Doctor as professional and doctor as leader: same attributes, attitudes and values?

This article examines the links between medical professionalism and medical leadership and discusses how the values that are required to be a 'good doctor' are the same as a 'good leader'. The potential of this overlap to inform the debate on developing and assessing both medical leadership and professionalism is evaluated.

The 'professionalism movement', as defined by Hafferty and Castellani (2010), has existed in the medical education literature for about 15 years. The reasons for the rise of professionalism are varied and conflicting, with many commentators citing the medical scandals such as Shipman, the Bristol Royal Infirmary heart scandal and the Alder Hey organ retention case as the underpinning reasons for the focus on professionalism. However, changes in society and expectations from doctors and the medical profession have also led to an acceptance of the need for a changed informal contract between society and doctors.

In addition, researchers have demonstrated a link between unprofessional behaviour and complaints against physicians (Ginsburg et al, 2000) and a link between disciplinary action against doctors and unprofessional behaviours exhibited at medical school (Papadakis et al, 2004). In the last decade, considerable effort has been devoted to defining medical professionalism (van Mook et al, 2009a) and looking at ways to develop and assess it in medical students and junior doctors (van Mook et al, 2009b).

Professionalism definitions and frameworks

One of the most influential definitions of professionalism is that set out in a report by the Royal College of Physicians (2005), *Doctors in Society: Medical Professionalism in a changing world*:

> **'Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.' (Royal College of Physicians, 2005)**

Other authors have attempted to define these values, behaviours and relationships in a number of overlapping frameworks (Ginsburg et al, 2000; Swick, 2000; Hilton and Slotnick, 2005; Jha et al, 2006). In addition, national competency frameworks such as the Canadian CanMEDS (2006) framework and the General Medical Council's (2006) *Duties of a Doctor* include specific competencies related to professionalism.

Approaches to developing and assessing professionalism

The development and assessment of professionalism is now well established in the undergraduate medical curriculum. The General Medical Council's (2009) document *Tomorrow's Doctors* prescribes outcomes for all medical curricula in the UK leading to an MBChB (or equivalent) in three categories:

1. The doctor as a scholar and scientist
2. The doctor as a practitioner
3. The doctor as a professional.

A survey of the literature on assessing professionalism (van Mook et al, 2009b) analysed the types of assessment methods that are being used. This work is supported by a study (Levenson et al, 2010) that asked medical students what sorts of assessments they were being exposed to. The most common types are portfolios, objective structured clinical examinations (OSCEs), peer appraisal, clinical and faculty staff appraisal of professionalism and reflective writing.

As doctors progress through foundation and speciality training, professional behaviours are also assessed through a range of workplace-based and written assessments including case-based discussion, mini clinical evaluation exercise, team assessment of behaviour, OSCEs and e-portfolios. Fully qualified doctors are also required to demonstrate and evidence a range of professional behaviours through revalidation, including multisource feedback from patients, colleagues and peers. Reflective writing is seen as one of the core tools through which students and doctors both learn and demonstrate their understanding of what being a professional means in practice.

Leadership, as a defined set of specific skills or competencies, is not currently routinely assessed in either undergraduate or postgraduate contexts. Given some of the overlaps between professionalism and leadership, it is possible to use some of the methods used to assess professionalism to assess leadership. Conversely, many leadership programmes use a combination of multisource feedback, reflective writing and workplace-based assessment to formally assess leadership development.

The Medical Leadership Competency Framework (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010) provides many examples at all stages of education and training of how competencies might be learned and assessed, and it is therefore also feasible to explore how current assessments of professionalism might easily incorporate elements of leadership development.

Mapping professionalism frameworks with the Medical Leadership Competency Framework

In order to understand more fully the overlaps between professionalism and leadership, aspects of the Medical Leadership Competency Framework are compared with some of the key profes-

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sionalism frameworks and the General Medical Council's (2006) *Duties of a Doctor* (*Table 1*). From this analysis there are some clear areas of overlap, such as ethics, integrity and high moral standards; respect for patients, communication and building relationships with patients; reflection, self awareness and self management.

In a report on the views of professionalism and leadership in medical students, Levenson et al (2010) comment that students accept and understand that leadership is a part of every doctor's professional practice but that there is an ambivalence towards the role of management. Colleagues who had taken on significant management responsibilities were seen as having 'gone over to the dark side'. Although working in the context of a US health-care system, Souba (2011) effectively summarizes this dilemma:

'The ethical foundation of the medical profession, which values service above reward and holds the doctor–patient relationship as inviolable, continues to be challenged by the commercialisation of healthcare.' (Souba, 2011)

Souba goes on to argue that it is the fundamental personal values of a leader that can safeguard the longstanding ethical basis of medicine. He suggests four (ontological) pillars of leadership that anchor leadership to professionalism:

1. Awareness – the ability of a leader to be a perceptive observer, with a knowledge of his/her own biases and weaknesses, who is able to perceive, feel and be conscious of events, object and sensations
2. Commitment – this is a commitment to a purpose larger than ourselves, to not be focused only on ourselves or self-fulfilment
3. Integrity – sticking to one's word and honouring promises – being transparent
4. Authenticity – acting as being in a manner that is consistent with your own beliefs – avoiding the lure of desire for approval or needing to look good (Souba, 2011).

These four pillars are strongly reminiscent of the main areas of overlap between the Medical Leadership Competency Framework and the professionalism frameworks, suggesting that these are the main areas of interest that demonstrate the relationship between professional values and behaviours and medical leadership. This is supported by empirical work that has looked at leadership qualities that support leadership effectiveness (Alimo-Metcalfe and Alban-Metcalfe, 2001; Souba et al, 2007; Alimo-Metcalfe et al, 2008).

Writing from a broader leadership perspective, Nonaka and Takeuchi (2011) have argued for a reinstatement of the ability to lead wisely. They suggest that leadership knowledge is not enough to ensure success in an increasingly complex set of challenges and that wisdom is the essential missing element. They also argue that wise leaders are able to practise moral discernment, quickly sum up a situation and grasp the key essence of a problem, that they can create a context that promotes organizational learning, that they can communicate in a way that everyone can understand, that they can exercise political

Table 1. Comparison of notable definitions and frameworks of medical professionalism with key aspects of the Medical Leadership Competency Framework

Medical Leadership Competency Framework* (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010)		Hilton and Slotnik (2005)	Swick (2000)*	Jha et al (2006)*	Arnold and Stern (2006)*	General Medical Council (2006)*
1. Demonstrating personal qualities	1.1 Developing self awareness	Reflection and self awareness	Reflection	Personal awareness	(Excellence)	Recognize and work within the limits of your competence
	1.2 Managing yourself	Responsibility/ accountability for actions	Accountability	Management	Accountability	You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions
	1.3 Continuing personal development					Keep your knowledge and skills up to date
	1.4 Acting with integrity	Ethical practice	Adhere to high ethical and moral standards	Compliance to values	Ethical and legal understanding	Be honest and act with integrity
2. Working with others	2.1 Developing networks					
	2.2 Building and maintaining relationships	Respect for patients		Doctor–patient relationship	Communication skills	Listen to patients and respond to their concerns and preferences
	2.3 Encouraging contributions					
	2.4 Working within teams	Working with others				Work with colleagues in the ways that best serve patients' interests
		Social responsibility	Respond to social needs	Motivation (altruism)	Altruism Humanism	Never abuse your patients' trust in you or the public's trust in the profession

* indicates that not all elements of the framework have been included in the table. Brackets indicate that some interpretation was used by the authors in placing the particular element in the table

power judiciously and that they can foster practical wisdom in others.

Wisdom is not present explicitly in any of the leadership or professionalism frameworks that have been examined in this article. However, Hilton and Slotnik (2005) discuss the concept of 'phronesis' in their writing, this being a Greek word for practical wisdom. They argue that phronesis is about much more than attitudes, referring also to insights and judgements based upon experiences of dealing with uncertainly and complex situations. They contend that this stage of phronesis can only be acquired after a period of experience and therefore medical students, while capable of exhibiting exemplary professional values and behaviours, can only be considered as 'proto professionals' (Hilton and Slotnick, 2005).

Turning the good doctor into a good leader

If we accept the concept of phronesis as an essential component of both the doctor as a professional and the doctor as a leader, it seems that doctors need a period of time working on the front line delivering a relevant service before they can become effective leaders. Learning to be a medical professional and a leader takes time and both learning and assessment need to be relevant and timely.

Medicine is unique among the traditional professions for being managed by managers who are not part of the profession but who are often drawn from wide-ranging managerial or commercial backgrounds. In education, head teachers and vice chancellors invariably start out as teachers or lecturers, the military is led by former soldiers, sailors and airmen, and bishops and archbishops start out as vicars or priests. In these professions, leadership is often learned 'on the job', whereas for doctors there have not been so many opportunities for learning leadership and management skills and the prevalence of 'professional managers' in the NHS has been a disincentive for doctors to fully engage in managing and leading clinical services.

However, times are changing and with the widespread implementation of the Medical Leadership Competency Framework, opportunities for management and leadership development are rapidly increasing. Such opportunities include academic foundation programmes, Darzi fellows and clinical leadership postgraduate programmes. The establishment of the Faculty of Medical Leadership and Management in February 2011 has provided further opportunities for development and acknowledgement of leadership and management roles. But, in order to ensure that doctors develop leadership and management skills and 'learn leadership' as part of their emerging professional development and identity, this needs to be embedded into all curricula at all stages. In earlier articles (McKimm and O'Sullivan, 2011; O'Sullivan and McKimm, 2011), the authors have provided examples of how such development might be included in undergraduate and foundation programmes, but this was considered perhaps more as a bolt-on for small numbers of students or trainees rather than as an integral part of professional development. Management skills, for example, are often not explicitly taught even though students and trainees are expected to self-manage, to project manage and to carry out management tasks such as clinical audit.

Conclusions

The relatively recent focus on teaching, learning and assessing professionalism provides an opportunity to embed leadership development within these aspects of programmes. Ensuring that doctors can effectively lead as well as follow, and can distinguish when to step up and when to step back is all part of becoming an effective team player, particularly in interprofessional teams. Understanding your impact on others and developing insight helps ensure emerging leadership behaviours are appropriate but also helps relationships with patients, colleagues and peers.

If we look from the other side of the coin, maybe it is equally timely for those developing and implementing professionalism programmes to take a look at the leadership literature and ways of developing future leaders, because many of the skills, behaviours and qualities that make a good leader are those required by doctors as professionals. As Souba (2011) highlights above, what makes a good doctor and a good leader is intrinsically about personal behaviours, qualities, insights and maturity. It is vital that students and doctors have the time and opportunity to learn about and develop personal insight and skills that enable them to work with and relate to others appropriately and effectively. This involves knowing the limits of competence, the roles and responsibilities of the health-care team, enabling effective communication (especially in times of crisis or conflict) and ensuring patient safety.

Alimo-Metcalfe and Bradley (2009) emphasize that the 'how' of leadership (the practical wisdom) is as vital as the 'what' (the skills), and it is in this area that the overlap of leadership with professionalism is most profound. **BJHM**

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KEY POINTS

- Medical professionalism has been the focus of attention in the literature for the past 15 years with a large body of work on defining professionalism.
- Professionalism is now an established part of undergraduate and postgraduate curricula.
- Evidence is starting to emerge on the most effective ways to develop and assess professionalism.
- There are significant overlaps between professionalism frameworks and the Medical Leadership Competency Framework.
- Studies of medical professionalism and medical leadership have much to offer one another in terms of identifying appropriate values and behaviours as well as methods of developing and assessing what makes a good doctor and a good leader.

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