

Research Article

Leadership Styles of Medical Professionals

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Abstract | Leadership is an obligatory inter-personal skill for executive positions and medical professionals are no exception. They play crucial roles in variety of scenarios including leading wards, camps, campaigns, open houses, seminars and symposiums as well as day-to-day bases dealing with clinical directors and managers. This research was conducted to study the leadership styles among the medical professionals. For this purpose, a cross sectional and non-probability convenient sampling was conducted involving 59 medical professionals of Azra Naheed Medical College, Lahore. The assessment of leadership-style (T-P leadership rating scale) was applied. The age of subjects was 37.42 ± 11.91 years; 29(49.15%) were males and 27(45.76%) were female whereas 3(5.1%) were undisclosed gender. The mean age of males was 41.28 ± 12.85 years and average age of females was 32.83 ± 9.03 years. A total of 36(61.02%) of participants were married and 17(28.81%) were unmarried whereas 6(10.2%) did not disclose their marital statuses. Regardless of the gender, age and character, no dominating leadership-style was identified among the medical professionals participated in this study, highlighting the need for leadership development in health professionals. This present a great challenge for health professionals to understand how their leadership behaviors affect the performance. Further research is required to provide more comparable evaluations in health sector leadership in diverse cohorts and the presented study provides the baseline to improve this feature in healthcare professionals.

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Introduction

Leadership is an obligatory on the part of those who worked in different executive positions. Medical professionals are no exception to it as they have to put in their efforts in a variety of scenarios like clinical directors⁽¹⁾ and managers for the conduct of their routine duties such as leading the wards, camps, campaigns, open houses, seminars and symposiums⁽²⁾. In certain position they have to participate as acade-

micians in the areas of medicine and surgery and on other occasions they have to discharge duties in their executive positions⁽³⁾. They have to divulge in a variety of behaviors, which are not count sale in all scenarios. In managing patients, they have to regulate the processes as the manager. In academic sessions, they have to reflect upon their experiences, share it with others and make a complex decision which they have to defend, support and follow. In all these positions they knowingly or unknowingly discharge leadership

in a variety of styles. The working of medical professionals demands them to be humble, accommodative, polite and caring. Their role as the counselor and care provider is more directed toward a democratic style of leadership. However, this style is not supposed to work with equal effectiveness and efficiency⁽⁴⁾. Medical professionals have to act differently from the management scenarios as they are bound to link the processes and services in a more coordinative and collaborative manner⁽⁵⁾. Senior health professionals are required to reflect upon the academic phase of the medical learning environment that makes it more congenial and conversant with the style of those who are on the learning end.

The concept of power and authority no doubt rest with the medical professionals but put them on the end to be sharing and caring with all those who are their colleagues in a variety of their capacities⁽⁶⁾. Probably in academics, they are more positivistic towards attendance, class interaction and sharing of case studies. But in the wards with the patients and their attendants they are seen as totally changed personalities making them coincide with the ground realities. They have to act as the mentor and monitors of the staff on duties, which demand the leadership qualities. Like other educational institutes, it remains the concern of the medical professionals to make their classes more interactive and productive with maximum involvement of the learners⁽⁷⁾. Quality of the academic process and ensuring the patient safety with the concept of accountability is another dimension of the medical practice⁽⁸⁾. Here the role remains influencing the subordinates and colleagues to be effective in their positions and face the realities with confidence, courage and proper application of knowledge⁽⁹⁾. They are not supposed to follow bureaucratic style though they have power and necessary ways to influence others but their leadership is expected to be all positive, contributive, successive and encouraging for all those who are working in capacities of levels⁽¹⁰⁾.

This paper is an endeavor to explore which way the medical professionals manage to explore their leadership. Hence, the focus remains on the study of leadership styles of the medical professionals with respect to gender and experience⁽¹¹⁾. Medical professionals have to obtain training to interact with patients and their colleagues almost in a very humble way in spite of being under tension and over text. There is no doubt that in this profession with the seniority, the respon-

sibility and its delicacies elevate and demand their role to be more matched with the context. To be very precise and making the problem more embracing, the study focused on the leadership styles of medical professionals. The objectives of this study were to identify the leadership roles played by medical professionals in their capacities with respect to gender, position in ladder, experience and to explore the styles of leadership being opted by the medical leadership in academics and in operational procedures.

Materials and Method

A cross sectional study was conducted and non-probability convenience based sampling technique was adopted. The sample of this study consisted of 59 males and females medical professionals of Azra Naheed Medical College, Lahore. After the approval of institutional ethical review committee, 70 medical professionals of Azra Naheed Medical College were contacted and 59 of them willingly participated in the survey. The calculated sample size was 43 faculty members. It was calculated by the following formula keeping the margin of error equal to 10% and level of significance equal to 5%.⁽¹²⁾

$$n = \frac{Z_{1-\frac{\alpha}{2}}^2 P(1-P)}{d^2}$$

P: Proportion of patients with democratic leadership= 52%⁽¹³⁾; d²: Margin of error = 15%; Z 1- α /2: Desired level of significance = 95%.

Leadership instrument for the assessment of leadership style (T-P leadership rating scale was adopted by Richie and Thompson, 1984) was used⁽¹⁴⁾. With the help of this rating scale one can identify the two dimensions leadership including task oriented and people oriented⁽¹⁴⁾. Proper consent was obtained. All respondents indicated that they had no problem in completing any of the items of the rating scale. Professors, Associate Professors and Assistant Professors were considered as “consultants” whereas Senior Demonstrators, Registrars and Medical Officers were considered as “Non-consultants”. The data was organized, entered and analyzed in SPSS 22. Categorical data like gender, designation etc. is presented in the form of frequency (Percentage) and numeric data is presented in the form of mean \pm S.D. Mann Whitney U test is applied on ordinal data. It is a non-Parametric

Table 1: Leadership scale of study participants according to gender, designation and experience.

		Concern for Task (mean±S.D)	Concern for People (mean±S.D)
Gender	Male	13.21±2.87	6.72±2.20
	Female	13.37±3.59	7.33±1.90
Designation	Professor	13.67±2.42	6.67±2.94
	Associate Professor	11.33±2.89	6.00±2.65
	Assistant Professor	13.94±2.69	7.06±1.53
	Senior Registrar	13.00±2.83	10.50±0.71
	MO/Demonstrator	13.04±3.67	6.89±1.91
Teaching Experience	Below 5	13.37±3.25	7.03±1.98
	6-10	13.33±4.09	6.56±2.24
	11-20	13.00±0	7.00±0
	Above 20	13.20±2.59	7.20±2.59

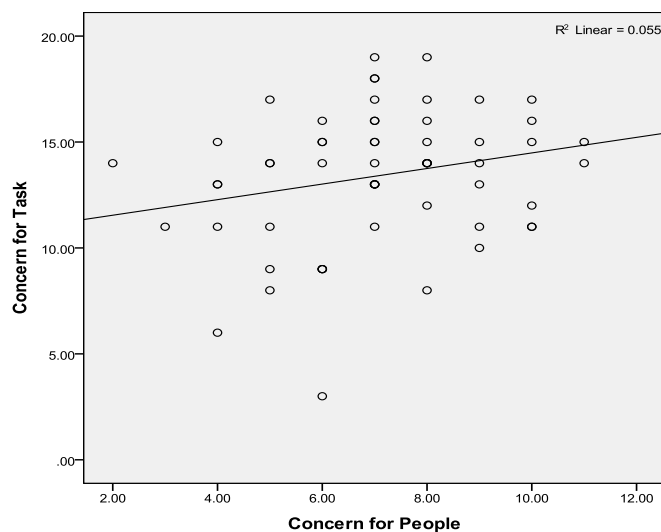


Figure 1: Relationship between concern for task and people.

test and alternative to independent sample t-test. Similarly the Spearman's Rank correlation was applied to determine the strength of the relation between two variables. The p-value of 0.05 or less was considered as significant.

Results and Discussion

A total of 59 medical professionals participated in this study with a mean age of 37.42±11.91years. Among them 29 (49.15%) were males and 27 (45.76%) were females whereas 3 (5.1%) did not disclose their identity. The mean age of the males was 41.28±12.85 years and average age of females was 32.83±9.03 years. 36 (61.02%) of the participants were married and 17 (28.81%) were not married whereas 6 (10.2%) did not disclose their identity. A total of 38 (64.4%) had teaching experience below 5years, 9 (15.3%) had 6-10 year teaching experience, 1 (1.7%) had 15-20 years of teaching experience and 5 (8.5%) had above 20 years

teaching experience and 6 (10.2%) gave no response. 6 (10.2%) were Professors, 3 (5.1%) were Associate Professors, 16 (27.1%) were Assistant Professors, 2 (3.4%) were Senior Registrars, 28 (47.5%) Medical Officers/Demonstrators and 4 (6.8%) did not respond.

The results presented in Table 1 showed, that on average, concern for task and people was at medium level in both male and female participants. Although the difference was not statistically significant but the mean score of concern of task and people was higher in females than in males (p-value 0.567 and 0.307 respectively). Mean score of Concern for Task in consultant level medical professionals was 13.56±2.68, which was slightly higher than non-consultant level health professionals 13.03±3.58. The difference was not statistically significant (p-value 0.727). The mean score of concern for people in consultant level was 6.84±1.99, which was lower than non-consultant health professionals 7.13±2.06, but the difference was not statistically significant (p-value 0.864). There was a weak positive correlation between both domains of leadership. The value of $r=0.228$ indicates a positive relationship but the strength of relationship is weak.

Figure 2 showed the degree of correlation regarding concern for people in both genders. Nine (31.0%) males showed low concern for people, 20 (69.0%) showed medium concern for people and none showed high concerns for people. Four (14.8%) females showed low concern for people, 21 (77.8%) showed medium concern for people and 2 (7.4%) showed high concern for people. Figure 3 showed the strength of concern for task in both genders. No male showed low concern for task, 5 (17.2%) showed me-

dium concerns for task and 24 (82.8 %) males showed high concerns for task.

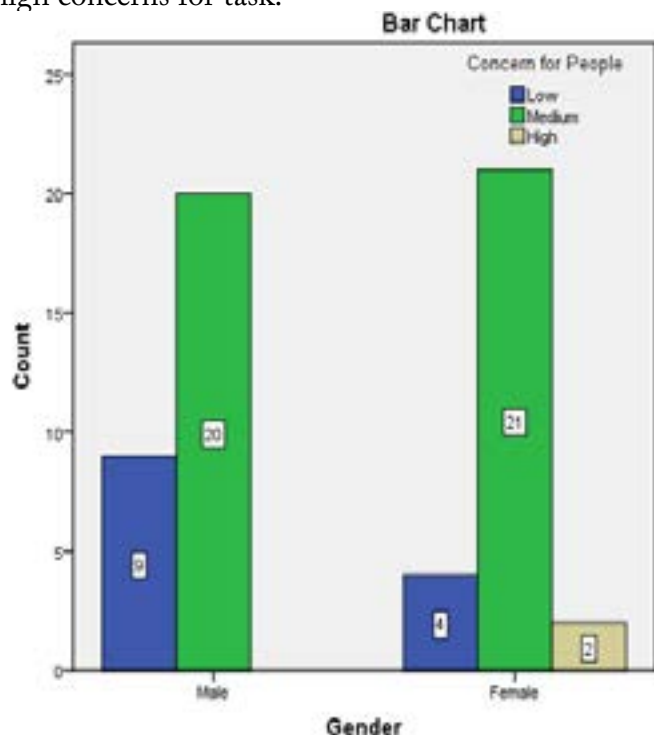


Figure 2: Degree of concern for people between both genders.

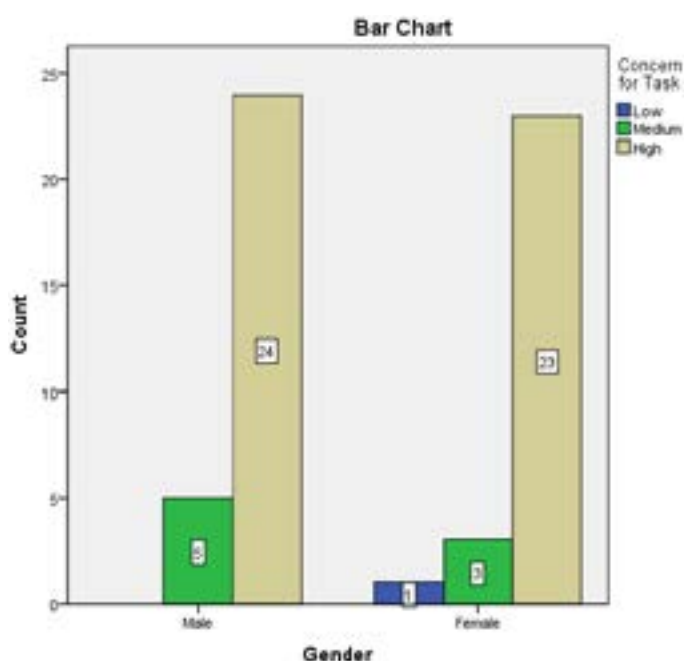


Figure 3: Degree of concern for task between both genders.

Only one (3.7%) female showed low concern for task, 3 (11.1%) females showed medium concern for task and 23 (85.2%) showed high concerns for task. Figure 4 represented that two (33.3 %) Professors showed low concern for people, 4 (66.7%) showed medium concern for people. Two (66.7%) Associate Professors showed low concern for people, one (33.3%) showed medium concern for people and none Associate Pro-

fessors showed high concern for people. Two (12.5%) Assistant Professors showed low concern for people, 14 (87.5%) showed medium concern for people and none Assistant Professors showed high concern for people, none of the senior registrars showed low concern for people, 1 (50.0%) showed medium concern for people and 1 (50%) showed high concern for people. 6 (21.4%) Medical Officers/Demonstrators showed low concern for people, 21 (75.0%) showed medium concern for people and 1 (3.6%) showed high concern for people.

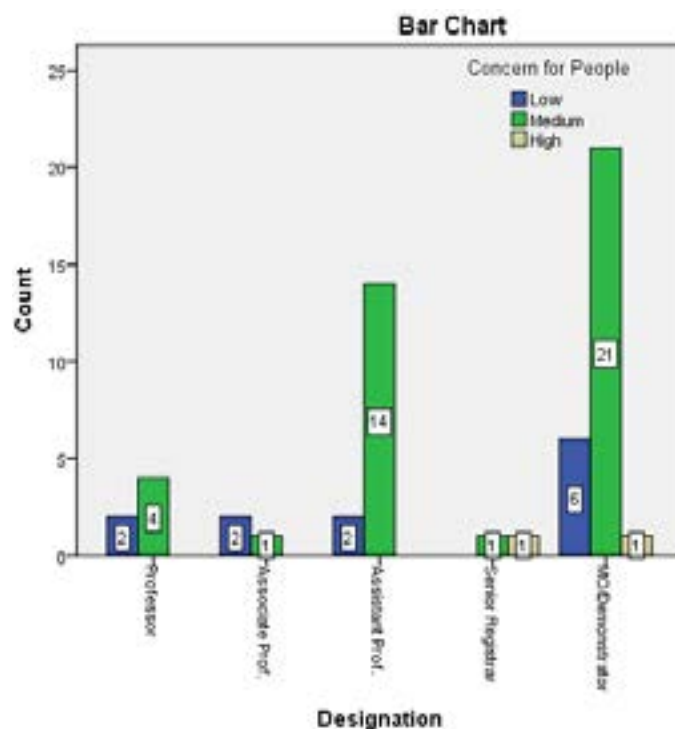


Figure 4: Degree of concern for people against designation of study subjects.

Figure 5 showed that one (16.7%) Professor showed medium concern for task and 5 (83.3%) showed high concerns for task. One (33.3%) Associate Professor showed medium concern for task and 2 (66.7%) showed high concerns for task. Two (12.5%) Assistant Professors showed the medium concern for task and 14 (87.5 %) showed high concerns for task. Two (100%) senior registrars showed the high concern for task. One (3.6%) medical officer/demonstrator showed the low concern for task, 4 (14.3%) showed medium concerns for task and 23 (82.1%) showed high concern for task.

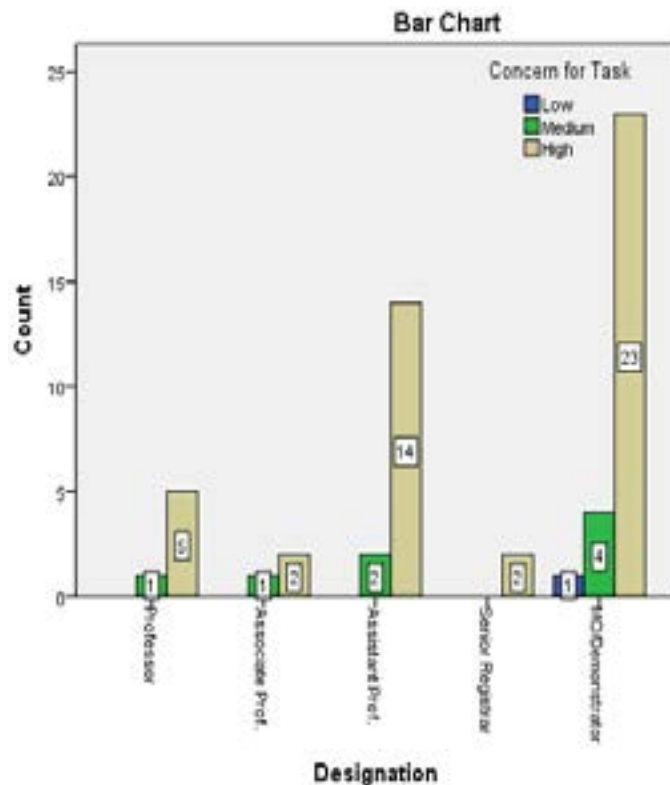


Figure 5: Degree of concern for task against designation of study subjects.

Leadership can be defined as the behavior of an individual, which guides and directs the activities towards a shared goal. The role of leadership in medical profession is well established. This study involves the two leadership styles of medical faculty i.e. autocratic and democratic leadership styles. Weak correlation shows that there is no prominent leadership style. The findings of this study demonstrate that there is no single dominating leadership style of medical professionals. It represents that a single typical style in medical leader does not exist. The available relevant literature describes the benefits of different leadership styles in different settings of medical profession. These professionals respond to the complex situations in organizational settings and ensure the improvements in their working. For this purpose literature offers wide range of versatile leadership styles⁽¹⁵⁾. Research also concludes that there is lack of leadership practices and leadership development plans for the medical professionals⁽¹⁴⁾. The findings of this study support the view point that medical professionals do not exhibit a prominent leadership style. This study investigated the autocratic and democratic styles of leadership. Autocratic leader emphasized performance, make decisions and show little interest in their employees whereas democratic leader focus on people and their performance. They communicate, motivate and pro-

fessionally help to develop the human resource for better performances. Research also concludes that the leaders should adopt both leadership styles according to the situation⁽¹⁶⁾. The results of this study provide insight about gender, designation and the style of leadership. The findings of the study are limited to the small number of participants from a single private institute. However it is recommended to further investigate it by selecting a large number of health professionals from different institutes. Moreover, for the improvement of medical profession there is a need to initiate a comprehensive leadership development program⁽¹⁴⁾.

It is also revealed that both male and female medical leaders are exhibiting same leadership behavior. There is no difference of leadership style found among consultant and non-consultant health professionals. The findings about leadership styles with reference to gender and designation favored the results of some other relevant researches conducted by Bosiock D, Raja AS and Hassan A in 2013 and 2011 describing that gender had not any effect on leadership styles^{(17), (18), (19)}. Research studies also proved that gender is not the significant differentiator of leadership styles. The findings of this study elaborate the need to research this topic, which should include high number of males and females and should find the differences of leadership styles in both genders. The findings also elaborate the strength or degree of people oriented and task oriented leadership styles. Females show medium level of concern for people than males and for task oriented behavior males show high concern than females. Consultants and non-consultants show medium level of concerns for people, but a high level of concerns for tasks. This study should be considered as an initial step to explore the leadership styles of medical professionals in Pakistan.

Conclusion

Current study identifies the need for leadership development in medical professionals. It explores the leadership style or combination of leadership styles that should be more effective in working situations. This is a great challenge for health professionals to understand how their leadership behaviors affect their performance and which styles are more effective for handling their situations. Further research need to be carried out using the same rating scale to provide more comparable studies in health sector leadership.

Rahila Nizami: Research design, literature review and discussion.

Muhammad Zahid Latif: Review of literature, data collection, data entry and data analysis.

Intzar Hussain: Data collection and data analysis.

Khalid Rashid: Article review, corrections and finalizations.

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