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LAMP: Leadership, Advocate, Management, Professional—a new simple and dynamic medical management competency model for doctors

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Abstract

Hospitals are complex organisations. Hospital managers have to deal with this complexity, and this management requires a focus on the competencies that managers need in order to be effective. Attention has been given to the development of management competencies, including medical management competencies, but the development of doctors' competencies in their roles in managing hospitals remains an under-researched area. This paper reviews the current literature from Australia, the United States and the United Kingdom and proposes a simple and dynamic medical management competency model for doctors based on existing competency frameworks. This LAMP model has four major competency domains: Leader, Advocate, Manager and Professional. This model shows these four competency domains to be in constant, dynamic tension with each other. This new competency framework opens up a new area for research in relation to theories relating to possible competing tensions between medical management competencies for doctors, and can be used as a framework for medical management training, development and practice.

Keywords: Health management, medical management, hospital management, competency models, doctors in management

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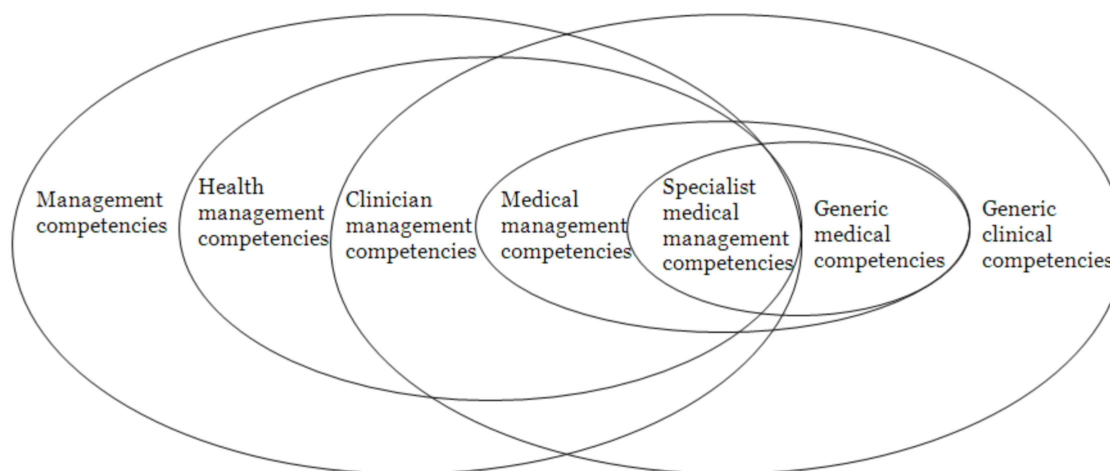
Introduction

'Competencies' are the underlying characteristics of an individual that are causally related to performance in a job or situation (Spencer & Spencer 1993). Managers bring attitude, skills and competencies to the role and by competencies we are referring to the attributes tied to performance of their role as managers. As hospitals become more complex, hospital managers need both generic and specific competencies in order to be effective (Kovner & Rundall 2006). Similarly, doctors who work in health management also need such competencies (Clark & Armit 2010). However, the development of generic management competencies (Dimmock et al. 2003; Pilling & Slattery 2004) and specific medical management competencies (Davies 2006) for doctors is under-researched (Dwyer 2010). Generic management competencies are management competencies that can be applied in any industry or setting (Lussier 2006; Mintzberg 1998; Dimmock et al. 2003; May 1999; Randlesome 2000; Sudsakorn & Swierczek 2009; Viitala 2005). In contrast, generic clinical competencies are those competencies that are required by clinicians (Craig 2006; Magobe et al. 2010). Of these, the technical competencies required by doctors that are not related to management can be called generic medical competencies (Frenk et al. 2010; Offenbeek 2004).

Doctor's clinical competencies overlap with generic management competencies, as Figure 1 demonstrates. In broad terms, management competencies, such as communication, overlap with generic clinical competencies. This overlap occurs when clinicians like doctors or physiotherapists get promoted and start to manage other clinicians, while maintaining a clinical workload. Such competencies are called *clinician management competencies* (Braithwaite 2004; Fulop & Day 2010). Clinical directors are an example of doctors who are clinician managers (Degeling et al. 2003). Health management competencies can be viewed as a subset of management competencies. In turn, clinical management competencies are a subset of health management competencies. Medical management competencies, specific to doctors, are a subset of clinical management competencies, and specialist medical

management competencies a subset of general medical management competencies. Together with generic medical competencies, these medical competencies are part of clinical competencies.

Figure 1 **Conceptual diagram of management competency relationships**



Note: Management competencies overlap with clinical competencies, leading to a common area encompassing clinician management competencies, with its subsets (including the doctor-specific management ones).
Source: developed for this article.

Literature review

The main subject areas for the literature review were identified and a search strategy based on them was developed to look for medical management competency models. The following databases were searched: Proquest health and medical complete (including access to MEDLINE) and Proquest (including medicine, business and law journals). Abstracts were appraised to identify relevant search terms, and full articles were reviewed if such search terms were identified. Publications from local and international medical specialty colleges and organisations were also reviewed. Generic and medical management competency models were compared and a new model was developed from the literature review.

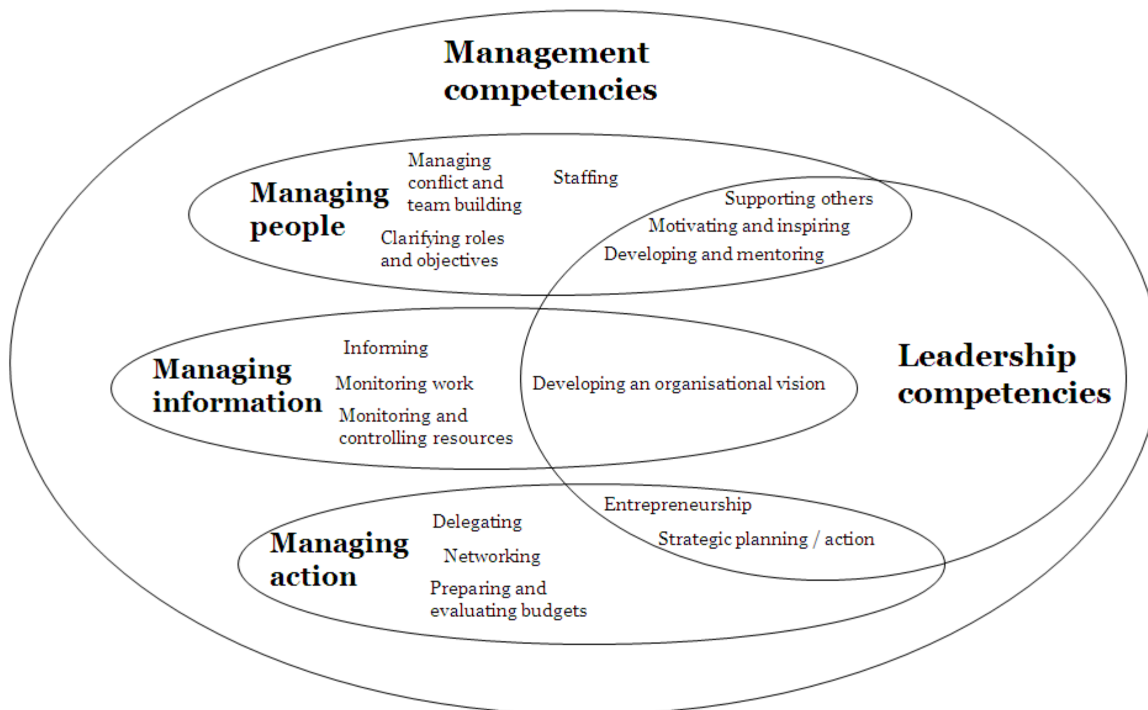
Generic management competency models. Management can be seen as the performance of the manager and the range of outcomes related to that performance (Drucker 1973). Management is also a set of processes that can keep a complicated system of people and technology running (Kotter 1996). These functions can be condensed into four basic ones: planning, organising, leading and controlling (Kotter 1990; Mintzberg 1998). There are also three foci of managing: managing information, managing through people and managing action (Mintzberg 1998). Often deemed to be different from management, leadership is inspirational, visionary, helping others to achieve a common vision (Fagiano 1997; Mintzberg 2004). In general, managers maintain the stability of the organisation, while leaders adapt the organisation in response to changes in the external environment (Kotter 1990; Bennis 1998). Leadership can be defined as a set of processes that creates organisations in the first place or adapts them to changing circumstances (Kotter 1996).

However, distinctions between leadership and management such as these are becoming somewhat artificial (Mintzberg 2009) and even arbitrary (Yukl 1998). One of the bases of the distinction is conditions of stability for management (for example, during times of consolidation or steady growth) as opposed to conditions of change for leadership (Millett 1998). However, this distinction may not be relevant in turbulent conditions (Carlopio et al. 1997). As a result, managers must be able to lead in conditions that are always changing (Quinn et al. 1996). The ability of a manager to have leadership competencies in order to lead change during difficult circumstances is important (Karp 2006). Managers who are unable to lead are therefore deficient in one of the core functions of management and are, consequently, poor managers (Lewis 1996). Indeed, leadership is an integral aspect of management (Mintzberg 1973; Yukl 1998; Carlopio et al. 1997) and leadership of organisational change is a crucial task of management (Higgs & Rowland 2005).

Thus, leadership and management can be seen as complementary systems of action, with each having its own, albeit sometimes *overlapping*, function and characteristic activities (Kotter 2001). For the purposes of this article, leadership is viewed as *the* core component of

management (Kotter 1990; Mintzberg 1998). This coreness is shown diagrammatically in the generic management competency model in Figure 2, where certain management competencies are a part of leadership and vice versa. That is, the generic management competency model of this article includes leadership as the core component of management.

Figure 2 **Generic management competency model**

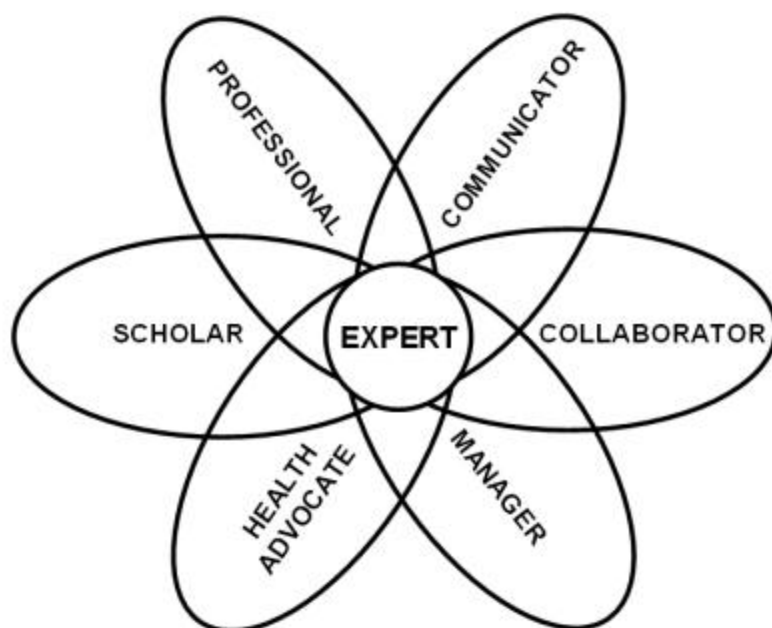


Source: developed for this article, adapted from Mintzberg (1998), using his three domains of managing people, information and action.

Generic medical competency model for doctors. Now consider doctors in particular. Generic domains of ability displayed by an effective doctor are a basis for the formation of core competencies for doctors (Epstein & Hundert 2002; Aretz 2003). Consequently, the doctor's CanMEDS framework of postgraduate medical training, based on generic medical competencies, has been developed (Frank 2004). CanMEDS competencies are: Medical Expert (the central role), Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional, as shown in Figure 3. The CanMEDS framework has been adopted by most

medical schools and medical specialty colleges around the world (Frank 2005). The CanMEDS framework, which is not specific to management but applicable to all doctors, includes Manager as a core competency. This placement suggests that competency in management is becoming just as important as other competencies for doctors.

Figure 3 **CanMEDS framework**

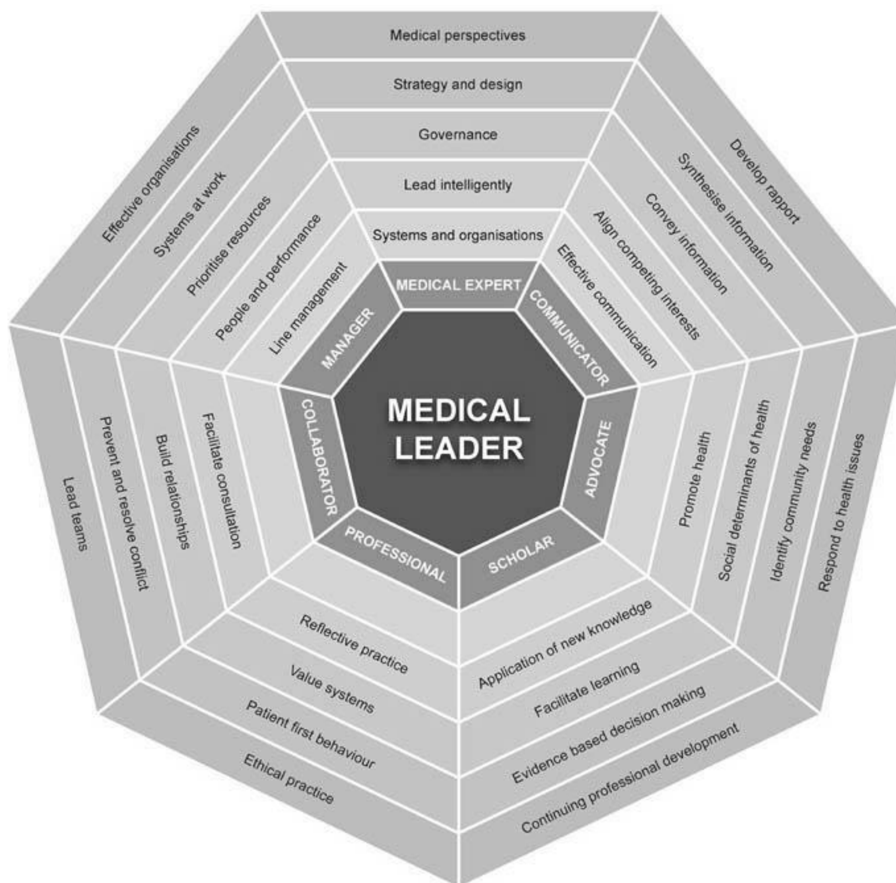


Source: Frank (2004, 2005).

Medical management competency models for doctors. In addition to generic medical competency frameworks like CanMEDS, there are medical management competency frameworks in Australia (RACMA 2010), the United States (ACPE 2011) and the United Kingdom (NHS 2011). These are all management competency frameworks that are specific for doctors. The Royal Australasian College of Medical Administrators (RACMA) is the official accredited body that trains medical administration medical specialists in Australia. It has a postgraduate medical training system based on a management competency framework, which is in turn based on the CanMEDS generic medical competencies (RACMA 2011). The seven RACMA competency domains are: Medical Leader (the central role), Medical Expert,

Communicator, Collaborator, Health Advocate, Manager, Scholar and Professional, as shown in Figure 4. The seven domains can be divided up into 21 competencies. The key addition to the CanMEDS model is the central leadership competency domain, which is seen as a core competency for specialist medical administrators.

Figure 4 **RACMA Medical Administration Management Competencies**



Source: RACMA (2011).

On the other hand, the United Kingdom model has been designed to be applicable to all doctors, with a focus on medical leadership. The National Health Service (NHS) in the United Kingdom, through the Institute for Innovation and Improvement, has developed a medical leadership competency framework (NHS 2011), as shown in Figure 5. This framework has the following competencies set out as actions: setting direction,

demonstrating personal qualities, working with others, managing services, and improving services, with a focus on delivering the service.

Figure 5 **NHS medical leadership competency framework**

Source: NHS (2011).

In contrast, the American health management competency model has been developed by the Healthcare Leadership Alliance (HLA) that was formed as a partnership between six of the major healthcare leadership professional associations in administration, nursing, and medicine (Garman & Johnson 2006). The American College of Physician Executives (ACPE), one of the members, is the medical specialty college for physician executives, specialists medical doctors in management (ACPE 2011). This model has five competency domains: communication and relationship management, professionalism, leadership, knowledge of the healthcare system, and business skills and knowledge (HLA 2011), as

shown in Figure 6. Like the RACMA model, it also has leadership as one of its competency domains.

Figure 6 **HLA competency domains**

Source: HLA (2011).

A new medical management model

An initial medical management competency model for doctors was developed based on the existing competency frameworks and synthesised from the current literature. The initial model begins with the three foci of management: managing information, managing through people and managing action (Mintzberg 1998) overlapping with leadership as shown in Figure 2. Figure 2 can therefore be divided up into two domains: Leader and Manager. However, the model shown in Figure 2 includes only generic management competencies, and there are specific competencies that are missing, such as ethics, clinical governance and

teamwork, as outlined in the existing medical management competency models for doctors examined. It is possible to add these missing medical management competencies into this initial model. These additional medical management competencies can be grouped into two domains: Professional and Advocate. Therefore, conceptually, we can group all the management competencies into two generic management domains: Leader, Manager and Communicator; and two medical management domains: Professional and Advocate. Table 1 demonstrates how these four proposed competency domains map to existing medical management competency models for doctors.

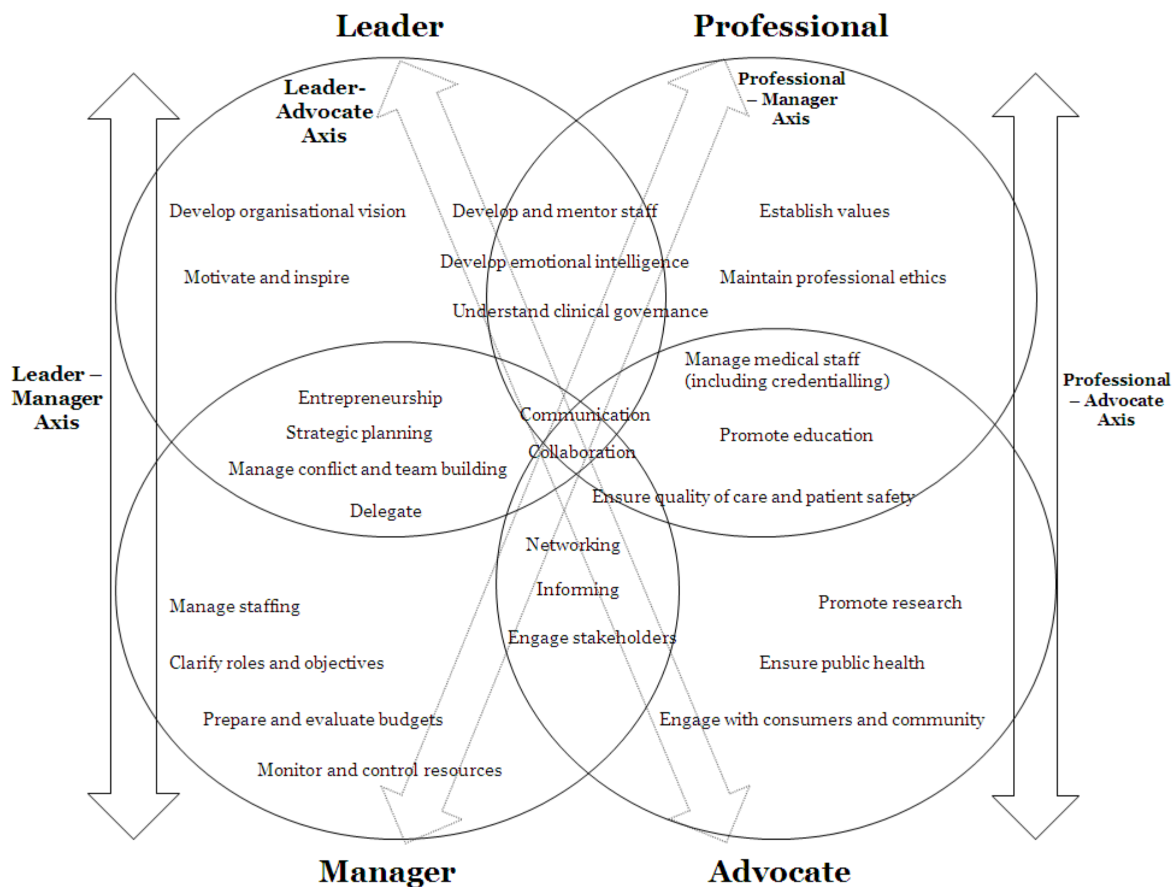
Table 1 **Proposed medical management competency domains mapped to existing medical management competency models for doctors**

Proposed management domains	**CanMEDS domains**	**RACMA domains**	**NHS domains**	**HLA domains**
Leader	Medical Expert Communicator Collaborator	Medical Leader Medical Expert Communicator Collaborator	Setting direction Working with others	Leadership Communication and relationship management
Manager	Manager	Manager	Managing services Delivering the service	Business skills and knowledge
Professional	Professional Scholar	Professional Scholar	Demonstrating personal qualities	Professionalism
Advocate	Health Advocate	Advocate	Improving services	Knowledge of the healthcare environment

Source: developed for this article.

The LAMP model. The proposed medical management competency model is the LAMP model, with four major competency domains of Leader, Advocate, Manager and Professional, as shown in Figure 7.

Figure 7 **Final LAMP medical management competency model**



Note: there are two vertical axes and two diagonal axes representing the tensions between the domains.
Source: developed for this article.

The first LAMP domain is *leadership*. The ability to lead and have others follow is a key competency for doctors in management roles that sits within the leadership domain (Degeling et al. 2003). Leadership in the medical context can be defined as the ability to influence peers

to act and enable clinical performance, provide peers with support and motivation, play a role in enacting organisational strategic direction, challenge processes and possess the ability to drive and implement the vision of delivering safety in healthcare (Edmonstone 2009; Cook & Leathard 2004; VHA 2009a; VQC 2005; VHA 2009b; ACSQH 2006).

Moreover, doctors, because of their training and experience, find it more palatable to be directed by another doctor than by someone outside their profession (Degeling et al. 2003). That is, leadership skills and competencies do not depend on a formal management position or role but flows from a doctor's ability to influence and change the behaviour of his colleagues (Degeling et al. 2003). A medical leader can therefore be seen as an expert clinician involved in providing direct clinical care who influences others to improve the care they provide (Cook & Leathard 2004). In addition, the transformational style of leadership has been found to be the most effective in hospital management (Xirasagar et al. 2005) - doctors are most influenced by hospital managers who adopt a transformational style of leadership (Davidson & Peck 2005).

Another LAMP domain is that of *manager*. Generic management competencies have been discussed already in this article and the ability to manage people, resources and systems is a fundamental competency for hospital managers. This domain includes competencies relating to financial management, human resource management, organisational governance and information management (HLA 2011).

The next competency domain in the LAMP model is *professionalism*. Two characteristics of a profession are uncertainty and complexity (Southon & Braithwaite 1998). The uncertainty relates to the inability to predict the outcome of a task, because each has its own characteristics. The complexity relates to the body of knowledge required to deal with specialty issues. Professions are provided with a monopoly over a particular area of specialty and expert knowledge, and with this comes autonomy in the form of self-regulation through

which professionalism is exhibited by the guarantee by the profession of integrity, altruism and service (Cruess et al. 2002).

Therefore, medical managers have a role to play as a member of the medical profession, to ensure that self-regulation systems are in place to provide safe patient care (Irvine 2004). The general public expects such systems to ensure patient safety from hospitals and hospital management structures (Irvine 2007). Thus, the medical hospital manager must exhibit professionalism, and also ensure that the medical peers and the hospital meet the same obligations in support of professional behaviour. A comprehensive system for credentialing, performance appraisals and management form part of this responsibility, and this system is an expectation by the community that must be met (Cruess et al. 2002).

A profession also includes its own set of professional values (Offerman et al. 2001). Hospital medical managers are required to model their own value set to their colleagues and others who are their followers, and this calls for authentic leadership (Gardner et al. 2005). Exhibiting values is an integral part of clinical leadership (Stewart & Mazza 2006). Personal integrity has been found to be an important quality for senior medical managers (NHS 2006). These values influence the way a medical hospital manager behaves and models (NHS 2009).

The final competency domain in this LAMP model is *advocacy*. The effective medical hospital manager is an effective advocate who can advance the quality and safety of health care through influence, innovation and improvement on behalf of patients. Because doctors are among the clinicians who deliver patient care, they are positioned to evaluate its quality and implement improvements through clinical governance (Kos & Kavanagh 2011). Clinical governance can be defined as a framework through which organisations are accountable for improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Scally & Donaldson 1998). Health leaders should adopt a total patient approach and continuously look for opportunities to improve the quality of care for patients (Meredith 2006).

Indeed, improving patient safety and quality relies on a healthy culture of openness and accountability, and this culture requires effective leadership on the part of the medical hospital manager (Reason 2000; Ojha 2005). An unhealthy culture reliant on a top-down approach leads to a reduction in error reporting and a decrease in quality of care (Edmonson 1996). Through effective advocacy by the medical hospital manager, local business process variation across clinical settings can be minimised down to a controlled range in order to standardise work practices for optimum quality of care (McNulty & Ferlie 2002). Medical hospital managers play an influential role as promoters and catalysts for major organisational change, and critical for their success (Fitzgerald et al. 2006; Pettigrew et al. 1992).

Two vertical axes and two diagonal axes can be added to the proposed medical management competency model, and are included in Figure 7. The first vertical axis connects the Leader domain to the Manager domain, and basically reflects the possible tension that exists between the leader competencies and the manager competencies. For example, the leader needs to operate at a strategic level while the manager needs to focus on operational issues instead. The second vertical axis connects the Professional domain to the Advocate domain, and reflects the tension between professional competencies and advocacy competencies. In other words, tension exists between the need to focus inwards on internal staff professional matters, and the need to focus outwards to address the needs of the consumer and community. For example, when a clinical error occurs, the hospital manager may need to balance the need to protect the professional staff against the need to protect patients.

Similarly, two diagonal axes were also added to the proposed medical management competency model of Figure 7. The first diagonal axis connects the Professional domain to the Manager domain, and reflects the tension that exists between the imperative to meet professional staff needs versus the need to manage resources for the organisation. For example, a hospital manager has to balance the need to meet the demands of the professional staff against the available funds that are available for the hospital. The second diagonal axis connects the Leader domain to the Advocate domain, and reflects the need for a hospital

manager to lead the organisation to achieve its vision against the need to consult with the community and ensure consumer needs are met.

Conclusion

The final medical management competency model from this article, distilled from the existing literature, is a new competency model that seeks to simplify existing frameworks. This new model uses the LAMP acronym to represent four competency domains expressed as roles – Leadership, Advocate, Manager and Professional – making it easy to remember. It is also unique in that it dynamically shows these four competency domains to be in constant tension with each other. This new competency framework opens up a new area for research in relation to theories relating to medical management competencies for doctors, and can be used as a framework for medical management training, development and practice.

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