LEADERSHIP IN THE PRIVATE MEDICAL CLINIC

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Abstract: *The study refers to the current preoccupation to develop the management of private medical system. The business and medical performance depends on leadership. The leadership theories (theory of traits, behavioural, situational theories, transactional and transformational model of leadership) and their applications in the private clinic are analyzed.*
Also, the study includes references to several current problems from the practice of private clinic (setting objectives, personnel motivation, control activity, etc.).
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1. Introduction

As an answer to the modernization need of the medical system, the reformist current appeared predominantly from the beginning of the year 2000 in the Romanian medicine, which launched the principle idea that the management in medical system must be developed. The first clear tendency

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was the *obligation that physicians and other sanitary personnel categories with management positions train in the management field* and become "much better managers". Forms of management training have been established (Avram, Ciurea, Săceleanu, 2015).

In the medical structures, leaders are first of all physicians with management positions, with clinical and administrative activities (medical director, head of department). The other physicians have clinical management attributions and also organization and management competences of operations, activities, having under subordination the body of nurses, healthcare assistants. Physicians are leaders even in the relation with the patient because they establish objectives and organize actions necessary for the patient disease management in order to obtain results.

Management developed a new managerial thinking conception in the organizations from the private medical system: business development is correlated with the development of competences. The following are taken into account in this system: careful selection of personnel, facilitation of organization mission understanding, awareness increase of important, priority things. Leaders are invested with competence authority in the private medical unit, but they aim to develop personnel team spirit, flexibility and enthusiasm, aspects which animate the workplace behaviour. In this environment, quality, performance, excellence are central concepts which imply effort and also satisfactions.

In the hospital, the leader must face the pressure, overcome the fear of failure, stress and pressure of circumstances and find ways to help others overcome obstacles. Therefore, the context in which the medical leader works is not perfectly predictable. In order to increase stability and face events, the medical leader must perform a series of activities:

- establish a series of objectives;
- define a set of important values or things;
- support the resolution of current problems;
- be active in risk management;
- apply practices of personnel motivation;
- focus on what is achievable, possible;
- take part in the development of employee abilities;
- establish priorities (LePine et al., 2016).

In a desirable way, leaders have the capacity to create an organizational environment in which employees achieve performance in agreement with standards, understand the over-ordered objectives (Breevaart et al., 2016).

Major interest subjects for the management of organizations are located at the forefront of current studies. There are analyzed: the leader capacity to serve the community or organization, being focused on growth and not on his/her power statute (servant leadership) (Neubert et al., 2016), leader capacity to manage the change of organization to better (Nohe&Michaelis, 2016), leader capacity to make correct decisions (Heyler, et al., 2016; Zeni et al., 2016), ethical leadership aspects (Chen, & Hou, 2016), leader collaboration with the group (Bøggild&Laustsen, 2016), leader authenticity (Banks et al., 2016), emotional aspects involved in the leadership activity (Manz et al., 2016). The concepts of good leadership remain relevant (Meyer et al., 2016), but also that of destructive leader (Aasland et al., 2010).

2. Leadership models – applications in private medical units

According to the ***personal or traits model***, leaders are more competent, talented to lead if they have personality traits or abilities, resulted from personal equipment for leadership. From the practical point of view, it would result that the candidates who know to lead, who have talent for leadership, must be identified and brought into the organization. Among the personality traits invoked, we mention: initiative, scrupulosity, extroversion, persistence in actions, behavioural flexibility, capacity to influence people, etc.

The applicative procedure is the following: analyze the categories of personality traits which have a role in the activity of the medical-sanitary personnel; extract from literature the traits necessary for the efficiency of sanitary leaders. Introduce these criteria in the professional selection activity.

According to ***the functional model,*** *the efficiency of leaders depends on the way in which they fulfil certain functions.* These functions have as consequence the results in situations, contexts specific to work. Also, they aim the interaction of the leader with the personnel for specific objectives. The functions can be: decision, collection of information, information analysis, settlement of problematic situations, management of collaboration and communication, initiative, supervision, etc.). From the perspective of this model, the leadership competences can be learned, developed and improved. A

special attention is given to the efficient training of leaders by training processes (Mintzberg, 1973).

The applicative procedure is as follows: establish the list of functions and definitions of functions of physicians with leadership role; for each function discuss the best and most unproductive practices; analyze the opportunity to elaborate activity procedures and opportunity to prepare the management personnel from their perspective.

The model of behavioural categories and leadership styles evaluates the leader efficiency from the perspective of concrete behaviours (behavioural anchors) or groups of behaviours in work situations. The leader efficiency is the result of his/her behaviours and resides in the level of group productivity, absenteeism, personnel fluctuation or morale of employees. The behaviours can be organized in structures such as:

- behaviour in relation with employees (*consideration*: treatment with respect, confidence, preoccupation, warmth, support and appreciation, participation of group members to decision making, encouragement of two-way communication),
- behaviour in the organization activity – *structuring initiative* – extent to which the leader defines and structures the interactions of employees and organizes the activities for achieving the formal purposes (definition of the role of each member, distribution of tasks, planning, establishing action procedures, etc.).

A series of moderating aspects appear in the manifestation of leader behaviours. These refer to the subordinates (experience of employees), to the leader (his/her influence on higher hierarchical levels), to the task (stressful nature of task or task context), to the group nature (depending on the field of activity, for example organization is more important in emergency services and it is necessary the initiative of stronger structuring) and others.

The applicative procedure is the following:

1. identify in circles of discussions and write down which are the aspects which the employees appreciate the most at their superiors; communicate these aspects to leaders and introduce these indicators in the evaluation of management personnel;

2. analyze with the leaders the organizational problems and standard procedures which are necessary so that each leader performs the most efficient

administration-organization operations; train new leaders in training programs in order to know the most efficient work procedures.

The situational models and the contingent model take into account the analysis of situational factors in leadership equation (Hersey & Blanchard, 1993)[15]. The primary situational model of leadership claims that

(a) people with different personalities impose themselves as efficient leaders in different situations,

(b) a person becomes leader in a particular situation because he/she is the most adequate to that situation,

(c) leadership does not reside in person, but it is a function of situation and certain types of interactions,

(d) the leader does not produce leadership, but it is the instrumental factor by whom the solution is obtained;

(e) the situation is the one which allows or not a certain mental, psycho-social, cultural, etc. trait to manifest itself as a leader trait.

The applicative procedure is as follows: establish a list of leader physicians; for each leader, analyze the situations in which they are very efficient; analyze the factors which contribute to the differences between them, elaborate action procedures which stabilize the efficient action patterns of leaders in work situations that require higher efficiency.

The situational interactionist (mixed) model or contingent model is based on Fiedler's ideas (1967). This aims to understand and harmonize the multi-varied relations between organization components. The efficiency is established empirically according to the principle: establish the context in which, when this leadership practice is efficient. The undertaking implies the particularization of corresponding efficient situations and behaviours, which would require the operationalization effort of the leader model.

It is showed that the leadership efficiency "depends on", it is "dependent on" at least 3 aspects of leadership activity:

- power position of leaders – persuasion capacity, capacity to generate objectives and obtain results from employees by virtue of the fact that they listen to their leader.
- task structure – clarity of objectives, predictability, organization of actions (the tasks are more or less structured).
- leader-subordinate relations, which can vary as good-bad continuum.

Different work situations and the necessity to approach the activity with certain behaviours result from the combination of these aspects. For example, if superior-subordinate relations are good, but the tasks are not structured, it is necessary to moderately manifest power. If the relations are bad and the tasks are not structured, it is necessary the manifestation of leader power.

The applicative procedure is the following: make a list of situations with 3 importance categories (high, average, current); list in each column the tasks/responsibilities necessary to be fulfilled by employees; estimate the power, task structuring and superior-subordinate relations; mention the actions which the physician must take in order to be efficient in the given situation and in the situation of deviations from the standard action.

The transactional model *stipulates that* transactions, social exchanges between leaders and subordinates are very important in the leadership action. These transactions lead to influence and counter-influence processes. The leaders and subordinates interact, the first having to act so as to satisfy the necessities of the latter (rewards, appreciation) in return of compliance to norms and expected or negotiated levels of work performance. The studies proved how important are the interaction and immediate and balanced feedback in order for the leadership transactions to be really efficient (Kluger & DeNisi, 1996).

Applicative procedure: analyze which are the transactions that you make in relations with employees – what do you ask them and what you offer in order to help them work and to motivate them.

Transformational leadership became a considerable interest concept for the leadership theory and practice (Bass, 1998; Avolio and Bass, 1994; Avolio & Bass, 2004) found that when managers from all levels, from all over the world, were requested to describe the characteristics and behaviours of the most efficient leaders with whom they worked in the past, these descriptions included more elements than simple attempts to reward the effort and corrective orientation. Thus, the leaders who had the highest influence were described as leaders who not only maintain the system but they also transform it. They are transformational leaders, namely they inspire, stimulate from intellectual point of view, challenge, they are visionary, they are oriented to their development and that of persons around them and who are decided to maximize performance.

The transformational leader encourages others to develop and obtain higher performance than the standard one. This effect appears not only by encouragement, but also by personal example of supported effort, by sacrifice model in reaching objectives (Jung, Chow & Wu, 2003). In this way, subordinates become more attached to the organization and identify much more with its purposes and mission. The motivational level is increased by personal identification with the mission, self-efficiency is increased and the availability of employees to accept challenges is higher.

The transformational leader can motivate employees to do more than they initially thought it would be possible. The employees discover that they can do more when they are led by an inspirational leader. The perceptions of employees on their performance capacity (self-efficiency), their self-confidence, perception on their own development potential are improved in time (Howell & Avolio, 1993).

The transformational leadership finally establishes consciously or sometimes unconsciously humanistic purposes and objectives, which lead to the development of other persons, transforming them in leaders in time or laying the bases of collective leadership groups, as it is the case of self-led teams (Avolio, Bass & Jung, 1996).

Application: medical managers can consult the literature about leadership and can modernize their own leadership style in order to develop modern activities, visions, approaches in the private medical system.

3. Several dilemmas and solutions in clinic management

The personnel with management position solve a series of management problems in the private clinic. Some of them can be considered dilemmas (Pleş, 2015).

Planning dilemma: leaders should plan objectives, policies, programs, budgets (a) in a clinical environment characterized by instability and emergency, (b) in a medical system in which legal and budgetary modifications are often. The solutions involve:

a. general planning and training to approach urgent or changing situations,

b. remaking action plans,

3. training/information of personnel on potential changes and course of events.

Another dilemma refers to the relation with the patient: physicians can plan the treatment, can make predictions but the condition of the patient can be endangered due to aspects related to the patient: unfavourable life conditions, traumatic events, low compliance. These potential risks can be communicated to the patient and his/her family.

The organization dilemma results from apparent unbalances between organization principles. Labour and responsibility distribution at individual level is absolutely necessary but there are situations in which it is necessary to intervene in order to give support in tasks for which other employees are responsible. The solution is to define clear principles of organizational civism (definition of situations in which responsibility belongs to everyone). The grouping of labour activities, definition and authority delegation are taken into account. The individual distribution of easy versus complex tasks raises the problem of procedural equity of treatment: some consider that they received the most difficult or unpleasant tasks or in other situations the tasks which are too simple (non-stimulative). The solutions involve the approach of three systems of task distribution, each with certain adjustment:

1. the superior distributes the tasks (advantage: equity, without conflicts, disadvantage: capitalization of capacity and preferences of some persons and undercapitalization of other persons),
2. the physician lets the team distribute its tasks (the principle of "rotation" applies for less agreeable tasks, disadvantage: not all persons can agree),
3. the ad hoc distribution is allowed (advantage: the problems are solved on the way depending on the person who is available, disadvantage: the older subordinates assume the responsibility of preferred tasks and distribute the less preferred ones to the younger ones, this leads to inequity). The general solution is that the leader distributes objectives and verifies the mode of distribution of tasks between team members, but also the quality of results. This approach is perceived as just, fair and correct.

Dilemma of investment in human resources is a dilemma concerning the investment in people: if we invest in personnel training, there is the risk that the good ones leave some day; if we do not invest in people, the performance will be low. The solution is the management of personnel retention, the investigation of employee attitudes and finding motivating solutions to keep them within the structure.

Authority dilemma – authoritative leadership decreases the morale of employees, but maintains the performance level in a dynamic and unpredictable clinical environment. Leading the clinical activity depends on the capacity to be focused on the task in important and urgent actions (setting objectives, their achievement and evaluation) as well as on the personnel (the democratic style is applicable depending on context).

Quality dilemma. The physician's responsibility for performance and potential errors of subordinated personnel is stipulated in the medical system. What is more important: not to have errors or to have a high quality? The solution of these dilemmas is ensured by the management of personnel professional training and quality management (listing quality criteria for each task and evaluation of their fulfilment).

Coordination dilemma: each person must reach his/her objectives, but he/she cannot ignore the whole, namely the assembly of other's objectives. You cannot say that you completed your task, but you must ensure the activity continuity. The patient does not belong to a certain physician, but to the entire hospital. The personal responsibility in the relation with the patient is not completed after the end of the collaboration with him/her. The doctrine *each person must do his/her job as better as possible* leads to individualism and must be balanced with a doctrine that makes people become aware of general objectives. The solution is given by driving coordination skills (in trainings), processes of socialization and professional experience sharing, experience exchange. When the employees collaborate, when they know each other and when they know what their colleagues are doing, what the problems they are facing with are, they better coordinate their efforts with the others, adhere to organizational solidarity, support, understanding and reciprocity.

The control dilemma consists in the following:

1. frequent control (denotes mistrust in employees) or rare control (leads to the creation of a high degree of liberty which can be inadequate to performance),
2. intuitive control (it is quick, global, but it does not help the orientation of performance increase, because it does not provide details) or detailed control (according to a grid – it shows on details what is good and what is not good, but it increases the stress and demobilizes when the standard is not reached),
3. unique control (one superior verifies the results, advantage: the uniformization of the performance criteria, disadvantage: some feel

less appreciated than others who "are preferred by the superior") or multiple control (more superiors carry out verifications, advantage: it increases the equity, disadvantage: it increases diversity, each has some particular standards of "good practice"),

4. feedback focused on the identification of deviations or mainly appreciative feedback (the physician shows and praises the success)?, informative or formative feedback (the physician shows the deficiencies, deviations from the standard and indicates remedies)?

The settlement of these moral dilemmas can be carried out by: informational training from employment of medical care personnel (to know from the beginning that multiple hierarchy implies different work styles), investigation of the best verification and feedback practices (appreciations, but also observations and guidance are issued at the visit and evening visit), elaboration of clear specifications concerning the performance expectations and situational mentions (when some criteria are modified depending on the case).

Dilemma of personnel motivation: we determine the personnel to work better by means of specialized guidance, sanction for inadequate fulfilment of tasks or by other stimulating means (personal model, management of objectives, stimulation of ambition to performance, etc.)? The system of rules must be active. The errors cannot be tolerated in the medical system because they can endanger the patient life. The positive motivation actions must be active in order to maintain personnel in the scheme and necessary activism (Pleş, 2015)[(22)].

Conclusions

Nowadays, in the modern clinics, the management principles are transposed in complex practices and methodologies which aim at the scientific management of organization resources, activities. There is intense concern for development, performance. A special emphasis is laid not only on interventions in case of crisis or problematic situations, but also on interventions for organizational and managerial development, processes which are initiated exactly in the conditions in which the organization is efficient, prosperous. In order for these interventions to take place, it is necessary that the people responsible for the medical organizations should be involved in structuring strategies, in elaborating concrete management projects and programs, in defining organization and personnel efficiency criteria. The development of

managerial capacities of superiors from the medical field is a necessity and it is in the same time a very important direction of management modernization in the system. This modernization implies the collaboration with other specialists in the organizational development processes and, on the other hand, implies the contribution of existing managers (Avram, Ciurea, Săceleanu, 2015).

The future challenge for the managers of private medical system is to understand the fundamental truth concerning the business development in correlation with personnel development: the development and maintenance of a welfare factor at the workplace in the actual economy do not only depend on the objective (increase of profit), but also on the personnel capacity to achieve performance. In order for the personnel to collaborate with the private clinic and in order for the results to be very good in medical operations, it is necessary a well-structured policy of personnel selection, motivation and training.

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