From medical doctor to medical director: leadership style matters

Leadership is a skill to be developed by all doctors from the foundation trainee to the director of the board. This article explores the impact of leadership style on performance and considers techniques to develop doctors' leadership skills and personal effectiveness.

Introduction

Management of change might be considered the defining feature of leadership (Gill, 2011). Significant change in relation to the NHS is impending and inevitable in this climate of austerity and unprecedented health service pressures. Darwin's quote 'It is not the strongest or the most intelligent who will survive but those who can best manage change' would seem as appropriate for our present situation as for the evolution of species. During the ongoing political drives for health service transformation, imposed salary cuts and the proposed 7-day working week, doctors' ability to manage change within the NHS will be tested (NHS England, 2013c).

Despite obvious differences in focus and approach, doctors, patients, managers and politicians share a common health service vision to improve efficiency, reduce wasted resources and create a climate of excellence (Berwick, 1994). However, the service reforms that arise from these broad intentions may, at times, be challenged and even undermined by doctors. Doctors are positioned at an implementation fulcrum within the NHS, able to either resist or drive quality improvement at organizational and national level. The extent of clinician engagement in medical leadership and management of services has been identified as the key element to bring common goals for the future NHS into reality (Guthrie, 2005), and it is therefore essential that doctors are fully engaged in policy and service developments.

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Improving awareness and attitudes towards medical leadership will continue as both the Francis inquiry and Keogh mortality review (NHS England, 2013a,b) place leadership as both cause and potential solution to turn around failing hospitals. The quality of leadership at all levels 'from the board to the ward' can either drive forward excellence or reinforce unacceptably poor standards of patient care (General Medical Council, 2012).

Do I have what it takes?

Some individuals seem to naturally possess the personal qualities and characteristics defined as essential for leaders: intelligence, self-confidence, determination, integrity and sociability (Northouse, 2012). Focus group research suggests that doctors themselves attribute certain characteristics to medical leaders: passion, integrity, honesty, accountability and enough clinical credibility to ensure their actions and service plans consider patients' interests over organizational interests. Political communication skills and a hunger to contribute to the education of doctors in training complete the common perception of how the senior clinical leader should behave (British Medical Association, 2012). Many of these personal attributes may come with experience, others are already used on a daily basis and the remainder can be developed.

Leadership theory and style

Leadership is more than a shopping list of personality traits. In basic terms Adair (2013) defines leadership as acting out task and relationship behaviours in balance: empowering individuals, building the team and achieving the task. Polar leadership styles have been described by Bass (1990) as a continuum between transactional and transformational. The transactional style is classically managerial and analogous with carrot-stick, push-pull, reward-sanction 'transactions' to motivate at a basic level. Transformational leadership addresses individual or group needs for higher order achievement or purposes, engaging with these needs to raise self-worth, confidence, competence, creativity and autonomy (Gill, 2011).

The importance of adapting the style to the situation cannot be overemphasized. Effective leaders recognize when to adopt one technique in preference to another as a variety of styles exist and each can be effective when used correctly. A leader should consider how directive-passive, hands-on or hands-off he/she should be in the given context. For example, a cardiac arrest requires a highly directive leadership style with minimal flexibility. In contrast, chairing a meeting to plan health service provision over a 10-year period would require a negotiated, political, minimally directive approach to gain consensus and get results.

Situation and context matter, and the flexibility to tailor leadership style to fit the situation may be more crucial than the individual strengths and characteristics of the leader (Covey, 1999). Goleman (2005) summarized the key elements of the four non-technical skill sets required for high performance, effective leadership within his concept of emotional intelligence (*Table 1*).

In a large study in the corporate sector, Goleman (2005) suggested that maximum productivity is achieved when a leader's style contains the correct ingredients in ideal quantities to create a productive work atmosphere or climate. *Figure 1*

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describes the impact of the various styles, each of which has benefits and drawbacks, with no single style appropriate for every situation. Goleman suggests these leadership styles should be used as a pro golfer uses clubs. For example the coercive leadership style could be seen as a sand wedge: a useful tool to get out of tricky situations, but highly ineffective if used for every shot on the course.

In most situations, providing team members with the flexibility to get the job done in the most efficient way they can is a key component for any team to foster creativity innovation and better working practices. Clearly defined targets and outcomes provide focus and standards set the quality of work to be achieved and a sense of responsibility and reward for work well done can be achieved through fostering deeper, shared motivation and a willingness to address individuals' higher developmental needs.

Table 1. Emotional intelligence skills

Self-awareness	Ability to understand how emotions affect your personal performance and those around you, your evaluation of your abilities, limitations and self-worth
Self-management	Controlling emotion, being trustworthy, conscientious, adaptable and focused
Social awareness	Empathy, political skill, networking, understanding 'the way things work' in an organization. Awareness of service user needs
Social management	Ability to inspire, be creative, persuasive, a clear communicator and develop others. Interpersonal skills required to deescalate and resolve conflict. Ability to promote cooperation, build teams and develop individuals

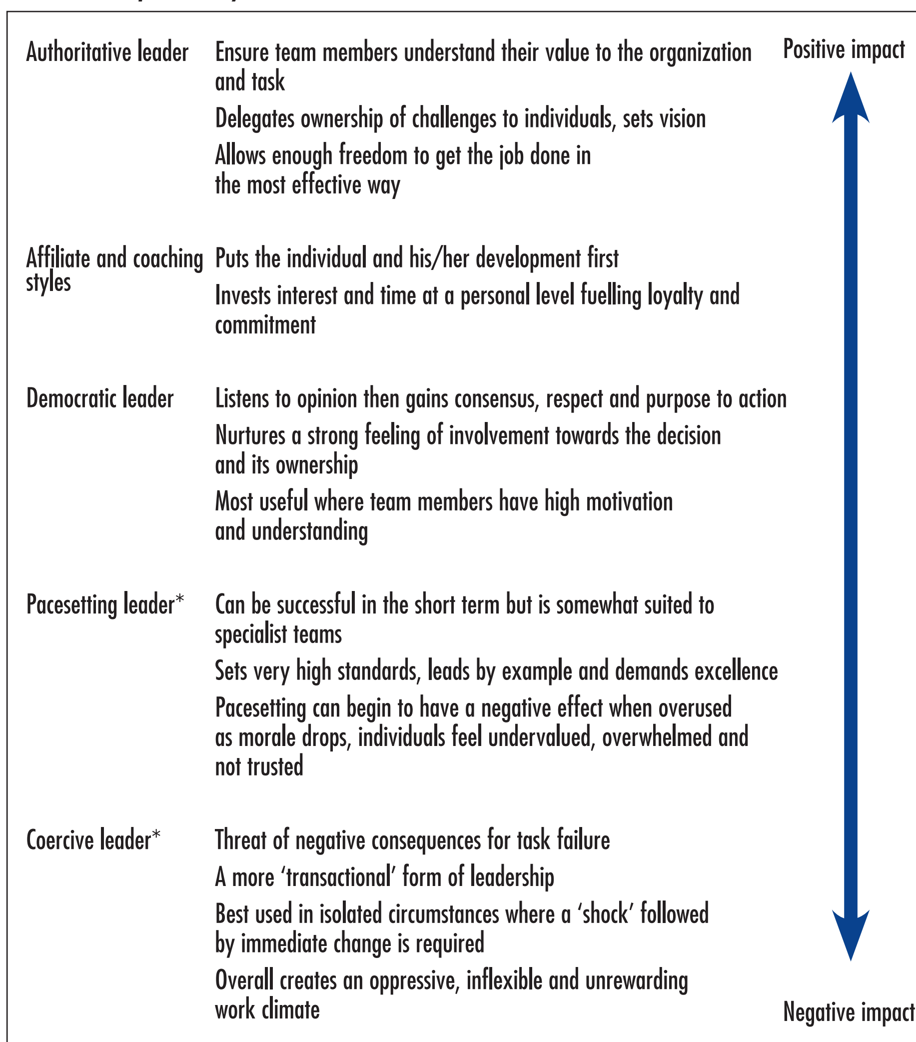

Figure 1. Leadership styles. From Goleman (2005). *Use sparingly as style creates an overall negative effect on team productivity and morale.

Current leadership practice within NHS settings has begun to focus on collective leadership and 'leadership at all levels', attempting to create a culture of leadership where all employees are encouraged to lead and take responsibility for organizational success (West et al, 2014). This concept of collective leadership recognizes that changing organizational culture requires more than just the individual actions of those within formal leadership positions.

Improving your leadership within the NHS

The General Medical Council (2012) and the Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement (2010) describe leadership as a non-technical clinical skill to be developed. Competency frameworks for leadership exist which in simple terms were viewed as checklists building towards senior leadership roles. Recently, the focus has shifted towards developing and supporting leadership at all levels and stages of career. Reflecting this approach, two of the most recent frameworks are the NHS Leadership Framework (NHS Institute for Innovation and Improvement, 2011) which focuses on a set of essential and desirable behaviours and the Faculty of Medical Leadership and Management's (2015) *Leadership and Management Standards for Medical Professionals*.

Even clinicians with no desire to enter official organizational leadership roles require these intangible skills to improve personal and team performance on the ward, in clinics and the operating theatre (Swindall, 2011). To nurture appreciation of the importance of senior clinicians taking up medical leadership roles most speciality training programmes now integrate management and leadership training throughout.

According to independent sources (Mossialos et al, 2015), the NHS is seen as the world's best example of universal health care and this reinforces the commitment to quality, pride and improvement found throughout NHS organizations. The literature and experience clearly demonstrate that engagement with clinical leadership at

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all levels within the NHS is key to sustain quality, improve services, reduce mortality and foster motivation for the necessary changes that will successfully form the future NHS (Ham and Dickenson, 2008).

Lack of time, resources and a perception that management roles divert clinicians away from direct patient care are commonly cited inhibitors to engagement with medical leadership. The negative stereotype attributed to NHS management has fostered a perception that doctors who take on leadership roles are considered to have gone over to the 'dark side' (Iacobucci, 2013). Encouragement from colleagues, improved access to leadership opportunities and an understanding of their importance might empower more individuals with suited personal qualities and interests to seek out, engage with and lead change within their respective organizations (British Medical Association, 2012).

Conclusions

This article has introduced some current concepts in medical leadership. Understanding more about the impact of leadership styles on working 'climate' helps us to see why we perceive the experience of working with some colleagues as negative. It may be because they are 'pacesetters' (demanding too much of themselves and others) or they use a 'coercive' style instead of a collective or collaborative style. Paying attention to leaders' styles and approaches also helps us see how positive leadership role models from our past have influenced our practice and by further appreciating the impact of leadership style, we can learn to select the right approach in different situations. Engaging in the wide range of leadership development opportunities available, seeing ourselves as 'leaders at all levels' and working towards achieving competencies or meeting leadership standards will also help us become better leaders and improve the culture and practice of the NHS. **BJHM**

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KEY POINTS

- Leadership is a personal skill which can be developed.
- Leadership styles are multifaceted and should be adapted to individual and situation.
- Local and national drivers continue to increase awareness of and engagement with medical leadership development.

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