Personality, self development and the compassionate leader

This article discusses how the recent publication of the Francis Report aligns with contemporary thinking on leadership development and professionalism, and that development and demonstration of appropriate personal qualities is central to effective medical leadership.

'Patients must be the first priority in all of what the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture, and protected from avoidable harm and any deprivation of their basic rights' (Francis, 2013).

This quotation from the recent Francis report highlights as vital that all staff working in health care, whatever the difficulties, constraints and circumstances, need to deliver compassionate care. The report goes on to note that, while health workers at all levels must display the values of the NHS, leadership and role modelling is essential: 'The common culture and values of the NHS must be applied at all levels of the organization, but of particular importance is the example set by leaders' (Francis, 2013).

These sentiments are echoed in other guidance and policy documents. For example the General Medical Council (2012) notes that:

> **'...being a good doctor means more than simply being a good clinician. In their day-to-day role doctors can provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole. However, unless doctors are willing to contribute to improving the quality of services and to speak up when things are wrong, patient care is likely to suffer.'**

Such statements reiterate common themes running through contemporary literature, the findings of inquiries and the media response: that the public and professional bodies expect doctors and other health professionals to consistently provide good, compassionate care for patients and families, to strive actively to improve services and to lead by example, including speaking out when care fails to meet acceptable standards. This poses leadership challenges for organizations and individuals alike, challenges which are explored in this article.

Professor Judy McKimm *is Dean and Professor of Medical Education, College of Medicine, Swansea University, Swansea SA2 8PP and* **Dr Helen O'Sullivan** *is Senior Lecturer in Medical Education and Director of the Centre for Excellence in Evidence Based Learning and Teaching, University of Liverpool, Liverpool*

Correspondence to: Professor J McKimm (j.mckimm@swansea.ac.uk)

A culture of engagement

Since the publication of the Darzi review (Department of Health, 2008), a number of writers have tried to tease out what medical leadership might be and explain why many doctors do not see themselves as leaders. One of the issues identified is that many doctors see moving into a leadership role as becoming more managerial, and that moving into 'management' involves moving to the 'dark side' (Spurgeon et al, 2011). The divide between managers and medical or clinical leaders is long-standing, based partly on the power and perceived autonomy of the medical profession and the appointment of non-clinical managers who are often seen (by applying targets, protocols and guidelines) as threatening professional expertise.

Forbes et al (2004) suggest that there are two types of doctor-manager: the 'investor' and the 'reluctant'. Investors move into management in order to achieve particular agendas or change, some see themselves as natural leaders and accept that effective management is needed to make significant health innovations and improvements. Reluctants have not moved into management through conscious choice and see their role as more negative (the dark side), often conflicting with their clinical role. Many doctors are reluctant to give up clinical work, as this is central to their professional identity and is also perceived to give credibility.

Dickinson et al (2013) showed that while there have been improvements in the involvement of doctors in medical leadership and management, a gap still exists between doctors in leadership positions and their medical colleagues. The report recommends increasing the number of doctors in formal leadership roles and improving the culture of engagement. In order for this to happen, doctors and other health professionals need to work together to establish the elements of this engaging, caring culture. The Francis (2013) report suggests that: 'the common culture of caring requires a displacement of a culture of fear with a culture of openness, honesty and transparency, where the only fear is the failure to uphold the fundamental standards and the caring culture'.

At the heart of developing this culture must lie demonstration of doctors' personal qualities and values as they apply in practice, however busy and time pressured. All working in health services also need to acknowledge that the vast majority work with the patients' best interests at heart, even though their roles may be very different.

Personal qualities that make a good leader

Early theories of leadership considered that personality traits and qualities were fundamental to effective leadership, with the emergence of the heroic leader as the archetype. While traits such as integrity, drive, inspirational, authenticity and approachability seem fairly stable across all contexts, writers now see this as only one element to leadership and that listing personal characteristics does not really help explain why different leadership works better in different situations and how leadership can be learned.

Although trait theory has been criticized, there is increasing evidence that certain personal qualities in leaders can have an impact on personal effectiveness and leadership success. In a review of empirical studies looking at the link between traits and leadership effectiveness, Zaccaro (2007) identified studies that showed a link between such attributes as optimism, proactivity, adaptability and nurturance. The paper also identifies a meta-analysis of 78 studies that linked one or more of the 'big five' personality factors (extroversion, conscientiousness, neuroticism, openness and agreeableness) to leadership. Although extroversion showed the strongest correlation, openness was also positively correlated. While this conceptualization of openness is not exactly the same as the construct of openness mentioned in the Francis report (Francis, 2013), being open to different experiences and people fits with the distinction Forbes et al (2004) make between the investor and the reluctant doctor-manager. Zaccaro (2007) lists several personal qualities where there is some form of evidence linking that quality and effective leadership:

1. Cognitive capacities: general intelligence, creative thinking capacities
2. Personality: extroversion, conscientiousness, emotional stability, openness, agreeableness, Myers–Briggs type indicator preferences for extroversion, intuition, thinking and judging
3. Motives and needs: need for power, need for achievement, motivation to lead
4. Social capacities: self-monitoring, social intelligence, emotional intelligence
5. Problem-solving skills: problem construction, solution generation, metacognition
6. Tacit knowledge (Zaccaro, 2007).

Qualities that can be categorized as 'social capacities' have received attention; in particular, the role that emotional intelligence plays in medical leadership and medical professionalism has been demonstrated to be linked to effective leadership in the general leadership literature (Mayer et al, 2008). However, there is a limited amount of evidence that emotional intelligence (as measured by a range of validated instruments) can be increased through educational interventions during medical training (Cherry et al, 2012). Although emotional intelligence is linked to improved communication skills in medical students and junior doctors (Cherry et al, 2013), further research is needed to make a direct link between emotional intelligence and being an effective medical leader.

Even though there is no clear link between emotional intelligence and 'being a good doctor', there is an increasing interest in using aspects of emotional intelligence testing in medical schools admissions. So far studies of this have been in the US and a review of best practice in UK medical admissions found no evidence of current use of personality or emotional intelligence testing (Cleland et al, 2012). Despite this, current shifts in selection methods at all stages of a doctor's career are placing more emphasis on trying to assess characteristics including caring, resilience, prioritization, ethical decision-making and motivation through the use of methods such as multiple mini-interviews, extended interviews and situational judgment tests. The discourses in professional guidance also state attributes such as compassion and empathy and the role of the doctor as leader and manager more explicitly (O'Sullivan and McKimm, 2011; General Medical Council, 2012).

Other studies also show the importance of personal qualities to clinical leadership. Alimo-Metcalfe and Alban-Metcalfe (2006) carried out a large scale empirical longitudinal study of multi-professional teams working in the NHS and found evidence of a cause–effect relationship between clusters of leadership qualities and objectively measured productivity. They describe the possession of a combination of these qualities as an 'engaging leader' who is someone who encourages and enables the development of an organization characterized by a culture based on integrity, openness and transparency, and the genuine valuing of others (Alimo-Metcalfe et al, 2008). Alimo-Metcalfe and her group have amassed significant empirical evidence about the factors that are important in engaging leadership and overall leadership effectiveness. Her team have developed the research tool into a diagnostic tool that can be used in leadership development. They suggest that identifying the presence of qualities that are rated highly and negatively can have a powerful impact and can direct personal development activities (Alban-Metcalfe and Alimo-Metcalfe, 2013).

In other professions, there is an increasing emphasis on acknowledging the impact of 'emotional labour' – 'a requirement to produce emotional states in others or exercise a degree of control over the emotional activities of others' (Crawford, 2009). Held and McKimm (2012) suggest that the more congruent and authentic leaders' emotional displays are and the more skillfully they can use affect (expressed emotion), the more at ease they are with their actions and the more impactful they are on those around them. 'Leaders and followers constantly balance the tensions between rational thought, emotion and intuition' (Held and McKimm, 2012).

The Medical Leadership Competency Framework sets out the competencies required for medical leadership at different stages of development (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010). However, Alban-Metcalfe and Alimo-Metcalfe (2013) argue that it is useful to distinguish between the activities leaders perform, e.g. leading

a team (as defined by a competency framework) and how they act or behave (as defined by a leadership style), in other words the way they lead the team (assertively, through delegation). They also suggest that a combination of competence assessed using a competency framework combined with what they term an 'engaging' style of leadership produces effective clinical leadership.

How this research evidence translates into developing good medical leadership is open to debate. Souba et al (2007) argue that teaching doctors about leadership is different from creating doctors who are leaders and that we will not create good medical leaders by imparting a series of behaviours and traits. Rather we should be creating a culture where there are opportunities to develop leadership deep into the organization through it being a 'lived' experience: ontological leadership.

Personaldevelopmentinmedicalleadership

Given the importance of personal qualities in what is required and expected of doctors as professionals and as leaders, it should be possible to integrate professional development activities towards both those ends. Until relatively recently, the development of 'professionalism' was seen as something that occurred through maturation, and learning was primarily through exposure to positive role models and socialization into the profession. However, now professionalism is actively taught and assessed at all stages and increasingly so is leadership and management, sometimes as part of 'professionalism', sometimes separately.

Leadership and management theories can help us develop clinical leadership understanding and skills, develop as a professional and usually underpin development programmes. At whatever level or context in which a student, trainee or doctor is working, it is helpful to think of developing leadership and management under three headings as many of the theories place their emphasis on one of these:

1. Developing and building on the personal qualities or personality of the leader as an individual
2. Developing skills relating to the interaction of the leader with others
3. Learning about leadership in relation to the environment or system.

What is also vital, as described above is that, while we tend to use the word 'leadership' and not 'management' to refer to medical leadership and management, leadership is not better than management – most activities involve a combination of both, and doctors need to learn to manage as well as lead. Accepting that systems, services and people need to be managed as well as led and that doctors can and should do both will help to address the divide discussed earlier.

Because effective leadership draws on personal qualities as well as understanding of other people, systems and organizations, development of self insight is essential and thus leadership cannot be wholly learned through online courses or readings. The most effective leadership programmes provide opportunities for reflection, gaining feedback from others and a safe place to practice skills and test out ideas. Assessment is a key driver in ensuring that performance across domains is both measured and improved. It is important that assessment of leadership and management moves away from self-assessment (useful though that is) and that robust assessments involving other people (including patients) are used in development programmes and in the workplace. Tools such as multi-source feedback or 360 appraisals, measuring health innovations, audits and efficiency savings and assessing application of health improvement tools (e.g. the Productive Ward; Quality, Innovation, Productivity and Prevention; and Situation, Background, Assessment and Recommendation) are examples of effective assessment methods used in leadership and management development. The Francis report suggests that mandatory annual performance appraisals should be introduced and 'each clinician and nurse should be required to demonstrate their ongoing commitment, compassion and caring shown towards patients, evidenced by feedback of the appraisee from patients and families, as well as from colleagues and co-workers. This portfolio could be made available to the General Medical Council or the Nursing and Midwifery Council, if requested as part of the revalidation process' (Francis, 2013).

As mentioned above, the Medical Leadership Competency Framework provides a clear structure for individuals, groups and organizations to teach and assess leadership (including a self-assessment tool; NHS Leadership Academy, 2012) against five domains: demonstrating personal qualities, working with others, managing services, improving services and setting direction (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010). The Medical Leadership Competency Framework is one element of the wider NHS Leadership Qualities Framework which includes two other domains: creating the vision and developing the strategy. The Medical Leadership Competency Framework suggests that medical leaders should be able to demonstrate the following personal qualities:

- Developing self awareness by being aware of his/her own values, principles and assumptions, and by being able to learn from experiences
- Organizing and managing him/herself while taking account of the needs and priorities of others
- Continuing personal development by learning through participating in continuing professional development and from experience and feedback
- Acting with integrity by behaving in an open, honest and ethical manner.

However, in the light of the Francis report and other writings, although all bodies are now starting to actively respond to the Francis report by reframing the models and rhetoric, qualities such as compassion, caring and courage are more implicit than explicit in the current version of the Medical Leadership Competency Framework. And while the Medical Leadership Competency Framework and Leadership Competency Framework both emphasize the importance of shared, collaborative leadership, at all levels,

that is dispersed throughout the organization, more person-centred leadership theories such as authentic (Gardner et al, 2005), relational (Tepper et al, 2006), servant (Greenleaf, 1977) or ontological (Souba et al, 2007) leadership are not explicitly drawn from. The increasing importance of enabling health professionals and doctors to develop leadership skills and understanding and provide fora for debate, development and resources have led to the establishment of the NHS Leadership Academy (www.leadershipacademy.nhs.uk) and the Faculty of Medical Leadership and Management (www.fmlm.ac.uk) which work across the UK, as well as other bodies and activities in the devolved countries.

Conclusions

Developing and demonstrating appropriate personal qualities is central to effective clinical leadership but that does not mean that there is no room for individual difference, indeed this must be nurtured. However, the Francis report and other inquiries into sub-standard health care have brought into sharp relief that clinical leadership and doctors' engagement in management is vital to maintain the focus on providing compassionate care to all through demonstrating behaviours that patients and the public expect.

As discussed, whatever form development and assessment of leadership takes, it is very similar to developing professionalism in that embedded, integrated approaches are needed that incorporate workplace-based assessments, appraisals and professional reviews, and encourage long-term development and reflective practice. Many medical schools and training programmes now include specific activities designed to develop leadership skills and the personal qualities that are required from a compassionate and clinically effective doctor. In addition, many medical educators are exploring how assessments can be made more robust both in selecting suitable applicants for the medical profession and assessing their personal development once they are there. We must be cautious, however, not to use validated tools that assess such factors as personality and emotional intelligence until we have more secure evidence about the role that these characteristics play in being a good doctor and a good medical leader. Self development aligned with robust measures will enable a culture shift in the NHS, and we should in future see more doctors engaging in leadership and management at all levels to improve health services and the patient experience. **BJHM**

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KEY POINTS

- The publication of the Francis report has stimulated a reframing of medical leadership that incorporates care and compassion.
- Personal qualities are central to medical leadership and clinical engagement.
- The qualities that underpin effective, value-led leadership are closely aligned with qualities that underpin professionalism.
- A wide range of development programmes, resources and organizations is available to support the development of leadership and personal development.
- There is some evidence that desirable personal qualities such as emotional intelligence can be improved through a development programme.
- Assessment of behaviours based on demonstration of personal qualities should be embedded in multisource feedback, appraisals and performance reviews as well as in routine workplace-based assessment for trainees and students.