

Medical leadership: from policy to practice

Medical leadership is now becoming embedded at all stages of medical education and training. This article summarizes key policy and practice drivers, highlights some of the debates around what constitutes medical leadership and provides examples of leadership development initiatives.

This article, the first of a short series on clinical and medical leadership, looks at medical leadership in the UK and, set in the wider policy, practice and professional context, at some leadership development initiatives at undergraduate and postgraduate stages and those for senior clinicians and medical managers. Future articles will explore some of the issues and strategies adopted by different organizations and specialities to develop and train existing and future leaders.

The policy and practice context

'Doctors must take lead responsibility for driving change in their organisations. Rather than blaming "management", all doctors must recognise their own managerial responsibilities' (Douglas, 2010).

As many writers have noted (Clark and Armit, 2010; Hadley et al, 2010; Swanwick and McKimm, 2011), a publicly funded NHS which employs nearly 1.5 million people inevitably results in tensions around business and cost efficiency, patient expectations, the role of management, professional autonomy and responsibility and the provision of safe, high quality clinical care.

Attempts to resolve such tensions and address the failure of the medical profession to monitor its own performance in high profile cases highlighted by the Bristol Inquiry, the Shipman Inquiry and the Royal Liverpool Children's Hospital (Alder Hey) Inquiry have led to a swathe

of different policy and strategy initiatives at national and local levels. These have attempted to identify a model of leadership and management which engages doctors and other health professionals in taking clinical leadership and management roles while ensuring that the NHS 'business' runs efficiently to provide the right care, at the right place, at the right time – delivered by the right people (Spragg, 2009).

Since the establishment of the NHS in 1948, much attention has focused on how to manage the ever-growing NHS, with the primary rationale being that management was best done by 'managers' and clinicians should focus on caring for patients. The Griffiths Report (Department of Health and Social Security, 1983) led to specially trained managers being brought in from outside the NHS to engage in general management training schemes and this, coupled with the increased specialization of management, led to a separation between clinicians and managers with management often being viewed as 'the dark side' (Imison and Giordano, 2009).

More recently, however, clinical and medical leadership have become key watchwords for the NHS and for all those who work within it. In the foreword to *Inspiring leaders: Leadership for quality* (Department of Health, 2009), David Nicholson, the then NHS Chief Executive, set out core tenets for all clinical leaders around the four principles of:

1. Co-production – all parts of the system working together on shaping and implementing change, engaging people across the system to work together to make change happen
2. Subsidiarity – ensuring that decisions are taken at the right level of the system, collaboratively with clinicians and patients, as close to the patient as possible
3. System alignment – quality as an organizing principle to achieve complex cultural changes

4. Clinical ownership and leadership – in which the quality agenda will mobilize and empower clinicians: clinical leadership needs to be part of everything that we do.

An increasing emphasis on quality improvements is set in an approach that acknowledges the importance of health care being delivered within a whole complex system by clinicians and managers, in partnership with patients and communities.

Over the last two decades, activities have increasingly focused on specifically engaging doctors in managing health systems at various levels, moving away from a focus on simply managing care at the level of the individual patient or population. Alongside this change in emphasis, a number of shifts have occurred which require doctors to take broader management and leadership roles. These include making structural changes within organizations (e.g. establishing clinical directorates, appointing medical managers), devolving budgets to local levels, setting up new commissioning and purchasing arrangements and embedding clinical governance throughout organizations (Hadley et al, 2010; Swanwick and McKimm, 2011). All clinicians, with doctors seen as having a particular leadership role, are considered instrumental to effecting widespread change in the NHS to improve patient safety, the patient experience and health-care outcomes. However, this sea change has not been fully implemented and has not been without critics and problems.

Doctors as leaders

In the light of the policy background and health-care context described above, the Royal College of Physicians (2005), in its influential report *Doctors in Society*, concluded that medical leadership was seriously failing. They recommended that 'the Royal Colleges and Faculties, medical schools, the British Medical Association, and other healthcare organisations take on the responsibility to develop a cadre of

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clinical leaders. These bodies need to define the skills of leadership that they seek, and implement education and training programmes to develop doctors with those skills.' (Royal College of Physicians, 2005).

These views were further articulated in the Tooke report (Modernising Medical Careers, 2008) and by Lord Darzi (Department of Health, 2008). Darzi specifically emphasized the key roles of all clinicians in working with patients and health systems as those of practitioner, partner and leader. The medical profession has taken hold of the ideas encapsulated in these reports in a very different way from other professions, particularly through the Enhancing Engagement in Medical Leadership project, a collaborative project involving the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement.

Emerging evidence indicates that widespread engagement with leadership of a high standard is related to good clinical outcomes. For example, Bloom et al (2010) noted that 'management quality – measured using a new survey tool – is strongly correlated with financial and clinical outcomes such as survival rates from emergency heart attack admissions'. Other research corroborates these findings with recent research by a team from the NHS Institute for Innovation and Improvement concluding that 'the research clearly indicates that medical engagement plays a crucial role in supporting organisational achievement and that leadership is essential in creating the appropriate culture for medical engagement to flourish' (Atkinson et al, 2011).

However, for doctors at all levels to engage meaningfully in leadership and management activities, the most appropriate activities need to be defined and doctors need to be trained to carry out activities effectively.

Professionalism and leadership

The emergence of medical professionalism as a distinct discipline within medicine has brought many attempts to define professionalism and to articulate what it means for practising doctors and those in training (van Mook et al, 2009). A widely regarded and concise definition was proposed by a working group of the Royal College of Physicians in 2005:

'Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.'

Further work on professionalism established a number of lists of skills and attributes of a 'good professional'. For example, Hilton and Slotnik (2005) suggest there are six domains where professionalism might be expected:

1. Ethical practice
2. Reflection and self-awareness
3. Responsibility for actions
4. Respect for patients
5. Teamwork
6. Social responsibility.

There is much overlap in the domains of professionalism and the competencies required for medical leadership, in particular the areas of reflection and ethical practice, self awareness and responsibility for actions. Emotional intelligence may also be a bridge between professionalism and leadership. Although there is evidence of a link between high emotional intelligence and leadership in general (Greenockle, 2010) the evidence linking emotional intelligence, professionalism and leadership is less well established (Fletcher et al, 2009).

Interestingly, medical students recognize the need for leadership skills but are less convinced about the need for management skills, seeing them as separate entities

(Levenson et al, 2010). All doctors need to understand resource management, the structure and function of various parts of the NHS as well as quality improvement and management performance as essential parts of the leadership–management overlap. The Medical Leadership Competency Framework aims to weave together management and leadership competencies, aligned with medical student, trainee and qualified doctors' day-to-day practice.

The Medical Leadership Competency Framework in practice

One of the main outcomes from the Enhancing Engagement in Medical Leadership project was the Medical Leadership Competency Framework which defines 'the leadership competencies doctors need to become more actively involved in the planning, delivery and transformation of health services as a normal part of their role as doctors' (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010).

The framework has five domains: demonstrating personal qualities, working with others, managing services, improving services and setting direction (*Figure 1*).

The unique aspect of the framework is that it is structured in three sections, covering the competencies that would be

Figure 1. Medical Leadership Competency Framework. From NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges (2010).



expected at medical school, during postgraduate training and post qualification. Supplementary updates on using the Medical Leadership Competency Framework have already been produced for undergraduate programmes and for integrating the framework into postgraduate curricula (Clark and Armit, 2010).

Applying the Medical Leadership Competency Framework at undergraduate level

In 2009, the latest edition of the General Medical Council's guidance for undergraduate curricula was published. *Tomorrow's Doctors* contains specific reference to leadership and followership (General Medical Council, 2009). The outcomes for undergraduate medical education are broken down into three domains: the doctor as a scholar and scientist, the doctor as a practitioner and the doctor as a professional.

Tomorrow's Doctors notes clearly that graduates should be able to 'demonstrate ability to build team capacity and positive working relationships and undertake various team roles including leadership and the ability to accept leadership by others' (paragraph 22(d), General Medical Council, 2009). And paragraph 7 (outcomes for graduates) makes it clear that leadership is a central part of all doctors working practice: 'In accordance with Good Medical Practice, graduates will make the care of patients their first concern, applying their knowledge and skills in a competent and ethical manner and using their ability to provide leadership and to analyse complex and uncertain situations' (General Medical Council, 2009).

Although *Tomorrow's Doctors* does not directly echo the Medical Leadership Competency Framework, the framework's competencies are represented in the outcomes of *Tomorrow's Doctors* and the document refers to the Medical Leadership Competency Framework as a key source for further development. In order to ensure that all medical undergraduates are able to demonstrate these outcomes, medical schools need to provide structured learning opportunities. The Medical Leadership Competency Framework provides many examples of the sorts of activities in which medical students can take part (see *case example 1*). Most of these are integrated into current curricula but medical pro-

grammes must make it clear to the students how they are developing these skills and clearly define them as 'leadership'. The Enhancing Engagement in Medical Leadership project team is working with a group of medical schools to develop guidance on how these competencies can be developed and (most importantly) assessed (Clark and Armit, 2010).

Applying the Medical Leadership Competency Framework at postgraduate level

'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' (Douglas, 2010).

Empowerment, both as an attribute of leadership and as a tool in developing leadership, has been demonstrated to be effective (Gardner and Olson, 2010). Although medical students and junior doctors are working towards a career where responsibility, autonomy and authority are at the highest level, they often find themselves treated as the lowest of the low. Students usually arrive in medical school having had an enormously successful school career and

having had a range of leadership roles, such as head boy or girl, sport team captain, Duke of Edinburgh awards and many other impressive responsibilities. Most medical schools have a range of societies and other self-organizing groups that provide an outlet for these attributes. Giving medical students and junior doctors responsibility for activities within the formal curriculum (for example becoming involved in curriculum or other committees or taking leadership roles on problem-based learning activities) allows them to develop their leadership skills and can improve the outcomes for the programme. At postgraduate level, all foundation trainees are required to participate in an audit project which enables engagement with clinical governance, quality improvement and management activities at local level and enables trainees to take a leadership role (see *case example 2*).

In the foundation programme, a range of generic competencies have been described that relate to teamworking, leadership and collaborative working. For academic trainees, the opportunity exists for specific training in clinical leadership and management. Here, the academic competencies

Case example 1: University of Liverpool

All undergraduate medical students at Liverpool are required to undertake an annual appraisal known as the Student Feedback Appraisal. Before this appraisal, students collect feedback on their professional behaviour from tutors, clinicians and their peers and undertake a series of tasks relating to their career management and professional development. One of the activities that is required from year 2 is leadership tasks. In year 2 students are introduced to leadership styles and asked to analyse and compare the leadership styles of two clinicians who they have come across in a workplace setting and who they have identified as 'good leaders'. In years 3 and 4 the students document their progress towards meeting specified outcomes from the Medical Leadership Competency Framework so that they can make a direct link between the work that they are doing and the leadership and management competencies expressed in the Medical Leadership Competency Framework.

Case example 2: First year foundation trainees at Leighton Hospital

Dr Salman Zalman, the Postgraduate Clinical Tutor and Foundation Programme Director at Leighton Hospital (Mid Cheshire Hospitals NHS Foundation Trust), has led a project for first year foundation trainees. In this project, first year foundation doctors were divided into teams and asked to identify a problem with the Trust and to design and implement a solution. The trainees have a short series of introductory lectures on the structure and organization of the NHS, the concept of clinical leadership and the role of doctors in management. Each group had a mentor from within the management of the Trust and senior Trust managers were present at the final presentations by the groups and awarded prizes for the best projects. One of the projects, to redesign the foundation teaching timetable, was implemented and is now in operation for the subsequent foundation year one trainees.

Evaluation of this project demonstrates an increase in knowledge and understanding of management and leadership by the trainees who took part in the project as well as an improvement in attendance at the following year's foundation programme. This indicates a desired outcome for the trainees (improved leadership and management skills) and an improved outcome for the programme (better attendance from subsequent years).

have been mapped onto the Medical Leadership Competency Framework to produce a framework for clinical leadership and management that combines foundation competencies with those of the Medical Leadership Competency Framework. The application of this framework will be discussed in more depth in a future article in this series.

Developing senior medical leaders

It can be seen that all doctors at all levels need leadership and management skills in order to carry out their professional duties effectively and that a range of initiatives exist to support this development. But what about those professionals who aspire to leadership positions within organizations as well as those who develop into academic leaders or leaders in medical education? Those who may be interested in these career routes need a structured and supportive continuing professional development framework in leadership and management. In addition, doctors benefit from being able to take on secondments and to undergo coaching and benefit from a mentor (Ham et al, 2010).

For 'senior leaders' a range of development opportunities exist at local, specialty, national and international levels. Within organizations, many doctors have already taken advantage of leadership and management programmes, but the view that 'medical leadership' requires the establishment of tailored programmes has led to the development of a variety of programmes specifically for doctors.

Examples include Masters' programmes (such as the Royal College of Physicians, Birkbeck College and London School of Hygiene and Tropical Medicine MSc in Medical Leadership collaboration); the Open University Clinical Leadership Programme (offered in collaboration with the *BMJ*); the former British Association of Medical Managers 'Fit to lead' programme; the Royal College of GPs's RCGP Leadership Programme and the London Deanery Leadership Centre which brings together leadership development activities (such as 'Darzi fellows', workshops and award bearing programmes) at many levels. As with the London Deanery provision, these programmes are often offered in collaboration with deaneries and medical Royal colleges.

A number of interprofessional initiatives have also been established such as the NHS East of England senior clinical leaders' programme and a range of Masters' programmes at universities throughout the UK. That leadership development often occurs for specific professional groups (e.g. doctors, nurses) may need to be kept under review as this is somewhat against the spirit of collaborative practice in health care and may run counter to other interprofessional development activities (World Health Organization, 2010; McKimm, 2011).

The recently established Faculty for Medical Leadership and Management has been set up to promote the advancement of medical leadership, management and quality improvement at all stages of medical careers. It will ensure that doctors in management and leadership roles have received high quality, appropriate training. Peter Lees, the founding faculty director, noted that 'there is a diverse range of medical leadership positions in the UK which are essential to the delivery of better health and healthcare. These roles are increasingly complex and challenging and it is, therefore, very timely to establish the Faculty' (Lees, 2011). This move also reflects the processes of international organizations such as the Royal Australian College of Management and Administration which enables doctors with key management roles to belong to a college which supports the 'speciality' of management and administration (McKimm et al, 2009).

Conclusions

At the time of writing, the passage of the new White Paper on reforming the NHS is paused for key ministers to reflect on issues identified through consultation and make changes. However, it appears that a key

tenet of the paper, the role of GPs in commissioning services, will be implemented in the next few years. This will have huge impact on the management, business and leadership skills that all GPs will need. It is anticipated that although GP consortia will buy in relevant business skills they will still need a substantial understanding of management and be able to show excellent leadership.

Against the backdrop of further immense structural changes in the NHS, it remains clear that the expectation of doctors to take leadership and management roles at all levels and engage in leading change and innovation is now fully embedded in policy and practice agendas. The role of the doctor as health-care leader and manager is one which all practitioners, health-care delivery and education and training organizations need to both implement and support. **BJHM**

Figure 1 is reproduced courtesy of the NHS Institute for Innovation and Improvement and Academy of Royal Medical Colleges.

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KEY POINTS

- Clinical leadership is a key part of a whole system approach to improving health outcomes and patient safety.
- A range of policy agendas underpin the establishment of doctors' engagement in medical leadership.
- The Medical Leadership Competency Framework is now being embedded at all levels of education and training.
- Many collaborative initiatives exist that provide opportunities for doctors to engage in leadership development activities.
- The NHS is poised for more structural change, clinical leadership will be important in ensuring continuity and effective implementation of new initiatives.

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