances can more readily erode satisfaction and loyalty. However, tinkering with the incentive system is generally neither the most efficient nor the best means of enhancing the efficiency of an organization. If a degree of revenue-based pay is expected, leaders should consider basing it on the segment, department, or school level and not simply on the individual basis. Otherwise people may be actively hostile to each other and the organization of which they belong may disintegrate. It's important that leaders keep clinical profits from undermining the other things doctors need to think about [44]. The leaders of medicine need to understand how much their success depends on the quality of the science that we support. We face immense challenges including infectious diseases, cancer, dementia and trauma. To stop advancing means slipping further and further behind. By comparison, one of the best ways to encourage patient safety and ensure fruitful and satisfying careers for ourselves and our colleagues is to take a leadership role in the study. It is important that future leaders maintain and increase the research commitment of the medicine. But simply having more research funds or giving physician-scholars more academic time won't get the job done. Science isn't just the result of how much time or money we devote to it. Best research demands something more, something which in the human psyche speaks to a deeper desire. We need to deepen our grasp of this deep desire. The more we understand the essence of curiosity, the more we will be prepared to develop professions, departments and disciplines that deliver a chance to have this passion completely involved. Medicine is first and foremost a human science and art, and we need to make sure that the people we train to practice it will rely on the full spectrum of human learning. They don't need to be the most experienced individuals in any single field, but they should be among the most liberally trained and well-rounded of all professions, with the highest dedication to public service. The broader and deeper the acetones in academic medicine, the greater the diversity of the faculty that will be drawn to them and the better the level of interdisciplinary dialogue and collaboration that will arise from them.

Academic researchers and medical schools are excellent at exchanging expertise in many ways. Teaching, which inevitably includes the exchange of expertise, constitutes a key interest among many academic doctors. Equally, the quality of science is measured in terms of public meetings and reviews. In clinical medicine the exchange of knowledge is facilitated through both teaching and research. And the actual exchange of knowledge does not consist of a single information transfer. In pursuit of a deeper understanding, it includes giving and taking thoughts, rational reasoning, and constructive teamwork. It's real exchange of information that universities can be all for. Indeed, some aspects of clinical medicine prohibit the exchange of knowledge. Achievement appears to be established at the individual level, beginning with the earliest years of premedical education. They have to compete with each other for academic acceptance and residency places until they enroll in medical school. Upon preparation, academic physicists are generally recruited, encouraged and personally compensated. Medicine applies a heavy evaluative tendency against academic competence to the emphasis on human achievement. People are mainly awarded for the presentation of what they know, and we prefer to assume that the best doctoral students, house officers and faculty members are the ones who know the most. Where doctors and medical organizations struggle to adequately exchange expertise, all groups perform below their capacity. This causes everything a department does, from research, patient care, and service to teaching. Only by re-examining academic medical institutions, considering the importance of information exchange, can we reach the degree of competence that is possible in actual learning and practicing communities [45]. The delivery of safe, high-quality medical care relies on health practitioners' expertise, decisions, and judgments, often operating in teams. Nurses are increasingly leading and shouldering responsibility for making clinical decisions. Both nurses and health care professionals are responsible for their acts and acts are founded on choices, whether knowingly or unconsciously they make those decisions. Ultimately, someone needs to take the lead in making a decision on a problem to avoid incidents from haphazardly following their path. Excluding the ability of health professionals to make clinical decisions, the standard of treatment that occurs can be uncertain. Not only are ethical considerations that affect health professionals'

decisions, but choices in the area of nursing and healthcare are also linked to various concerns, desires, challenges and future considerations. Marquis and Huston relate decision making to problem solving and critical reasoning (describing them as the 'critical triad'), emphasizing the significance of clinical practitioners' decision-making. It does matter in healthcare which path people take and which decision they make. In order to finish something, fix something or make up one's mind on something, decisions are made to decide an outcome. The word 'decision' in the Latin source, decision, means 'to cut down.' Thus decision-making should cut off the ambient confusion to allow one to see a path to a goal that can be pursued with all of its consequences. Rider Ellis and Love-Hartley describe a decision as a structured logical method in which healthcare practitioners ought to evaluate alternatives, analysed those alternatives and come to a conclusion. More recently, decision-making has been identified as the crux of patient-centered care, with Shared Decision Making (SDM) being the mechanism by which a patient and the health care provider make mutual health related decisions based on the best information available. There was, however, a propensity to perceive SDM mainly as making care decisions. A wider conceptualization of SDM, whereby patients and health providers collectively play an active role in patient health decisions, can be extended to a variety of decision making processes, such as the patient's contribution to defining and articulating the complexity of their issue, the management of care, and the way care is delivered. The decision-making process is 'the mechanism by which a healthcare leader can create and choose a course of action from a group of alternatives.' Thus, a decision can lead to a particular action or refrain from action, based on the situation in which individuals are generally seen in terms of the decision-making capability of the individual, making the big call, deciding a course of action or a plan. The broad decisions made by leaders or CEOs are critical in the face of the development of a nation or the performance of a company. However, the choices the health professionals make every day, every hour or every minute are as large for the individuals they influence in the scheme of people's lives. The argument here is that health practitioners who are in some doubt about their leadership ability should only count the amount and influence of the countless decisions taken every day to obtain an insight into their position as leaders. Barriers to the involvement of nurses and health practitioners in decision-making can be addressed and approaches implemented so that nurses and other professionally oriented health workers can be actively engaged in decision-making that impacts both patients and the work community. Globally, the value of reforming the education of nurses, physicians and public health professionals to establish a mutual mission and collective approach that reaches beyond the boundaries of national borders and the silos of particular careers is continually emphasized. Transformative learning requires a paradigm change from empirical memorization to knowledge discovery, interpretation and synthesis of information for decision making [46].

Discussion

Consideration of clinical leadership to some degree means commitment to one's power: to yourself, to your ideals and beliefs. Health leadership factors such as inspiration, dispute solving, professional decision-making, creativity, and progress management suggest a desire for the individual to obtain strategic experience and an understanding of their own ideals, convictions, capabilities and shortcomings. Teamwork, though, is linked to the influence of many: the willingness of the leader to understand the abilities and shortcomings of others around them, and also realize that team members do not have to have all the expertise that make a team successful. However, a leader should know how to create, build or sustain successful teams, particularly interdisciplinary teams, so that the team can help and bring about progress and encourage quality improvements. In current healthcare settings, an effective organization consists of integrated teams in which individuals combine their expertise, abilities and experience in order to solve difficult challenges and pursue innovative solutions. Successful teams should establish a common goal and a shared vision, such that they can quickly conquer the obstacles they encounter, resulting in consistently high-quality results. Teamwork encourages and recognizes a sense of mutual duty. A variety of healthcare providers with similar expertise and shared interests and the use of a collaborative method to assess, prepare and analysed patient care are needed for a healthcare team to work efficiently. This can only be done by teamwork, interdependent working, efficient communication and joint decision-making among team members (including clients. This approach to healthcare teams can contribute to improved outcomes and bring value to operational and staff-related performance [47].

Conclusion

Our medical system is facing several new challenges which require substantial health reforms. We need to make greater effort to build a new generation of skilled and successful medical leaders. In doing so, our health ministries must understand the value of educating experienced medical leaders at all levels of their healthcare structures: the patient, the doctor, the executive and the official of the government. Having already seen a number of encouraging interventions relating to the introduction of medical leadership, we must intensify our efforts to resolve a range of fundamental problems that remain very present within the public health system. There are several imminent steps that can be envisaged to give healthcare a more comprehensive and solidly driven framework. Among the different ways of enhancing national medical leadership, the following recommendations must be followed: (a providing increased recognition to health professionals in leadership roles, (b providing higher wages and greater rewards to inspire potential medical practitioners to be geared towards careers in health-related management, (c selecting more medical students with the capacity to become leaders, (d prioritizing the filling of healthcare leadership positions by managers

with a solid clinical background. Good healthcare leadership ultimately relies on the understanding of the essential role played by all levels of health care staff involved in the operation of a hospital. Therefore, a large and skilled management and leadership workforce is needed to navigate the sector across the dynamic network of overlapping factors and drive initiatives to deliver successful and productive health care.

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