INTRODUCTION

In a profession where decision making cannot afford to be erroneous, it is rightly expected that proficiency, expertise and professionalism are well demonstrated in theory and practice (Wiles & Widerstrom, 2001; Nath & Clark, 2014). But if confidence is debased the bulk of the culpability goes to the medical practitioner and the systemic structure (Dennis, 2014). Over the years, investigation and prosecutions have resulted in the convictions of hundreds of proprietors, managers and staff members of nursing homes and other residential care facilities, cascading into the recovery of millions of dollars, and positive changes in training and supervisory procedures

- Leadership of self
- Leadership of others (teams, direct reports)
- Leadership of organisations within systems

Leadership of self or personal leadership refers to the embers of influence that one has to change oneself (Mohapel & Dickson, 2007). Adjustments must appeal to clinicians at an individual level in order to change the behaviours of clinicians in general (Swanwick & McKimm, 2011b). Leadership of others relates to concepts of supervisory leadership which may relate to both formal structural leadership positions and also less formal, influential processes (Mohapel & Dickson, 2007). That is, leadership in a structural sense may be symbolic as well as practical but individual personality traits are also important in persuading and inspiring others and both may combine to influence cultural factors (Mohapel and Dickson, 2007). Leadership of organisations effectively refers to strategic leadership. Mohapel and Dickson (2007) suggest that strategic leadership is one of the key elements in increasing physician engagement, but is insufficient without the other two aspects.

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accountabilities. This clearly stands as a quite different stance towards leadership than those cited by Firth-Cozens and Mowbray (2001) where the leaders are solely those within official positions of authority, and suggests would require quite a different approach to leadership development (i.e. developing an individual's ability to influence others not necessarily via a top-down demonstration of power, but through other processes). Examples such as those from Firth-Cozens and Mowbray, (2001); Degeling et al., (2003) and the clinical micro-systems studies suggest that leadership is a social process and leaders influence followers through social processes. Leading change is a complex and dynamic process, but medical leaders might influence followers by resonating with and drawing upon certain aspects of culture and professional identity.

What this also suggests is that due to the strong professional underpinning of the majority of clinical identities that this process of transformation may be more successful if those leading change efforts are clinical or medical leaders themselves (Baumeister, Campbell, Krueger, & Vohs, 2003). However, such leadership will be deficient because effective leadership involves a constellation of leaders from various backgrounds and at different levels who might influence a range of sub-cultures in diverse ways, though within a context where there is top management leadership and support. The importance of effective followership is again underscored by this analysis. Silversin and Kornacki (2000) similarly emphasize the critical role of followers in their analysis of physician leadership in the United States.

Poor Sensitization and Planning

However, clinical leadership has been observed to be a major factor affecting the performance of health system which is attributable to the weakness in leadership role of health managers and policy makers (Firth-Cozens & Mowbray, 2001; Mott, 2008; Busari, 2013). To enhance clinical leadership and management capacity of the clinicians in strengthening the health sector it is imperative to organize a staff/ organisational appraisal/performance assessment of clinicians in managed care organizations as perceived by policy makers and stakeholders (Mohapel & Dickson, 2007). Health policy makers and other stakeholders including directors, project and program managers, and the heads of department under the ministries of health, hospital administrators, chief executive officers of civil society groups including non-governmental organisations, leaders of national health based associations and health directors and managers in uniform services need to be sensitized on the gains of adopting clinical leadership practices.

When summed making clinicians' organisational leaders is a huge and costly task (McKinsey, 2008). Is it worth it? Especially given the many competing demands on clinicians' time? They and others will rightly seek evidence of the link between clinical leadership and a health organization's performance, both clinical and financial. Proof of a direct correlation will remain elusive, thanks to the inherent complexity of health systems, whose performance is affected by multiple, overlapping variables of which clinical leadership is only one (Busari, 2013).

In conclusion, the assessment of healthcare systems have often demonstrated that most healthcare organisations have mission and goals and these are not formally linked to planning(Woolnough & Faugier, 2002). In addition, healthcare organisations should have annual human resource plan, because most of the them signify that the plan is not always linked to healthcare leadership responsibility, staff supervision work, work planning, performance review, job classification system, and relationship with unions, clinician-patient compensation, labour law and organisational planning among others (Hewison & Griffiths, 2004). Other reports indicate that inadequate funding of development programmes and trainings is a common problem in health sector of most low-to-middle-income countries particularly in Africa and Asia (Adano, 2006; Asante & Hall, 2010).

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