

Building capacity for clinical leadership

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High-quality healthcare increasingly relies on teams, collaboration, and interdisciplinary work, and clinical leadership is essential for optimizing and improving health system performance. Healthcare systems that are serious about transformation and innovation must harness the energies of their clinicians as leaders. How can we achieve this? How can health systems build capacity for clinical leadership through leadership development?

While we may use the term “leadership” to describe motivating and influencing others to bring about change, management is often associated with achieving specific results through planning, organizing, and solving problems (1). We may see leadership and management as separate systems and logics of action, but we often use the two terms interchangeably. The backdrop for this project was an international trend focusing on promoting and strengthening clinical leadership in healthcare. The conceptual paper “When Clinicians Lead” by James Mountford & Caroline Webb was one source of inspiration for the project (2): How can clinicians’ capacity to lead be developed?

Leadership Development

Leadership development can promote key functions in organizations, such as performance improvement, succession planning, and organizational change. The literature on leadership provides evidence that leadership development helps organizations achieve their goals (1). Target groups for leadership development may include individuals with or without formal leadership roles. Leadership development programs may be delivered internally, externally, or as a combination of both. The scientific literature draws a distinction between leader development (building individual leadership

competencies) and leadership development (building collective leadership capacity) (3). Nonetheless, we often use the term leadership for activities aimed at developing individual leaders as well as for building capacity within an organization.

Physician Leadership Development – Does It Work?

I was affiliated with Yale School of Public Health during my year as Harkness fellow, with Professor Elizabeth H. Bradley as a mentor. In collaboration with colleagues at Yale, I conducted a systematic review of medical literature on physician leadership development programs (1). We included articles that described programs designed to expose physicians to leadership concepts, outlined teaching methods, and reported evaluation outcomes. We identified forty-five studies that met eligibility criteria, published from 1950 through 2013.

We found that most programs focused on skills training and technical and conceptual knowledge, while fewer focused on personal growth and awareness. We used a four-level typology by Professor Donald L. Kirkpatrick (1924–2014) to categorize reported program outcomes (4): Reaction (level 1), knowledge (level 2), behavior/expertise (level 3), and system results/performance (level 4).

Half of the studies used pre/post intervention designs to assess program's effects, and four studies used a comparison group. All studies reported positive outcomes, although most relied on learner satisfaction scores and self-assessed knowledge or behavioral change. Only six studies measured and documented system results and favorable organizational outcomes, such as improvement in quality indicators for disease management. The leadership programs and courses in our review used multiple learning methods, including lectures, seminars, group work, 360-degree feedback (multi-source feedback) and action learning projects in multidisciplinary teams.

The systematic review on physician leadership development has been a key reference in the field, with more than 480 citations (Google Scholar) since 2015.

Added Value of Blending Different Professional Groups?

During the fellowship year, I interviewed sixteen healthcare executives from various hospitals and health systems, including Geisinger Health System, Mass General Brigham, Montefiore Einstein Medical Center, Yale New Haven Health System, Cleveland Clinic, Mayo Clinic, University of Missouri Health Care, and Kaiser Permanente.

The interviews focused on leadership and governance structures within the organization, leadership development activities, and the organization's experiences with leadership development. I also explored questions related to professional background and role identity, inspired by research that suggested that different groups of health professionals went through a process of negotiating a new and "hybrid" identity after taking on a leadership role (5). How did executives experience programs targeting one professional group versus programs targeting multiple professions?

Ivan Spehar (University of Oslo) and I analyzed the interview data and published an article investigating the perceived benefits and negative effects associated with multidisciplinary leadership development programs (6). In this qualitative study, we found that one group of executives perceived programs targeting one profession as advantageous, promoting openness and professional relationships among peers (6). Other respondents argued that multidisciplinary programs could add value because such programs helped bridge professional boundaries, strengthen networks, and build leadership capacity throughout an organization.

One informant said: "[I]f we don't understand each other's thinking and acting and why, it just, it seems like we're missing a key component [in leadership development], and so many fears that people have about mixing the two together, I mean, we're mixing them in the workplace!" (6).

Costs, timing, organizational culture, and a lack of knowledge about how to run multidisciplinary programs were challenges the informants associated with delivering multidisciplinary leadership development programs. The study identified issues and challenges related to diversity that can inform organizational policies and decisions about leadership development programs.

Further Research

In 2019, Jaason Geerts (Canadian College of Health Leaders and University of Cambridge) and Oscar Lyons (University of Oxford) invited me to collaborate on a comprehensive and updated review of the physician leadership development literature (7). The twenty-eight studies we examined contained information about learning outcomes or objective measures. We found that programs with internal or mixed faculty were significantly more likely to report organizational outcomes than programs with external faculty only. Furthermore, programs that encompassed an entire organization were associated with better outcomes at the organizational level than small group initiatives and external courses. Additionally, project work, access to a mentor or coach, and the use of instruments to stimulate reflection were

associated with organizational outcomes of leadership development programs.

A Gold Standard Program?

Ideally, healthcare leadership programs should be evidence-based to support leaders in improving and transforming health systems. I joined Jaason Geerts and colleagues in designing and describing a novel “Inspire Nursing Leadership Program” that would incorporate gold standard evidence into its design, delivery, and evaluation (9). We developed the program based on a needs analysis, research evidence, and input from nursing, indigenous, and equity, diversity, and inclusion experts. The program’s goals included enabling participants to develop leadership capabilities, cultivate strategic community partnerships, lead innovation projects, and connect with colleagues. Design features include an outcomes-based approach, the LEADS framework developed by Canadian College of Health Leaders, and alignment with the principles of adult learning. The program includes leadership impact projects, 360-assessments, blended interactive sessions, coaching, mentoring, and application and reflection exercises.

The IHF Leadership Model 2023

In 2022, I joined an international group that revised the International Hospital Federation’s competency model for healthcare leaders, the “IHF Leadership Model 2023”. Forty-five experts from thirty countries and regions reviewed the original framework competencies, provided feedback through electronic surveys and online interviews. We incorporated this iterative feedback to revise the framework design, competencies within the framework, and their associated behavioral descriptions. I joined Sylvia Basterrechea (International Hospital Federation) and Andrew N. Garman (Rush University) in writing a report about the process and the revised competency model (10).

The revised model includes thirty-two competencies organized into a framework of six domains: Values, self-development, execution, relations, context management, and transformation. Out of the thirty-two competencies, nine did not appear in the previous version. These nine competencies include: Emotional intelligence, translation and implementation, preparedness and crisis management, digital technologies in healthcare, compassionate leadership, advocacy, sustainability leadership, organizational resilience, and entrepreneurship. Environmental sustainability is emphasized in “Sustainability Leadership” and incorporated across multiple

domains, highlighting the significance of this new area of competencies for future healthcare leadership.

Reflections

The Harkness fellowship program offered me insights about US healthcare and global health policy that have been highly relevant and transformative for my academic work. The Harkness project resulted in a highly cited review article and a qualitative study of healthcare leadership development policy and practice. This research laid the foundation for further collaboration with scholars in the field of healthcare leadership internationally. The fellowship experience also gave me valuable insights that was helpful when I subsequently designed and led leadership development initiatives and programs.

In 2018, I met Dr. James Mountford at the 20th Anniversary Celebration of the Harkness Fellowships in Health Policy and Practice in Dorking, England. He told me that he had recently been appointed Editor-in-Chief of “BMJ Leader”, a new journal dedicated to healthcare leadership. Over a cup of coffee, I gladly accepted his invitation to serve as Associate Editor. During these years “BMJ Leader” has grown to become a major arena for publishing research, commentaries and blogs within the field of healthcare leadership. The journal played a pivotal role as an arena for sharing experiences and reflections about leadership challenges during the COVID-19 pandemic.

The Harkness fellowship gave me the opportunity to interact with co-fellows and excellent and inspiring people at numerous hospitals, health systems, agencies, organizations, and universities. The Commonwealth Fund put me in a position to study leadership development practices across major and leading US health systems.

Initially, I searched for the best model and the best approaches to leadership development. Gradually, I learned that various models and approaches may work, and that leadership models could vary from centering on unitary leadership approaches to dyadic-, team-based and distributed leadership approaches. I realized that clarity about the organization’s leadership model and formal structures, a culture for alignment and a sense of strategic direction and commitment were key elements in well-functioning healthcare organizations. These insights have inspired and influenced my own personal approach to leadership in different settings.

Literature

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