Abstract

Background: A positive link between medical leadership, better patient outcomes, and organizational performance has been well demonstrated. Grade Medical Officers play a key role in planning, organizing, delivery, and transformation of health care services. The majority of primary curative and preventive healthcare institutions as well as units of secondary and tertiary care hospitals are led by them. Acts of leadership are not restricted to people who hold designated posts, and they can arise from anyone in the healthcare organization, as appropriate at different times.

Objectives: To determine the knowledge, attitudes, and practices on medical leadership among grade medical officers in Galle district, Sri Lanka.

Methods: This descriptive cross-sectional study consisted of both quantitative and qualitative methods. The quantitative component was conducted among grade medical officers in government health care institutions in Galle district using a pretested, self-administered questionnaire and systematic sampling. Descriptive statistics were used to describe the sample data, and non-parametric tests were used to identify the associations. Eight purposefully selected supervisors of grade medical officers took part in semi-structured key informant interviews in the qualitative component. Manually analyzed qualitative data were presented as narratives with quotes, and content analysis with word frequency queries was carried out using word cloud generators.

Results: The study included 287 grade medical officers with a response rate of 80.6%. Among grade medical officers, the mean scores for overall knowledge, attitudes, and practices on medical leadership were 0.73 (SD 0.13), 0.76 (SD 0.11), and 3.87 (SD 0.52),

respectively. There was a significant association between overall knowledge and service duration; between overall attitudes and service duration; and between seniority grade and current postgraduate training status. Significant differences were also observed in overall practices and service duration, current postgraduate training status, and depending on whether they have worked previously as the head of a healthcare institution or a unit and whether they have received any training on leadership after graduation. The qualitative component revealed that lack of incentives or additional benefits, unfavourable attitudes, fewer learning opportunities, and time constraints as common barriers for medical officers to engage in medical leadership.

Conclusions and Recommendations: The majority of grade medical officers had a satisfactory level of overall knowledge and favourable attitudes on medical leadership although some unfavourable attitudes and deficiencies in knowledge in some aspects were evident. Doctors with more service duration demonstrated higher levels of knowledge, attitudes, and practices than others, while postgraduate trainees demonstrated higher levels of both attitudes and practices. Medical officers who have worked previously as the head of a health care institution or a unit and those who have received training on leadership reported better practices. This study suggests that grade medical officers' learning opportunities in both theoretical and practical aspects of medical leadership be improved, and that their medical leadership practices be recognized with appropriate incentives.

Key words: Medical Leadership, Knowledge, Attitudes, Practices, Doctors