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LEADERSHIP – ANOTHER VITAL FUNCTION THAT DOCTORS SHOULD LOOK AFTER?

VODSTVO – JOŠ JEDNA VITALNA FUNKCIJA NA KOJU DOKTORI TREBAJU OBRATITI POZORNOST?

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Abstract: *In addition to the complexity of health systems, the dynamics of changes in the environment to which these systems are exposed and have to respond to, emphasizes the need to strengthen the role of the leader as part of the health care management. This scientific review results from the application of a qualitative methodological framework, with the aim of analyzing the role of leadership in the healthcare, distinguishing the physician as the team leader and the physician as the leader of an organization. It has been established that the effectiveness of healthcare organizations should be defined through the fulfillment of their multiple goals - providing quality healthcare, managing business costs, ensuring patient and employee satisfaction as well as effective work organization. In order to examine the part of clinical leaders in the realization of so defined efficiency, this study started from the question whether efficiency depends on the possession of leadership knowledge and skills and whether doctors should be educated in this area. Two hypotheses have been conclusively generated: that the success and efficiency of medical teams and organizations depends on the leadership skills and knowledge the doctors poses and apply; and that doctors should be educated in this regard. As such, this conceptual paper provides a well-argued basis for future mixed-method research in the area.*

Keywords:*leadership, clinical leaders, leader competencies, healthcare*

Sažetak: *Uz kompleksnost zdravstvenih sustava, dinamika promjena u okruženju kojima su ovi sustavi izloženi i na koje moraju odgovoriti, naglašava potrebu jačanja uloge voditelja kao dijela upravljanja zdravstvenom zaštitom. Ovaj znanstveni pregled proizašao je iz primjene kvalitativnog metodološkog okvira, s ciljem analize uloge vodstva u zdravstvu, razlikovanja liječnika kao vođe tima i liječnika kao vođe organizacije. Utvrđeno je da se učinkovitost zdravstvenih organizacija treba definirati kroz ispunjavanje višestrukih ciljeva - pružanje kvalitetne zdravstvene zaštite, upravljanje troškovima poslovanja, osiguranje zadovoljstva pacijenata i zaposlenika te učinkovita organizacija rada. Kako bi se ispitao udio kliničkih vođa u ostvarivanju tako definirane učinkovitosti, ovo je istraživanje pošlo od pitanja ovisi li učinkovitost o posjedovanju znanja i vještina vodstva te trebaju li se liječnici educirati u tom području. Zaključno, generirane su dvije hipoteze: da uspjeh i učinkovitost medicinskih timova i organizacija ovisi o vještinama i znanju iz područja vodstva koje liječnici posjeduju i primjenjuju; te da se u tom pogledu liječnici trebaju educirati. Kao takav, ovaj konceptualni rad pruža dobro argumentiranu osnovu za buduća detaljnija istraživanja u ovom području primjenom mješovitih metoda.*

Ključne riječi: *Vodstvo, liječnici vođe, kompetencije vođa, zdravstvo*

1. Introduction

Regardless of the level of the country›s development, the political environment in which the health system operates, and the availability of resources (human, financial, and technological), the effectiveness of the health system depends to a large extent on its leaders. However, health systems are complex across a variety of contexts and health service levels. Due to the complexity and distinct characteristics of health systems, the capacities needed by health managers and leaders are not yet well understood, more so because they are country-specific (Figueroa et al., 2019).

In addition to that, all aspects of human activity are progessively influenced by numerous changes in the environment. When talking about the health system, lessons should be learned from the COVID-19 pandemic which, more than all other recent challenges, has pointed to significant shortcomings in the health system. Among other things, that crisis indicated the need for quality and effective leaders in healthcare organizations.

Following all of the above, the authors of this paper theorize that there is a knowledge gap as well as the need to understand and advance doctors› leadership skills. Objectives of the research are:

1. to conduct an extensive review of scientific literature related to leadership within the health system,
2. to study the role and characteristics of leadership within the healthcare system,
3. to develop substantiated hypotheses to serve further investigation.

In order to meet those objectives, the main research questions in the course of presented research have been:

1. Is performance of medical teams and health institutions dependent, among other, on the quality of leadership skills and know-how demonstrateted by the chief physicians?
2. Should doctors take part in educational programmes on management and leadership knowledge and skills?

After a brief introduction and explanation of the chosen scientific methodology, the paper presents a thorough overview of theoretical approaches to leadership. The subsequent chapter considers the role of leadership in the healthcare, providing also the insight into specifics of leadership practiced by doctors at different levels, being the team leaders or the leaders of an organization. The fifth chapter discusses leadership training programmes i.e. educational programmes with purpose of clinical leaders development. The final chapter brings conclusion remarks.

2. Methodology and methods applied

This paper intends to provide a scientific recognition of leadership as part of doctors' careers, which has been done relying on qualitative methodology. Such an approach was found to be the most appropriate because the intention of the authors had complied with the key qualitative research aim: gathering knowledge and reaching an understanding without starting assumptions (Milas, 2005). In its essence, it is a conceptual paper, following the usual structure of qualitative studies (Bricki and Green, 2007): it starts with research questions and setting research goals so that, as a result, well-founded hypotheses arise at the end of the manuscript.

As Lincoln and Guba (2016) explained, qualitative research seeks to reveal hidden perceptions and their meaning in order to understand, describe, and explain phenomena from the perspective of the actors involved. Such an approach does not assume a hypothesis to be tested and proved but has a focus of inquiry that seeks to understand and explore. The main intention is to explain particular

topics and factors and make relations between them to show possible interconnections. Creswell and Creswell (2018) confirmed the importance of the qualitative approach, saying qualitative research takes an inductive approach and builds general themes from the particular, with the researcher subsequently interpreting the meaning of the data collected.

Sometimes, specific issues seem to be part of common sense. However, failing to apply them suggests they need to be tested and proven before substantiated knowledge occurs and before their integration into legislation and application in practice may be expected. Given that the Croatian healthcare system still lacks the systematic recognition and application of leadership competencies, this conceptual work represents part of the research of one of the author's doctoral theses, which is in progress.

Qualitative research usually relies on several research methods (Denzin and Lincoln, 2005). Data for this study was gathered using relevant secondary sources. Afterward, as just advised, several scientific methods were applied to the data extracted from the state-of-the-art studies in the field. Primarily, induction has been used to bring about relevant causalities and implications. In addition to that, methods of content analysis, as well as the synthesis summarizing the previous findings, have been administered.

Ultimately, this qualitative, conceptual study has generated a substantiated base for future quantitative or mixed-method research.

3. Review of theoretical approaches to leadership

When talking about the definitions of leadership, it can be said that there are as many different definitions of leadership as there are people who tried to define it (Bass et al., 1990). The existence of different approaches to defining the concept of leadership and the ever-large number of definitions of leadership make scientific research and comparison of the obtained results significantly more difficult. Therefore, the idea emerged that an integrating framework, which would connect different approaches and enable the development of a comprehensive theory of leadership, is needed. In that sense, there are authors (Van Seters and Field, 1990) who advocate that the effectiveness of leadership cannot be defined with any single approach, but only through the simultaneous interaction of several types of variables.

Beside planning, organization, control and managing human resources, leadership is considered one of 5 key management functions (Weihrich and Koontz, 1994). However, there is a tendency to use the terms management and leadership interchangeably. Whilst there is signifcant overlap, both practically and academically, the two terms are not synonymous as there are fundamental personal and practical domains that distinguish the two (Nicol, 2012). It could be said that "Leadership is of the spirit, composed of personality and vision, its practice is an art. Management is more of the mind, a matter of calculations and statistics, timetables and routines, its practice is a science" (Stewart, 1996).

As leadership is in the focus of this paper, it should be added that there are also newer, perhaps more comprehensive definitions, describing leadership as a process in which an individual influences a group for the purpose of a common goal (Northous, 2010). This definition indicates the key components that explain the process of leadership, being the influence, group context and goal achievement. These components provide the basis for different approaches to leadership (Van Seters and Field, 1990: 29).

Spector (2011: 332) outlined one of the most common leadership typologies. The most important features of the listed approaches are presented hereinafter.

3.1. Leadership approach based on personal characteristics of the leader

The first theories of leadership at the beginning of the 20th century were based on the innate traits of the individual, i.e. research was aimed at determining the special characteristics of individuals that make them leaders (Jago, 1982: 317). Within this, so called trait school, the psychological instrument - Myers Briggs Type Indicator, has been developed and used in order to differentiate personality types. It has been argued that a leader needs to know himself as well as his subordinates, in order to be able to adapt his/her leadership style for getting the task done and keeping the team motivated (Sethuraman and Suresh, 2014). Critics regarding the trait theory are based mostly on the Great Men Theory, which would mean that experience and training have nothing to do with leaders development and success. Today, it is mostly believed that certain genetic predisposition for sure exists, but is not sufficient for modern cognition of successful leadership (Conger, 1992).

3.2. Leadership approach based on behaviour of the leader

In the period from 1940s to the 1960s, leadership studies were influenced mostly by the behavioural or style school, which assumes that leadership can be learned, that effective leaders can be made and that they adopt behaviour they find adequate (Turner and Müller, 2005). Researchers supporting behavioral theories can be categorized into two groups. Researchers who concentrate on leadership styles ranging from authoritarian to democratic to laissez-faire comprise the first category. Researchers who typecast leadership styles into those that are task- or people-oriented make up the second category of researchers (Sikavica et al., 2008).

3.3. Leadership approach based on a specific situation

During 1960s and 1970s the most popular leadership approach has been the contingency school, stating that effective leaders are not products of only their personal characteristics, but also of a given situation in which they act and make decisions (Šandrk Nukić et al., 2022). Scholars from that phase elaborate that leadership is a relationship among people in a particular social situation and that people who are effective leaders in one particular situation do not necessarily have to be effective leaders in another situation (Turner and Müller, 2005).

3.4. Leadership approach based on charisma i.e. vision of the leader

Visionary or charismatic school of leadership emerged in 1980s and dominated until the new Millenium (Turner and Muller, 2005). This view does not seek sources of leaders' traditional or legitimate authority but is based on charisma as defined by Max Weber - influence emerging from the perception of followers that the leader is filled with supreme inspiration, giving him/her the unquestionable authority (Aaltio-Marjosola and Takala, 2000). Later, charismatic leaders have been equalized by transformational leaders as defined in Transformational Leadership Theory (Šandrk Nukić et al., 2022). The theory differentiates transformational leadership which demonstrates charisma from transactional leadership which emphasizes contingent rewards (Northous, 2010).

Such typology can be complemented by one more approach to leadership, promoted by the competency school (Turner and Müller, 2005: 53). Leadership based on leader's competences is lately the most endorsed approach. Competences encompass personal characteristics but also knowledge and skills. Therefore, crucial difference to trait school is that competencies can be learned, so the leaders can be made, not necessarily born (Sethuraman and Suresh, 2014). Dulewicz and Higgs, probably the most influential scholars belonging to the competency school, suggested (2003) that competences should be categorized as intellectual, managerial and emotional. According to findings of these authors (2003), intellectual competences (critical analysis and judgement, vision and imagination,

strategic perspective) account for 27% of leadership performance, managerial skills (communication, managing resources, empowering, developing, achieving) account for 16% of performance and emotional competences (self-awerness, emotional resilience, motivation, sensitivity, influence, intuitiveness, conscientiousness) prevail with 36%!

In healthcare, leadership is probably best defined as looking to overcome some of the main modern challenges such as improving healthcare quality whilst making efficiency savings and engaging grass roots workers to deliver sustainable, long term improvements to healthcare system (Nicol, 2012). Even the term clinical leader has grown a decade ago, to encompass anyone with a clinical background who occupies a leadership role, whether formal or informal (Stanton et al., 2010).

4. The role of leadership in healthcare

In the current era of rapidly evolving technologies for providing medical care, the occurence of previously undiscovered diseases, and an aging population driving up demand for healthcare services, effective leadership in the healthcare industry is more important than ever for ensuring the productive functioning of healthcare institutions. Effective leadership should be part of a long-term strategy as a key factor of improving the quality of healthcare, as well as of improving work processes in the organization (Hartley and Benington, 2010; Lobdell et al., 2020).

Generally, patient satisfaction is considered a key healthcare outcome (Graham et al., 2018; Gleeson et al., 2016). Findings point that staff job satisfaction and work engagement are positively related to patient satisfaction (Dawson, 2018). In addition to that, the most recent study (West et al., 2022) suggests that patient satisfaction is also influenced by healthcare leaders support: a cross sectional study of of National Health Service (NHS) in England, conducted over a sample of more than 63000 participants, has proven that leaders influence patient satisfaction by ensuring that work environments are managed in a way which protects the well-being of staff. This primarily concerns influencing staff experience related to work pressure.

Recently, other aspects are becoming obvious, too. The healthcare system, due to the expensive technology and medicines as well as high labor costs, generates significant costs in every country. However, increasing costs are not always in positive correlation with the level of users/patients' satisfaction, especially in public healthcare institutions. Very often, the answers to this problem are sought in frequent reforms that are not thoroughly prepared. Previous research has shown that constant reorganizations and short-term decisions lead to loss both of people and financial resources (Sandhu, 2019: 614).

Other authors too (Berwick et al., 2008) claim that quality leadership in the healthcare is associated with the triple aim: to improve care, health and cost. Achieving that aim implies compassionate leadership at every level of the system - from the clinical microsystem (teams and institutions) to the national healthcare bodies. According to Bailey and Burhous (2019) prerequisite for that is a development of an appropriate organizational culture, but such effort and behavioural change takes time. A study by Kumar and Khiljee (2016) identified medical staff's resistance to change as the most important factor underpinning the efficiency of leadership by healthcare professionals.

For the efficient functioning of healthcare institutions, transformational leadership is cited as the most suitable way of leadership, which is often associated with increased efficiency and positive results and consequently achieves greater success in implementing changes (Žibert and Starc, 2018: 219).

However, there is no single leadership approach that could be claimed to be the best. All healthcare organizations focus on the patient, i.e. their goal is to provide healthcare services of the highest level of quality, but there are many ways to achieve that goal. The way the entire healthcare system

functions is being changed and adjusted under the influence of variety of environmental factors such as community expectations, demands of founders, positive and negative experiences, political pressure, financial goals and opportunities (Turner, 2019: 72).

Another study of healtcare management (Buchbinder and Shanks, 2017: 77) claims that a clinical leader who is self-confident, optimistic and passionate about his work can "instill" the same in his followers. On the other hand, weak and negative leaders can influence the disinterest of others. Therefore, one could outline the following as the key qualities of leaders in the healthcare: professionalism, mutual trust and respect, optimism and passion for work, visibility, open communication, ability to take risks, admitting mistakes and balancing the role of motivator, visionary, analyst and organizer of activities.

The most recent research (Elkomy et al., 2023) has proven that leadership quality indeed matters for the quality of healthcare provision. More specifically, the scholars have identified that, considering different leadership styles and several quality metrics, task-oriented leadership has the strongest effect on staff-rated hospital quality while change-oriented leadership affects most patient satisfaction and the clinical performance indicators. From such insight, authors of this paper propose that leadership role of physicians is equally important at both team and organizational level and therefore should be analysed as such.

4.1. A doctor in the role of the leader of a medical team

The healthcare system, in the part that relates to the direct work with patients, is completely based on teamwork. It is impossible to design a healthcare service for patients without it being provided by a well-organized team in which each member knows his job and his role in the team. Of course, the level of complexity of teamwork depends on the type of health service provided. There are teams at the level of primary care offices, where the team consists of only two members, and there are complex specialist teams where the team has a larger number of members, especially when it comes to multidisciplinary surgical teams. Regardless of the level of complexity of the teams, one thing is common to all of them - the medical teams are led by doctors. As previously stated, teamwork is not easy for doctors to embrace as they usually see themselves as lone heroic healers. Furthermore, providing health service often requires individual decision-making and giving orders, especially in urgent situations. However, there is much more to team leading than decision-making particiption, so it is reasonable to assume that leading a team is one of the key doctor's competences in all types of health care providers (Lee, 2010).

Knowing that doctors are ultimately legally responsible for the outcome of treatment, it is not surprising that they want to decide on it independently. This has been proven (Lee, 2010) to be acceptable to team members from other medical professions (nurses, technicians, laboratory technicians, etc.) and it does not cause conflicts. However, there are situations when several doctors work in a team and subordinate doctors believe that the exchange of ideas, their contribution and coming to a joint decision would provide better care to the patient.

In order to minimize conflicts between doctors within teams, a successful medical leader could take several steps to minimize conflicts among his team-members (Dye and Garman, 2014):

- ensure a fair distribution of resources among team members,
- reduce the possibility of the emergence of cliques within the team,
- keep personal reactions to the situation out of professional discussions,
- ensure that team members have a clear understanding of their team role,
- ensure that discussion stays within team.

When talking about teams of experts in the field of medicine, the exchange of experiences becomes imperative. It is to be expected that the level of knowledge about a certain field of medicine does not mean at the same time an equally high-quality predisposition for leading and participating in team activities, but efficient leadership requires the development of high performing teams. Leaders can take positive action by regularly seeking feedback and finding ways to ensure the team can reflect and improve their team working (Bailey and Burhous, 2019). A study by Shanafelt et al. (2015) recommended to clinical leaders that showing interest in the work of subordinates and encouraging them to make suggestions related to the improvement of the work processes is the best way of inspiring them. However, a generational shift which have happened means that today many workforces consist of five generations, each responding to different motivators, forcing leaders to adapt and meet the varying needs. This is one of the greatest challenges that has implications for leadership in all sectors, including healthcare (Stephenson, 2019).

4.2. A doctor in the role of the leader of an organization

The environment in which the leadership process takes place in the case of leading an institution is fundamentally different from that of a medical team. Primarily, the goals are different, but another significant difference comes from the fact that health institutions are managed by an interdisciplinary board made up of members from different professions, each in charge of a different business segment, who do not have the same perception as doctors.

The characteristics of doctors compared to other board members at the top management level of a health institution are significantly different, influencing their leadership propensity and style of leading as well as explaining their very common mutual misunderstanding (Dye et al., 2013). Those characteristics have been outlined in Table 1.

Table 1. Characteristics of doctor and non-doctor Board memebers of health institutions

Doctor member of the Board	Non-doctor member of the Board
Science oriented	Work oriented
One-on-one interaction	Group interaction
Appreciates independence	Appreciates cooperation
Pacient focused	Organization focused
Is identified with the profession	Is identified with the organization
Individual thinkers	Group thinkers

Source: adapted from „Developing physician leaders for successful clinical integration“ by C. Dye and J. J. Sokolov, 2013, p. 119, 1st edition, Health Administration Press, Chichago, USA

When talking about clinical leaders and their influence on the success of a healthcare organization, one should appreciate the duality of that role. As expert professionals, doctors are trained to advocate for their patients care, while on the other hand, as leaders in organizations, they are expected to support the goals of the organization. Often, they must find ways to reconcile the demands and expectations of these two different missions (Vimr and Thompson, 2011). Most often, doctors are being promoted to managerial positions and expected to be leaders due to their title and reputation. But, that title and reputation emerged from another line of education, so expecting doctors to be equaly successful as leaders is not exactly straightforward.

In the business world, leaders lead their teams towards achieving the organization’s goals based on the information their team reports to them. In the case of doctors, their subordinates report only about patients’ condition, not about data which would provide basis for heading towards the organizational

goals. But, they do expect to be led in that direction, which consequently requires a high level of skills and knowledge that the doctor must possess (Gayathri and Warrier, 2022).

Doctors as individuals can not independently achieve the most optimal organizational outcome (Blumenthal et al., 2012) so managing large and structurally diverse teams as well as keeping pace with intense scientific and technological progress can be achieved only by leaders who are individually strong but are not affraid to cooperate with other board members.

However, the tendency of doctors to resist cooperation and teamwork has been observed, as they are taught to control the situation by themselves. An interesting study (Lee, 2010) suggested several reasons which might cause the reluctance of doctors to cooperate with team members. These reasons emerge from the fact that doctors resist team work due to their deep-rooted reliance on independence. Furthermore, such doctors' characteristis are considered to be an obstacle to implementing changes in system.

Doctors don't even see a problem in acting alone because they believe that if they can treat and save patients' lives, then they certainly have the competence to do something as simple as leading an organization (Rogers, 2012). They think of leadership as of something that is learned over time. However, practice shows that cooperation with others is a skill that is difficult for doctors to master after years of independent work, a skill that doesn't come naturally but should be tought, as should other leadership skills. Studies confirm that there is a need to organize a system of specific leadership education and training programmes for physicians (Lega and Palumbo, 2021).

5. Training and development of clinical leaders

It can be noticed that leadership and decision-making in traditional healthcare system are highly centralised, which often results in slow reactions and inefficiency. Authors of this paper find it reasonable to suggest that the only way of meeting the dynamics of the progress of medicine and society is the transition to a leadership in which leaders would share their vision and be the first among equals, in which they would develop a sense of belonging to the organization and encourage personal development and initiative.

In order to enable such transition, different forms of leadership education should be introduced as part of medical staff training. Learning about leadership in the course of formal education of future doctors would create not just the knowledge foundation but also the initial awareness of the topic significance. Additionaly, it could serve as a base for their leadership competences upgrade through lifelong learning programmes. The last but not the least, educational programmes created specially for (future) doctors could and should encompass all specific characteristics of the healthcare system.

The advancement of doctors' potential for leadership should begin in the early stages of their career development, more precisely during their education (Rogers, 2012), as that would enable them to acquire certain skills necessary to become leaders open to new ideas through collaboration with others. Creating the adequate leadership training for physicians imposes the need to understand and appreciate their natural being: from the very beginning of their career, decision-making is all about the speed of thinking about how to approach a patient, which treatment method to choose and which medical procedure to apply. It requires an effort to make them aware that leadership functions differently, and that it's a know-how they should combine with their medical training and put into one complete framework of a "clinical leader" (Rogers, 2012).

A good example of effort to achieve that are Leadership and management standards for medical professionals, published by the Faculty of Medical Leadership and Management (2016) in London.

According to the Standards, four determinants of physician behavior are defined as prerequisites for successful leadership:

1. the ability of doctors to know and understand themselves and the influence they have on others
2. the ability of doctors to know when to lead, when to follow and how to organize and lead a team
3. the ability of doctors to understand and contribute positively to the strategic guidelines and operation of their organization
4. the ability of doctors to understand and contribute positively to the healthcare system

Actually, United Kingdom has been pioneering education of clinical leaders. Following the report published by the UK Department of Health (2007), which initially recognized that „…leadership is not just to maintain high standards of care, but to transform services to achieve even higher levels of excellence“, NHS Institute for Innovation and Improvement, in collaboration with the Academy of Medical Royal Colleges, started to address the lack of formal managerial training for doctors and created a Medical Leadership Competency Framework (Nicol, 2012), shown in figure 1.

Figure 1. Medical Leadership Competency Framework

Source: „Improving clinical leadership and management in the NHS,“ by E. D. Nicol, 2012, Journal of Healthcare Leadership, 4, p. 4 (https://doi.org/10.2147/JHL.S28298).

The Framework has been based on NHS Leadership qualities Framework (NHS Institute for Innovation and Improvement, 2011), the document recognizing personal qualities as those in the centre of needed change and wanted leadership performance. The higlighted personal qualities are: self belief, self awareness, self management, drive for improvement and personal integrity. All these qualities belong to the category of emotional intelligence (Nicol, 2012), which highlights exactly

this type of personal competence in terms of primarily desirable skills, which is in compliance with previously mentioned Dulewicz and Higgs's findings and contemporary leadership recommendations.

In fact, academic research on health leadership is remarkably consistent. Beside giving priority to interpersonal skills and emotional intelligence, it also emphasizes certain managerial skills (human resources management, skills in teamwork, communication and negotiation), intellectual skills (analytical and conceptual reasoning, finance, information technology, strategic planning,) as well as industry knowledge (both clinical process and health-care institutions) and ability to adapt to the changing environment (Calhoun et al., 2004; Cherlin et al., 2006; Mouradian and Hebner, 2007; Abdullah et al., 2021).

Unfortunately, in the transitional countries the idea of creating an educational framework that would systematically and continuously educate health professionals on the skills and knowledge they need for successful leadership is still underdeveloped. The above presented findings and experinces could therefore serve as a good base.

The importance of continuous and uniform development of knowledge of all stakeholders involved in the functioning of the health system was recognized also by the European Parliament and the Council of the European Union by adopting the Regulation on the establishment of the EU Program for health for the period 2021-2027. (Uredba 2021/522). One of the four general goals stated in the Regulation is "strengthening health systems by improving their resilience and resource efficiency", within which "strengthening the health workforce" has been identified as one of the activities that will achieve the stated general goal (Uredba 2021/522).

6. Conclusion

The scholarly analysis presented in this paper underscores the critical impact that leadership and management quality within healthcare systems can have on decision-making processes and, consequently, the outcomes achieved.

Meeting the first research objective, extensive analiyisis of secondary sources has been conducted. It proved the starting assumption that although leadership roles in healthcare organizations are predominantly occupied by physicians, they often face challenges in effectively addressing the complexities of their roles due to a lack of comprehensive leadership skills and management knowledge.

Elaborating on the second research objective, being the role and characteristics of leadership within the healthcare system, the study suggests that the necessity of developing a system of education and training through which doctors would acquire the necessary management knowledge and leadership skills is unfortunately not sufficiently recognized in domestic practice. Although teamwork stands for the basis of the effective functioning of the health system at all levels, doctors still tend to make independent decisions without a habit to cooperate with other team members and generally demonstrate a very few competences from medical leadership competence framework.

Based on the conferred arguments, authors of this paper find it possible to meet also the final research objective and to generate two substantiated hypothesis:

H1: success and performance of medical teams and health institutions is dependent, among other, on the quality of leadership skills and know-how demonstrateted by the chief physicians

H2: doctors should be taught on management and leadership in the course of their formal education as well as later through on-job training programmes

Developing presented hypothesa answers the initial research questions and contributes to the existing body of knowledge through widening academic insight and enabling further research. It has been important to perform conceptual analysis and design substantiated base for the future empirical insights, because learning from foreign experiences should support identifying domestic specificities, crucial for clinical leadership improvements.

Suggested results, that leadership in healthcare impacts quality of healthcare, functioning costs, patient and employee satisfaction as well as work organization, raises discusion concerning several open questions: what would be the attitude of doctors towards professionals in leading positions; would they be keen of having leadership training in the course of their medical education; should leadership education be intended for everyone or only for leader position candidates; what are the motivators that should be applied and how to successfully manage changes; what are the most important leadership features that should be systematicaly developed in order to lead to improved leadership behaviour, performance and outcomes. Therefore authors feel that this study has brought a significant new knowledge, it also indicated the entire area for important future research.

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