

LEADERSHIP COMPETENCIES OF MEDICAL MANAGERS IN RUSSIA

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Abstract

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<p>Abstract</p> <p>For decades, medical management and leadership has been a sensitive topic world-wide. While Western European countries and the USA have a considerable tradition of studying leadership competencies in healthcare, the literature review of Russian sources identified a gap in this area. Consequently, the present study aims at developing a leadership competency model of Russian medical managers in order to help medical workers better understand their responsibilities.</p> <p>The work was commissioned with two state budgetary medical organizations X and Y located in Saint-Petersburg. The research utilized qualitative methods with an inductive approach. The study combined both theoretical and empirical researches. The theoretical part included literature review of reliable secondary sources on the topics of general and healthcare leadership, and competency identification. The primary data collection was conducted through personal structured in-depth interviews and an online qualitative survey. The sample included six medium-level and three high-level medical managers. The analysis is accomplished within thematic and framework Approaches and with the use of Weft QDA software.</p> <p>The resultant competency model consists of three domains: people-oriented approach, teamwork, and clinical supervision that are further divided into ten competencies. The study concluded that Russian medical managers are involved in leadership activities. Further, it highlighted the importance of people-oriented approach to leadership, and the development of psychological and clinical skills. The study shows general correlation with foreign researches and competency models. The difference includes new personal qualities such as stamina, perseverance, and painstaking approach. The work context in Russia is distinguished by the lack of resources, and the influence of gender and aggression.</p>		
Keywords Leadership, healthcare, competencies, competency model		

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1 INTRODUCTION

1.1 Background

Nowadays, the topic of medical leadership has drawn increased attention of researchers around the world. A considerable body of evidence indicates the need for actively involving doctors in management at all levels of clinical organization, including executive level. (Clay-Williams, Ludlow, Testa, Li & Braithwaite 2017, 9.) Studies have identified a clear positive relationship between the level of medical leadership and clinical outcomes. Moreover, effective leadership contributes to the well-being of service providers, thus increasing their job satisfaction and retention rate. It also encourages physicians and nurses to involve in quality improvement initiatives. (Blumenthal, Bernard, Bohnen & Bohmer 2012, 513—522.)

However, at the same time, doctors experience difficulties in assuming managerial work, partly because of the lack of role clarity and training. The ambiguity of managerial tasks and responsibilities causes feelings of frustration, uncertainty, and stress; leading medical peers and resolving conflicts becomes an unwanted task for them. (Bogdan 2012, 3; Berghout, Fabbicotti, Buljac-Samardžić & Hilders 2017.)

In Western countries, medical leadership has been investigated for a couple of decades; however, in Russia, the topic remains understudied. Preliminary search of Russian literature has identified no studies of medical management from leadership perspective. When identifying administrative competencies, Russian scholars tend to focus more on technical and professional aspects of management, leaving out leadership activities. This research gap has determined the focus of the present research.

One way of helping workers understand the needed skills and attributes is conducting competency identification by means of interviewing experts in the field. This constituted the topic of the research, which aims at discovering leadership competencies that medical managers need to master. This study will help them identify the core set of skills, attitudes and behavior that are in alignment with an organization's mission. (Dalgård, Jørgensen 2019.) In addition, it will facilitate the development of medical leaders' competencies as well as guide human resource management and hiring processes. Further, such study may be used by educational institutions in designing leadership programs for doctors.

1.2 Thesis objectives, research questions and limitations

The objective of the research is to synthesize knowledge about leadership, its specifics in healthcare, and experience of Russian clinical managers. Firstly, the study aims to introduce the concepts of leadership, competency identification and framework, and compare organizational structure of hospitals in Western Europe and Russia. Secondly, it aims to discover the most important leadership skills and attributes of medical managers. Finally, the primary aim of the study is to build a leadership competency model for Russian doctors in managerial positions.

Hence, the main research question is the following:

- What are the leadership competencies of hospital managers in Russia?

In order to answer the research question, the following sub-questions should be resolved:

- What kind of leadership do managers of Russian hospitals practice?
- How do competencies of medical leaders in Russia differ from those of medical leaders in other countries?
- What is the workplace context of Russian medical leaders?

In order to find answers to the questions, the author will, first, examine the existing literature to build a knowledge base, and, second, conduct an empirical study. The theoretical part will include a literature review on the topics of general and medical leadership, and existing foreign competency models of healthcare leaders. The empirical part will include interviews of Russian doctors in management positions in government hospitals.

Among the limitations of the study, there is limited geographical area: the Saint-Petersburg region of Russia. Moreover, the empirical study is done in budgetary institutions, where generating revenue is not among the key objectives, since the hospitals are subsidized by government. Further, the amount of interviews taken for empirical study is limited, and the majority of the participants pertained to medium-level healthcare management. Finally, due to time constraints, the duration of study is six months.

1.3 Theoretical framework

The theoretical framework of this thesis consists of four chapters. Firstly, the structure of hospitals in Western countries and Russia is presented in the sub-chapter 2.1. Such information guides the subsequent literature review, as it helps understand the levels of man-

agement in those institutions and the structural context of medical managers' work. In addition, the sub-chapter highlights the differences between the organizations, which impact the data collection and analysis processes. The sources for this part include two online articles written in UK and USA, a website of a university that is based in USA, an online interview of Russian medical CEOs, and two Russian textbooks on healthcare organization. Secondly, sub-chapter 2.2 introduces the theoretical knowledge of leadership in general and enables the author to identify leadership characteristics of medical managers. The overview is based on mostly US sources that include four books and a study conducted in a US hospital. Following this, sub-chapter 2.3 summarizes earlier studies of medical leaders, including their styles, activities, personal characteristics, and work context. This part is important in designing and conducting the empirical part, as it allows to consider medical leaders' competencies and ask suggestive questions during interviews. For this part, the author uses six systematic reviews as sources, as the author believes that such type of studies provides a more holistic picture of the topic. All of the studies are conducted by faculties of different medical universities, which are based in the USA, the Netherlands, and the Kingdom of Saudi Arabia. Finally, the theory related to competency identification and modelling is described in the sub-chapter 2.4 and used in the competency modelling of the present study. The sources include a book and an article from the USA, a critical review from the Kingdom of Bahrain, an article from Denmark, a review paper from India, and a model from Singapore. Almost all of the studies are conducted by universities, except the Danish article that was written by a consultant group.

1.4 Research methodology and data collection

This sub-chapter overviews the range of research methods that were used in the present study. Firstly, it introduces the differences between inductive and deductive approaches, and summarizes qualitative and quantitative methods. Thereafter, methodology choice of this study is presented. The more detailed justification and description of research methods is presented in the Chapter 3.

First, there are two kinds of research approach -- inductive and deductive. In a deductive approach, one studies a theory, creates a hypothesis, and then seeks to test the idea. On the contrary, in inductive approach one examines the focus of research itself, and then derives a theory from it. The nature of this research implies using inductive approach, since the study is explorative: the author will first gather the relevant data and then base the research conclusions on it. Second, there are two kinds of data collection methods -- qualitative and quantitative. Qualitative research is a manner of collecting observational, be-

havioral, or verbal information with a subjective approach to analyzing the data. The nature of such approach is more explorative than the one of quantitative. (SIS International Research 2018.) In contrast, quantitative research is a way of gathering and analyzing numerical, statistical, and mathematical data (DeFranzo 2011). The primary aim of such approach is to quantify a problem (SIS International Research 2018). This study aims at exploring leaders' behavior and gathering verbal data in the form of interviews and surveys. Consequently, the suitable data collection method for the research is a qualitative one.

The study is based on primary and secondary sources of data. The primary source includes structured in-person interviews and e-mail surveys of hospital leaders in Russia. Survey and interview questions are based on the literature review. The sample includes attending doctors in leading positions at all levels of organization, and the data is interpreted within the thematic Analysis and framework Analysis approaches with the assistance of a Weft QDA software. Finally, based on theoretical and empirical research, the leadership competency framework is created. The secondary sources comprise the theoretical framework and include published books, articles and interviews. The theoretical framework is based on foreign studies while the empirical research is done in Russia. Due to this, an additional chapter is introduced, which compares hospital structure in Western countries and in Russia and reveals the possibility of applying foreign theoretical data to Russian reality.

1.5 Thesis structure

This part serves to navigate the reader across the thesis by providing an overview of the subsequent chapters, which are illustrated in the Figure 1. The thesis starts with an introduction, where background, research questions and methodology are presented. Following this, Chapter 2 introduces a theoretical framework that was discussed in the previous section. The information from the chapter is used in the development and discussion of the empirical research of this study. Afterwards, the third chapter reports on the process of primary data collection and analysis, as well as provides the results of the empirical study. It describes the research participants, study methods, interview and survey design and the resultant competency model. Finally, the discussion, recommendations, and evaluation are provided in the Chapter 4. After the main part, references and the relevant appendices are presented.



Figure 1 Thesis structure

2 LITERATURE REVIEW

2.1 Hospitals in Russia and Western Europe

In order to understand the context of the study, the author provides a brief insight into organizational structure of hospitals in USA, Western Europe, and Russia. In USA, UK, and in the number of Western European countries, the management of healthcare organizations is divided into several levels, as illustrated in Figure 2. The highest governing body is board of directors, which develops overall mission and strategy of the institution. The board of directors is drawn from the professionals in healthcare sector and respective fields. The second managerial level involves executives which oversee entire operations of different departments, including finance, medical and health services, and strategy and decision-making. At the third level, medical and non-medical department administrators operate, supervising the everyday activities; the examples of their titles are "chief of surgery", "chief of public relations", and "human resources manager". The fourth level is comprised of patient care managers, who are the leaders of groups of nurses and physicians that deliver direct patient care. Finally, at the end of the chain there are service providers that interact directly with patients or manage technical operations needed for a hospital to function. This group of people includes doctors, nurses, and a technical team. (Rivier University Online 2019.)



Figure 2 Hospital management hierarchy (Rivier University Online 2019)

The current involvement of clinicians in healthcare management is estimated to be 50 per cent (Clay-Williams et al. 2017, 2). Since the introduction of clinical directorate model in the second half of the twentieth century, the governance of a certain department, or directorate, within a hospital is shared between a medical consultant and a healthcare manager. That is, a clinician is now supported in his or her managerial role by a professional with a relevant degree in healthcare administration. Likewise, a board of directors includes professionals with clinical and managerial background. (Buchanan, Jordan, Preston & Smith 1997, 132.) As an example, Figure 3 shows the clinical directorate organization of Leicester General Hospital in UK.

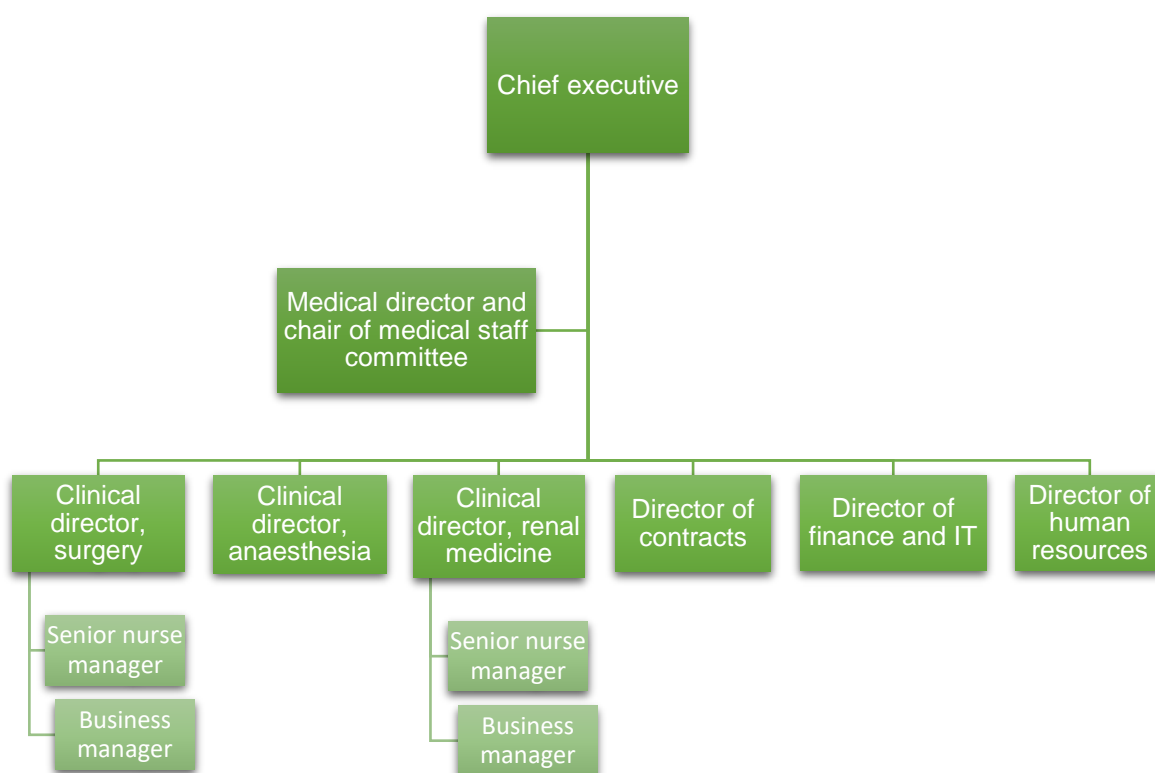


Figure 3 Clinical directorate organization of Leicester General Hospital, UK (adapted from Buchanan, Jordan, Preston & Smith 1997, 134)

As seen in the diagram, the chief executive officer leads the organization with the help of a medical director. Clinical directors of each department report to CEO and coordinate with a senior nurse manager and a business manager. Non-medical activities such as finance and human resources are arranged in separate directorates.

The modern tendency in healthcare management implies active involvement of clinicians in administration to streamline hospitals' operations. In USA, around half of the executive doctors abandon their clinical practice, while in UK doctors have negative attitude towards doing so, which results in combination of clinical and managerial duties. (Clay-Williams et al. 2017, 2.)

In Russia, the prevailing type of hospital is hospital clinic. At the top of a hospital's management hierarchy there is one person with a title Head Doctor, as shown in Figure 4. They are accountable for all the activities of the organization. The head doctor's duties are supported by deputy directors of medical, polyclinical, and administration and maintenance departments, the last of which embraces all the non-medical activities from maintaining utility rooms to managing financial and human resources. In respect to the size of clinical hospital, its financial activities may be organized in a separate division. (Litsin 2007.)

Medical department is divided into inpatient departments of various clinical specializations, which are led by their heads, as can be seen in the Figure 4. The heads subsequently delegate duties to attending medical doctors and nurses, who deliver direct medical care. (Medik & Juriev 2009, 222—226.)

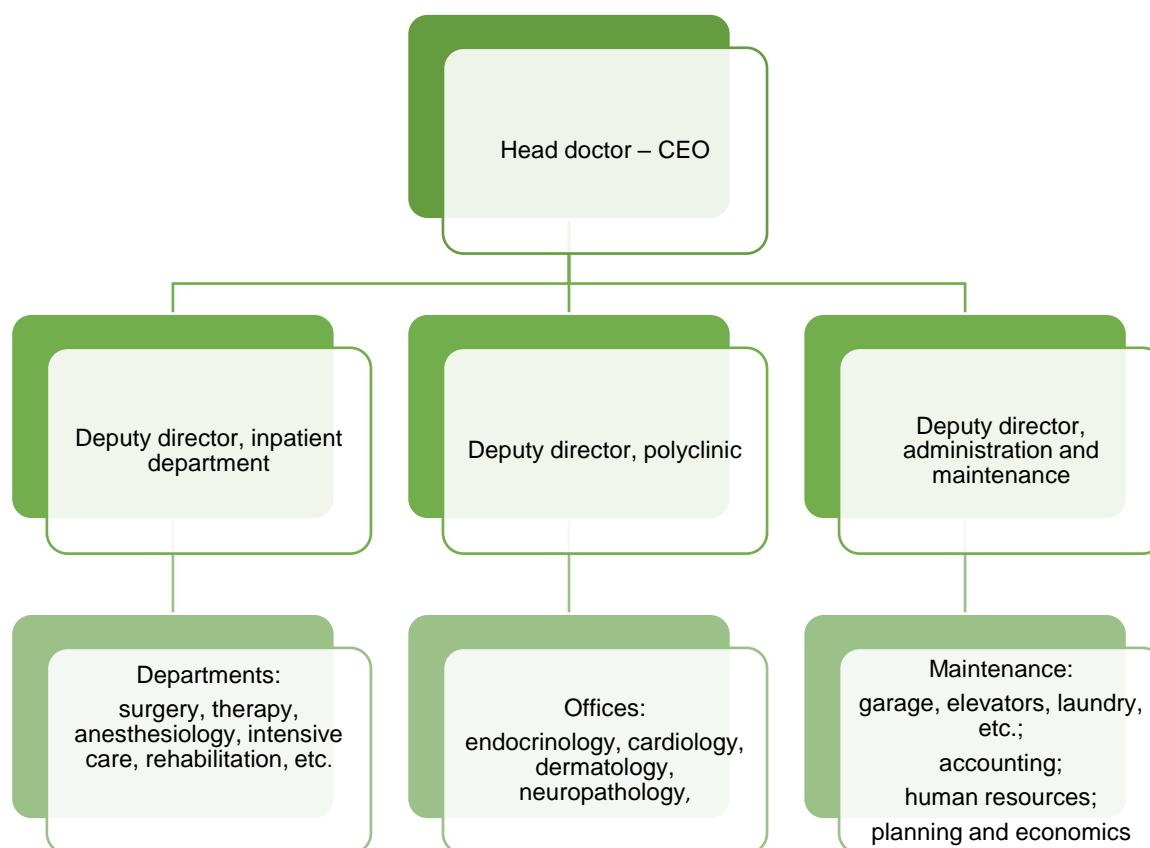


Figure 4 Organizational structure of a Russian hospital clinic (Lisitsin 2007)

As opposed to their Western counterparts, the CEO and medical deputy directors of a hospital can be only clinicians, often with an additional degree in management. Moreover, neither the head doctor, nor the deputy directors are supported by business managers, which means that they devote more time on managerial and bureaucratic issues than doctors in UK and USA. (Latishkevitch 2019.) Despite these differences, the nature of medical management in all countries implies the need to master leadership competencies. Subsequently, the author of this thesis concludes that reviewing foreign literature on the topic is to a large part relevant for the purpose of this study. However, the different context of their work may cause differences in the needed leadership attributes; therefore, it should be taken into account.

2.2 What is leadership?

The concept of leadership has constantly changed throughout the twentieth century. Reviewing the relevant works, Bass (2009) draws the general contemporary definition of leadership: “leadership is the ability to influence, motivate, and enable others to contribute to the effectiveness and success of the organizations of which they are members”.

Leadership’s main functions are envisioning the desired outcome and motivating other members towards the goal by personally inspiring them. The result of the leader’s activity is a move, a change, and an innovation in an organization. In this way, leadership differs from management, whose main objective is to bring order and consistency in a team’s daily operations. (Kotter 1990, 4.)

In order to broaden the understanding of the concept, the comparison between leadership and management is provided below. Management focuses on present activities of an organization, with the aim of meeting the company’s current key objectives. It sets direction in the form of guidelines, and then creates a structure that would allow to delegate the tasks to the responsible individuals. The strategy is executed by monitoring and regulating work processes. It is manager’s formal position that entitles them to exert authority over others. On the contrary, leadership focuses on the future in the longer term. Its main goal is to produce a change, often a rather significant one. It sets direction by envisaging the outcome and inspiring other members towards the goal. In order to execute their project, leaders make use of effective communication to assemble a team that will share their mission and strategy. A leader is chosen by other members; this way, their position may be

either formal or informal. (Bass 2009.) In order to prosper, a company needs both management and leadership; one of the functions cannot fully replace another (Kotter 1990, 4-7). At the same time, a combination of managerial and leading functions is found to be common for both managers and leaders (Nahavandi 2015, 32). As a result, managerial and leadership activities often involve interrelated competences, and, in practice, the distinction between them may be unclear (Blumenthal, Bernard, Bohnen & Bohmer 2012).

In an extensive survey, Kouzes and Posner (2003, 24) have identified the four most important qualities of a leader. When they choose a leader, followers most often look for such personal features as: credibility, honesty, visioning, and competence. The authors provide the following explanation of these qualities: credibility refers to the consistency between the leader's words and deeds; honesty means sincerity and truthfulness; visioning is related to seeing a well-defined future; finally, competence means the ability to finish the set projects.

2.3 Leadership in healthcare

Currently, the accumulated body of evidence concerning physician leadership lacks clear definition and conceptualization (Berghout et al. 2017). In a systematic survey, Berghout et al. (2017) have found the following definitions that are used more often when describing medical leaders. Medical leaders are perceived as "key champions", "visionaries", knowledgeable and credible physicians that influence and inspire others, and physicians are committed to team work and hospital success. At the same time, studies that focus on physicians' formal leadership roles, define them as "(senior) doctors who have assumed management responsibilities".

The systematic review has identified two types of medical leadership: formal and informal. The former is associated with physician formal managerial role, while the latter refers to direct service providers and is linked to the notion of shared leadership. Shared leadership means that every doctor providing patient care has to be a leader of their own duties as well as lead their collaboration with other members. This is a characteristic of healthcare industry: individual doctors have more autonomy than individual workers in other fields. (Berghout et al. 2017.) In addition, there is a reported duality in medical leadership attitudes. In different circumstances, managers exert either a directive or developmental leadership. Directive leadership refers to control, planning, and implementation and is associated with a more authoritative behavior, which is needed in time-sensitive and critical patient care situations. On the contrary, developmental style allows more independence of team members, but focuses more on coaching and providing support, and can be applied

in routine activities. (Rosenman, Shandro, Ilgen, Harper & Fernandez, 2014, 1295—1306.)

As mentioned in previous chapters, studies often overlap key activities of management and leadership, and the area of healthcare is no exception. Speaking about leadership tasks, researchers first of all identify responsibilities that for the most part pertain to general leadership and management. Such roles include managing resources (including finance, time, and human capital), administration, delegation, quality improvement, and leading change. Setting vision and mission as well remains a crucial skill for medical leaders. (Frich, Brewster, Cherlin, Bradley 2014; Khoshhal, Guraya 2016; Berghout et al. 2017.) Teamwork plays a large role in providing quality medical care (Blumenthal et al. 2012, 513-522). Therefore, an important aspect of medical leadership is team management and collaboration. The aspect includes such activities as communication, conflict management, and staff motivation. (Rosenman et al. 2014, 1295—1306.) Moreover, emotional intelligence is found to be paramount for successful team work (Hargett, Doty, Hauck, Webb, Cook, Tsipis, Neumann, Andolsek & Taylor 2017, 69—78). A distinguished feature of medical leadership is the need to balance between managerial and medical departments, which are often portrayed to have conflicting interests. Therefore, understanding both sides of hospital organization is essential for medical managers. (Berghout et al. 2017.)

The most important personal features of medical leaders fall into five categories: credibility, skills, knowledge, and attitude. Firstly, credibility refers to support and trust of both clinicians and managers. It empowers clinicians to manage both departments and prevents them from working in isolation. Credibility is achieved through medical excellence and commitment to clinical work. Secondly, addressing significant areas of medical leaders' knowledge, studies mention clinical knowledge, as the most important expertise. Other knowledge areas that are unique for medical leadership include understanding health system as well as health policy and law. At the same time, general leadership expertise includes awareness of finance, IT, and organizational structure. (Frich, et al. 2014; Berghout et al. 2017.) Thirdly, among medical leaders' attitudes, studies underscore motivation, patient centeredness, and cooperativeness (Berghout et al. 2017; Hargett et al. 2017, 69—78).

In order to assess the difference between medical leadership and general leadership, work specifics and environment should be taken into account. Previous studies have drawn several factors that affect clinical leaders most in their workplace: conflict of inter-

ests, lack of time, role uncertainty, and support. Firstly, as mentioned earlier, conflict of interests often arises when physicians have to liaise with managerial or business objectives. More specifically, their choice falls between patient care quality and efficiency, engaging in teamwork and maintaining autonomy, as well as performing management work and maintaining clinical practice. Secondly, lack of time is a sensitive issue for leading doctors, because of the need to combine clinical and leadership work. Such an approach stems from the notion of credibility among physicians, who are more likely to trust and be influenced by a practicing doctor. This results in assuming management and leadership roles on a part-time basis and as an additional activity. (Berghout et al. 2017.) However, despite this being a major trend, there are cases in USA and Russia when doctors abandon their clinical practice and yet manage to run big healthcare organizations successfully. According to an interview with a Russian medical CEO, the ability to maintain managerial-clinical balance largely depends on the type of medical organization. In Russia, for example, public hospitals are non-profit organizations that run on state budget and report to government; therefore, in such entities, executives are less concerned with financial and economic objectives than in private clinics. Consequently, public hospitals' CEOs have a more feasible opportunity to maintain clinical practice than heads of private hospitals. (Latishkevitch 2019.) Thirdly, role uncertainty contributes to physicians' stress and frustration. As doctors report, a well-defined role description and tasks would help them to overcome many dichotomies within a medical leadership work, which were addressed earlier in this chapter. However, some physicians view such uncertainty positively, as the open-for-interpretation position allows them to be more flexible in their leadership function. (Berghout et al. 2017.)

2.4 Competency identification

This thesis focuses on competency identification, which is a part of the competency model concept. Therefore, the author will also provide a description of a competency model and its importance for organizations. Competency model is a description of competencies that are required for outstanding performance in a specific job, in alignment with work context, technical requirements, and responsibilities and relationships within an organization (Sanghi 2016, 24; Megahed 2018, 105). It arranges and groups competencies in a certain structure to represent their levels and relationships in alignment with an organization's mission and strategy. The current tradition is to supplement a model with a competency dictionary, performance indicators, and descriptions of behavior associated with each of the included competency. (Dalgård & Jørgensen 2018.)

Appendix 1 shows an example of Medical Leadership Competency Framework developed within a national health system of United Kingdom (Image 1). The model is presented in a circular form. In the center is the institute's mission, surrounded by the first level of competencies – core competencies. Each of the core competencies is then sub-divided into smaller sets of behavioral competencies.

Competency modelling consists of five steps (Megahed 2018, 117; Dalgård & Jørgensen 2018):

- 1) Preparation: determining the scope of the project, sample, and data collection and analysis methods.
- 2) Competency identification
- 3) Supplementation of competencies with their performance examples and verbal explanations
- 4) Arrangement of competencies into a model
- 5) Validation.

Competency identification is a crucial part of competency modelling and the related competency management. Concept advocates have identified that understanding the required competencies brings significant benefits for organizations. First of all, identified competencies help to maximize company's effectiveness. They result in team players of all levels being aware of the organization's expectations and success factors, which, in turn, set the direction to where focus their efforts. Second of all, competency models are found to facilitate performance management. Furthermore, through assessment, competency gaps may be identified, which may lead to corresponding trainings and employee development. In addition, the implementation of leadership competency frameworks leads to standardized practices that unify the organization. Finally, competency models optimize recruitment process. (Sanghi 2016, 19-20 ; Vazirani 2010, 126—127.) Nowadays, there are available generic leadership competencies, which may be applied in a given company. However, although using existing models saves much time, they are developed to suit all situations, that is, to suite none precisely. In contrast, industry-specific competencies take into account specific work needs and environment. (Megahed 2018, 105.)

In essence, competency is a capability that makes one suitable for one's job and a measure of workers' successful performance (Vazirani 2010, 121). According to Parry (1998, as cited in Chong, Ho, Tan & Ng 2000), the concept represents a cluster of job-specific knowledge, skills, and attitudes that has four characteristics: 1) greatly affects one's work

2) corresponds to job's performance 3) can be compared against a set of standards, and 4) can be developed or improved. McClelland (1973, as cited in Vazirani 2010, 122) has developed the concept by including such personal attributes as motives, traits, and self-concept in addition to skills and knowledge. In light of the above mentioned properties of competency, Vazirani (2010, 124) has formulated a more developed definition of the concept:

Competencies are thus underlying characteristics of people that indicate ways of behaving or thinking, which generalizes across a wide range of situations and endure for long periods of time.

McClelland (1973, as cited in Vazirani 2010, 122) has represented all these attributes as parts of an iceberg (see Figure 5), where knowledge and skills constitute a visible tip that is based on inner personal traits, which are not observable. It can be seen that competency is not merely knowledge and skills, but it is a more complex concept, which is constituted by inner personal characteristics of an individual.

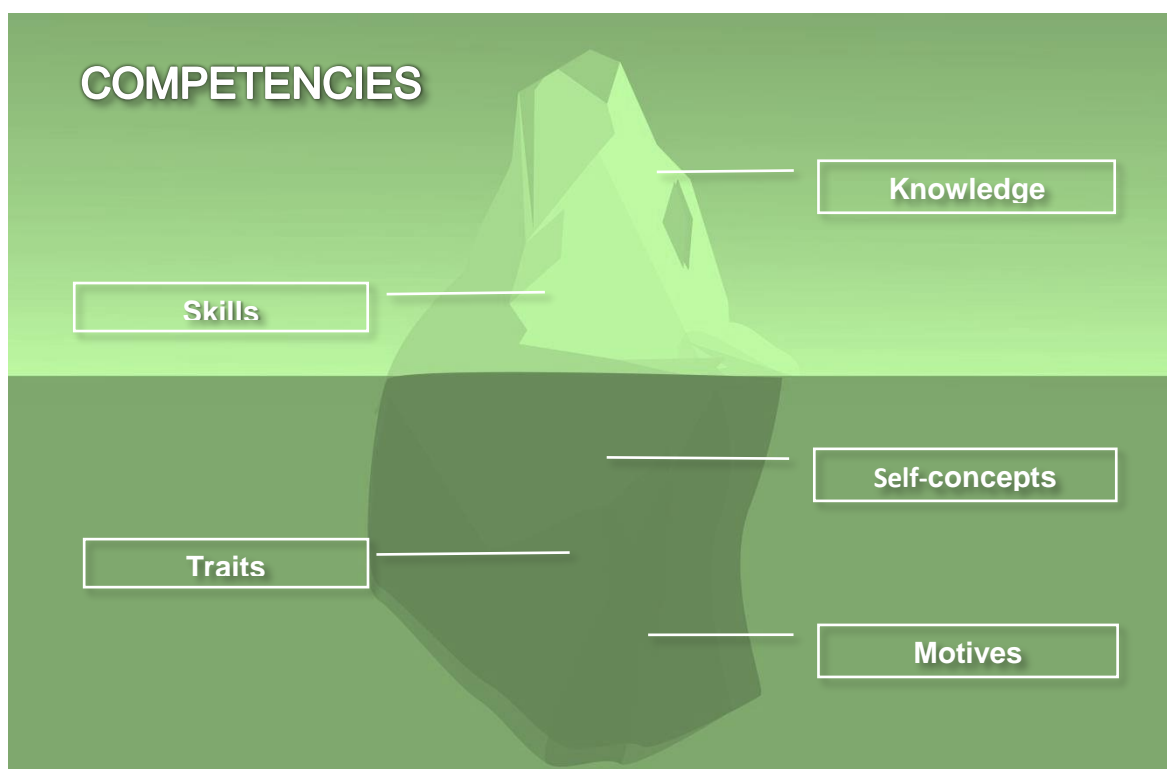


Figure 5 "Iceberg" model of competencies (adapted from Vazirani 2010, 122)

The five constituents of competency are defined as follows:

- *Knowledge* refers to acquired information of an individual (Vazirani 2010, 124)

- *Skill* is an ability to perform work-related activities, including thoughts (cognitive skills), interactions with materials and mechanisms (technical skills), and communication (interpersonal skills) (BusinessDictionary.com 2019)
- *Self Concepts and Values* refer to self-image of their behavior, abilities, and characteristics (Cherry 2018). *Values* refer to beliefs and ideas of desired and undesired behavior, accepted standards, and perceptions of good and evil, which may strongly influence one's behavior (BusinessDictionary.com 2019).
- *Traits* are physical capabilities and a unique way of responding to circumstances and information. As an example, he provides a case of surgeon, whose preferable physical characteristic is good eyesight, and a way of reacting to situations is an ability to maintain self-control and remain calm under pressure. (Vazirani 2010, 124.)
- *Motives* are inner impulses such as emotions, concern, desire, or need that provoke one's action (Vazirani 2010, 124).

In order to develop a competency model, companies should first go through a process of competency identification. As the name suggests, it is a process of discovering competencies that lead to successful performance in a given position (Sanghi 2016, 24). Competency identification consists of four steps. First step relates to determining the goals and scope. This activity involves identifying organization's needs for competency profiling, targeted roles, and appropriate data collection and analysis methods. In addition, two basic approaches to competency modelling should be considered. One implies "starting from scratch" and use internal collection of qualitative data, whereas the other way, "validated method", implies using an existing generic model and adopting it for the organization. (Sanghi 2010, 45—46 .) In practice, companies may combine the two approaches. For example, they may first identify a set of competencies internally, and with its help select, purchase, and validate a generic model (Megahed 2018, 115).

Second step: sampling identification in accordance with selected needs and purposes. In his original work, McClelland suggested to determine outstanding and average performers by means of ratings that were assigned to workers by managers and colleagues. Doing so would later allow comparing the results from both groups and discovering features distinctive to top-performers. After that, the selected themes could be clustered into competencies. (Megahed 2018, 115.) Other approaches to sampling could involve selecting field experts or only outstanding performers, as literature review suggests.

Third step: data collection. Qualitative data is collected through focus groups, interviews, and surveys. Two possible ways of questioning could be asking interviewee's direct opinions about the required competencies or conduct a behavioral event interview (a variation of critical incident interview). In either case, a fieldworker should aim at not only obtaining descriptions of capabilities, but also discover circumstances, actions, and results that associate with those competencies. In a Validated Approach, individuals are given a list of competencies from existing models, from which they can choose the most relevant items. Experts warn that this approach has inclination to gather non-technical information; therefore, fieldworkers should especially focus on identifying technical competencies as well. (Megahed 2018, 115—117.)

Fourth step: data analysis. Thematic analysis and clustering as well as framework analysis are often used in competency profiling (Dine, Kahn, Abella, Asch & Shea 2011; Hargett et al. 2017). In order to ensure the clarity and meaningfulness of results, competencies should be supplemented with examples of associated behavior (Dalgård & Jørgensen 2018). However, it is important to remember about a certain limitation of competency profiling. While knowledge and skills are relatively easy to identify, motives and traits of employees may be difficult to measure. Such attributes cannot be described in behavioral terms. Instead, certain types of behavior are associated with various personal traits. (Vazirani 2010, 128.)

3 EMPIRICAL RESEARCH

3.1 Research participants

For the purpose of the study, a specific type of medical entities was targeted. Specifically, the study focused on state budgetary institutions. Such a distinction was made in order to make this research comparable with previous foreign studies, which focused on state hospitals. Overall, six organizations were involved in the study. Among them, four medical institutions engaged in interviews and two institutions participated in the survey. Considering their location, entities situated in the city of Saint-Petersburg and in the near towns of Vyborg and Gatchina in the North-West Region of Russian Federation. The first three organizations under study (Organizations 1, 2, and 3) were located in Vyborg, Organizations 4 and 5 situated in Saint-Petersburg, and Organization 6 was located in Gatchina. Medical institutions varied in terms of their specialization and size. Organization 1 combined a hospital, a polyclinic, and an outpatient-advisory department. Organization 2 was a narcological dispensary comprised of a dispensary-polyclinic department (three offices) and a hospital (with the capacity of 103 beds). The number of doctors working in the institution was 22. Organization 3 was a city children's hospital that included a hospital (with the capacity of 100 beds), a polyclinic, and a clinical diagnostic laboratory. The total number of personnel in the organization was 88. Organization 4 was an outpatient tuberculosis dispensary comprised of a polyclinic and a clinical diagnosis laboratory. The organization employed 21 doctor and 32 nurses. Organization 5 was a surgical hospital with the capacity of 184 beds and 79 employed doctors. Organization 6 was a large district hospital that comprised a central hospital, a polyclinic, a children's hospital, a dental polyclinic, and a dozen of outpatient clinics in near villages. In total, 1,650 medical workers were involved in the organization.

Sampling criteria for participants related to their position and work experience. In addition, interviews featured a question that asked the accessible population to reflect on their own effectiveness as medical leaders. The participants that involved in interviews had considerable leadership experience (over 15 years), and all but one of them identified themselves competent in leadership. Total of nine medical leaders participated in the study. Six of them took part in face-to-face semi-structured interviews and three of them responded to an online survey. The majority of the respondents – six leaders -- belonged to the medium level of management, and three of them pertained to high-level management. It is also notable that two of the samples were CEOs of hospitals.

TABLE 1 Interview Schedule

Date	Organization	Participant	Title	City
29 March 2019	Organization 1	Participant 1	Head of a department	Vyborg
31 March 2019	Organization 1	Participant 2	Team leader of remedial gymnastics	Vyborg
1 April 2019	Organization 2	Participant 3	Head of a department	Vyborg
3 April 2019	Organization 3	Participant 4	Former head of a department	Vyborg
5 April 2019	Organization 4	Participant 5	Chief Executive Officer	Saint-Petersburg
9 April 2019	Organization 1	Participant 6	Former Chief Executive Officer	Vyborg

TABLE 2 Survey schedule

Date	Organization	Participant	Title	City
29 March 2019	Organization 5	Participant 7	Head of a department	Saint-Petersburg
4 April 2019	Organization 5	Participant 8	Head of a department	Saint-Petersburg
6 April 2019	Organization 6	Participant 9	Chief Medical Officer	Gatchina

3.2 Research methods of data collection and analysis

The study aims at discovering medical leadership competencies in Russia. The target information for the research is related to opinions, thoughts, and experience of medical managers. Therefore, the study is exploratory and qualitative in its nature. Qualitative research is a manner of collecting observational, behavioral, or verbal information with a subjective approach to analyzing the data. The nature of such approach is more explorative than the one of quantitative, and it may aim at identifying reasons for a phenomena. It

is opposed to a quantitative research method, which is a way of gathering and analyzing numerical, statistical, and mathematical data, and whose aim is quantifying a problem. (Adams, Khan & Raeside 2014, 6.) More specifically, the study applies phenomenological method. Such method is related to examining people's perceptions of a particular phenomena. The analysis can be based on interviews, observation, and texts and videos. As a result, a researcher gains an insight of events from the participants' point of view, and discovers their motivations and meaning that they give to events. (Guest, MacQueen, Namey 2012, 13.) Further, the study utilizes inductive reasoning. The method of induction focuses on generating a theory from a number of specific observations. This approach was used because no theory or hypothesis were set at the beginning of the research. Rather, the final results allowed to identify the nature of observations and develop explanations for the observed patterns. (Adams, Khan & Raeside 2014, 10.)

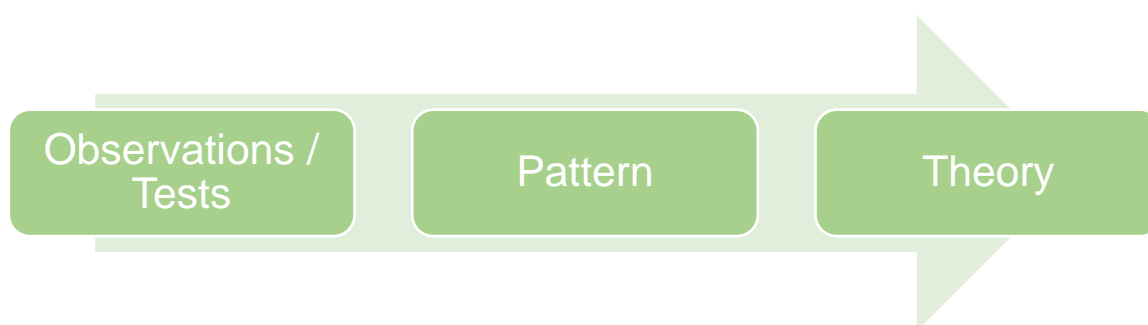


Figure 6 Inductive reasoning (Adams, Khan & Raeside 2014, 10)

The chosen method of data collection is interviews with open-ended questions, since the study needs to elicit verbal information in the form of medical experts' thoughts and accounts of their experience. Such type of interrogation allows to collect in-depth information through one-to-one conversations (Walle 2015, 74). Interviewing is preferred to other methods, because focus groups are difficult to organize due to tight schedule of respondents. At the same time, surveys cannot provide deep enough information on the topic. Nevertheless, a survey was launched in this study as an additional, supportive method of data collection.

In order to select the relevant type of interview, the author considered their study's objective, as suggested by Walle (2015, 69). In the case of the present research, the study aim is related to identification of leadership competencies needed to manage medical workers. The additional objective of the study is to organize the data into a competency model. Consequently, such goals stipulate the need for a structured interview that, however, leaves some room for deviations (Walle 2015, 74). Therefore, the data collection of this study is conducted through structured interviews with predetermined lists of questions. At

the same time, the interview design allows a fieldworker to ask clarifying questions about participants' behavior, attitudes, and reactions of other people. The chosen interview mode is personal interviewing, as participants of this study find it the most comfortable type of interrogation.

The interviews' structure contains the total of eight questions. The first two questions are connected with the respondents' work positions and experience. Following this, the main set of questions asks about the medical leaders' key activities, knowledge, skills, and personal characteristics. In addition, the author makes heavy use of suggestive questions that are developed on the basis of the literature review. Finally, interviews end with a question that asks participants to evaluate their own effectiveness in a leadership position. The interviews' language is Russian and their duration is one hour. In order to secure data reliability, interviews are recorded, translated, and transcribed word-to-word in English. In the survey, only the main set of open-ended questions remained. Some of them were accompanied with relevant definitions and example answers in order to ensure that participants understand the inquiries. Finally, the survey contained a description that concisely stated its purpose and target participants. It was launched through a SurveyMonkey platform.

Data analysis started with translating the interviews from Russian into English and transcribing them word-to-word. Thereafter, the author used an inductive approach and conducted thematic and framework analyses of the transcripts. Thematic analysis is used to distinguish trends of meanings in qualitative data (Braun & Clarke 2004, 6). The method implies detecting both semantic and underlying ideas. It involves the stages of coding, themes development, and identification of relationships between themes. (Guest et al. 2012, 13.) In addition to thematic analysis, framework analysis was partly utilized, since it allows to create categories and an analytical framework in different stages of an analysis process (Gale, Heath, Cameron, Rashid, Redwood 2013, 4-5). The analytical framework of this study was based on the concept of competency iceberg. Initially, the key interview questions represented the main categories in data sorting. Following this, thematic coding was used to develop sub-categories within the chief categories as well as create new groups. Finally, different categories were assembled into themes that represented competencies. The process of theme development also included comparing code frequencies and graphically illustrating relationships between codes and themes. The analysis was assisted by Weft QDA software.

3.3 Phases of the study

The study began in the week 47 of 2019 and started with initial literature review, identification of the scope of work and research questions and methods. Afterwards, the topic-related literature review was conducted from the week 2 until the week 11 of 2019. Consequently, in the week 12, interview and survey were designed and tested. As a result, direct questions about personal motives and attitudes were excluded, as they were too difficult to understand and answer. However, such information was elicited from indirect questions and during data analysis. Moreover, the test revealed a need for defining and explaining some terms, such as competency, leadership, and skills. Further, the interviewer had to ensure that discussions remained focused on leadership and would not shift to management and general clinical activities.

Following this, empirical data collection was done from the end of week 13 to the end of week 15. Interview collection started with contacting the administration of Organization 1 and six other hospitals in Saint-Petersburg via phone on 28 March. On the following day, 29 March, letters with a link to survey were sent to thirteen hospitals. However, the attempt was not successful, as hospitals' administration was unwilling to collaborate. At the same time, medical management of lower levels was not eligible to give interviews without the permission of administration. Therefore, the author changed the approach and made use of personal contacts to reach clinicians instead of contacting them officially. Consequently, clinical managers of the six participating organizations were approached via phone during the weeks 14 and 15. During a phone conversation, the author shortly explained the aim of the research, its importance, the value of participants' opinions, and confidentiality of results. These issues were explained in more detail during one-to-one meetings. Overall, ten inquiries were made, which led to six interviews and four refusals. Therefore, the interview response rate was 60 per cent. The author conducted in-person interviews in Russian language that lasted for one hour. However, two interviews were shortened to 30 minutes due to the time constraints of the participants.

At the same time, survey participants were contacted. The author contacted each informant via e-mail that explained the study purpose and value, and approximate duration of interrogation. Officially, the author obtained none response to 13 requests. At the same time, there were three replies to five unofficial inquiries. Consequently, the response rate to the survey was 17 per cent. Additionally, the author had a five-minute meeting with the survey Participant 9, during which they underscored the most important issues in their response.

Thereafter, data collection was followed by data analysis, which occurred in the week 16. Consequently, the results were discussed in the light of literature review in the week 17. Finally, in the weeks 18 and 19, recommendations for future research and evaluation of the study were made.

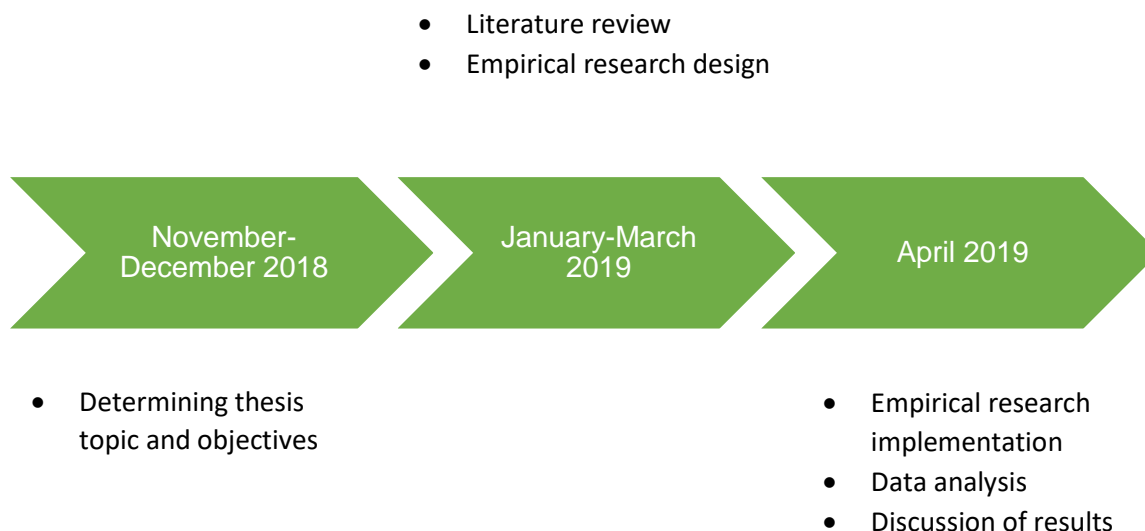


Figure 7 Data collection and analysis timeline

3.4 Results

The result of the present study aims at providing a leadership competency model. Therefore, at the beginning, it is important to understand the ultimate goal or the mission of medical leader's efforts. Consequently, the first question of interviews and surveys addresses this issue. The summary of the responds indicates that their goal is to protect people's health and provide patient care. Having a clear understanding of and commitment to the ultimate goal is highly important for general and medical leaders in order to build a close-knit team around a shared vision.

Activities

It is necessary to understand the work-related activities of Russian medical leaders in order to formulate their functional competencies. Therefore, the first area of interrogation was Activities and Responsibilities. Overall, the Activities and Responsibilities category may be divided into two large groups: Management and Leadership. As the theoretical part suggested, management and leadership activities are closely related, which may lead to their confusion and overlap. Indeed, some of the responsibilities that the experts listed

pertain to management; consequently, the author had to create the additional group of Management. The author will present Management briefly, and after that focus more on other categories of investigation.

Medical leaders have mentioned the following responsibilities, associated with managing medical staff: coordination, conflict prevention, innovation management, human resources management, regulation of conduct, workflow optimization, supervision of occupational safety, provision of clear definition and control of rules that are based on the government requirements, and establishment of organization's goals that are based on funding. Firstly, coordination refers to managing and linking patients with service providers, as well as establishing links within medical teams, so that different types of specialists could collaborate smoothly. There is also a need to coordinate the work of different departments over the same patient. In addition, it was noted that maintaining strong subordination of different levels of medical personnel at workplace is vital for smooth workflow. Similar to other organizations, human resources are managed by the special department for the most part. However, medium-level leaders are responsible for selecting and replacing employees. Head Doctors naturally supervise the whole human resources activities and, specifically, resolve controversial questions in commissions and promote personnel qualification by means of trainings and conferences.

Leadership

Person-oriented approach is an overarching theme that defines the most important personal characteristics of a medical leader and determines the communication with medical personnel. It is associated with mentoring type of leadership and believed to be the most optimal method of medium-level management, while high-level management may utilize both mentoring and directive styles. The interviews revealed that the essence of the approach is in establishing a unique psychological contact with every subordinate, considering their personal characteristics and understanding their problems, demands, and abilities. Personal characteristics of an employee influence leader's manner of speaking, choice of language, motivation methods, penalty, sometimes even work and innovation process. Medical personnel may differ by such characteristics as age, gender, emotional and physical condition. One of the respondents even suggested that it is helpful for a medium-level leader to be aware of personal and family matters of their team members.

Anyway, this is where the method of individual approach to personnel takes place. It is very important at a lower level of medical leadership. This is where

directive style of leadership is not relevant. Here, only person-oriented and individual style of leadership is relevant, when you need to have a certain approach to every person.

Within the person-oriented approach, demands and reprimands are made in a respectful way, avoiding directory tone, and are accompanied by explanations, persuasion, education, and humor.

I think that a leader should primarily love people, and demand from them the things they are required to do, but one should demand not by hard means, but by means of convincing.

Among their most important person-oriented methods of leadership, one of the respondents mentioned the increase of personnel responsibility, the development of workers' initiative and improvement of individual excellence.

I do not focus so much on labor optimization, but rather on the increase of responsibility. Another very important point is the development of workers' initiative and improvement of individual excellence.

It is important that workers themselves aim at increasing their level of expertise and excellence, because if not, it is all going to be ruined. I stimulate them towards that (developing excellence).

Like in general leadership, medical leaders develop vision and communicate it to the team. They define the desired outcome, believe in it, explain it clearly and consistently to the team, and influence team members to achieve it. They also endeavor to unite the team around the same goal.

That is why the head doctor should consistently, clearly, not only to control with the stick in their hand, but to explain the targets and believe in them.

But one should set one goal for all and say that the hospital is the place where people come with pain, and they should leave the place relieved. There should be goodwill at every place.

Medium-level leaders envision the general desired outcome as patient recovery, while high-level management may orient their team towards achieving organizational targets that are usually set for 2-3 years.

And the patient should be at the center. All the services should be around a patient. And our goal is to release them from the hospital in a healthy state, provide them health assistance, do surgery.

A medical leader strives to build a close-knit team that will share the same values and goal. They create a team by “choosing the right people” and targeting the same outcome. It is also possible to strengthen the team spirit by common activities, such as conferences where clinicians could share their experience. Medical team is easier to unite with a person-oriented approach, which is especially appropriate at lower levels of management.

The task of the leader is to choose right people for a team, so that there would be no confrontations, the team should be calm.

The most important thing... calm is when everyone do one job, when they target one goal.

Clinical leadership

The distinctive feature of medical leadership is the deep involvement in clinical work and the need to monitor the whole process of service provision. The leader should be able to provide practical and methodological help to doctors. Therefore, similar to foreign countries, the notion of authority plays a key role in medical leadership in Russia.

It is very important that a leader at this level has enough professional knowledge in this area. Because they should know the duties of all the medical staff inside out, including nurses and social workers. Such a leader has to know especially nuances of the work. Because a head doctor does not need to know it. But a lower leader has to do it, and, therefore, he or she needs to have a large work experience.

In addition, experts note the importance of defining precise responsibilities of medical personnel.

As for the personnel – they should know their responsibilities and perform them precisely, clearly, and within the borders of their defined responsibilities. Without creativity and personal wishes. But rather the way that is needed and defined.

Another activity associated with clinical leadership is education and nurture of medical staff. Finally, personal and emotional motivation plays an increasing role in light of low salaries in the industry. Authority is an indispensable feature of medical leaders. Russian

leaders characterized authority as clinical excellence, knowledgeability, hard work, and being an informal leader, which means being chosen as a leader by the team.

Knowledge

The most cited area of knowledge is psychology, which enables medical leaders to use person-oriented approach to personnel.

As I have said, one needs to have personal approach to everybody. So here one needs to apply methods that are used by psychologists and psychotherapists.

So, having such knowledge I can orient on what is going on with a worker, and, before saying and demanding something, I need to understand in what condition they are. It is very important, and important especially at our place.

Further, clinical knowledge is a prerequisite for medical leadership. Medium and low-level leaders should know the work processes of doctors, nurses, and maintenance staff up to the smallest details. Higher-level leaders should have general medical knowledge of services provided by different medical specialists.

In addition to that, medical leaders need to be legally literate. Firstly, similar to other areas, medical leaders should know labor code. Secondly, compliance with legislation in the area of healthcare is necessary for them. Thirdly, the need for additional legal knowledge may depend on specialization of a medical department. For example, a leader of narcological dispensary should know the rights of children and legal issues related to informative agreement and personal information.

This obliges us to be legally literate.

Of course, they should know the labor code.

Another knowledge that medical leaders need refers to management. This area includes financial management, human resources management, project management, purchasing, conflict prevention, and team work.

Skills

First of all, medical leaders need skills that empower them to use person-oriented method of leadership. Specifically, leaders need to be able to talk to people in different ways and understand their demands, needs, and abilities at a given point of time.

Another important skill is the ability to talk to different people in different ways.

Other skills that relate to psychology as well refer to emotional control. Medical leaders stress the need for displaying confidence and controlling their temper, which could be very difficult at times.

One has to be able to control their temper in order not to shout and not to kick somebody out of the office.

Other skills refer to communication, decision-making, conflict-management, team-management, critical thinking and education. Communication and public speaking skills are used to communicate goals and motivate team members. Decision-making implies the abilities to solve problems in a timely manner, make fast decisions in an evolutionary way, and prioritize.

Personal characteristics

Mentoring style of medium-level leadership requires a person to be humanist and have natural inclination towards feeling people.

Without humanistic approach, a leader will become insensitive, with a directory style of leadership. And this does not promote teamwork.

...one has to see people, feel their condition.

At the same time, such a person needs to be demanding.

...being demanding – yes, it is needed.

Due to tough and often aggressive environment and frequent stressful situations, emotional stability and patience are required.

A person should be emotionally stable.

Moreover, a medical leader should be organized and focused. Assertiveness and confidence are also crucial in order to motivate employees and negotiate with administration. Other characteristics include professional honesty, keeping personal and emotional distance, commitment, and perseverance.

Work context

Participants were asked to name work-related factors that influence their leadership. Most often, they mentioned lack of resources, which refer to the lack of finances, departments' capacity, amount of drugs, personnel, and time. Lack of resources causes additional

stress, work impediments, and aggression by patients. At some places, lack of personnel results in doctors performing unqualified work, which, in turn, causes time pressure for them.

Number of patients is way more than the capacity of their department.

Because funding was insufficient, I do not even mention the present situation – very insufficient funding, from my point of view.

Well, I work without a nurse and I have to write down patients' personal information, such as name, date of birth etc.

Another significant influencer is gender. As medical leaders say, the predominance of females in medical teams makes them susceptible to emotions; therefore, a leader should know how to deal with emotions, have patience, and communicate carefully. In addition, several respondents characterized medical environment in Russia as tough and aggressive. Other influencers include conflict of rights of a patient and a medical worker, seasonal work, and the need to comply with sanitary and epidemiological regime.

We have mostly female team. That means that there are more emotions.

Because the environment is very tough. In our culture people tend to behave aggressively and pushy to achieve their goals.

Finally, the author groups the identified competencies into a model, applying thematic analysis and the knowledge of competency modelling practices. The resultant figure is presented on the next page.

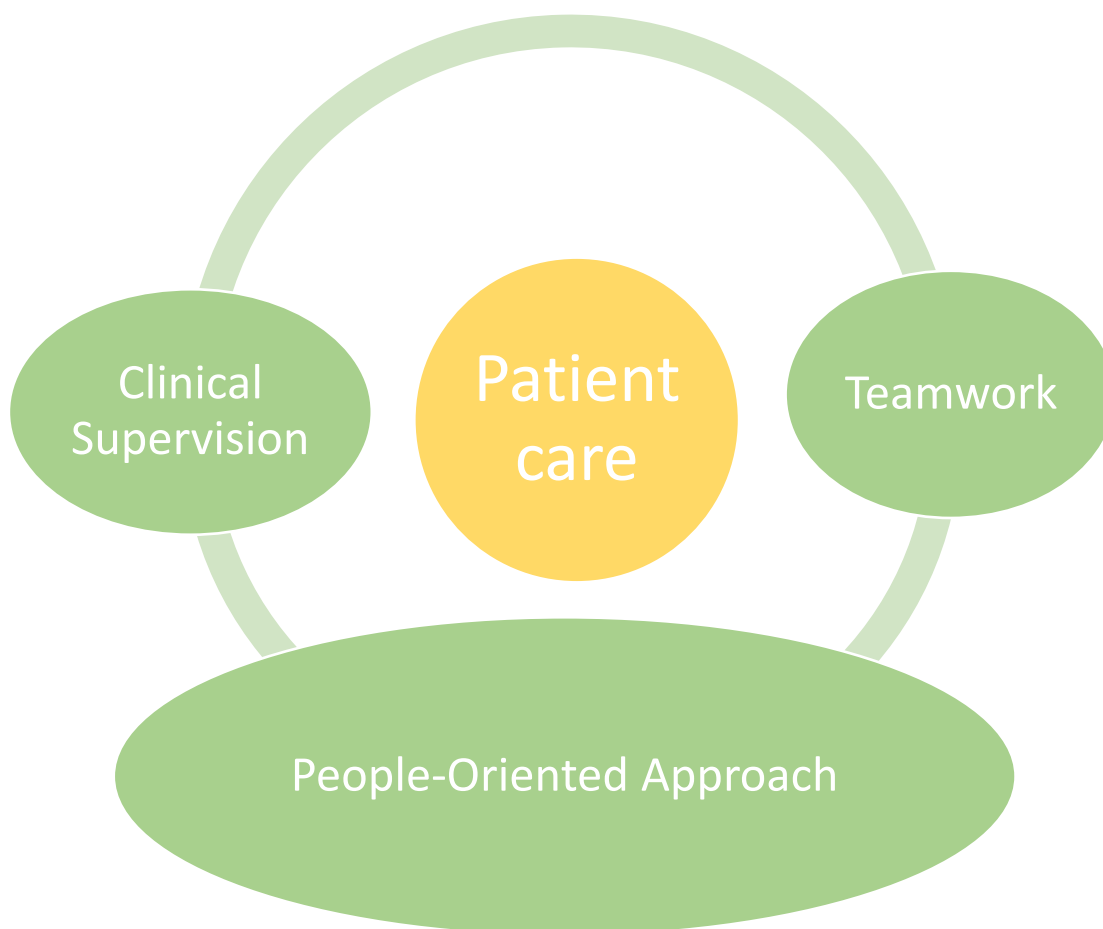


Figure 8 Leadership competency model

Table 3 Leadership competency model

People-oriented approach			
People-oriented style of leadership focuses on developing relationships within the team. The leader mentors and develops employees, addresses their needs, and creates a comfortable work environment.			
Building Relationships	Developing Employees	Emotional Control	Self-Analysis
Building Relationships			
Medical leader:			
<ul style="list-style-type: none"> - Understands personnel needs, demands, and abilities - Considers employees' emotional and physical condition - Talks to people in different ways 			

- Utilizes knowledge of psychology and psychotherapy for the above mentioned activities
- Demonstrates humanistic approach

Behavioral examples:

- The natural inclination towards loving and feeling people helps a leader to master the skills related to understanding employees' personal characteristics.
- In order to promote relationships within their team, they avoid being directive and bossy, but rather try to be approachable and respectful. In case when an employee makes a mistake, a leader listens to their explanations and considers their condition before making their decision.
- A leader makes a careful choice of language, intonation, and attitude when they talk to people of different backgrounds, gender, and psychological types.

Developing Employees

Medical leader:

- Educates and nurtures employees
- Develops employees' initiative
- Involves employees in improvement of individual excellence
- Develops personnel responsibility

Behavioral examples:

- In case of underperformance, the leader tries to understand its reasons. If needed, the leader addresses the employee's knowledge, skills, or attitude gap. When doing so, the leader tries to avoid being directive, but rather utilizes mentoring style of behavior.
- By building positive relationships, increasing the area of personnel responsibility, and showing involvement in employee's development, a leader inspires their team members to take initiative and improve their excellence.

Emotional Control

Medical leader:

- Is emotionally stable
- Controls their emotions and temper
- Deals with emotional employees
- Keeps personal distance

Behavioral examples:

- The leader does not lose their temper and behave aggressively towards colleagues.
- The leader does not allow personal preferences such as friendship to have influence on their decisions.

Self-Analysis

Medical leader:

- Monitors team's satisfaction
- Assesses their control over the team

Behavioral example:

- Leader collects employees' feedback regarding their job satisfaction. In addition, they monitor team's meeting discussions and analyze employees' reactions to the leader's behavior in order to see the level of leader's control over the team.

Teamwork

Medical leader builds a reliable and united team that shares the same values and goal. They maintain team's effectiveness by preventing conflicts, coordinating, and performing human resources activities.

Team Creation

Conflict Prevention

Coordination

Team Creation

Medical leader:

- Clearly determines the vision and values
- Unites team members by communicating the vision and encourages them to achieve the desired outcome by means of explaining and convincing
- Assesses employees' competence and recruits the most appropriate candidate
- Builds a close-knit team that supports a leader and shares their values
- Motivates employees emotionally when financial motivation is insufficient

Conflict Prevention

Medical leader:

- Prevents conflicts
- Ensures that conditions and reasons for decisions are understood by subordinates
- Regulates relationships within a team (e.g. by replacing workers)
- Deals with aggression from patients and colleagues
- Seeks the optimal solution to comply with the rights of a patient and a medical worker that often contradict each other

Coordination

<p>Medical leader</p> <ul style="list-style-type: none"> - Utilizes strong communication and collaboration skills to coordinate clinicians and different medical departments - Negotiates with higher management and assertively defends the interests of the team - Ensures strong subordination 		
<p>Clinical supervision</p> <p>Clinical supervision is the process of controlling, supervising and mentoring clinical services delivered by the team.</p>		
Clinical Competency	Demonstrating Personal Qualities	Decision-Making
Clinical Competency		
<p>Medical leader:</p> <ul style="list-style-type: none"> - Earns trust and respect of employees by displaying supreme clinical knowledge and skills, erudition, and hard work - Monitors the whole process of service delivery - Provides practical and methodological help - Clearly defines and communicates tasks, responsibilities, and rules - Strictly controls and demands the needed performance - Applies clinical and leadership knowledge 		
Demonstrating Personal Qualities		
<p>Medical leader demonstrates such personal qualities as:</p> <ul style="list-style-type: none"> - Painstaking approach 		

- Stamina
- Tolerance to stress
- Self-organization
- Honesty
- Perseverance
- Confidence

Decision-making

Medical leader:

- Demonstrates general decision-making and problem-solving skills
- Demonstrates ability to set priorities
- Demonstrates ability to make quick decisions in an evolutionary way

Behavioral example:

- The leader reduces personnel stress by planning and scheduling changes in advance.

4 CONCLUSIONS

4.1 Discussion of results

The study reveals that leadership takes a large part in the activities of medical managers in Russian public hospitals, which makes their approach similar to that of medical leaders in a number of Western European countries. Interview analysis has indicated that both medium-level and high-level managers use leadership approach in their daily work. Naturally, orientation on leadership is prevalent at the lower-level management, while Head Doctors (CEOs) and Medical Deputy Directors (Chief Medical Officers) are more preoccupied with managerial activities. However, the study shows that both groups must have certain leadership characteristics in order to be successful in their positions. Firstly, they need to earn authority and be informal leaders of the medical team. Secondly, they utilize visioning to influence others and build a team of like-minded people that share their values and goals. Thirdly, personal inspiration plays a significant role in medium-level leadership, because of both people-oriented approach of leaders and the lack of sufficient financial motivation. Table 3 summarizes the comparison of Russian medical leadership and the leadership theory presented in the theoretical framework,

TABLE 4 Comparison of the leadership theory and the medical leadership in Russia

Leadership theory (Chapter 2.1)	Medical leadership in Russia (Chapter 3)
"...leadership focuses on the future in the longer term."	Leaders describe their vision as relieving a patient and strengthening people's health.
"It sets direction by envisaging the outcome and inspiring other members towards the goal." "In order to execute their project, leaders make use of effective communication to assemble a team that will share their mission and strategy."	Several leaders reported that they formulate the vision, consistently and clearly explain it to employees, and convince them to achieve it.
"A leader is chosen by other members; this way, their position may be either formal or informal."	Leaders have indicated the need to be informal leaders of the team.

<p>“The result of the leader’s activity is a move, a change, and an innovation in an organization.”</p>	<p>The efforts of medium-level medical leaders aim at achieving better results and developing employees’ competence.</p> <p>In addition to that, high-level managers aim at meeting operational objectives of the organization.</p>
<p>“When they choose a leader, followers most often look for such personal features as: credibility, honesty, visioning, and competence.”</p>	<p>Leaders have mentioned three of these characteristics, including honesty, visioning, and competence. However, they have not provided enough information related to credibility.</p>

The data analysis has shown that out of six interviewees, three interviewees utilize people-oriented approach, two of them apply task-oriented approach, and one interviewee has not provided enough information on this topic. Although this study has given much attention to modelling competencies needed for people-oriented approach, it is still cannot be argued that this approach is the only appropriate style of leadership. Similar to those who applied people-oriented approach, two leaders that displayed task-oriented style has been securing successful results of their department’s work. Nevertheless, the need for being demanding is displayed by the majority of leaders, which indicates that medical leaders may combine the two styles.

After identifying the most important medical leadership competencies in Russia, the results of the study can be discussed in view of the existing literature on this topic. As mentioned earlier, the part of the theoretical framework is based on the studies of healthcare leadership in Western European countries. At this point, the comparison between medical leadership in Russian and Western countries could be made to see if the results are different, and if the experience of Russian medical leaders bring a new facet in the understanding of medical leadership. The results of this thesis show that there are many corresponding dimensions in the activities and personal characteristics of both kinds of leaders. First of all, similar to their Western counterparts, Russian medical leaders utilize two different approaches of leadership: directive and developmental. Some of the leaders use directive approach as the main mode of behavior, while others rely chiefly on the developmental style and apply directive approach only in cases of emergency.

Considering roles and activities of medical leaders, the results of this study show correlation with the results of other systematic reviews. The exception is the need for balancing between conflicting interests of medical and managerial departments. Although such an activity was found in the literature review, participants of the present study did not mention it. Moreover, this study does not include financial management and IT, as they are part of management activities. Knowledge and skills that were elicited in the present study appear to be similar to the ones found in the systematic reviews.

Similar to literature review, this study recognizes that Emotional Intelligence is paramount and that it supports all the other activities of medical leaders. However, this competency is not in the base of the present study's model. Rather, Emotional Intelligence is complemented with a pair of other sub-competencies, and the resultant People-Oriented Approach competency is identified as a keystone of the model. In addition, the model presents new personal qualities of medical leaders, such as stamina, perseverance, and painstaking approach. Further, Russian medical leaders did not devote as much attention to leading change and innovation as their foreign counterparts did. Moreover, the study discovered that context-related influencers of Russian medical leadership differ from that of other countries in three areas: lack of resources, gender, and aggression. These factors stipulate that Emotional Intelligence, Humanistic Approach, and Conflict Management competencies are especially critical and difficult to sustain in Russian work environment.

4.2 Answers to research questions

In order to maintain a clear focus of researches, authors formulate the main research question. In addition, they create the sub-questions that guide the study through all the steps of building the needed knowledge. In the end, a valid research produces information that answers all of the inquiries clearly. This sub-chapter is devoted to answering the research questions that were presented in the introduction. The author answers the sub-questions first, and later proceeds to answering the main question.

1) What kind of leadership do managers of Russian hospitals practice?

The study shows that the managers perform mainly people-oriented leadership with a marked dependence on building and maintaining personal relationships. Related to the people-oriented approach, a developmental style of leadership is applied as well. At the same time, medical managers must be able to maintain strong subordination of personnel and hold them accountable in the area of their responsibilities. Therefore, the leaders use a mixed approach of people-oriented and task-oriented leadership.

- 2) How do competencies of medical leaders in Russia differ from those of medical leaders in other countries?

For the most part, the competencies in Russian context correlate with those in English-speaking countries. The differences include, first, the lack of knowledge in the areas of innovation and shared leadership. Second, the study identifies the new personal qualities of medical leaders, such as stamina, perseverance, and painstaking approach. Third, the different context of those leaders involves the impact of insufficient resources, gender, and aggression.

- 3) What is the workplace context of Russian medical leaders?

The most significant context influencer of medical leadership in Russia is the lack of resources in state organizations. Such a lack refers to the insufficiency of finances, capacity, materials, personnel, and time. Those factors impede the leadership work, and hamper the person-oriented approach in particular. Another context-related factor is gender. There is predominance of women in the medical industry, which makes medical teams more susceptible to emotions than male teams. Additionally, medical leaders in Russia often deal with aggression, which may come from both patients and employees. Finally, seasonal workload also influences medical leadership.

After resolving the sub-questions, the author is able to answer the main research question:

- 4) What are the leadership competencies of hospital managers in Russia?

With the help of the literature review, the empirical study was evaluated, analyzed and organized into a competency model, which is graphically presented in the results section. Here, the author will list them in the text format. The identified competencies are grouped into three main themes: People-Oriented Approach, Teamwork, and Clinical Supervision. The first theme, People-Oriented Approach, includes competencies related to building relationships, developing employees, emotional control, and self-analysis. The second theme, Teamwork, involves the ability to create teams, which, in turn, includes conveying a unifying vision, assessing employees' competences and recruiting the right candidates, and motivating. In addition, the theme requires the competencies of conflict prevention and coordination. The final theme, Clinical Supervision, encompasses Clinical Competency, Demonstrating Personal Qualities, and Decision-Making. Clinical competency encompasses outstanding clinical knowledge and skills, authority, as well as the ability to define the goals and monitor their execution.

Further, Demonstrating Personal Qualities includes a list of personal qualities that features self-organization, painstaking approach, honesty, stamina, tolerance to stress, perseverance, and confidence. Finally, Decision-Making relates to the ability of making quick decisions in an evolutionary way and an ability to set priorities.

4.3 Evaluation of the study

The author utilized both secondary and primary data and commenced certain steps to assure their reliability and validity. First, the literature review comprised of the expert materials in the field, including peer-reviewed scholar articles, review papers, and books. Prior to utilizing any secondary source, the author checked them for a recent date of publication, literate language, reliable references, research methods, and authorship. Second, data collection and analysis were performed in a clear and consistent way. The interview and survey design closely match the research questions and the theoretical framework. Further, the interaction with interviewees was carefully considered during the pilot interview. As a result, the pre-made list of clarifications and concept definitions accompanied each meeting, thus ensuring that participants understand the questions correctly. In addition, each interview was preceded by the explanation of the research objectives. Moreover, the interviews followed a defined structure in order to ensure their relevance and comparability. At the same time, the interview structure allowed clarifying and suggestive questions to take place. The relevance of information was further secured by selecting a sample with a large experience in leadership positions. Thereafter, the reliability of the analysis process was maintained by a word-to-word transcription and translation of the answers. Overall, the size of the study corresponds with a qualitative nature of the research and provides sufficient extent of information for the purpose of the study.

4.4 Recommendations for future research

Several suggestions for future research arouse at the end of the study process. First, as any model, the resultant competency model should be tested in medical organizations to discover its suitability in such processes as recruitment and competency development within hospitals, and leadership education in universities. Second, the concept of shared leadership presented in the literature review was not sufficiently studied yet in Russian context. Third, the competency model of this study lacks information on leading change and innovation, although the literature review identified this area as an important aspect of leaders' work. Consequently, there is a need to study this topic deeper.

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Interviewee 6. 2019. Chief Executive Officer. Organization 1. Interview 9 April 2019.

APPENDICES

Appendix 1 The NHS Medical Leadership Model



Examples of learning and development opportunities



As professional lead within management teams, ensures that professional values and ethics are faithfully represented

Identifies incompetent or sub-optimal practice and investigates to determine reasons, taking corrective action where necessary

Acts on information which would lead to improved practices and services

Doctors show leadership through **acting with integrity**: behaving in an open, honest and ethical manner.

Competent doctors:

- Uphold personal and professional ethics and values, taking into account the values of the organisation and respecting the culture, beliefs and abilities of individuals
- Communicate effectively with individuals, appreciating their social, cultural, religious and ethnic backgrounds and their age, gender and abilities
- Value, respect and promote equality and diversity
- Take appropriate action if ethics and values are compromised.

Appendix 2 Interview questions

- 1) What is your position in the organization and work experience in the leadership position?
- 2) What are the key activities of a medical leader?
- 3) What is the needed knowledge?
- 4) What are the needed skills?
- 5) What personal characteristics are important for a good medical leader?
- 6) Can you provide behavioral examples of those characteristics?
- 7) What is the job-specific context that influences medical leadership?
- 8) Do you consider yourself an effective medical leader?

Appendix 3 Survey questions

- 1) What is your position in the organization and work experience in the leadership position?
- 2) What are the key activities of a medical leader?
- 3) What is the needed knowledge?
- 4) What are the needed skills?
- 5) What personal characteristics are important for a good medical leader?
- 6) What is the job-specific context that influences medical leadership?