Strengthening medical leadership

The current focus on improving medical leadership reflects the profession's feeling that it has lost control of its destiny and of the broader health agenda. The consensus statement on the role of the doctor (Tooke et al, 2008) stressed that, as the critical decision makers in clinical teams, doctors must be capable of both leadership and management. The Royal College of Physicians of London's report on *Doctors in Society* (Royal College of Physicians of London, 2005) suggested that doctors were too often negative and defensive and recommended that the colleges and other professional groups act to promote the development of clinical leaders.

To set our house in order, the Academy of Medical Royal Colleges is endeavouring to deliver clear policy agreed among all the colleges, and when views occasionally and inevitably differ, to identify and stress the areas of agreement. Only if we present a unified view to the public and to politicians will the colleges be effective.

In addition, in conjunction with the NHS Institute for Innovation and Improvement, the Academy of Medical Royal Colleges has developed the Medical Leadership Competency Framework for doctors at all career stages (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2009), based on the concept of shared leadership. This recognizes that leadership can come from anyone in an organization, not only those appointed to managerial roles, and encourages a shared sense of responsibility for the organization's success.

The relevant components of the competency framework have been embedded in undergraduate teaching via the General Medical Council's new version of *Tomorrow's Doctors* (General Medical Council, 2009) and in the postgraduate training curricula both at foundation and specialty training levels through the revisions of the curricula currently being considered by the Postgraduate Medical Education and Training Board and General Medical Council.

Much of the focus on improving medical leadership has been directed at increased involvement of senior doctors in the management of the NHS, a highly desirable goal towards which significant strides have been made, especially in England. A subspecialty of medical management will be developed by the Academy of Medical Royal Colleges working with others.

However, it is even more vital that careers in medical management become regarded as desirable and prestigious, ranking alongside leading research and clinical roles. Career pathways need to be improved to facilitate movement between trusts at clinical director level, and also between trusts, strategic health authorities and the Department of Health at medical director level. There is a real need to increase the number of doctors rising to Chief Executive and board level posts in trusts and strategic health authorities to ensure that quality of care and clinical priorities are understood at the highest levels in decision making.

Involving all doctors

Beyond senior clinical management, however, competent and creative leadership by doctors is needed in improving the quality and cost efficacy of local services, inspiring research teams, and running academic units, journals, specialty societies and colleges. Arguably the most important area where medical leadership is needed – and an area which is relevant to almost every practicing clinician – is the postgraduate supervision and training of the next generation of doctors.

UK trainees in hospital specialties are not happy. The Medical Training and Appointment Service fiasco in 2007 had a profound and persistent effect on morale (Douglas, 2007). Successive Postgraduate Medical Education and Training Board surveys have shown that trainee satisfaction is lower in all hospital specialties than in general practice. Satisfaction is lowest in hospital medicine, obstetrics and gynaecology and surgery (Postgraduate Medical Education and Training Board, 2009). Training in general practice receives much higher ratings from trainees, perhaps because it is conducted by selected and trained trainers who have protected time in which to train, and who achieve increased status by being a trainer. There is always a clear line of clinical supervision for every GP trainee.

In hospitals, lower trainee satisfaction scores are associated with trainees feeling they were being undermined by their seniors, while higher satisfaction scores are associated with good senior support and with regular feedback. These factors are not unique to medicine – successful leaders in any field would recognize that such support is central to staff morale, productivity and retention. There is an urgent need to improve training in hospitals which goes beyond any redesign of training curricula or change in regulatory body. Trainees must be treated well and valued locally and senior clinicians must show leadership to deliver this despite clinical pressures – the future of the profession and of health care depends on improving hospital training.

As intelligent and creative individuals who were often leaders at school or university, trainees must be empowered to make change within an organization, rather than feeling at the mercy of an uncaring and immovable juggernaut. Basic management of trainees is too often uncaring, severely affecting morale. Local medical leaders should ensure that trainees:

- Know who is covering them at all times and can easily contact them
- Are actively encouraged to seek assistance, not made to feel that is an admission of incompetence
- Get notice of their rotas at least 6 months in advance. It is inexcusable laziness on the part of rota makers to inform trainees on the first day of the attachment whether they start with nights or compulsory leave
- Are able – and encouraged – to feedback suggestions for improving both service and training.

The ceaseless priority of the NHS to hit targets has diverted clinicians from non-clinical areas of professional practice and decreased the importance clinicians have been able to give to training. The attitude

that nothing must get in the way of patient care has been addressed nationally by a joint statement from the Academy of Medical Royal Colleges, NHS Employers, the General Medical Council, Postgraduate Medical Education and Training Board and the Confederation of Postgraduate Medical Deans (Postgraduate Medical Education and Training Board et al, 2009) which states that:

> **'we need all trainers to ... identify where any shortfall in resources (including time) is limiting their ability… All our organisations will continue to work together to ensure that appropriate recognition and resources are embedded throughout the health services of the UK.'**

In theory, this empowers local trainers to ensure that the time and resources are given them through job planning but in the current financial climate, such resources will not come easily. The Academy of Medical Royal Colleges' report on *Improving Assessment* (Academy of Medical Royal Colleges, 2009), which has been accepted by the four Chief Medical Officers, states that trainers require 0.25 programmed activities per week per trainee, a mere hour per week per trainee, but strong local leadership is needed to ensure this is built into job plans and delivered as high quality training. Local postgraduate training leaders have both the opportunity and responsibility to drive such improvement.

The training outcomes must be monitored, using the Postgraduate Medical Education and Training Board/General Medical Council survey and other measures of quality, and published. Importantly the data will allow trainees to select where to train but they must also affect local training budgets. Ultimately those hospitals which fail to deliver satisfactory training should have their training status withdrawn – all hospitals do not need to train just because that is the British tradition.

Conclusions

For the profession to regain its self-confidence, doctors must take lead responsibility for driving change in their organizations. Rather than blaming 'management', all clinicians must recognize their own managerial responsibilities starting close to home: by ensuring that their trainees are appropriately supervised, valued and empowered. Teaching leadership is only a small part of the answer, trainees must experience leadership from their seniors and have real opportunities to demonstrate it themselves. BJHM

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KEY POINTS

- All doctors should demonstrate leadership at all stages of their career.
- Local leadership within your clinical team is important.
- Senior medical management must become as valued a career option for doctors as being a clinical or academic leader.
- Although leadership should be taught, learning by example and experience is key.
- Greater leadership by doctors is needed to improve training in hospital specialties.

Leadership in medicine

To learn about one deanery's approach to developing clinical leadership, see our article on p. 220.

If you would like to comment on this or any of the articles in *British Journal of Hospital Medicine*, or any issues which are relevant to our readers, please write in no more than 250 words to:

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