# ASSESSMENT OF DOCTORS' PERCEPTION ON CLINICAL LEADERSHIP: A CASE OF TERTIARY HOSPITALS IN DAR ES SALAAM TANZANIA

**CYPRIAN G. NTOMOKA**

**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION**

**DEPARTMENT OF ACCOUNTING AND FINANCE**

**THE OPEN UNIVERSITY OF TANZANIA**

**2022**

## CERTIFICATION

The undersigned certify that he has read and hereby recommends for acceptance by the Open University of Tanzania a dissertation entitled: Assessment of Doctors' Perception on Clinical Leadership: A Case of Tertiary Hospitals in Dar es Salaam Tanzania in partial fulfillment of the requirements for the degree of Master of Business Administration (Leadership and governance) of the Open University of Tanzania.

.....

Dr Chacha Matoka

(Supervisor)

.....

Date

## COPYRIGHT

## DECLARATION

I, **Cyprian G. Ntomoka**, declare that, the work presented in this dissertation is original. It has never been presented to any other university or institution. Where other people's works have been used, references have been provided. It is in this regard that I declare this work as originally mine. It is hereby presented in partial fulfillment of the requirement for the Degree of Master of Business Administration (MBA) of the Open University of Tanzania.

…….

Signature

……

Date

## DEDICATION

This work would have been possible without the love and patience of my wife Alice Samweli and our daughters Miriam, Milcah and Millicent; thank you very much!

## ACKNOWLEDGMENT

All the glory goes to the Almighty God for the life and courage given to pursue the research. I owe gratitude to many other people who made the dissertation successful inclusive MBA students' class 2017/2018.

The success of this research is a result of undivided attention and support from Dr Chacha Matoka who was my supervisor all the way from proposal development to the point of writing this final report; he definitely takes the credit for the work. My course coordinator Mr Michael Mwacha is also remembered for his primary guidance into the matter.

Most importantly, none of this work would have been possible without the love and patience of my wife Alice Samweli and our daughters Miriam, Milcah and Millicent; thank you very much!

Finally, thanks to all who haven't been mentioned above but took part in my study program.

## ABSTRACT

This study sought to investigate the perception on Clinical leadership of doctors working in tertiary hospital in Dar es Salaam Tanzania. The study was guided by the following objectives; to find out whether clinical leadership and health care leadership mean the same thing for doctors, to determine the perceived difference between medical leadership and clinical leadership and to examine the perceived similarities of doctors' leadership and clinical leadership all aiming eventually to lay a foundation of clinical leadership studies in Tanzania. Using a pre-tested structured questionnaire, doctors with a minimum of first degree working with Muhimbili (plus Mloganzila), JKCI, MOI, Aghakan, ORCI and CCBRT filled the questionnaire physically or submitting an electronic copy of the same. Descriptive statistics and correlation analysis were used to analyse data. The study found that healthcare leadership was significantly positively and moderately correlated with clinical leadership, Doctors' leadership was positively correlated with clinical leadership and Medical leadership was also positively and significantly related to clinical leadership. Conclusively, the study recommends that policy makers and leaders in health care industry should give more leadership chance to clinical personnel than non-clinical personnel. A more well-structured research on clinical leadership targeting practices, attributes, barriers and enablers should be conducted as a follow up to this one.

**Keywords:** Clinical leadership, health care leadership, medical leadership, doctors' leadership

## TABLE OF CONTENTS

**CERTIFICATION** ..... **ii**

**COPYRIGHT** ..... **iii**

**DECLARATION** ..... **iv**

**DEDICATION** ..... **v**

**ACKNOWLEDGMENT** ..... **vi**

**ABSTRACT** ..... **vii**

**LIST OF TABLES** ..... **xii**

**LISTOF FIGURES** ..... **xiii**

**LIST OF ABBREVIATIONS** ..... **xiv**

**CHAPTER ONE** ..... **1**

**INTRODUCTION** ..... **1**

1.1 Overview ..... 1

1.2 Background of the Study ..... 1

1.3 Statement of the Problem ..... 4

1.4 General Objective ..... 5

1.5 Specific Objectives ..... 5

1.6 Research Question ..... 5

1.7 Significance of the Study ..... 6

1.8 Organization of the Study ..... 6

**CHAPTER TWO** ..... **8**

**LITERATURE REVIEW** ..... **8**

2.1 Overview ..... 8

2.2 Definitions of Concepts ..... 8

2.2.1 Clinical Leadership ..... 8
2.2.2 Health Care Readership ..... 8
2.2.3 Medical Leadership ..... 9
2.2.4 Doctors' Liadership ..... 9
2.3 Review of Clinical Leadership Theories ..... 9
2.4 Empirical Review ..... 14
2.4.1 Global Review ..... 14
2.4.2 African Context Review ..... 19
2.4.3 Tanzanian Review ..... 22
2.5 Research Gap ..... 23
2.6 Conceptual Framework ..... 24
**CHAPTER THREE ..... 26**
**RESEARCH METHODOLOGY ..... 26**
3.1 Overview ..... 26
3.2 Research Philosophy ..... 26
3.3 Research Approach ..... 26
3.4 Research Design and Strategy ..... 26
3.5 Description of the Study Area ..... 27
3.6 Justification for Choosing this Area ..... 27
3.7 Population of the Study ..... 28
3.8 Sampling Design ..... 28
3.8.1 Sample ..... 28
3.8.2 Sample Size ..... 29
3.8.3 Sampling Techniques ..... 29

3.8.4 Inclusion Criteria ..... 30

3.8.5 Exclusion Criteria ..... 30

3.9 Methods of Data Collection ..... 30

3.10 Tools used in Data Collection ..... 31

3.11 Data Analysis ..... 31

3.11.1 Variables and Measurements Procedure ..... 32

3.12 Data Cleaning and Processing ..... 32

3.12.1 Error Check ..... 32

3.12.2 Missing Data ..... 32

3.13 Validity ..... 32

3.14 Reliability ..... 33

3.15 Ethical Consideration ..... 33

**CHAPTER FOUR ..... 34**

**EMPIRICAL RESULTS AND INTERPRETATION ..... 34**

4.1 Overview ..... 34

4.2 Sample Description ..... 34

4.3 Descriptive Statistics Results ..... 36

4.3.1 Descriptive Statistics Results for General Understanding of Doctors' on Clinical Leadership ..... 36

4.3.2 Descriptive Statistics Results for Does Clinical leadership and Health Care Leadership Mean the Same Thing for Doctors ..... 36

4.3.3 Descriptive Statistics Results for the Perceived Difference between Medical Leadership and Clinical Leadership ..... 38

4.3.4 Descriptive Statistics Results for Clinical Leadership and the Perceived Similarities of Doctors' Leadership ..... 39

4.4 Variables Descriptive Statistics, Reliability and Correlation Analysis ..... 40

4.5 Discussion of the Findings ..... 41

4.5.1 To Find out Whether Clinical Leadership and Health Care Leadership Mean the Same Thing for Doctors ..... 42

4.5.2 To Determine the Perceived Difference between Medical Leadership and Clinical Leadership ..... 43

4.5.3 To Elucidate the Perceived Similarities of Doctors' Leadership and Clinical Leadership ..... 45

4.5.4 General Understanding of Clinical Leadership and Correlation with the Independent Variables ..... 46

**CHAPTER FIVE ..... 50**

**CONCLUSION POLICY IMPLICATION AND RECOMMENDATIONS ..... 50**

5.1 Overview ..... 50

5.2 Summary ..... 50

5.3 Policy Implications ..... 52

5.4 Limitation of the Study ..... 52

5.5 Recommendations ..... 53

## LIST OF TABLES

Table 3.1: Population of the Study ..... 28

Table 3.2: Sample of the Study ..... 30

Table 4.1: Sample Description ..... 35

Table 4.2: Descriptive Statistics Results for Dependent Variable *'s* General Understanding of Doctors' on Clinical Leadership ..... 37

Table 4.3: Descriptive Statistics Results for does Clinical Leadership and Health Care Leadership Mean the Same thing for Doctors ..... 38

Table 4.4: Descriptive Statistics Results for Perceived Difference between Medical Leadership and Clinical Leadership ..... 39

Table 4.5: Descriptive Statistics Results for Clinical Leadership and the Perceived Similarities of Doctors Leadership ..... 40

Table 4.6: Variables Descriptive Statistics, Reliability and Correlation Analysis ..... 41

## LIST OF FIGURES

Figure 2.1: Conceptual Framework ..... 24

## LIST OF ABBREVIATIONS

| | |
|---|---|
| AMO | Assistant Medical Officers |
| CEO | Chief executive officer |
| CPD | Continuous Professional Development |
| DDS | Degree of Dental Surgeons |
| DMO | District Medical Officer |
| FMLM | Faculty of Medical Leaderships and Management |
| HOD | Head of Department |
| IMTU | International Medical Technological University |
| IRB | Institution review board |
| KCMC | Kilimanjaro Christian Medical College |
| MBA | Masters of Business Administration |
| MBBS | Bachelor of Medicine and Bachelor of Surgery |
| MD | Medical Doctors |
| MLCF | Medical Leadership Competency Framework |
| MOI | Medical Officer in Charge |
| MUHAS | Muhimbili University of Health and Allied Sciences |
| NHS | National Health services |
| OUT | Open University of Tanzania |
| RMO | Regional Medical Officer |
| UDOM | University of Dodoma |

# CHAPTER ONE

# INTRODUCTION

## 1.1 Overview

This chapter covers mainly historical background of clinical leadership and its importance. It briefly highlights some research topics which have been done concerning clinical leadership, addresses the main gap, significance of addressing the gap and finally the chapter includes statement of the problem, main objective, specific objectives, research questions and organisation of the study.

## 1.2 Background of the Study

Literature related to clinical leadership and its relationship to Health Professionals (HPs) is scant and there is almost no specific research related to HP clinical leadership. Therefore, huge gaps exist in what is known about the concept of clinical leadership and its application with HP (beyond nursing and medicine). Adding to what can be known in this area is vital if HPs are to play an enhanced part in quality healthcare delivery.

Clinical leadership refers to incorporates of roles and resources that help frontlines clinicians to introduce new ways of working, redesign care for improvements, achieve quality and safety of care outcomes (Malby, 2018). Clinical leadership is very important in influencing point of care innovation and improvement in both organizational processes and individual care practices (Daly et al., 2014). Clinical leadership is crucial to patients centred timely care delivery; system integrity, efficiency and integral components of the health care system (Schyve, 2014). The

implementation of clinical leadership in Tanzania effectively will boost hospital performance and deliverance of standard services to the patients (Chakupewa, 2017).

Before 1970s clinicians were expected to perform clinical issues and management was a role of non-medical personnel like politicians, administrators and managers (Schyve, 2014). After 1980s clinicians began to take management position in hospitals in the developed world and later in the developing countries and the call for clinical leadership in health industries was attributed more by; increase of demand for access to health care, workforce challenge, changing of consumer expectations, mandate to improve patient cantered care, and need of quality and safety of health care (Watson, 2008). Progressively clinicians who engage in leadership has increased globally and positive impacts in hospitals are observed. Currently various departments have been established in different hospitals for the purpose of improving standard services to patients and most of leaders are clinicians (Casey, 2011). Various programs have been introduced to fit curricula and training to develop both professions and leadership to clinicians worldwide (Mannix, 2014).

This study was made in Dar es Salaam city of presumably because it has the tertiary health care facilities and is home to almost one third of all doctors working in Tanzania. The study was meant to bridge the geographical and knowledge gap on the perception of doctors on clinical leadership and eventually as reported in other studies contribute to improved system performance in hospitals, achievements of health reform objectives, timely care delivery, system integrity and efficiency, quality health care provision and patients' safety (Daly et al., 2014). The perfect understanding and implementation of clinical leadership in Tanzania effectively would boost hospital

performance and deliverance of standard services to the patients (Chakupewa, 2017). Clinical leadership in Tanzania will bring positive impacts to clinicians, patients and hospital development; patients' need, complaints, opinions, demand for access to health care, improved patients centred care, quality services, standard services and safety of health care will be achieved timely (Njau, 2016). Proper understanding of clinical leadership is important to doctors as will open up its application fostering increased motivation and performance, workers' needs satisfaction, make their voices to be heard immediately, solve work force challenges in Tanzanian's hospital resulting into high level interpersonal skills and empowerment to other health staff (Kacholi, 2020).

Study by Njau (2016) in Dar es Salaam regional hospitals on challenges of medical leaders, found that medical leadership takes the big chance in clinical leadership and that clinicians were being driven by political figures and lacked leadership knowledge; they had no mandate to reform anything in hospitals without consent from politicians. Another study by Kacholi (2020), in regional hospitals Tanzania on sustainability of quality improvement of health staff, found that whenever clinical leaders were involved in management, improvement in health care services to patients, development of hospitals and motivation to the health staff were noted. In Tanzania the study on doctors' perception on clinical leadership had never been done before creating a gap, which this study wished to fill.

There is a wealth of literature that deals with the role, nature and purpose of nursing and medical leadership, the leaders' characteristics and the value of developing and nurturing nurse and medical leaders. As well, there is a multitude of literature about

the developmental needs of those who aspire to nursing or medical leadership positions. Pintar, Capuano, and Rosser (2007) and Jeon (2011) offer interesting examples of this from a nursing perspective, and Fulop and Day (2010) offer a thesis on the challenges clinical "managers" face as they learn leadership skills. However, there is much less of this type of literature and very little of an empirical nature, related to HP leadership.

The significance of addressing the gap was to test the theory that shows clinical leadership practises to be affected by it being perceived as health care leadership, medical leadership or doctors' leadership all aiming at establishing clinical leadership practises in the country for the purpose of improving health care service delivery. Furthermore, this would build strong confidence to doctors that they can spend their moment serving patients and performing management at the same time.

### 1.3 Statement of the Problem

Clinical leadership practice in Tanzania is not optimal; medical leadership in which non-health personnel take lead in planning for hospital budget, procurement and employment of health staff, is reported to result in dissatisfaction of patients and worker's needs (Schyve, 2014, Njau 2016). Hospital managers and administrators who are often not on a frontline of health care delivery remain as sole planners and largely involved in medical procurement, monitoring the workers performance and treatment outcome in the hospitals (Mianda, 2019). Non-health personnel working as hospital managers, politicians and administrators are not on the frontline to serve the patients; hence client's views, complaints and preferences are often not considered first during planning and excursion. Moreover, medical personnel workers voices and

recommendation are comparatively ignored leading to demotivation and underperformance in delivering care to the patients and hospital development (Hughes 2018, Stokes 2012). Clinical leadership practises is dependent on the perception of the target health professionals in such a way that the more perfect the perception the higher will be the practices. This study aimed at assessing doctors' general understanding on clinical leadership and how their perceptions affect the clinical leadership practices on top of answering the questions whether medical leadership, healthcare leadership and doctors' leadership are synonymously perceived to be clinical leadership.

### 1.4 General Objective

So as to eventually improve clinical leadership practices in the country the study's general objective was 'Assessment of doctors' perception on clinical leadership'

### 1.5 Specific Objectives

(i) To find out whether clinical leadership and health care leadership mean the same thing for doctors.

(ii) To determine the perceived difference between medical leadership and clinical leadership.

(iii) To examine the perceived similarities of doctors leadership and clinical leadership.

### 1.6 Research Question

Because clinical leadership terminology offers interchangeable meaning in the health industry, proper understanding may affect how one practice or support its practice. I therefore had these questions to be answered by this research:

(i) Do healthcare leadership and clinical leadership mean the same thing?

(ii) What are the perceived difference between medical leadership and clinical leadership?

(iii) Is clinical leadership synonym to doctors' leadership?

## 1.7 Significance of the Study

The study aimed at generating a quantitative theoretical knowledge on the doctor's perception on clinical leadership. This would eventually contribute to policy changes and health care industry adjusting to give more chance for clinicians not only to do clinical works but lead in planning and excursion of quality patient centered health care at all levels. Furthermore, being the first of its kind in the country would form the basis for further researches in the area of clinical leadership. Lastly, the research was part of completion of MBA training in leadership and governance at the Open University of Tanzania

## 1.8 Organization of the Study

The study started the background studies to site out the problem we want to solve. Main and specific objectives were enumerated followed by literature review to get the empirical reviews internationally, in Africa and in Tanzania. Conceptual framework indicating dependent and independent variables was formulated.

Using pretested structured questionnaire after non-probability convenient sampling of doctors from the Dar e s Salaam tertiary hospitals respondents were interviewed. Positivism philosophy and descriptive cross sectional study approach using psychosomatic Likert scales were used to capture data. Handling all the data collected

meticulously to include only those that fit in the methodology and discard the rest, analysis and interpretation of the results was done under IBM SPSS Version 20 software assistance.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Overview

The chapter presents conceptual framework of the study, review of theories and models, empirical reviews, research gap and conceptual framework. It provides us with the backbone of the study and justification for the endeavors.

## 2.2 Definitions of Concepts

### 2.2.1 Clinical Leadership

Clinical leadership refers to putting clinicians at the helm of determining and administrating clinical services (Swanwick, 2011). It refers to putting clinicians to manage hospitals in order to influence point of care innovation and improvement in both organizational processes and individual care practices to achieve quality and safety of care outcomes (Malby, 2018). Lindell et al., (2018) further defines clinical leadership to incorporate a variety of roles and resources that help frontlines clinicians to introduce new ways of working and redesign care for improvement.

### 2.2.2 Health Care Readership

Health care readership according to Jonas et al., (2011) is interchangeably used as clinical leadership meaning setting inspiring, promoting values, visions, using frontline clinical team irrespective of cadre capitalizing in their experience and skills to ensure the needs of the patients are the central focus to the organisation’s aims and delivery of quality health services to the patients.

### 2.2.3 Medical Leadership

Medical leadership is a convention leadership style in the health industry in which medical and non-medical people are given some roles together to run the hospital. Medical personnel in this type are senior doctors and Nurses who are not necessarily actively practising and non-medical can either be some of the political figures or with connection with the government nominees. Njau et al (2016).

### 2.2.4 Doctors' Liadership

Doctors' leadership refers to the Doctors roles in a medical leadership in which most of the senior doctors who are retired or not actively practising are given administrative duties like what we see in RMO, DMO leadership style in Tanzania health system. Kacholi et al (2020).

## 2.3 Review of Clinical Leadership Theories

Clinical leadership theory grossly perceive it to be the skill-based power given to actively practicing clinicians (not necessarily doctors) to manage the hospital staff, treat patients and perform any mandatory duty needed for the purpose of improving staff's working environment, health care services and patient safety. This clinician must have relationship skills, proper personality, patient focused leadership style and technical competences.

However, many clinicians are theoretically not engaging in leadership because of limited perception where others think it is for only doctors, or goes with non-clinical personnel. Still others think it is because of time limitation, institutional and system bureaucracy, lack of peer support, overwhelming clinical works on top of the fact that

their basic medical school training concentrated more on giving clinical competences than acquiring leadership skills.

The theory has been described by many authors with perception varying depending on the respondent groups. In a study using semi structured interview of the senior retired NHS leaders, clinical leadership was seen to stand for doctors taking active role delivering 21st Century health care but was also found to be an ambiguous terminology mixing its meaning with medical leadership. Clinical leadership was suggested to be termed healthcare leadership meaning the leadership provided by clinical personnel to improve health care delivery irrespective of the background professional and not necessarily from doctors. In this study one ought to had clinical competence to be a clinical leader on top of other attributes like good relationship skills that requires self-awareness, emotional intelligence, personality integrity, approachability, listening skills, humility and compassionate. This person should also have a leadership personality meaning a strategic thinker, flexible with, reflective, passionate, good communication skills, team player, and enthusiastic, grounded, team player, charismatic and comfortable with both clinical and managerial roles. More over apart from having both awareness on big and little politics s/he should have patient focused leadership style, technical competences like financial skills, risk management skills, proper understanding of the organisation, deep cooperate knowledge, credible business skills and ability to balance both clinical and managerial roles (Nicol 2014).

To further define the clinical leadership theory in UK, a study on doctors' perception using focused group discussion and grounded theory defined clinical leadership

similarly stressing the skills based, innovative, clinically engaging, leading by example provided by an active clinician in this sense meaning doctors. One should have good communication skills, political skills and clinical credibility as necessary attributes to become a clinical. However, several doctors felt that their basic training put more emphasis on acquiring clinical knowledge and skills than leadership skills and therefore cannot do the roles. This was also again because they are overwhelmed by clinical works, have no enough time, they lack peer support, presence of institutional bureaucracy and limited opportunity to be clinical leaders (BMA 2012).

To qualify the theory more, a study of allied health workers' perception on clinical leadership (excluding nurses and Doctors) using mixed approach with more quantitative methodology insisted that clinical leadership is a clinically focussed leadership that affect clinical care, staff support, change and service improvement. In this study about 79% of allied health workers saw themselves as clinical leaders proving that the term isn't limited to doctors alone but rather all health care workers with leadership skills. Clinical leaders should be role models, have good communication skills, clinical competence, approachability and supportive as necessary attribute. Lack of time because of high clinical demand, bureaucracy, limited opportunity; system problems and lack of support from managers were highlighted as barriers for the allied health workers to be clinical leaders (Stanley 2017).

From the above account clinical leadership theory as summarized here seem to be so useful in the health care industry because of several factors; direct involvement of clinicians in patients care means a leader does management, supervision and treatment

of patients. By so doing there is a theoretical reduction in the cost of running the organisation by minimizing employment of routine administrators (in a medical leadership view which put non-clinicians more in power than clinicians) who are not going to be directly touching patients. This fit in even what Spehar, 2014 said “make clinician focus on patient needs during planning and excursion of plans to yield a satisfying health care industry”.

More over the theory offers a possibility of creating high level of interpersonal relationship among the clinical team by considering clinical leadership as health care leadership where by all cadres are given chance to lead the clinical team; this in turn motivate the whole team toward health care delivery. This is because Clinicians who are leaders have been proved even in other studies to have high motivation, displaying expertise which usually leads to deliverance of quality health services to patients which cannot be achieved by politicians in health industry on top of the fact that this care is also delivered timely because the decision makers become the same person as the service deliverer unlike when the non-clinicians are in leadership (Leggat et al., 2013, Shap et al., 2016). It is also envisioned that taking doctors as clinical leaders yields an increased commitment to high quality practices in the presence because these doctors become committed fully to clinical practice and can relatively easily deliver quality services to the customers because of being in the frontline of service delivery as compared to non-clinical managers or any other health personnel (Bayline et al., 2014).

Furthermore, the theory is related to the possibility of increased team empowerment. As described by other researchers too, having a person who faces the same challenges

as the clinical team creates a sense of trust from the team that s/he will do justices in addressing the bottle necks making it relatively simpler for the leaders to motivate and empower the rest of the clinical team regardless of the challenges as themselves are affected by the same (Edmonstone, 2017).

It is more over important that the whole hospital have a good system performance. Having a clinician as a leader makes relatively easier to coordinate the whole system from procurement, service delivery, human resource and talent management something that isn't easily done by a non-clinician manager; these activities once well-coordinated lead to improved system performance.

Howbeit the theory seems to be beneficial to the health care delivery it poses some possible challenges too. Imagine the busy duties of a routine manager/administrator put on an active doctor or nurse (in health care or doctors' leadership), there is a likelihood that this clinician may fail to deliver clinical services to patients on time because of concentration in procurement, management meetings and supervision. As said by other researchers, routine administrators as in medical leadership would rather be better in supervising hospital activities and attend management meeting than clinicians (Cinaroglus, 2016; Ham, 2014).

Moreover with clinical leadership as healthcare or doctor's leadership there is a possibility of increase in the cost of running the hospital; clinicians have formal education concerning with health care delivery and less of administration, this means for a clinician to be a fruitful leader s/he needs knowledge on how to lead others necessitating giving some incentives to them and re training on leadership and

management. This cost could be saved by using the administrators and routine managers in medical leadership who already are more trained in this discipline than clinicians (Chadi, 2017).

Compromised hospital function may also be the bad side of clinical leadership theory using doctors; most clinicians are married to clinical works than administration (BMA 2012); involving them in administration may affect the hospital performance especially when the said doctor is busy attending patients. This may still justify the role of non-clinicians in doing hospital administration and leadership.

## 2.4 Empirical Review

### 2.4.1 Global Review

Stanley et al., (2017), studied on health professions' perception of clinical leadership in Europe, methodologies used were case study and statistical product and service solution (version 12) for analysing the data, found that most of health staff proposed to be given chances to lead health organizations themselves instead of politicians, administrators and managers; they further thought clinical leadership should be for all healthcare personnel not only doctors or with non-clinical team; the respondents proposed that all barriers like time limitation, bureaucracy, and lack of opportunity to be clinical leaders should be eliminated and the study recommended effective implementation of clinicians in leadership to improve clinical care and changes in practice of health staff. Clinical leadership was found to influence quality services and safety for patients. The weakness of this study excluded nurses and doctors when collecting data, nurses and doctors are key persons in health industry thus should be included in any study concerning leadership in the health industry.

BMA (2012) using focused group discussion methodology studied doctors' perspectives on clinical leadership and enumerated clinical credibility, good communication and political skills to be the attributes for the doctor who wants to be a clinical leader. The discussion showed that doctors aspire to give expert leadership to the health service, driven by their clinical skills, deep knowledge and advocacy of patient interests. While the study generated important findings, the fact that it was done in UK NHS system, which is more advanced, generalized conclusion may not be drawn from it and may not be representing the rest of the world's health systems.

Dossary (2017), studied on nursing leadership in South Africa, methodologies used were study review and synthesis for analysing the data, found that some of nurses were given leadership in units to lead their fellow nurses in many hospitals, recommended that all clinicians (not necessarily doctors) should be considered first when appointing hospital leaders. When nurses were given leadership there was increased level of performance by spending 70% of their time in taking care of the patients and 30% in leadership, this was found to result into good quality of services and development of the hospitals as the needs of patients were met on time and effectively. The weakness of this study had concentrated on nurses only excluding doctors who are literally and historically meant to lead the clinical teams.

West (2013), studied on leadership and leadership development in health care in Asia, methodologies used were case study and XLSTAR (version 21) for data analysis, found that clinicians were not given power to run the hospitals themselves as non – health actors were involved in health leadership to direct health staff; recommended that the government should set strategies to develop clinicians to be leaders in

hospitals. Clinical leadership once given enough opportunity was found to deliver the customers' needs at the right time rather than politicians and administrators (non-health personnel) who do not know the needs of the customers and results in delayed service provision. The weakness of this study failed to describe barriers for clinicians to be leaders in health industry.

Doherty (2013), studied on strengthening clinical leadership in hospitals around the world, methodologies used were review study and narrative for analysing the data, found that globally clinical leadership has been noted as the tool of bringing evolution in hospital industry, it is given priorities in many countries currently, recommended that all bottom neck facing the clinicians to be leaders should be addressed and promote clinical leadership. This study had proposed that clinicians should be given chances to lead hospitals and the governments should help and develop them to take leadership positions in health industry. However, the study was week in assessing exactly the statistics of clinicians who were involved in clinical leadership globally.

Uba (2014), studied on challenges of clinical leadership in UK, methodologies used were case study and SPSS (version 20) for analysing the data, found various barriers such as lack of administration professions and lack of support from the government, recommended that effective strategies to address all outlined barriers in this study should be eradicated to provide chance for clinicians to be leaders. Clinical leadership once implemented effectively in hospitals was found to influence performance of health staff and resulted into better services to patients and development of hospitals. The study's weakness could be that the findings may not be generalized to the rest of the global health industries.

Daly et al., (2014), studied on the importance of clinical leadership in the hospital setting in Australia, methodologies used were case study and PASS for analysing the data, found that clinical leadership will results; patients' safety, needs of the consumers and health quality care and improvement of health system. The study recommended that future strategies should aim to address all barriers for clinicians to be leaders. This study had addressed that effectively implementation of the clinical leadership in hospital will improve health serves to consumers. The weakness of this study failed to propose which criteria to be considered in nominating clinicians to leaders in hospitals.

Figueroa CA et al (2019) studied on priorities and challenges for health leadership and workforce management globally, methodologies used were review study and narrative – synthesis for analysing the data, found that medical leadership in which non - heath actors and health actors were involved in health management worldwide, proposed that only health actors (health care leadership) should be given chances to lead the hospitals for the positive impacts to consumers and development of the health industry. The weakness of this study failed to explain why non – health actors should not be involved in hospital management.

Swanwick (2011), studied on what is clinical leadership and why it's important internationally, methodologies used were review study and synthesis for data analysis, found various meaning of clinical leadership such as; putting clinicians at the helm of determining and administrating clinical services and importance of clinical leadership such as; quality and standard services to the patients, motivation and good performance to clinicians, recommended that the importance of clinical leadership

should be recognized by governments and policymakers in order to support and develop clinical leadership . This study had shown that effective clinical leadership was associated with optimal hospital development and quality of health care. The weakness of this study failed to propose clear strategies to promote clinical leadership internationally.

Thompson, P. et al (2014), studied on global nursing leadership, methodologies used were case study and SAS for the data analysis, found that in Canada nurses were given leadership in units and departments to lead fellow nurses and serving the patients in hospitals. The study recommended that nurses should be developed to be leaders (not necessarily doctors) for better results on patient's services and hospital development. This study had shown that whenever nurses were given leadership in hospitals there was improvement in service provision and hospital development. The weakness of this study failed to assess other professions in hospital to see their involvement in hospital management.

Lega (2018), studied on an international perspective on medical leadership, methodologies used were review study and narrative - synthesis for analysing data, found that globally clinical leadership was accepted by all clinicians and governments, many states had shown readiness to support clinicians to take leadership positions in the hospitals more than non-clinicians and recommended that policy makers should plan effectively how to develop clinicians to take potions of managing hospitals. The study had shown that clinical leadership was the best solutions to reduce the challenges facing health industry. The weakness of this study was generalizing clinical leadership worldwide without touching clear figures in each country.

### 2.4.2 African Context Review

Ezeh (2015), studied on health leadership in Africa, methodologies used were review study and narrative for data analysis, found that politicians, administrators and managers dominate much in health leadership than clinicians. The study had shown that clinical leadership using health care personnel and more or so doctors would solve all challenges facing health industry and deliver quality health care to consumers. This study failed to address negative sides of the clinical leadership in the hospitals.

Solange (2019), studied on barriers to clinical leadership in the labour ward of district hospital in Kwazulu South Africa, methodologies used were case study and Graph pad for data analysis, found that clinical leadership (using trained nurses over non-clinical personnel) in labour ward reduced children and maternal deaths in hospital, promoted motivation, good performance and standard health services to patients and recommended that nurses should be given priority of leadership in all wards for better outcomes. The study had shown that clinical leadership can be a solution to maternal and a children death in hospital once is effectively implemented. This study failed to assess other departments and other health cadres and see how clinical leadership can contribute in reducing maternal and children deaths to zero in hospitals.

Nzinga, (2018) studied on examining clinical leadership in Kenya's public hospital, methodologies used were case study and SPSS (version 20) for analysing the data, found that clinical leadership received relatively little attention in the country; politicians, managers and administrators control the clinicians and manage all public hospitals, recommended that the government should give priority clinicians to be

leaders rather than politicians and managers. The study has shown the betterment of clinical leadership such as provision of standard services to the patients and hospital development. The weakness of this study failed to assess the private hospitals and observe the situation of clinical leadership in them.

Doherty (2013), studied on barriers to clinical leadership in South Africa, methodologies used were case study and SPSS IBM (version 20) for analysing the data, found barriers such lack of awareness to clinicians that can manage hospital resources and serve patients at the same time, political inference in the development of clinical leadership and conflict of interest from administrators; recommended that all hindrance for clinicians to be leaders in South Africa should be overcome. The study had shown that clinical leadership could improve both patient services and development of the hospital. The weakness of this study failed to address the conflict of interest between administrators in medical leadership and clinical leadership clearly.

Mianda (2017), studied on developing of clinical leadership interventions for frontline health care providers in Africa, methodologies used were review study and synthesis for data analysis, found that the hospitals with effective implementation of clinical leadership using active clinicians resulted into quality health care, patient safety, motivation to health services and commitment in serving the patients, recommended interventions to all hindrance facing the clinicians to be leaders. The study had shown that clinical leadership would be the solutions to all challenges facing the hospitals. This study however failed to differentiate doctors' leadership and health care leadership as regarding to clinical leadership.

Pulcini at el., (2020), studied on advanced practice nursing leadership, an African perspective, methodologies used were review study and synthesis for analysing the data, found that nurses were given training frequently to lead the hospital units, positive impacts in units and departments which were led by clinicians, recommended that nurses should be given short courses periodically to prepare them for being leaders. The study had shown that once all hospitals are given attention to clinical leadership will resolve all complaints and improve needs of the patients and deliver quality services to the customers. The weakness of this study failed to assess the people's perspective in each country and show how the situation is when other health care personnel are involved in leadership.

Uba (2018), studied on clinical leadership as a corollary for professional practice and patient safety in Sub – Sahara Africa, methodologies used were review study and synthesis for analysing the data, found that clinical leadership was a health care personnel centred care, emphasize collective and collaborative behaviours, is the point of care innovation and improvement in both organizational processes and individual care practices to achieve better services to the patients, recommended that all positions of leadership in hospitals should be given to clinicians over non-clinicians. The study had shown that clinical leadership is a key factor for the patient's services and hospital development. The weakness of this study failed to address how non – health actors in medical leadership interfere real clinical leadership and health care industry in general.

Taylor (2012), studied on experiences of leadership in health care in sub – Sahara Africa, methodologies used were review study and narrative - synthesis for analysing

data, found that clinical leadership was relatively given little attention, lack of awareness to governments and stake holders inhibited clinician's leadership from serving and manage others at the same time. The study recommended that clinicians should be trained and developed to manage the hospitals and that clinical leadership needs to be given much attention in order to deliver standard services to customers and organization development. The weakness of this study generalized all sub – Saharan countries instead of assessing specific countries and come out with clear situation in each country.

### 2.4.3 Tanzanian Review

Njau (2016), studied on composition and challenges of medical leaders in regional hospital Dar es salaam Tanzania, methodologies used were case study and SPSS IBM (version 20) for analysing the data, found that many doctors lack leadership education, proposed that medical postgraduates level should incorporate leadership training as to solve the need of leaders in medical field and formal leadership education should be set as an added criteria for appointing leaders in medical institutions. The study had shown that development of clinical leadership in hospitals will influence standard services to consumers and organization development. The weakness of this study failed to clearly differentiate the medical leadership and clinical leadership,

Kacholi (2020), studied on improvement of clinical leadership in selected regional referral hospitals in Tanzania, methodologies used were case study and SPSS IBM (version 2020) for the data analysis, found that when senior management in hospitals and clinical leaders were not included in serving the patients lowered the quality

services and patient's safety, recommended that all clinical leaders should be involved in treating the patients for better outcomes from the hospitals. The study has shown that management should be involved in providing services to patients and not to be as observers. The weakness of this study is that it concentrated more on doctors' leadership excluding other health care professionals like nurses and paramedical.

Cunningham C., et al., (2017), studied on nursing leadership in Tanzania, methodologies used were review study and synthesis for analysing the data, found that clinical leadership is valuable in hospitals, short courses to the nurses improve service provision to patients and individual practices and proposed that clinicians need short courses to keep them up to date and improve health quality care and standard services to the consumers. This study focussed more on nurses only and could not include doctors and other health care workers and therefore could not differentiate healthcare leadership and doctors' leadership promptly.

## 2.5 Research Gap

The review of related literature shows that most of studies on clinical leadership were done outside of Tanzania and involving more healthcare workers other than doctors; few studies were done in some regions of Tanzania not involving active clinicians with inconclusive remarks on the differences or similarities of medical leadership, healthcare leadership, doctors' leadership and clinical leadership proper. The fact that the evidence we have is from more developed health systems and more in other healthcare workers than active doctors and that little is gathered to elucidate the terminologies surrounding clinical leadership calls for a focused study on doctors who historically are known to be clinical team leaders. This study was therefore designed

to fill in the geographical/system, professional and perception gaps by addressing Dar es Salaam tertiary hospitals doctors' perception concerning clinical leadership hoping to get results, which reflect leadership and health system function in the country.

## 2.6 Conceptual Framework

According to Goodwin (2005), conceptual framework is the cause-and-effect relationship in a study. Conceptual framework is a set of broad ideas and theories that assist and guide the researchers to properly identify the problem they are researching before collection of data (Smyth, 2004). Broadly clinical leadership is envisioned to be a skill-based role given to clinicians to run the hospital, engineer a patient focused service delivery so as to improve in the quality of services.

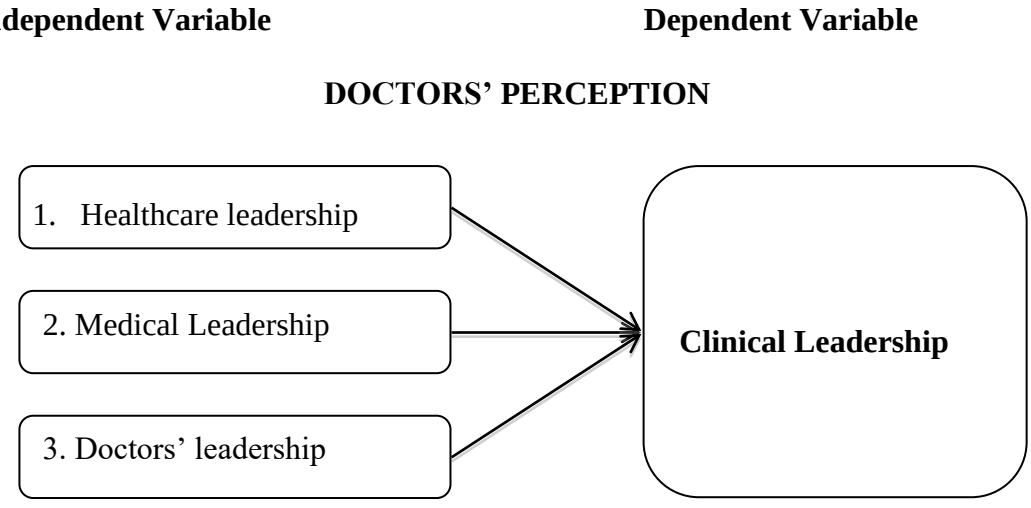


**Figure 2.1: Conceptual Framework**

Source: Field data (2021)

However, there are many ambiguities in the term where by some considers it to be same as medical leadership meaning anyone who leads and manage the healthcare facility regardless of the professional background, health care leadership meaning

anyone who leads and manage with the background profession from health industry and or doctors' leadership meaning leadership provided by doctors. In all these controversies it is agreed that clinical leadership is a necessary factor for proper hospital function.

# CHAPTER THREE

# RESEARCH METHODOLOGY

## 3.1 Overview

Throughout this chapter the researcher provided the study methodologies, how the data was collected, processed and interpreted. The researcher offered the philosophical view on the process of getting data and provided a bias free environment to make the results credible**.**

## 3.2 Research Philosophy

The study adopted positivism philosophy because it contributes to explain what is acceptable to human knowledge, valid and legitimate and how it is transferred to others (Saunders et al., 2009). The philosophy was chosen because it would help to focus and challenge on what is already known to be true (i.e., clinical leadership practice is affected by the perception of the health care workers) and would justify the criteria to classify what does and does not constitute clinical leadership.

## 3.3 Research Approach

The study used quantitative deductive approach because we have to support that the known reality is socially and is subjective to different factors (Saunders et al, 2009). It was therefore a suitable approach for research that seeks to interpret the perception of individual doctors on clinical leadership and other similar studies on perception (Petersen et al, 2020).

## 3.4 Research Design and Strategy

It was intended to use descriptive cross-sectional survey method to obtain perception data from the study population. Surveys has been found to be among the popular and

common strategy of business and management research most likely including questionnaire and interviews (Saunders et al., 2009). Quantitative analytical techniques were then used to draw inferences from the data collected concerning the existing relationship between dependent variable (clinical leadership perception) and independent variables (clinical leadership as medical leadership, clinical leadership as healthcare leadership and clinical leadership as doctors' leadership).

### 3.5 Description of the Study Area

Dar es Salaam is the largest city and former Capital of Tanzania. The City have the best registered hospitals in the country under each registration category; those that are classified at the tertiary National and specialized referral hospitals includes; Muhimbili & MUHAS Mloganzila National Hospitals, Muhimbili Orthopaedic Institute, Jakaya Kikwete Cardiac Institute, Ocean Road Cancer Institute (Public hospitals) and Aghakan and CCBRT Hospital (Private). Out of about 6000 registered doctors in Tanzania about 2000 works in Dar es Salaam hospitals and 30% of whom are found in the tertiary private and public hospitals. This number is distributed as Muhimbili &Mloganzira (450), Muhimbili Orthopedic institute (70), Jakaya Kikwete Cardiac Institute (50), Ocean Road Cancer Institute (42), Aghakan Hospital (120) and CCBRT (35).

### 3.6 Justification for Choosing this Area

The study used doctors working in the Tertiary hospitals in Dar es Salaam because those being at the apex of the health industry pyramid are affected much by the hospital leadership both in terms of quantity and quality of their works. Besides, it is in these hospitals where we get the top-notch technology, best health care and high

political social influences to health care delivery. The perception of doctors in the tertiary Dar es Salaam Hospitals would therefore be representative of the rest of the doctors.

## 3.7 Population of the Study

Population is defined as a group of individuals, objects or items from which samples are taken for measurement, Kondo et al (2006). A population under study must have characteristics in common that is of interest to the researcher (Omari, 2011). The population of this study was doctors with a minimum first degree in medicine (MD, MBBS and DDS) working at the tertiary level hospitals in Dar es Salaam as tableted here in the Table 3.1.

**Table 3.1: Population of the Study**

| Name of Facility | Number |
|---|---|
| Muhimbili and Mloganzila | 450 |
| Muhimbili Orthopedic Institute | 70 |
| Jakaya Kikwete Cardiac Institute | 50 |
| Aghakan Hospital | 120 |
| Ocean Road Cancer Institute | 42 |
| CCBRT Hospital | 35 |
| **Total** | **767** |

Source : Field Data ( 2021)

## 3.8 Sampling Design

### 3.8.1 Sample

According to Kothari (2000), a sample refers to a group of respondents or elements drawn from the population with individuals who have common characteristics of the

entire population from which a researcher is interested to collect the data. The sample for this study was tertiary hospitals and medical doctors working in those hospitals who would be available for interview at a specified period of time.

### 3.8.2 Sample Size

The sample size for this study was estimated using the following formula

$N=z^2$ p (1-p)/$Ɛ^2$, whereby P= Expected proportion of 10% estimated prevalence in Tanzania (EP), Z=statistics for the level of confidence at 95% (z value is 1.96) E = Margin of error (E) ± 5%

$N=1.96^2$ x 0.1(1-0.1)/$0.05^2$

N=138 doctors

N+10% error

138+14will results 152 respondents (Kothari, 2000).

### 3.8.3 Sampling Techniques

Sanders et al (2002), argues that choice of sampling technique is dependent on the feasibility and sensibility of collecting data to enable answering of the research questions and with ultimate objective of addressing the objectives of the targeted population**.** The type of sampling procedure that was used in this study was proportional sampling for the total number of doctors to be studied in each hospital where guarded by our sample size 20% was chosen as the baseline per each facility. Non- probability convenient sampling was then used for doctors who were present and ready for the interview during the study period working in the selected tertiary public and private hospitals in Dar es Salaam.

**Table 3.2: Sample of the Study**

| Name of Facility | Number |
|---|---|
| Muhimbili and Mloganzila | 48 |
| Muhimbili Orthopedic Institute | 13 |
| Jakaya Kikwete Cardiac Institute | 10 |
| Aghakan Hospital | 22 |
| Ocean Road Cancer Institute | 9 |
| CCBRT Hospital | 9 |
| **Total** | **152** |

Source : Field Data ( 2021)

### 3.8.4 Inclusion Criteria

The following criteria were considered for Inclusion of the health facility:

Health facility was necessarily located in Dar es Salaam, at the level of tertiary hospital as per the Ministry of Healthy registration and with potential respondent doctors. In recruiting for the respondents all clinicians with at least first degree in medicine (MD, MBBS, DDS) and ready for the interview were included.

### 3.8.5 Exclusion Criteria

The following criteria were considered for excluding the health facility and respondents; those tertiary and secondary hospitals with no potential respondents at the time of study and all non-degree holders' doctors or those who were not present at the time of the study.

## 3.9 Methods of Data Collection

This study used primary data collection method; data were collected from qualified respondents by using a structured questionnaire, Kigobe, (2015). The qualified

respondents were given structured questionnaires to fill according to their own consent. The questionnaire collected information on doctors' perception concerning clinical leadership, medical leadership, healthcare leadership and doctors' leadership.

### 3.10 Tools used in Data Collection

Questionnaires were used as a tool of collecting data in this study, consisted closed - ended questions with attention finders all done targeting to tailor the specific objectives of the study, Uriyo (2011). The questionnaires were administered physically to all doctors who were available at the time of study and willing to fill the questions instantly; those that were found busy with no time to fill the questionnaire instantaneously shared their e-mail address and received electronic copy of the same questionnaire, which was filled at their convenient time. All dully filled questionnaires (hard copy and soft copy) were then collected together for processing, analysis and interpretation.

### 3.11 Data Analysis

All data from the complete questionnaire (incomplete ones were discarded) were extracted, compiled and analysed using IBM statistical package for social sciences (SPSS) version 20. The collected data were computed and descriptive statistics, including tables, frequencies, and percentages were used to present the analysed data.

Descriptive statistics (mean, standard deviation, minimum, and maximum scores) were calculated for dependent and independent variablesand reliability and Correlation analysis were computed to check the effect of the independent variables on the dependent variables using the cut-off points suggested in Albdour et al (2014), adjusted to 5-point rating levels.

### 3.11.1 Variables and Measurements Procedure

The researcher used Likert scale. According to Sauro (2015), Likert scale is a psychometric scale from which respondents choose one option that best aligns with their view. The researcher used five points in questionnaire to give options to respondents to choose one which suite them and ranged from strongly agree, agree, neutral, disagree and strongly disagree. The researcher chose to use Likert scale due to; its easiness on data collection, very easy to analyse, simplest to draw conclusion and display the feelings of respondents to the maximum.

## 3.12 Data Cleaning and Processing

### 3.12.1 Error Check

A researcher assessed the collected data and discarded data that did not associate to the objective of this study and impossible to interpret, thus only meaningful responses and measurements were considered prior analysis of data (Kigobe, 2015)

### 3.12.2 Missing Data

Missing data were qualified as not applicable or non – responsive to aid analysis of data. The researcher accepted only tolerable percent of missing data in non – responsive and not applicable; the missing data was to be small enough to tolerate, Mhina (2015).

## 3.13 Validity

Research validity is a measure of how sound the research is (Silverman, 2006). Validity in data collection means that the findings truly represent the observable facts that are claimed to be measured (Bryman, 2008). The researcher ensured validity of

this study by choosing suitable population, appropriate and adequate sample size, effective sampling technique and reliable statistical tests.

### 3.14 Reliability

Research reliability is a degree to which an assessment tool produces stable and consistence data to represent the appropriate situation and phenomena that have been measured, Moskal (2000). The researcher performed pre – testing of questionnaires prior to the fieldwork to see whether there any difficult in understanding the language used to frame the questions or any other ambiguous. The researcher used simple and easy language in framing the questions to be understood by all participants. The attention questions in between the objective questions were used to help measure the concentration of the respondents to avoid happy triggers.

### 3.15 Ethical Consideration

Ethical consideration is an accumulation of values and principles that address questions of what is good or bad in human affairs, ALRC (2010). According to Trochin (2006), ethical consideration during evaluation includes informed consent, voluntary participation, do no harm, confidentiality, anonymity and assess only relevant components. In social research, ethical issues contribute directly to the integrity of the research, Bryman (2008). Ethical clearance for the study was sought from OUT IRB and researcher observed to all the essential rules, cultural values and human rights of all participants, who were doctors in MD, MBBS and DDS in the study. The researcher regarded the Clearance form, respondents' own consent and any other information private and Confidential.

# CHAPTER FOUR

# EMPIRICAL RESULTS AND INTERPRETATION

## 4.1 Overview

This chapter presents empirical results and their interpretations. The study starts by exploring the population statistics to elucidate any association with its objectives. It additionally looks into general understanding of doctors on clinical leadership by examining what they know about clinical leadership, its importance, barrier to it and their willingness to be involved as clinical leaders. The chapter further shows how clinical leadership as healthcare leadership (leadership provided by health care personnel), medical leadership (hospital leadership provided by any other person), and doctors' leadership affected the general understanding.

## 4.2 Sample Description

A total of 156 doctors were interviewed and only 152 (97.4%) eventually fitted analysis as per the methodology set. The study participants were largely from the Muhimbili National hospital inclusive of Mloganzira teaching hospital making 89(58.6%) of all respondents; male predominated by 103(67.8%) and majority (68 (44.7%)) were between 40 and 49 of age. Most of them (72.4%) were MD by qualification whereas 91 (59.9%) had underwent postgraduate training in MMED/MDENT. Ninety-five (62.5%) had no leadership history and over half of the respondents (55.9%) had their undergraduate training at Muhimbili (MUHAS and MUCHS). Ninety-five participants (62.5%) had never had any hospital leadership position and only two respondents had MBA training. The fact that the majority of the responded have been trained in the same environments they work (MNH and

MUHAS) may affect the contribution of the rest of the other centers making a study more of Muhimbili institutions.

**Table 4.1: Sample Description**

| S/N | | Frequency | % | Mean | Std. Dev |
|---|---|---|---|---|---|
| | **Gender** | | | 1.32 | 0.469 |
| **1** | Male | 103 | 67.8 | | |
| | Female | 49 | 32.2 | | |
| | **Age** | | | 2.43 | 0.85 |
| | 20 - 29 | 25 | 16.4 | | |
| **2** | 30 -39 | 48 | 31.6 | | |
| | 40 - 49 | 68 | 44.7 | | |
| | 50 and Above | 11 | 7.2 | | |
| | What is your basic professional qualification? | | | 1.43 | 0.752 |
| | MD | 110 | 72.4 | | |
| **3** | MBBS | 18 | 11.8 | | |
| | DDS | 24 | 15.8 | | |
| | OTHERS | 0 | 0 | | |
| | Where did you study your first degree? | | | 2.3 | 1.85 |
| | MUHAS | 85 | 55.9 | | |
| | KCMC | 20 | 13.2 | | |
| **4** | IMTU | 12 | 7.9 | | |
| | BUGANDO | 12 | 7.9 | | |
| | UDOM | 9 | 5.9 | | |
| | OTHERS | 14 | 9.22 | | |
| **5** | What is your highest leadership position you have ever attained after graduation? | | | 2.04 | 1.63 |
| | NONE | 95 | 62.5 | | |
| | DIRCTOR/MANAGER | 16 | 10.5 | | |
| | MOI | 15 | 9.9 | | |
| | HOD | 18 | 11.8 | | |
| | OTHERS | 8 | 5.3 | | |
| | **Postgraduate training** | | | 2.37 | 1.83 |
| | MMED/MDENT | 91 | 59.9 | | |
| **5** | MPH/MSC | 10 | 6.6 | | |
| | PHD | 2 | 1.3 | | |
| | MBA | 2 | 1.3 | | |
| | NONE | 47 | 30.9 | | |
| | Name of the Hospital you work with | | | 2.18 | 1.64 |
| | MNH/MLOGANZILA | 89 | 58.6 | | |
| **6** | MOI | 13 | 8.6 | | |
| | JKCI | 10 | 6.6 | | |
| | AGAKHAN | 22 | 14.5 | | |
| | ORCI | 9 | 5.9 | | |
| | CCBRT | 9 | 5.9 | | |

Source: Data Analysis, (2021)

## 4.3 Descriptive Statistics Results

Descriptive statistics (mean, standard deviation, minimum, and maximum scores) were computed for whether clinical leadership and health care leadership mean the same thing for doctors, the perceived difference between medical leadership and clinical leadership and the perceived similarities of doctors leadership and clinical leadership and on the dependent variable Clinical leadership.

### 4.3.1 Descriptive Statistics Results for General Understanding of Doctors' on Clinical Leadership

Descriptive statistics (mean, standard deviation, minimum, and maximum scores) were computed for the dependent variable's general understanding of doctors on clinical leadership scale (Table 4.2). The results show that the item which stated that 'Clinical leadership is a key to good quality health care delivery scored highest' (M = 4.16, S.D. = 0.85) followed by 'It is important to have clinical leadership in hospitals' (M = 4.14, SD = 0.83). The lowest measurement scale was on Clinical leadership improves health system performance (M = 2.03, SD = .97) followed by 'There are no barriers for one to be a clinical leader,' (M = 3.07, SD = .79).

### 4.3.2 Descriptive Statistics Results for Does Clinical leadership and Health Care Leadership Mean the Same Thing for Doctors

Descriptive statistics (mean, standard deviation, minimum, and maximum scores) were computed whether clinical leadership mean same thing with healthcare leadership for doctors scale (Table 4.3). The results show that There is no difference between leadership by a doctor and leadership by any other health personnel scale score high (M = 3.95, SD = .88) followed by All health care workers' basic training

equip them to be clinical leaders (M = 3.71, SD = .93). The lowest Score was Clinical leadership is synonymous with health care leadership (M = 1.53, SD = .91) followed by Health care workers other than Doctors, Nurses and pharmacist shouldn't be given chance to lead. (M = 1.95, SD = 1.04).

**Table 4.2: Descriptive Statistics Results for Dependent Variable*'s* General Understanding of Doctors' on Clinical Leadership**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| I understand fully the meaning of clinical leadership | 152 | 1 | 5 | 3.09 | 1.28 |
| It is important to have clinical leadership in hospitals | 152 | 1 | 5 | 4.14 | 0.83 |
| I am satisfied with the quality of health care delivery at my facility | 152 | 1 | 5 | 3.10 | 1.14 |
| Clinical leadership is a key to good quality health care delivery | 152 | 1 | 5 | 4.16 | 0.85 |
| Clinical leadership improves health system performance | 152 | 1 | 5 | 2.03 | .97 |
| Clinical leadership increase clinician's commitment to high quality of care | 152 | 1 | 4 | 4.08 | .712 |
| I think employees at my facility are very well satisfied and motivated | 152 | 1 | 5 | 3.01 | 1.10 |
| Leadership isn't a necessary factor for health service delivery | 152 | 1 | 5 | 3.32 | 1.15 |
| Being an active clinician is mandatory for one to be a clinical leader | 152 | 1 | 5 | 2.51 | 1.28 |
| There are certain necessary attributes for a clinical leader | 152 | 1 | 5 | 3.45 | 1.10 |
| Balancing between clinical and managerial roles is mandatory for a clinical leader | 152 | 1 | 5 | 3.23 | 1.04 |
| There are no barriers for one to be a clinical leader | 152 | 1 | 4 | 3.07 | .79 |
| I am ready to hold any clinical leadership position in my hospital | 152 | 1 | 5 | 3.21 | .92 |

**Table 4.3: Descriptive Statistics Results for does Clinical Leadership and Health Care Leadership Mean the Same thing for Doctors**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Clinical leadership is synonymous with health care leadership | 152 | 1 | 5 | 1.53 | .91 |
| I recommend other health staff like nurses and pharmacists to manage the hospitals | 152 | 1 | 5 | 3.18 | 1.032 |
| There is no difference between leadership by a doctor and leadership by any other health personnel | 152 | 1 | 5 | 3.95 | .88 |
| All health care workers' basic training equip them to be clinical leaders | 152 | 1 | 5 | 3.71 | .93 |
| Health care workers other than Doctors, Nurses and pharmacist shouldn't be given chance to lead. | 152 | 1 | 5 | 1.95 | 1.04 |
| Clinical leadership is an impossible idea in Tanzania | 152 | 1 | 5 | 3.47 | 1.229 |

Source: Field Data (2021)

### 4.3.3 Descriptive Statistics Results for the Perceived Difference between Medical Leadership and Clinical Leadership

Descriptive statistics (mean, standard deviation, minimum, and maximum scores) were computed for the perceived difference between medical leadership and clinical leadership scale (Table 6).

The results show that Politicians and managers motivate clinicians in hospitals scale score high (M = 4.16, SD = .849) followed by Administrators, Non-health personnel like administrators, politicians and managers should manage the hospitals (M = 4.14, SD = .833). The lowest Score was Hospitals are better run by army generals (M = 2.91, SD = 1.08) followed by Non health leadership improve health services to patients and hospital development (M = 3.48, SD = 1.03).

**Table 4.4: Descriptive Statistics Results for Perceived Difference between Medical Leadership and Clinical Leadership**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Clinical leadership is not different from medical leadership | 152 | 1 | 5 | 3.52 | .95 |
| Non health personnel like administrators, politicians and managers should manage the hospitals | 152 | 1 | 5 | 4.14 | .83 |
| Non health leadership improve health services to patients and hospital development | 152 | 1 | 5 | 3.48 | 1.03 |
| Administrators, politicians and managers motivate clinicians in hospitals | 152 | 1 | 5 | 4.16 | .85 |
| Non – health personnel should work under doctors' supervision when managing the hospitals | 152 | 1 | 5 | 4.07 | .94 |
| Health personnel and non – health personnel should cooperate together to manage the hospitals | 152 | 1 | 5 | 3.98 | .93 |
| Hospitals are better run by army generals | 152 | 1 | 5 | 2.91 | 1.08 |

Source: Data Analysis (2021)

### 4.3.4 Descriptive Statistics Results for Clinical Leadership and the Perceived Similarities of Doctors' Leadership

Descriptive statistics (mean, standard deviation, minimum, and maximum scores) were computed for the dependent variable the perceived difference between medical leadership and clinical leadership scale (Table 4.5). The results shows that All doctors have the mindset required for a clinical leader scale scored high (M = 4.18, SD = .93) followed by The basic medical training equip well doctors to be clinical leaders (M = 3.57, SD = 1.17). The lowest score is Doctors are free to treat their patients anyhow (1.57, SD = .93) Followed by As compared to other health staff doctors perform well in leadership (M = 2.05, SD = .98.

**Table 4.5: Descriptive Statistics Results for Clinical Leadership and the Perceived Similarities of Doctors Leadership**

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|---|---|---|---|---|
| Clinical leadership means doctor's leadership in the hospital | 152 | 1 | 5 | 2.30 | 1.03 |
| I recommend doctors only to be given chances to be leaders in the hospitals | 152 | 1 | 5 | 2.22 | 1.02 |
| As compared to other health staff doctors perform well in leadership | 152 | 1 | 5 | 2.05 | .98 |
| The basic medical training equip well doctors to be clinical leaders | 152 | 1 | 5 | 3.65 | 1.12 |
| All doctors have the mindset required for a clinical leader | 152 | 1 | 5 | 4.18 | .93 |
| Doctors are free to treat their patients anyhow | 152 | 1 | 5 | 1.57 | .93 |

Source: Field Data (2021)

### 4.4 Variables Descriptive Statistics, Reliability and Correlation Analysis

Descriptive statistics and Correlation analysis were further computed to check the effect of doctors' perception on their general understanding on clinical leadership using cut-off points suggested in Albdour Altaraweh (2014), adjusted to 5-point rating levels. Results (Table 8) indicate that doctors' leadership was high (M = 2.46, S.D = .37). Medical leadership was higher (M = 2.66, SD = .54), the last independent variable to be computed was healthcare leadership, which also scored high means score (M = 3.75, SD = .71). The correlation between general understanding and doctors' or medical leadership was .50 and .76 indicating strong and significant relationship of the variable (Cohen, 1988).

Using the original cut offs of Albdour & Altarawneh (2014) doc on clinical was significantly positively and moderate correlated with clinical leadership ($r = .549^{**}$, $p < .01$). Doctor leadership was positively correlated with clinical leadership ($r = .09,^{*}$ p

< .05). Medical leadership was also positively and significantly related to clinical leadership (r = .239** p < .001).

Scale test for reliability analysis was carried out to determine the internal consistency of the measurements scales. Cronbach's alphas (Table 4.6) in the diagonal show good internal consistency for the clinical leadership and health care leadership .86, the perceived difference between medical leadership .95, the perceived similarities of doctors leadership .71 and clinical leadership .74 (George and Mallery, 2014).

**Table 4.6: Variables Descriptive Statistics, Reliability and Correlation Analysis**

| | | MEAN | SD | | | |
|---|---|---|---|---|---|---|
| DOCONCLINICAL | Pearson Correlation | 2.46 | .37 | **.86** | | |
| | Sig. (2-tailed) | | | | | |
| DOCTORLEADERSHIP | Pearson Correlation | 2.66 | .54 | .207* | **.95** | |
| | Sig. (2-tailed) | | | .011 | | |
| MEDICALLEADERSHIP | Pearson Correlation | 3.75 | .71 | .190* | -.059 | **.71** |
| | Sig. (2-tailed) | | | .019 | .47 | |
| HEALTHCARELEADERSHIP | Pearson Correlation | 2.97 | .58 | .239** | .09* | .549** |
| | Sig. (2-tailed) | | | .003 | .29 | .000 |

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Source: Data analysis (20221)

## 4.5 Discussion of the Findings

The study sought to determine Assessment of doctors' perception on clinical leadership- a case of tertiary hospitals in Dar es Salaam Tanzania. Descriptive statistics was used to analyse data with correlation analysis. Focusing on the study objectives, the discussion elaborates the findings information as generated from data analysis and compares or contrasts the current findings with what has been found out in previous related studies. Contributions of each finding are shown. By doing so, it

helps to clear and in-depth understanding of the assessment of doctors' perception on clinical leadership- a case of tertiary hospitals in Dar es Salaam Tanzania.

### 4.5.1 To Find out Whether Clinical Leadership and Health Care Leadership Mean the Same Thing for Doctors

This study found that doc on clinical was significantly positively and moderate correlated with clinical leadership. Clinical leadership is the skills-based leadership provided by frontline health care workers, using their skills to improve quality of service by putting the need of their patients first during planning and execution, Jonas (2011). Our study could agree with this basic truth by having a higher perception score in recommending other heath staff like nurses and pharmacists to manage hospitals on top of agreeing that clinical leadership can synonymously be considered as health care leadership.

Clinical leadership was suggested Nicol (2014) to be termed healthcare leadership meaning the leadership provided by clinical personnel to improve health care delivery irrespective of the background professional and not necessarily from doctors. In this study one ought to had clinical competence to be a clinical leader on top of other attributes like good relationship skills that requires self-awareness, emotional intelligence, personality integrity, approachability, listening skills, humility and compassionate.

Solange M (2017) in a mixed method study revealed clinical leadership as leadership provided by frontline health care providers regardless of their position in the health care system. Because it is skills based, every clinical personnel with leadership credentials can stand and administer leadership at his/her section as recommended by

doctors in our study. Most of the studies done in different clinical groups showed that each cadre aspire to give some leadership as it is suggested in this study Stanley (2017). Pulcin et al (2021) reported nurses to receive some on job training to help them lead their units; recommended there should be a plan to give short courses to clinicians periodically to equip them with some leadership skills a view that is partly equal to the low score of 'All health care workers' basic training equips them to be clinical leaders' in our study. A study of doctors' leadership with focused group discussion and interview in UK BMA (2012) showed that medical school training wasn't all enough equipping doctors to be clinical leaders recommending further on job training.

This is also found in some literatures which show lack of awareness of clinicians, governments and stakeholders on clinical leadership to contribute to low uptake of the discipline in their health systems, Doherty (2013), Taylor (2012) thereby suggesting the need to retrain health staff into clinical leadership. It is therefore imperative to say clinical leadership is the roles given to all frontline health staff with attributes to be leaders so that they use their clinical skills to serve people while leading their teams in planning and excursion of activities putting their client first.

### 4.5.2 To Determine the Perceived Difference between Medical Leadership and Clinical Leadership

This study found that Doctor Leadership was positively correlated with clinical leadership. In view of clinical leadership as medical leadership our study's results discouraged use of administrators, politicians and managers alone to run the health facilities. These people are not considered to motivate clinicians in hospitals and are

not significantly improving services to patients and organizations, because of this our study scored higher in item like health personnel and non – health personnel should cooperate together to manage the hospitals and Non – health personnel should work under doctors' supervision when managing the hospitals.

For many years in what is termed as medical leadership it has been part of health systems to find non-health personnel occupying the positions of managers and administrators than clinicians. West (2013), studied on leadership and leadership development in health care in Asia, found that clinicians were not given power to run the hospitals themselves as non – health actors were involved in health leadership to direct health staff. Figueroa CA (2019), studied on priorities and challenges for health leadership and workforce management globally, found that medical leadership in which non - heath actors and health actors were involved in health management worldwide, proposed that only health actors (health care leadership) should be given chances to lead the hospitals for the positive impacts to consumers and development of the health industry Ezeh (2015), studied on health leadership in Africa, found that politicians, administrators and managers dominated much in health leadership than clinicians. Njau (2016) in his study on hospital leadership in Dar es Salaam found that non-health personnel are doing leadership in the health facilities along with medical personnel. Nzinga et al (2018) did examine clinical leadership in Kenyan public hospitals and found little attention given to proper clinical leadership; politicians/managers and administrators predominated in the public hospitals and recommended the health systems to prioritize clinicians for leadership positions as recommended in our study results. The findings in these other studies may justify why

our respondents insisted on putting clinicians over non-health personnel in hospital administration.

Unlike in our study Non-health personnel or routine administrators are reported in some studies to be better supervisors of the hospital activities and good at attending management meetings than clinicians (Cinaroglus 2016, Ham 2014); they are more trained in leadership discipline than clinicians and are recommended by some studies to be used so as to reduce the cost of running the organization (Chadi 2017).

Lega et al (2018) studied international perspective on leadership and found that there was a rise in accepting clinical leadership by both clinicians and government and that clinicians were being favored over non-clinicians in medical leadership. Our study findings present a debatable result on absolute position of non-health personnel in the medical leadership but recommends mutual involvement of clinicians and non-health personnel in hospital leadership for better service delivery

### 4.5.3 To Elucidate the Perceived Similarities of Doctors' Leadership and Clinical Leadership

This study found that Medical leadership was also positively and significantly related to clinical leadership. It is a common belief in a medical industry that doctors are clinical team leaders; they believe to do better in leadership as compared to other cadres and that can justifiably be seen in our health system where we have MOI, CMO, DMO, and RMO all of which indicating doctors' superiority in the leadership tree e.g. Regional medical officer (RMO) cannot be a pharmacist or a nurse. Our study showed that doctors consider themselves to be better than other health personnel in leadership and that Clinical leadership means doctor's leadership in the hospital.

The findings partly equate what the BMA (2012) focused group and interview-based study found which in the NHS system doctors considered themselves more capable of leadership than others. Denis et al (2016) on medical doctors in healthcare leadership found that doctors are aspiring to be clinical leaders siting out multiple barriers stopping them from getting fully involved. Doherty (2013) studied on strengthening clinical leadership in hospitals around the world and found similar historical background that considered doctors to be at the apex of leadership other than the rest of the health care team and suggested equal opportunity in those with necessary attributes.

On another note, in a study about composition and challenges of medical leaderships in Dar es Salaam regional hospitals in Tanzania Njau et al (2016) reported a different view in which many doctors to lack leadership education and recommended medical post graduate curriculum to add some leadership modules. He emphasized formal leadership training to be added as a qualification for one to be a leader in a medical institution because the basic medical training isn't sufficient to provide the skills needed as recommended in this study. As much as doctors are considering themselves to be leaders there is a trend now of accepting sharing with the rest of the clinical team unlike how it used to be in the past.

### 4.5.4 General Understanding of Clinical Leadership and Correlation with the Independent Variables

The study sought to first access the general understanding of doctors on clinical leadership and see whether this understanding was getting affected by their basic

perception of clinical leadership as either health care leadership, medical leadership or doctors' leadership.

General perception of doctors on clinical leadership in this study strongly agree with the basic fact that It is so important to have clinical leadership in hospitals because of being the key to good quality health care delivery. However, it seems there are barrier of exercising clinical leadership in our health care facilities. This study's findings seem to be congruent with what other studies reported showing a mixed feeling. In the NHS focused group study on doctors' perception on clinical leadership (BMA 2012) doctors aspired to give expert leadership to health services driven by their skills; varied regarding clinical leadership perception, considered clinical leadership to be mandatory for a well-functioning clinical system and insisted that one should be clinically active to be a clinical leader siting out some necessary attributes for a person aspiring to be a leader. In this study there seemed to be multiple barriers to clinical leadership like limited time, overwhelming clinical works and lack of peer support.

Still in another study of health professionals on clinical leadership with mixed and quantitative methodology design (Stanley 2017) it was concluded that clinical leadership is a key for a successful health system, most of the respondents (79.2%) saw themselves as clinical leaders and there were necessary attributes for one to be a clinical leader including clinical activeness siting out some barriers like busy clinics, and institutional bureaucracy. As it is reported in our study whoever needs to have some hospital leadership should also be involved in providing clinical service not just as an observer as echoed by Kacholi et al (2020) in a study on improvement of clinical leadership in selected regional hospitals in Tanzania.

A Nigerian interview/ workshop study design (Donald 2015) reported a score of 50% more in hospitals practicing clinical leadership and showed that those organizations were successfully improving services and change delivery. Clinicians' decisions were seen to determine the quality and efficiency of care. They could site out barriers and enablers for clinical leadership.

In a bid to understand the perception of clinical leadership among frontline health care worker, a review article (Solange 2017) reported necessary attributes for clinical personnel to be a leader sitting out clinical activeness, approachability, visibility, availability and confidence during crisis to be among the attributes. The study endorsed clinical leadership as a way of motivating staff, retain them and improve service provision.

The effect of these perceptions on general understanding of clinical leadership was found to be true more with health care leadership. Meaning doctors who perceived clinical leadership as health care leadership had an increased likelihood of understanding well the clinical leadership. Most of the respondents were not supporting medical leadership and there was negative correlation of the medical leadership and general understanding of clinical leadership.

Our findings are not so different from what other researchers reported. Solange (2017) in a mixed method study revealed clinical leadership as leadership provided by frontline health care providers regardless of their position in the health care system. Because it is skills based, every clinical personnel with leadership credentials can stand and administer leadership at his/her section as suggested by doctors in our study.

Most of the studies done in different clinical groups showed that each cadre aspire to give some leadership as it is suggested in this study, Stanley (2017).

In all the discussed literature there was strong correlation between proper understanding of clinical leadership and the specific perception of the respondent groups, Stanley (2017). Clinical leadership ought to be all clinicians' duty meaning healthcare or health professional leadership. In our study there was significantly positively and moderate correlated of the general doc clinical with clinical leadership as well as some positive correlation with doctors and medical leadership. There was also good internal consistency for the clinical leadership and health care leadership. It is therefore an obvious observation that whenever doctors could clearly understand clinical leadership as health care leadership they scored higher in the general understanding of clinical leadership. The general understanding of our doctors on clinical leadership unfolds the true need of clinical leadership and the implementation of the same in our health care delivery systems is expected to add up to the quality of services given.

# CHAPTER FIVE

# CONCLUSION POLICY IMPLICATION AND RECOMMENDATIONS

## 5.1 Overview

This chapter concludes the study by providing a summary of how the study was approached, its empirical findings and their policy implications. It also points out limitations faced by the researcher and recommendation for the future study.

## 5.2 Summary

This study sought to investigate the perception on Clinical leadership of doctors working in tertiary hospital in Dar es Salaam. The main objectives were to find out whether clinical leadership and health care leadership mean the same thing for doctors, determine the perceived difference between medical leadership and clinical leadership and elucidate the perceived similarities of doctors' leadership and clinical leadership. Furthermore, the study correlated general doctors' understanding on clinical leadership with the main objectives.

Using a pre-tested structured questionnaire, doctors with a minimum of first degree working with Muhimbili (plus Mloganzila), JKCI, MOI, Aghakan, ORCI and CCBRT were interviewed by either filling the questionnaire physical or submitting an electronic copy of the same. Descriptive statistics (mean, standard deviation, minimum, and maximum scores), and reliability and Correlation analysis on general doctors understanding showed that the item stating that "Clinical leadership is a key to good quality health care delivery scored highest followed by "It is important to have clinical leadership in hospitals"; the lowest measurement scale was on "Leadership

isn't a necessary factor for health service delivery followed by "There are no barriers for one to be a clinical leader". As for the clinical leadership as health care leadership 'I recommend other health staff like nurses and pharmacists to manage the hospital' scored the highest followed by 'Clinical leadership is synonymous with health care leadership'; the lowest measurement scale was on 'Clinical leadership is an impossible idea in Tanzania' followed by 'All health care workers' basic training equips them to be clinical leaders. Regarding perceived difference between medical leadership and clinical leadership scale 'Health personnel and non – health personnel should cooperate together to manage the hospitals' scored the highest followed by 'Non – health personnel should work under doctors' supervision when managing the hospitals'; the lowest measurement scale was on 'Hospitals are better run by army generals' followed by 'Administrators, politicians and managers motivate clinicians in hospitals. In looking the perceived similarities of doctors' leadership and clinical leadership gauge showed that the item which stated 'As compared to other health staff doctors perform well in leadership' scored the highest followed by 'Clinical leadership means doctor's leadership in the hospital'; the lowest measurement scale was on 'Doctors are free to treat their patients anyhow' followed by 'All doctors have the mindset required for a clinical leader'. Using the original cut offs of Albdour and Altarawneh (2014) effect of healthcare leadership as a perception was significant, positively and strong correlated to general understanding of clinical leadership.

Conclusion: Clinical leadership in our study is seen as an important entity for the successful delivery of quality health care services. Doctors see leadership as important in motivating employees to function, improvement of health care services and client

satisfaction. Clinical leadership is correlated with health care leadership and less with medical leadership. In all scenarios a clinical leader ought to be clinically active with certain attributes. Basic medical training isn't fully sufficient to make someone a clinical leader necessitating some on job leadership training skills or additional leadership modules in the training curriculums. Removing all the barriers to clinical leadership and further studies on clinical leadership will improve its practices for the wellbeing of patients and the health care delivery systems.

## 5.3 Policy Implications

The empirical results of this study raise a number of policy issues regarding clinical leadership in the country. Advocacy on frontline clinical personnel doing both clinical works and management duties should be done to raise awareness of clinical personnel, general health industry, government and all stakeholders. On the other side there is a need to discourage using non-medical personnel to sorely run health care facilities. There is a need to review the basic medical training curriculum leadership modules so as to equip graduates with necessary clinical leadership skills. On job training in form of CPD and or short courses should be encouraged to fill in the knowledge gap identified.

## 5.4 Limitation of the Study

This study determined the perception of individuals on a matter, which can have a lot of personal confounding factors that are not excluded in the analysis. This was partly overcome by including attention finder question in the questionnaire so as to make sure all answers are personally filtered.

The concentrated on general perception leaving behind details on attributes, barriers and enablers for the clinical leadership.

No strong evidence for cause and effect in this study

Selection of tertiary hospitals may have confounded the findings by not including the experience of doctors in the lower service levels. Convenient sampling for doctors might have excluded some potential data that would have changed the final results. Including all potential participants at the time of study was made to minimize the effect.

Digitally submitted questionnaires have reduced credibility for they don't necessarily represent the real time views of the interviewee. We discarded those that had some incomplete and probable details to minimize the error

### 5.5 Recommendations

Clinical leadership is well recommended for health facility proper functioning. Different perception on the subjects may affect the practices of the respective group of clinicians. General all clinicians should be given opportunity to lead provided they have the required leadership attributes.

Policy makers and leaders in health care industry should try implementing the findings by giving more chance for leadership to the clinical personnel other than non-clinical.

A more well-structured researches on clinical leadership targeting practices, attributes, barriers and enablers should be conducted as a follow up to this one.

Albdour, A., & Altarawneh, A. (2014). Employee Engagement and Organizational Commitment: Evidence from Jordan. *International Journal of Business, 19(2),* 192-212.

Ezeh. A. (2015). Leadership and health in Africa. Volume 385, ISSUE 9983, P2141,. DOI: https://doi.org/10.1016/S0140-6736(15)61010-8

BMA, (2012). Doctors perspectives on clinical leadership. Health policy and economic research unit.

Bayline, P., & Moreira, P. (2013). Healthcare associated infections – on developing renewed health care management debate

Chadi, N. (2009). Medical Leadership: Doctors at the Helm of Change. McGill journal of medicine: MJM: *an international forum for the advancement of medical sciences by students;* 52, 7 vol 12. DO - 10.26443/mjm. v12i1.734

Cunningham, C., Brysiewicz, P., Sepeku, A., WhiteL, Murray, B., Lobue, N., & Sawe, H. (2017). Developing an emergency nursing short course in Tanzania, *African Journal of Emergency Medicine, 7(4),* 147-150, ISSN 2211-419X, https://doi.org/10.1016/j.afjem.2017.08.002.

Doherty, J. (2013). Strengthening clinical leadership in hospitals: a review of the international and South African literature. DO; 10.13140/RG.2.1.1273.0725

David, S., Denise, B., Amali, H., Marani, H., & Anna, M. (2017). Health professionals' perspectives on clinical leadership. A pilot study. Cogent Medicine, 4:1, DOI: 10.1080/2331205X.2017.1321193

Dohorty, J., Gilson, L., & Shung – King, M. (2014). Achievements and challenges in Developing health leadership in South Africa, (Un published thesis).

Denis, J. L., & van Gestel, N. (2016). Medical doctors in healthcare leadership: theoretical and practical challenges. *BMC Health Serv Res 16*, 158 https://doi.org/10.1186/s12913-016-1392-8

Daly, J., Jackson, D., Mannix, J., Davidson, P. M., & Hutchinson, M. (2014). The importance of clinical leadership in the hospital setting. *Journal of Healthcare Leadership.;* 6:75-83 https://doi.org/10.2147/JHL.S46161

Goodell, A. J., Kahn, J. G., Ndeki, S. S., Kaale, E., Kaaya, E. E., & Macfarlane, S. B. (2016). Modelling solutions to Tanzania's physician workforce challenge. *Global health action*, 9,https://doi.org/10.3402/gha.v9.31597

Budak, F. (2017). The Importance of Clinical Leadership in Healthcare Management. *Journal of Current Researches on Health Sector,* 7 (2), 1-20

Figueroa, C. A., Harrison, R., Chauhan, A., & Meyer, L. (2019). Priorities and challenges for health leadership and workforce management globally: a rapid review. *BMC Health Serv Res.* 24; 19(1):239. doi: 10.1186/s12913-019-4080-7. PMID: 31014349; PMCID: PMC6480808.

Ham, C. (2008). Doctors in leadership: Learning from international experience. *International Journal of Clinical Leadership,* 16 (1),11-16

Jha, R. K., Sahay, B. S., & Charan, P. (2016). Healthcare operations management: a structured literature review. "Decision: *Official Journal of the Indian Institute of Management Calcutta. Springer*, Indian institute of management Calcutta, 43(3), 259–279 (2016). https://doi.org/10.1007/s40622-016-0132-6

John. E. (2015). Developing healthcare leaders and managers: course-based or practice-based? *International Journal of Healthcare*, Vol. 1, No. 1

Kacholi, G., & Mahomed, O. H. (2020). Sustainability of quality improvement teams in selected regional referral hospitals in Tanzania. *International journal for quality in health care: Journal of the International Society for Quality in Health Care*, 32(4), 259–265.https://doi.org/10.1093/intqhc/mzaa032

Kwesigabo, G., Mwangu, M. A., Kakoko, D. C., Warriner, I., Mkony, C. A., Killewo, J., Macfarlane, S. B., Kaaya, E. E., &Freeman P (2012). Tanzania's health system and workforce crisis. *Journal of Public Health Policy.*, 33(1), 35-44.

Leggat S. G., & Balding, C. (2013). Achieving Organisational competence for clinical leadership: the role of high-performance work systems. *Journal of Health Organ Manag.* 27(3):312-29. doi: 10.1108/JHOM-Jul-2012-0132. PMID: 23885396.

Nicol, E. D., Mohanna, K., & Cowpe, J. (2014). Perspectives on clinical leadership: a qualitative study exploring the views of senior healthcare leaders in the UK. Journal of the Royal Society of Medicine, 107(7), 277–286. https://doi.org/10.1177/0141076814527274

Nzinga, J., McGivern, G., & English, M. (2018). Examining clinical leadership in Kenyan public hospitals through the distributed leadership lens. *Health policy and planning*, 33(suppl_2), ii27–ii34. https://doi.org/10.1093/heapol/czx167

Njau, B. (2016). Composition and Challenges of Medical Leaders in Regional Hospitals Dar es salaam. Masters thesis, The Open University of Tanzania. Tanzania Bureau of Statistics. Retrieved September 21, 2020.

Naylor, C., Curry, N., Holder, H., Ross, S., & Marshall, L. (2013). Clinical commissioning groups: supporting improvement in general practice. Research report. Nuffield Trust and King's Fund

Mianda, S., & Voce, A. (2018) Developing and evaluating clinical leadership interventions for frontline healthcare providers: a review of the literature. *BMC Health Serv Res.*1;18(1):747. doi: 10.1186/s12913-018-3561-4. PMID: 30285742; PMCID: PMC6167878

Mianda, S., & Voce, A. (2019). Enablers and barriers to clinical leadership in the labor ward of district hospitals in KwaZulu-Natal, South Africa. *BMJ Leader* 2019; 3:75-80.

Pilar, B., & Paulo, M. (2012). Healthcare-associated infections – on developing effective control systems under a renewed healthcare management debate, *International Journal of Healthcare Management, 5:2,* 74-84, DOI: 10.1179/2047970012Z.00000000018

Reem. N., & Dossary. A/ (2017). Leadership in Nursing Contemporary Leadership Challenges, Aida Alvinius, IntechOpen, DOI: 10.5772/65308. Available from:ttps://www.intechopen.com/books/contemporary-leadership-challenges /leadership-in-nursing

Swanwick, T., & McKimm J. (2011). What is clinical leadership…and why is it important? *Clin Teach. 8(1*), 22-6. doi: 10.1111/j.1743-498X.2010.00423 .x. PMID: 21324068.

Spehar, I., Frich, J. C., & Kjekshus, D. (2012). L.E. Clinicians' experiences of becoming a clinical manager: a qualitative study. *BMC Health Serv Res* 12, 421 (2012). https://doi.org/10.1186/1472-6963-12-421

Songul, C. (2016).Complexity in healthcare management: Why does Drucker describe healthcare organizations as a double-headed monster? International Journal of Healthcare Management, 9:1, 11-17, DOI: 10.1179/2047971915Y.0000000016

Thompson, P., & Hyrkas, K. (2014), Global nursing leadership. *J Nurs Manag, 22*: 1-3. https://doi.org/10.1111/jonm.12215

Uba, D. D. (2015). Clinical Leadership as a Corollary for Professional Practice and Patient Safety. *International Journal of Emergency Mental Health and Human Resilience,* Vol. 17, No.1, pp. 262-266, ISSN 1522-4821

Uba, D. D. (2015). Challenges of Clinical Leadership in Nigeria. *J Psychiatry, 18*: 210. doi:10.4172/2378-5756.1000210

Xu, Jie-Hui (2017). Leadership theory in clinical practice. *Chinese Nursing Research*. 155; 157( 4).DO: 10.1016/j.cnre.2017.10.001

Zoheir, E. (2012). The importance of clinical leadership in twenty-first century health care, *International Journal of Health Promotion and Education*, 50:5, 261-269, DOI: 10.1080/14635240.2012.723377.

# APPENDIXES

## Appendix I: Questionnaire

My name is Dr Cyprian G Ntomoka I am carrying out research entitled "Assessment **of doctors' perception on clinical leadership- a case of tertiary hospitals in Dar es Salaam Tanzania"** in fulfilment of the award of Masters of Business Administration degree of the Open University of Tanzania. Hereunder is a questionnaire, which I would like you to fill up. While filling up this questionnaire, please **encircle** the rating number **{1, 2, 3, 4, or 5}** that represents your excellent level of agreement with each statement where **1 = Strongly Disagree 2 = Disagree 3 = neither Disagree nor Agree 4 = Agree 5 = Strongly Agree.**

| | **SD** | **D** | **N** | **A** | **SA** |
|---|---|---|---|---|---|

| **A: Personal Information** | | |
|---|---|---|
| 1. Age of respondent | a. 20- 29( ) | c. 40-49 ( ) |
| | b. 30-39 ( ) | d. 50 and above ( ) |
| 2. Sex of the respondents | a. Male ( ) | b. Female ( ) |
| 3. What is your basic professional qualification? | a. MD ( ) | c. DDS ( ) |
| | b. MBBS ( ) | d. Others ( specify)……. ( ) |
| 4. Where did you study your first degree? | a. MUHAS ( ) | d. BUGANDO ( ) |
| | b. KCMC ( ) | d. UDOM ( ) |
| | c. IMTU ( ) | e. Others (specify)…….. |
| 5. What is your highest leadership position you have ever attained after graduation? | a. None ( ) | d. Director/Manager ( ) |
| | b. MOI ( ) | e. Others (specify)…..( ) |
| | c. DMO/RMO ( ) | |
| 6. Postgraduate training | a. MMED/MDENT | d. MBA |
| | b. MPH/MSc | e. None |
| | c. PhD | f. Others (specify)…..( |
| 7. Name of the Hospital you work with | …… | |

| **To assess the general understanding of doctors on clinical leadership** | **SD** | **D** | **N** | **A** | **SA** |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| I understand fully the meaning of clinical leadership | | | | | |
| It is important to have clinical leadership in hospitals | | | | | |
| I am satisfied with the quality of health care delivery at my facility | | | | | |
| Clinical leadership is a key to good quality health care delivery | | | | | |
| Clinical leadership improves health system performance | | | | | |
| Clinical leadership increase clinician's commitment to high quality of care | | | | | |
| I think employees at my facility are very well satisfied and motivated | | | | | |
| Leadership isn't a necessary factor for health service delivery | | | | | |
| Being an active clinician is mandatory for one to be a clinical leader | | | | | |
| There are certain necessary attributes for a clinical leader | | | | | |
| Balancing between clinical and managerial roles is mandatory for a clinical leader | | | | | |
| There are no barriers for one to be a clinical leader | | | | | |
| I am ready to hold any clinical leadership position in my hospital | | | | | |

| **To find out whether clinical leadership and health care leadership mean the same thing for doctors** | **SD** | **D** | **N** | **A** | **SA** |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| Clinical leadership is synonymous with health care leadership | | | | | |
| I recommend other health staff like nurses and pharmacists to manage the hospitals | | | | | |
| There is no difference between leadership by a doctor and leadership by any other health personnel | | | | | |
| All health care workers' basic training equip them to be clinical leaders | | | | | |
| Health care workers other than Doctors, Nurses and pharmacist shouldn't be given chance to lead. | | | | | |
| Clinical leadership is an impossible idea in Tanzania | | | | | |

| **To determine the perceived difference between medical leadership and clinical leadership** | **SD** | **D** | **N** | **A** | **SA** |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| Clinical leadership is not different from medical leadership | | | | | |
| Non health personnel like administrators, politicians and managers should manage the hospitals | | | | | |
| Non health leadership improve health services to patients and hospital development | | | | | |
| Administrators, politicians and managers motivate clinicians in hospitals | | | | | |
| Non – health personnel should work under doctors' supervision when managing the hospitals | | | | | |
| Health personnel and non – health personnel should cooperate together to manage the hospitals | | | | | |
| Hospitals are better run by army generals | | | | | |

| **To elucidate the perceived similarities of doctors leadership and clinical leadership** | **SD** | **D** | **N** | **A** | **SA** |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| Clinical leadership means doctor's leadership in the hospital | | | | | |
| I recommend doctors only to be given chances to be leaders in the hospitals | | | | | |
| As compared to other health staff doctors perform well in leadership | | | | | |
| The basic medical training equip well doctors to be clinical leaders | | | | | |
| All doctors have the mindset required for a clinical leader | | | | | |
| Doctors are free to treat their patients anyhow | | | | | |

## Appendix II: Research Clearance Letter

**THE OPEN UNIVERSITY OF TANZANIA**

*DIRECTORATE OF POSTGRADUATE STUDIES*

P.O. Box 23409
Dar es Salaam, Tanzania
http://www.openuniversity.ac.tz

Tel: 255-22-2668992/2668445
ext.2101
Fax: 255-22-2668759
E-mail: dpgs@out.ac.tz

**Our Ref: PG2017995390**

**4th March 2021**

**Director of Research and Training,**

Muhimbili National Hospital- Mloganzira,

P.O. Box 65000,

**DAR ES SALAAM.**

**RE: RESEARCH CLEARANCE**

The Open University of Tanzania was established by an Act of Parliament No. 17 of 1992, which became operational on the 1st March 1993 by public notice No.55 in the official Gazette. The Act was however replaced by the Open University of Tanzania Charter of 2005, which became operational on 1st January 2007.In line with the Charter, the Open University of Tanzania mission is to generate and apply knowledge through research

To facilitate and to simplify research process therefore, the act empowers the Vice Chancellor of the Open University of Tanzania to issue research clearance, on behalf of the Government of Tanzania and Tanzania Commission for Science and Technology, to both its staff and students who are doing research in Tanzania. With this brief background, the purpose of this letter is to introduce to you **Mr. NTOMOKA, Cyprian G Reg No: PG2017995390** pursuing **Master of Business Administration (MBA).**We here by grant this clearance to conduct a research titled **"Assessment of Doctor's Perception On Clinical Leadeship. A Case of Tertiary Hospitals in Dar es salaam Tanzania"**. He will collect his data at your office from 5th March 2021 to 31st March 2021.

In case you need any further information, kindly do not hesitate to contact the Deputy Vice Chancellor (Academic) of the Open University of Tanzania, P.O.Box 23409, Dar es Salaam.Tel: 022-2-2668820.We lastly thank you in advance for your assumed cooperation and facilitation of this research academic activity.

Yours,
**THE OPEN UNIVERSITY OF TANZANIA**

Prof. Magreth Bushesha
**DIRECTOR OF POSTGRADUATE STUDIES.**