# Clinical leadership: the challenge of making the most of doctors in management

***The need to develop the leadership and management capability of clinicians is deemed fundamental to address the cost and quality issues associated with health-care provision. The challenge facing the NHS is how best to bring this about.***

This article explores the concept of clinical leadership and the need for structured leadership development programmes to support the provision of high quality health services. It does so by first reviewing the academic and practitioner literature, and then by drawing on the experience of the Centre for Innovation in Health Management, based at the University of Leeds. The Centre for Innovation in Health Management is actively involved in delivering leadership development to doctors across the UK.

Effective development of clinical leaders is founded on the recognition that there are a number of inherent challenges in moving from clinical practice to leadership roles. Specifically, this article addresses those challenges around power, professionalization *vs* professionalism, new frames of reference for evidence and experience, and working collaboratively rather than individually. It proposes a new model for clinical leadership based around a role as agents of change, and sets out a range of best practice in the design and implementation of clinical leadership development.

## Clinical leadership

Although the concept of leadership has been explored extensively by researchers within and across different contexts, an all-encompassing definition remains elusive (Alimo-Metcalfe and Lawler, 2001; Ford, 2004). However, in analysing public service organizations Hartley and Allison (2000) conceptualize leadership from three perspectives: person, position and process. 'Person' and 'position' perspectives focus on the personality and behavioural characteristics of leaders, as well as the formal authority and status conveyed to them by virtue of the role they occupy within the organizational hierarchy.

Leadership as a process, however, is defined more in terms of social interaction and group dynamics in which greater emphasis is attached to followers and context (Wirrmann and Carlson, 2005), emotional intelligence, and the development of skills in areas such as influence, relationship management, communication and motivation. This definition is perhaps most applicable to clinical leadership in health care, particularly in the challenging and complex hospital setting, where clinical leaders are expected to help transform organizations by engaging and influencing colleagues (both medical and managerial) while leading multidisciplinary teams. This promotes shared governance and a more distributed model of leadership, which effectively ensures that all decisions and actions are practitioner owned and organizationally supported (Scott and Caress, 2005). In this regard clinical leaders are those who retain a clinical role, but at the same time play a significant part in setting direction, managing resources, and motivating and inspiring colleagues (Shortland and Gatrell, 2005). As such clinical leadership is not something separate from clinical practice, but 'a continuous and everyday activity that is an explicit part of all senior clinical roles' (Detmer and Ford, 2001).

Within the literature the challenges facing clinical leaders are seen as being diverse and multifaceted. While Malby (1998) argues that clinical leadership is largely like any other leadership role (involving expertise in creating and selling strategic visions, inspiring and influencing others to follow, securing and managing resources, and planning and implementation), others such as Shortland and Gatrell (2005) and Hartley and Benington (2010) suggest that the challenges facing clinical leaders, particularly in relation to constructing care pathways around individual patients' needs and redesigning services to improve efficiency and effectiveness, are quite unique and represent a considerable extension to the traditional view of the leadership role.

In short, the blend of activities clinical leaders are expected to perform requires them to considerably widen their managerial or leadership roles and develop both business expertise (business planning, budgeting, human resource management) and a range of interpersonal and interactive skills (Ham, 2003; Harris, 2006). Whereas previously doctors involved in management had a certain degree of choice about the emphasis they placed upon the managerial aspects of their jobs, they now have obligations and their leadership competence is more conspicuously related to organizational performance in the marketplace (Fitzgerald et al, 2006).

Clinical leadership is important because health-care organizations are professional organizations where front-line clinical staff possess a high degree of control over their work – what Marxists might term the 'means of production'. The ability of managers to directly influence clinical decision making is therefore constrained and contingent. Moreover, clinical decision making is typically collegiate in nature, so there is a premium on clinicians acting as leaders of change. In the fields of quality improvement and patient safety, little or no progress can be made without clinicians taking on leadership roles and forging stronger working relationships with organizational management. Consequently, effective clinical leadership not only involves defining and communicating a strategic vision for the future of health care, but also motivating

**Ms Rebecca Malby** *is Director,* **Mr John Edmonstone** *is Associate,* **Dr Duncan Ross** *is Director of International Development and* **Dr Neil Wolfenden** *is KTP Associate in the Centre for Innovation in Health Management, University of Leeds, Leeds LS2 9JT*

*Correspondence to: Ms R Malby*

and inspiring colleagues as well as developing and implementing practical strategies to help people understand and share commitment to change and service development (Shortland and Gatrell, 2005).

Increasingly, clinical leadership (which usually means doctor leadership) is portrayed as the remedy for a wide set of ills in the NHS. The White Paper *Liberating the NHS* (Department of Health, 2010) recommends putting power and responsibility for commissioning firmly in the hands of GP consortia in order to better meet the needs of patients and local health economies. Similarly, Rice (2007) and Castro et al (2008) provide evidence to show that stronger leadership by doctors can play a significant role in helping to lower infection and readmission rates, improve levels of patient satisfaction, staff morale and productivity, expand services and enhance financial margins.

However, the move into leadership and management positions poses a number of significant challenges for clinicians, largely because such positions are quite far removed from the role for which the clinicians have been formally trained (Zaher, 1996). In this regard, the transition from clinical consultant to clinical director, for example, can be problematic for some individuals. It involves moving from a domain in which they feel extremely comfortable, dealing with patients and issues relating to their specialty, to a situation in which they are routinely expected to work with a variety of different stakeholders (for example managers, commissioning organizations, inspectorate bodies) and consult on issues relating to budgeting, business planning, service improvement and change (Cowling and Newman, 1994; Dawson et al, 1995). These are all areas in which clinicians are likely to have limited experience and training. Consequently, there is a real risk that doctors recruited to leadership posts may well be 'out of their depth' and inadequately prepared to undertake the duties that they are being asked to perform.

## Clinical leadership development

Recognition of the importance of clinical leadership needs to be supported by appropriate training and development opportunities, and the establishment of explicit career structures for doctors with an interest in medical management (Ham, 2003). As noted by Kirkpatrick et al (2007), despite a concerted effort to increase doctor involvement in management over the past two decades, low priority has been given to training and educating doctors in this area. Similarly, Fitzgerald at al (2006) claim that the ability of clinical leaders to function as effective change agents is dependent upon development of the hybrid 'clinical-management' role. They do, however, state that: '...management training and development of clinical, hybrid managers and clinicians is very under developed'.

Nevertheless, over the past 2 years there has been increased investment in leadership and management development for doctors (e.g. the Darzi Fellows programmes, certificated programmes for doctors), GPs in professional executive committee roles, and consultants as clinical directors in hospitals. The *NHS Next Stage Review, High Quality Care for All* (Department of Health, 2008) promoted locally-led, patient-centred and clinically driven change with a quality focus 'at the heart of everything we do'. The report concluded that 'Leadership has been the neglected element of the reforms of recent years. That must now change'. Ensuring a continuing supply of high quality clinical leaders is therefore a top priority. Indeed, there are calls for this to be achieved through the adoption of more structured and embedded forms of leadership development.

According to Harrison and Miller (1999), for example, a well-conceived leadership or management development programme can help senior clinicians to enhance their strategic capabilities by increasing their competencies and skills, promoting knowledge connectivity, establishing them as members of the hospital's dominant coalition and helping to forge inter-organizational linkages. More generally, they suggest that the true value of clinical leadership development may actually lie in increasing understanding and familiarity with managerial issues among the clinical workforce. In this way, clinicians become more confident that they understand the language and processes of management and, therefore, better placed to contribute to strategic decision making.

## Challenges for clinical leadership development

The Centre for Innovation in Health Management has undertaken national research into clinical engagement and leadership (Kirkpatrick et al, 2007), and is currently leading an international research network which is exploring the conditions and approaches for engaging doctors in management in order to ensure positive impacts are made in the areas of innovation and quality. The centre's tacit knowledge of 'what works' has been developed out of its work on the NHS London Darzi Fellows programme, its work with practice-based commissioning groups, and through creating leadership programmes to meet the specific needs of individual trusts.

While senior clinicians are 'experts' in understanding the context and content of their clinical work, they often lack knowledge about 'organizations', 'organizing', and the process of leading 'change'. The authors' experience of working with doctors is that they typically join in from a place of certainty, whereby it is assumed that management is a frustrating process, yet simple and amenable to evidence and persuasion. However, as a result of participating in interactive and multidisciplinary forms of learning, doctors come to develop a more sophisticated understanding of management, and learn how to intervene as power leaders to bring about effective systems change.

## Tensions inherent in the clinical leadership development process

Through their work the authors have identified a number of tensions that frequently arise in the development of doctors as clinical leaders and medical managers. Addressing these tensions ultimately enables more efficient and effective forms of clinical leadership:

### Where power lies

Clinical leadership has a strong focus on the patient and clinical specialty, and is largely based on a combination of 'personal power' (credibility, respect, trust, ability to influence, persuade, debate, and negotiate) and 'expert power' (knowledge of the clinical condition). Managerial leadership, by contrast, tends to take the corporate or organizational viewpoint and is

largely based upon 'position power' or place in the managerial hierarchy, and often apes the medical model of 'expert power' (for example becoming a board level director usually requires expertise in a managerial speciality, not expertise in corporate management). What is interesting is to see how these have emerged as competing ideologies, rather than necessary tensions in the system.

### Professionalization *vs* professionalism

This is best explained in terms of the distinction between professionalization, through which members guard knowledge and work boundaries, and professionalism, where a set of core characteristics which shape how work is done in a professional service (*Table 1*).

### The illusions of expertise and evidence

Clinical leadership is marked by the use of persuasion rather than hierarchical power to manage the tension between the clinical 'expert system' and the managerial hierarchy of health-care organizations. There is a preference by clinical leaders for an incremental, evidence-based, planned and evaluated approach to change which involves clarification, a choice of options and consultation. This does not mean that this is necessarily the most effective way to lead; rather it describes the way clinicians tend to think about management.

However, the authors' experience is often counter to this view as it is often frustration with the system that leads clinicians to 'just do something'. As such, the role of the Centre for Innovation in Health Management is to develop much more rigour in clinicians' managerial thinking, which also includes developing skills for working with communities, service users, co-clinicians, and the wider organization, as well as the development of personal skills in working with diverse teams (how to have difficult conversations, feedback, negotiation).

Clinical leaders need to enjoy the respect and trust of their colleagues, based upon their perceived credibility and integrity. Indeed, it is worth noting that clinical leadership has also been dubbed 'influenceship'. This has a knock-on effect in terms of how training and development is designed so that any programme makes the most of clinicians' intellectual capabilities, tolerance and hunger for high challenge, as well as developing capacity for more effective personal relationships between clinical leaders and their managerial peers.

**Table 1. Characteristics of professionalization and professionalism**

| | |
|---|---|
| Professionalization | Mastery of knowledge |
| | Unilateral decision |
| | Autonomy and self management |
| | Individual accountability |
| | Detachment |
| | Interchangeability of practitioners |
| Professionalism | Reflective practice |
| | Interdependent decision making |
| | Supported practice |
| | Collective responsibility |
| | Engagement |
| | Practitioner specificity and strength |

Adapted from Davies (1996)

### Individual (specialization) *vs* collective (working together)

Clinical leaders also face an inevitable tension between taking a viewpoint predicated on individual patient need (and the best option for that individual) and population need (in terms of resources for that population, be it the whole of a hospital's patient population or a community for whom you are commissioning). As a professional group, the traditional role of clinicians has been to advocate for their patients on an individual basis using professional medical judgement and expertise. However, the move to 'we are in it together' for the good of the whole (e.g. organization, health economy) is a profound culture shift which clinical leaders need to embrace if they are to become effective in their hybrid professional roles.

## A model for developing clinical leaders as change agents

The major impetus driving clinical leadership in the NHS in England has come from the Darzi report (Department of Health, 2008), which asserted that undergraduate level curricula for all health-care professions needed to be reviewed to ensure that they provided appropriate leadership skills. Postgraduate curricula and appraisal processes were also deemed worthy of change and the report anticipated the development of postgraduate clinical leadership programmes at Certificate, Diploma and Masters levels.

Building on the Darzi report the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement undertook work to develop a Medical Leadership Competency Framework. Further flesh has been put on the bones of these proposals (National Leadership Council, 2010). One early manifestation of this work has been the emergence of the Clinical Leadership Fellows scheme (the Darzi fellows). Run by strategic health authorities and postgraduate deaneries, the scheme began with a medical-only focus (at SpR–ST3 level), but is increasingly becoming multi-professional. Although each scheme is tailored to local circumstances there are certain identifiable common features:

- The use of an underlying competency framework for assessment purposes: typically this is the NHS Leadership Qualities Framework, or the Medical Leadership Competency Framework, both of which use a 360° tool
- A personal development focus: psychometric tools are used for diagnostic purposes, personal development plans are devised, one-to-one coaching and mentoring is provided, and programme participants are subject to the support and challenge which comes from membership of action learning sets
- A service improvement focus: participants work on a service improvement project or projects across the duration of the programme
- Academic input: participants are introduced to theories and skills and techniques through workshops and masterclasses. In some instances participants also work towards a relevant Masters qualification.

Furthermore, alumni of these programmes are now starting to add to the debate on clinical leadership (Stanton et al, 2010).

Experience at the Centre for Innovation in Health Management indicates that the design of any clinical leadership develop-

ment programme has to address the tensions identified above and develop real systems, change understanding and provide opportunities to learn this through experimenting locally.

The key impact objectives for participating clinicians, and thereby their organizations include:

- Developing rigour and cohesion around strategy or strategic choices
- Developing processes that enable innovation and change – particularly using engagement approaches, working with diversity, and making the most of clinical leadership – for patient benefit through improved services
- Developing relationships and partnership capability across the health sector and with the local authority and voluntary or community sectors
- Managing effective current service delivery and developing capable local teams
- Developing rigorous management practice across the organization in order to achieve better patient outcomes (e.g. ensuring clinical practice is evidence based, recognizing that improving quality and value for money go hand in hand).

If organizations are taking the quality and efficiency agenda seriously, they need to be thinking radically about change, and change is everyone's business. This is the challenge for leadership – how to ensure organizational change becomes a natural part of every leader's job.

'Learning through doing' on a practical project is a critical part of the Centre for Innovation in Health Management's clinical leadership development programmes, which require clinicians to:

1. Identify a problem area that is truly complex
2. Provide a rationale for the proposed intervention based on theories of change, and through their own understanding of their personal leadership capabilities
3. Devise an engagement process for key actors
4. Identify 'metrics' for how success will be assessed
5. Share the impact locally.

Evaluation of these programmes has demonstrated that impact on clinical leaders has been far reaching and, in many cases, profound. Six areas of impact have been identified:

1. Growth in self understanding and personal skills
2. Increased knowledge and understanding of the organization and systems context of change
3. Enhanced understanding and skills in working with others
4. Change management, service improvement and capacity building knowledge, understanding and skills
5. Changed beliefs and values
6. Some revised career aspirations.

Personal change has been particularly significant, with a 'mind shift' in the way most clinical leaders view clinicians' roles in service change. Clinical leaders have been equipped with contextual knowledge of the NHS, and have gained a comprehensive understanding of the systems and processes of complex organizations. At the same time they have learnt things about themselves and developed interpersonal, quality improvement, and change skills to support, and sometimes lead, service improvement and leadership capacity-building projects. Although more difficult to determine, there is also evidence of a positive impact being made at organizational and wider system levels.

**'They [CIHM] have fostered a culture shift and succeeded in having a huge impact in shaping our attitudes, beliefs, approaches and ultimately, we believe, our behaviour and impact... Their enthusiasm, dedicated effort and approachability, alongside their credibility from vast experience... earned them considerable trust amongst our group' (Archer et al, 2009).**

The Centre for Innovation in Health Management has also identified a number of other factors which seem to influence the success of clinical leadership development. These include:

- Committed and learning-oriented medical director
- Supportive organizational culture
- Working on 'ambitious but appropriate' live projects
- High quality mentoring
- Learning programme that targets transformational change based on system dynamics
- Combining workplace and external learning
- Network of support.

## Conclusions

What might be the eventual outcomes of this high profile for clinical leadership? One expressed desire of the Chief Executive of the NHS in England is to see a clinician on the shortlist for all chief executive vacancies and this might well be extended to a growing expectation that senior positions in health care should often be filled by people with a clinical background.

As clinical leadership develops, it is highly likely that NHS managers will have to acknowledge that the different knowledge base of clinicians may change organizational priorities and that the agendas of health-care organizations will, therefore, reflect clinical concerns to a greater degree than they currently do. It is also true that clinicians are not as likely to be influenced by government and political directives as career managers. As clinicians 'step up to the plate' there will also need to be recognition that they do not possess all the basic managerial skills that career managers have acquired and, consequently, they will need significant support, both in terms of training and support staff.

At the same time, as the role of clinical leader develops there will be an increased need for clinicians to view the broader health picture, rather than just focusing narrowly on their specialist service areas. This will involve aligning their professional priorities more towards service and organizational goals, accepting financial responsibility for clinical decisions, and changing their perceptions of risk management away from wanting to do the very best for each individual patient, to accepting that prioritization and compromise are necessary. The prize, however, will be an NHS run increasingly by clinicians. **BJHM**

*Conflict of interest: none.*

Alimo-Metcalfe B, Lawler J (2001) Leadership development in UK companies at the beginning of the twenty-first century. Lessons for the NHS? *J Manag Med* **15**(5): 387–404

Archer K, Bajaj P, Bhandari A et al (2009) Re: Expression of support for the Centre for Innovation in Health Management. www.cihm.leeds.ac.uk/new/about-us/what-our-clients-say/ (accessed 20 May 2011)

Castro P, Dorgan J, Richardson B (2008) A healthier health care system for the United Kingdom. *McKinsey Quarterly* (February)

Cowling A, Newman K (1994) Turning doctors into managers: an evaluation of a major NHS initiative to improve the managerial capabilities of medical consultants. *Human Resource Management Journal* **4**(4): 1–13

Davies C (1996) The sociology of professions and the professions of gender. *Sociology* **30**(4): 61–78
Dawson S, Mole V, Winstanley D, Sherval J (1995) Management competition and professional practice: medicine and the marketplace. *British Journal of Management* **6**(3): 169–81
Department of Health (2008) *High Quality Care for All: NHS Review Final Report.* The Stationery Office, London
Department of Health (2010) *Equity and Excellence: Liberating the NHS.* The Stationery Office, London
Detmer D, Ford J (2001) Educating leaders for healthcare. *Clinician in Management* **10:** 3–5
Fitzgerald L, Lilley C, Ferlie E, Addicott R, McGivern G, Buchanan D (2006) *Managing Change and Role Enactment in the Professionalised Organisation.* National Co-ordinating Centre for NHS Service Delivery and organisation R&D, London
Ford J (2004) Editorial to special edition on leadership. *Journal of Health Organisation and Management* **18**(6): 387–92
Ham C (2003) Improving the performance of health services: the role of clinical leadership. *Lancet* **361**(9373): 1978–80
Harris C (2006) Engagement party: enhancing medical leadership. *Health Service Journal* (Suppl 7) **7 September:** 7
Harrison R, Miller S (1999) The contribution of clinical directors to the strategic capability of the organization. *British Journal of Management* **10**(1): 23–39
Hartley J, Allison M (2000) The role of leadership in modernisation and improvement of public service. *Public Money and Management* **20**(2): 35–40
Hartley J, Benington J (2010) *Leadership for Healthcare.* The Policy Press, Bristol
Kirkpatrick I, Malby B, Neogy I, Dent M (2007) *National Inquiry Into Management And Medicine.* Centre for Innovation in Health Management, University of Leeds
Malby B (1998) Clinical leadership. *Adv Pract Nurs Q* **4**(3): 40–3
National Leadership Council (2010) *Clinical Leadership: Interim Report.* Department of Health, London
Rice JA (2007) 'Investing in the Three Rs'. *Healthc Exec* **22**(6): 56–60
Scott L, Caress AL (2005) Shared governance and share leadership: Meeting the challenges of implementation. *J Nurs Manag* **13:** 4–12
Shortland DB, Gatrell J (2005) How to be an effective clinical director. *Current Paediatrics* **15**(6): 504–8
Stanton E, Lemer C, Mountford J, eds (2010) *Clinical Leadership: Bridging The Divide.* Quay Books, London
Wirrmann EJ, Carlson CL (2005) Public health leadership in primary care practice in England: Everybody's business? *Critical Public Health* **15**(3): 205–17
Zaher CA (1996) Learning to be a leader. *Physician Executive* **22**(9): 10–18

## KEY POINTS

- This article addresses some of the significant challenges the NHS faces in developing clinical leadership capability.
- It focuses on the role of clinicians in leading change in such fields as quality improvement and patient safety.
- A range of issues and best practice in clinical leadership development are explored.
- Learning through doing is important for realizing individual and organizational benefits.
- A set of emerging parameters for evaluating good clinical leadership development are laid out.