

What do doctors and nurses think about development of clinical leadership?

Over 30 years ago, the Griffiths report (Department of Health and Social Security, 1983) identified that the NHS was failing to use its resources efficiently. The review recommended that general managers should be appointed within the NHS's traditional structure, and that doctors 'must accept the management responsibility that goes with clinical freedom' (Department of Health and Social Security, 1983). While Griffiths advocated managers and clinicians working closely together, his report is widely seen to have distanced clinicians from leadership roles within the NHS. Despite this not being the intention of the reforms, the introduction of 'general managers' and the NHS management training scheme was felt to have disengaged doctors who, on the whole, withdrew from formal management processes, 'feeling outnumbered and out of place, talking about money' (Read, 2014). The somewhat unhelpful divide between leadership (seen as 'superior' to management) and management (which became seen as 'the dark side' (Spurgeon et al, 2011) by many doctors) still pervades today. Challenging these perceptions and addressing the issues which stem from the 'divide' requires massive cultural shift, and these issues are explored further in this article.

In the UK, the development of clinical leadership to improve the quality of health care received renewed interest following a number of high profile reports on the failings of leadership in health-care organizations (e.g. Darzi, 2008; Berwick, 2013; Francis, 2013). Supported by contemporary thinking, the leadership style recommended is one of collective leadership, where everyone (regardless of staff group) is required to take responsibility for the success of the organization as a whole (West et al, 2014). Other terms can be found in the literature, such as collaborative, shared, participative and distributed leadership. They all enshrine similar approaches regarding the involvement of people at all levels of the organization. The fundamental principle is for power to be shared, and leadership and management expertise to be developed at all levels, across traditional hierarchies and professional boundaries (Barrow et al, 2011; Fitzgerald et al, 2013). This should ensure that expertise from interprofessional teams is identified appropriately, and matched to the task at hand to deliver quality – the right person for the right job at the right time.

A range of targeted development programmes and bodies exists to support leadership development (Table 1). This demonstrates a desire for leadership development at

ABSTRACT

Leadership development for health-care professionals is a priority within the NHS. Training is generally targeted at individual staff groups in isolation, even though contemporary leadership thinking recognizes the benefits of collaborative leadership between different clinical disciplines. Focussing on the attitudes and perceived training needs of undergraduate and qualified medical and nursing professionals, this article highlights the similarities and differences and will help to inform the design of existing and future leadership programmes.

Table 1. Programmes and bodies supporting leadership development in the NHS

| Programme | Target audience | Web address |
|---|------------------------------------|--|
| NHS Leadership Academy | All clinical staff | www.leadershipacademy.nhs.uk/ |
| Faculty of Medical Leadership and Management | Primarily for doctors and dentists | www.fmlm.ac.uk |
| National Medical Director's Clinical Fellow Scheme | Doctors | www.fmlm.ac.uk/programme-services/individual-support/national-medical-directors-clinical-fellow-scheme |
| Leading Better Care Together | Nurses | www.leadingbettercare.scot.nhs.uk/ |
| Chief Pharmaceutical Officer's Clinical Fellow Scheme | Pharmacists | www.fmlm.ac.uk/programmes-services/individual-support/clinical-fellow-scheme/chief-pharmaceutical-officer's |

all levels and not just among doctors. However, one of the ongoing challenges with leadership development within the NHS has been the effective engagement of clinical staff to influence service development. Enhancing this engagement

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is now seen as a priority (The King's Fund, 2012), so it is important to understand the attitudes of clinical staff towards leadership and leadership development, since their views will impact on their engagement with the opportunities offered.

Introduction

Previous articles have addressed the attitudes towards leadership of individual staff groups (e.g. Cummings et al, 2008; Abbas et al, 2011) but not considered the differences in views between them.

Nurses and doctors make up the two largest clinical staff groups within the NHS. Together they account for one third of the workforce. Understanding the leadership needs and perspectives of these two clinical groups will facilitate the development of future education programmes and improve integrated working between these disciplines.

Using systematic review methodology, the authors used broad search terms (i.e. Leadership AND Attitude* OR perspective* OR view* OR perception* OR opinion* AND Medical OR healthcare OR clinical OR health OR medicine OR nursing OR care OR undergraduate OR student) in 16 databases in order to capture studies involving nurses, doctors, medical and nursing students internationally. Peer-reviewed articles (descriptive and evaluative), from 1997–2017, written in English, were included. Articles that focussed on other health professionals were excluded. The initial search identified 1010 articles, which, when the inclusion and exclusion criteria were applied, left 18 articles which are used as the basis of this article. This article explores the differences and similarities in perspectives between doctors and nurses in terms of their attitudes towards:

- Importance of leadership skills in clinical practice
- Characteristics of good leadership
- Delivery of leadership training
- Adequacy of existing leadership development programmes
- Perceived barriers to leadership development.

The importance of leadership skills in clinical practice

Medical students were found to be open to the prospect of doctors taking on leadership roles, and were accepting of leadership education in the undergraduate curriculum (Varkey et al, 2009; Quince et al, 2014), with 85% of students surveyed by Varkey et al (2009) expressing that leadership and quality improvement skills should be taught at medical school. Moreover, both leadership knowledge and the perception of its relative importance increased as medical students became more senior

(Butrous et al, 2011). Specifically, 76% of the 240 surveyed medical students felt that doctors need to have an understanding of the economic factors affecting the NHS and NHS structure.

Conversely, in focus groups involving 20 UK nursing students, Francis-Sharma (2016) found that participants did not regard leadership as an essential skill on qualifying, and commented negatively about the emphasis placed on leadership training during their final year. Their cohort placed more importance on the acquisition of clinical skills, and was apprehensive about having to prove themselves on their leadership abilities. Participants also suggested that leadership could not be taught: 'I'm just saying that...It's a skill and some skills... can't be taught'. Likewise, in a Turkish study (Ozturk and Kahriman, 2013) involving 213 nursing students, 42% of respondents did not know if there were leaders in nursing, and 27% felt there were no leaders in nursing at all.

In focus groups conducted by the British Medical Association (2012), most doctors believed that leadership can be shown by all doctors, particularly through leading by example. Similarly, a west African cohort of surgeons (Mahmoud et al, 2010) overwhelmingly felt that physicians are the inherent leaders of the health-care team. Although others have reported a lack of engagement in leadership programmes among doctors (Baker and Denis, 2011), it is possible that an evolving positive change towards embracing leadership roles is being seen among younger doctors. This is in accordance with opinions of senior health leaders which reported a positive change in attitude among doctors, particularly trainees, towards clinical leadership (Nicol et al, 2014).

Nurses, on the other hand, do not appear to view leadership as a necessary skill to develop during undergraduate training, despite this being a key issue and international priority for the future workforce (Royal College of Nursing, 2016). While nurse leaders view leadership as critical to improve quality, front-line staff perceive individual nursing skills as more important (Haycock-Stuart and Kean, 2012). It is possible that by the end of their training, nursing students may become embedded in front-line nursing culture, which fails to value the significance of leadership (Cubit and Ryan, 2011). However, while qualified nurses do not mention leadership skills specifically, when asked to discuss attributes necessary for effecting nursing, they did recognize skills within emotional, intellectual, communication and personality domains as important (Cleary et al, 2013). By contrast, however, nurses enrolled onto a leadership programme saw the potential of developing leadership skills to change their environments 'through better teamwork', 'healthier work environment', and a 'strong connection to front-line staff' (Dyess et al, 2016), indicating an increased awareness of the importance of clinical leadership as they progress through their career.

The characteristics of good leadership

Communication is consistently reported to be an important leadership attribute across all groups. From a medical student's perspective, leadership characteristics include:

- Communication skills
- Negotiation skills
- An understanding of society (political and economic landscape)
- Organizational structure (Quince et al, 2014)
- Professional ethics (McKenna et al, 2004; Varkey et al, 2009).

Perceptions of leadership characteristics among doctors (Hopkins et al, 2006; British Medical Association, 2012; Spehar et al, 2017) reflect those of medical students, identifying skills in communication, political knowledge and conflict resolution as important. However, vision was also recognized as an important leadership quality.

Nursing students cite fairness and being 'unbiased' as important leadership attributes (Ozturk and Kahriman, 2013; Francis-Sharma, 2016) as well as alluding to emotional intelligence through 'self-awareness' and 'authenticity'. While student nurses paint an image of leadership in more traditional terms – 'solo, charismatic leader, with intrinsic, natural qualities' (Bass, 1995), this is by no means unique among UK undergraduates (Hassali et al, 2016) and, following graduation, qualified nurses discuss leadership in more collaborative terms. Communication is again the main skill identified, in addition to having an understanding of ethics (Pereira et al, 2015), having vision (Demirbag and Ozturk, 2013), being a role model or demonstrating idealised behaviour (Demirbag and Ozturk, 2013; Amouri and O'Neill, 2014). Other characteristics of good leadership identified included being able to work collaboratively, being knowledgeable, having emotional awareness and being accessible (Cleary et al, 2013; Dyess et al, 2016).

Doctors appear to emphasize hard skills (political knowledge, organizational understanding), while nurses place more value on soft skills (emotional intelligence) as characteristics of good leadership.

The delivery of leadership training

Medical students were found to prefer 'on-the-job' training, and did not feel that either self-study, traditional coursework or didactic lectures were suitable mediums to deliver leadership education (McKenna et al, 2004; Varkey et al, 2009; Quince et al, 2014). Medical students also rate simulation training, small group work (Varkey et al, 2009) and mentoring from experienced leaders (McKenna et al, 2004) as the most effective ways to learn leadership skills. In contrast, Francis-Sharma (2016) found that a common belief held among the cohort of nursing students was that studying leadership is of little relevance, and something that 'might [be] put on the side' until qualification.

Studying doctors, Mahmoud et al (2010) found the majority advocated for courses during medical school and

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residency. They also felt that more opportunities to serve in management roles would allow 'learning on-the-job'. Power et al (2017) reported attitudes of a mixed cohort of primary care staff (which included GPs) in Scotland, and found a preference for e-modules and small group learning.

Following implementation of a formal leadership programme in Scotland, nurses reported increased confidence in their leadership abilities, and had mainly positive perceptions of clinical leadership, clinical team performance and improvement of care (Stoddart et al, 2014). Likewise, Hopkins et al (2006) found that nurses indicated support and resources from their organization to engage with professional development opportunities was viewed as more important than mentorship.

The adequacy of existing leadership training

Neither medical nor nursing students feel adequately trained to take on leadership roles. Varkey et al (2009) found that for each leadership competency studied, medical students' reported competence was less than the perceived importance of the same competency. This was echoed by Butrous et al (2011) who reported 64% of surveyed medical students felt more was required from their curriculum. In a Turkish study, 52% of the 213 surveyed nursing students did not feel that their education helped them to acquire leadership qualities (Ozturk and Kahriman, 2013).

Qualified nurses and doctors reported mixed experiences. Studies involving doctors report inadequate or lack of previous training (British Medical Association, 2012; Power et al, 2017; Spehar et al, 2017). Mahmoud et al (2010) found that adequacy of preparation for clinical leadership was perceived by respondents to increase with succeeding levels of education: 75% perceive adequate preparation at medical school, 78% at residency training level, and 87% following a professional leadership course. Three-quarters of nurses in one study (Pereira et al, 2015) reported not attending any leadership courses post-qualification. Leadership was said to have been enhanced where a formal programme is in place (Stoddart et al, 2014), or when supervision has been provided (Hyrkas et al, 2005).

The perceived barriers to leadership development

Medical students feel that traditional hierarchies within the profession, and negative attitudes of established clinicians towards leadership education, hinders their development (Quince et al, 2014). This perceived conflict in interest is

echoed by nursing students, who talk about the conflict that arises during competition for [leadership] role:

'If you put too many people [together] who want to be a leader, they're all going to be fighting for authority' (Francis-Sharma, 2016).

Studies involving doctors report lack of time, resources, support and cost as key barriers to leadership development (Hopkins et al, 2006; British Medical Association, 2012; Power et al, 2017; Spehar et al, 2017). Similarly, nurses highlight lack of time and resources as barriers to training (Demirbag and Ozturk, 2013; Stoddart et al, 2014; Pereira et al, 2015). GPs from Norway further discussed the conflict of holding clinical and leadership roles (Spehar et al, 2017). One study found that GPs experience conflict within their roles of being a clinician and team leader. This can be defined as the simultaneous existence of multiple incompatible expectations on one's behaviour. Hybrid roles have been shown to result in role conflicts (Kippist and Fitzgerald, 2009). Future leadership programmes should include instilling an awareness of professional boundaries and resilience training.

It has previously been reported that ethnic minority leaders felt that their ethnicity posed a barrier to accessing leadership roles (Chin, 2013). It is difficult to know whether these barriers are genuine or perceived, but consideration should be given to promoting access to leadership opportunities for minority groups. An example of one such initiative is the East Midlands Visible Leaders' Network (NHS East Midlands, 2010).

Discussion

Overall, medical students and qualified doctors demonstrate positive attitudes towards developing leadership skills within their profession, recognizing the importance of clinical leaders in improving care. Nursing professionals on the other hand appear to value individual nursing skills above those of leadership, until they are enrolled onto a leadership programme or assume leadership roles. This can be explained in a number of ways. First, the way in which doctors and nurses view 'leaders' and 'leadership' may affect their views on leadership development. It is possible that many nurses take a more traditional view, emphasizing personal qualities, as well as positional power and authority, as equating with a 'leader': the 'great man' approaches (Swanwick, 2017). From this perspective, leadership development might be seen as either irrelevant (as leaders have certain traits or qualities which others do not) or not relevant for students or junior nurses (because they are not in a leadership position).

Conversely, medical students are encouraged and supported to take on 'little' leadership roles (Bohmer, 2010) and, once qualified, are expected to take on increasingly senior and diverse leadership roles. However, medical students also report negative attitudes from established clinicians hindering their leadership development opportunities (Quince et al, 2014). Perhaps this is because

students are traditionally supposed to be submissive and unquestioning of their senior colleagues or because there is a 'generation lag' between more senior doctors (who traditionally learned on-the-job) and current doctors in training for whom more formal leadership development is becoming the 'norm'. Likewise, nursing students were concerned that conflict may arise between peers when everyone tries to lead which, again, potentially stems from more traditional views of 'solo leadership'. Clearly more effort needs to be made to espouse the aims and practical applications of 'leadership at every level'.

Second, it is possible that these divergent views stem from a traditional (and outdated) hierarchy in which doctors are seen as superior to nurses (Germov and Freij, 2009) and therefore are seen as the automatic 'leader' in clinical (and other) situations. Indeed, in many cultures nursing is still seen, socially and professionally, as inferior to medicine. Barrow et al (2011) highlight that there needs to be a fundamental change in the culture and mind set of health-care teams, which are still seen to be hierarchical. This New Zealand study explored the professional dynamics between junior doctors and nurses and found that, while both groups 'aspired' to lead, neither group viewed their counterparts as leaders in their own right (Barrow et al, 2011). Early career doctors viewed nursing leadership as 'management' and 'protocol adherence', while nurses felt junior doctors were still 'in training'. This discrepancy between the way nurses and doctors view leadership (and consequently the importance of leadership development) within their respective professions is of concern, and represents a barrier towards achieving effective collective leadership within the NHS. However, it also provides opportunities for developing programmes in which nurses and doctors learn from one another from an early stage, to share experiences, improve understanding, and to learn to value one another's contributions towards collaborative leadership. Interprofessional education at the undergraduate level is one way of helping to promote better understanding of each other's roles and increase cohesion (McKay and Narasimhan, 2012).

The issue of doctors being inadequately trained in management and leadership, but nevertheless expected to take on leadership positions, has been highlighted (Clark and Armit, 2008). Although many health-care professionals may be sceptical of leadership training at first, their views can be changed by experiencing it. A number of studies report positive change following implementation of a leadership programme (e.g. Martin et al, 2012; Leeson and Millar, 2013). Their training should therefore emphasize the importance of leadership development in addition to delivering leadership theory and skills, and should preference experiential on-the-job training (including mentorship) over didactic classroom-based learning. Embedding leadership development within training and education additionally helps overcome one of the main barriers perceived by both professional groups, in that there is a lack of time and resources for leadership

development. It is challenging to address these needs within current resource constraints and increasing clinical demand, but raises issues which need to be considered at higher strategic levels.

Conclusions

In terms of perceived characteristics of good leadership, adequacy of existing training, and barriers to leadership development, there is overall concordance in attitudes between students and qualified doctors and nurses. However, in terms of the importance of leadership training, there is an obvious discrepancy in attitude between the nursing and medical students, with nursing students largely feeling negative towards it. It is possible that this stems from outdated stereotypes about leadership and traditional hierarchies within health care. In order to facilitate more collaborative leadership, it is essential that the learning needs of both professional groups are met from an early stage, with consideration of interdisciplinary training from the undergraduate level. In order to be acceptable (especially when leadership development is seen as irrelevant) leadership programmes must acknowledge crowded health professions' curricula and reflect the needs of busy health-care staff.

This can be achieved by providing innovative and flexible ways of learning (including e-learning, experiential learning and mentorship), promoting and demonstrating the importance of leadership development, and applying leadership theory and concepts to practice in the context of current health-care priorities. Finally, leadership development needs to be set within a culture which emphasizes mutual respect and understanding of interdisciplinary roles, so that perceived hierarchical barriers can be broken down, silo working and tribalism between teams is minimized, and collective leadership can be promulgated throughout organizations. **BJHM**

Conflict of interest: none.

- Abbas MR, Quince TA, Wood DF, Benson JA (2011) Attitudes of medical students to medical leadership and management: a systematic review to inform curriculum development. *BMC Med Educ* **11**: 93. <https://doi.org/10.1186/1472-6920-11-93>
- Amouri SE, O'Neill S (2014) Leadership style and culturally competent care: Nurse leaders' views of their practice in the multicultural care settings of the United Arab Emirates. *Contemporary Nurse* **48**(2): 135–149. <https://doi.org/10.1080/10376178.2014.11081936>
- Baker GR, Denis J (2011) *A comparative study of three transformative healthcare systems with lessons for Canada*. Canadian Health Services Research Foundation, Toronto, Ontario
- Barrow M, McKimm J, Gasquoin S (2011) The policy and the practice: early-career doctors and nurses as leaders and followers in the delivery of health care. *Adv Health Sci Educ* **16**: 17–29. <https://doi.org/10.1007/s10459-010-9239-2>
- Bass B (1995) Theory of transformational leadership. *Leadersh Q* **6**: 463–478.
- Berwick D (2013) *A promise to learn – a commitment to act*. Department of Health, London
- Bohmer R (2010) Leadership with a small 'l'. *BMJ* **340**: c483. <https://doi.org/10.1136/bmj.c483>
- British Medical Association (2012) *Doctors' perspectives on clinical leadership*. Health Policy & Economic Research Unit. British Medical Association, London
- Butrous E, Park C, Ward T, Warren OJ (2011) Knowledge and opinions of undergraduate medical students on NHS structure, medical management and leadership: Defining the structure of curriculum improvement. *International Journal of Clinical Leadership* **17**(3): 131–138.
- Chin JL (2013) Diversity leadership: influence of ethnicity, gender, and minority status. *Open Journal of Leadership* **2**: 1–10. <https://doi.org/10.4236/ojl.2013.21001>
- Clark J, Armit K (2008) Attainment of competency in management leadership. No longer an optional extra for doctors. *Clinical Governance: An International Journal* **13**: 35–42. <https://doi.org/10.1108/14777270810850616>
- Cleary M, Horsfall J, Hunt G et al (2013) Recent graduate nurse views of nursing, work and leadership. *J Clin Nurs* **22**: 2904–2911. <https://doi.org/10.1111/jocn.12230>
- Cubit K, Ryan B (2011) Tailoring a graduate nurse program to meet the needs of our next generation nurses. *Nurse Educ Today* **31**: 65–71. <https://doi.org/10.1016/j.nedt.2010.03.017>
- Cummings G, Lee H, Stafford E et al (2008) Factors contributing to nursing leadership: a systematic review. *J Health Serv Res Policy* **13**(4): 240–248. <https://doi.org/10.1258/jhsrp.2008.007154>
- Darzi A (2008) *NHS Next Stage Review: A High Quality Workforce*. HMSO, London
- Demirbag BC, Ozturk H (2013) Opinions of nurse academicians on leadership. *Procedia Soc Behav Sci* **93**: 560–564. <https://doi.org/10.1016/j.sbspro.2013.09.239>
- Department of Health and Social Security (1983) *Griffiths Report: NHS Management Inquiry*. HMSO, London
- Dyess SM, Sherman RO, Chiang-Hanisko L (2016) Growing nurse leaders: their perspectives on nursing leadership and today's practice environment. *Online J Issues Nurs* **21**(1): 7. <https://doi.org/10.3912/OJIN.Vol21No01PPT04>
- Fitzgerald L, Ferlie E, McGivern G, Buchanan D (2013) Distributed leadership patterns and service improvement: Evidence and argument from English healthcare. *Leadersh Q* **24**(1): 227–239. <https://doi.org/10.1016/j.leaqua.2012.10.012>
- Francis R (2013) *The Mid Staffordshire NHS Foundation Trust Public Inquiry: Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Executive Summary. HMSO, London
- Francis-Sharma J (2016) Perceptions of leadership among final-year undergraduate nursing students. *Nurs Manag* **23**(7): 35–39. <https://doi.org/10.7748/nm.2016.e1535>
- Germov J, Freij M (2009) The Doctor/Nurse Game. In: Germov J, ed. *Second Opinion. An Introduction to Health Sociology*. 4th edn. Oxford University Press, Melbourne
- Hassali M, Saleem F, Aljadhey H et al (2016) Leadership attitudes and beliefs of pharmacy students: a cross-sectional study from a Malaysian University. *Journal of Applied Pharmaceutical Science* **6**(10): 189–194. <https://doi.org/10.7324/JAPS.2016.601026>
- Haycock-Stuart E, Kean S (2012) Contrasting perceptions about the delivery of care in the community. *Nurs Manag* **18**: 26–29 <https://doi.org/10.7748/nm2012.03.18.10.26.c8959>
- Hopkins M, O'Neil D, Bilimoria D (2006) Effective leadership and successful career advancement: perspectives from women in health care. *Equal Opportunities International* **25**(4): 251–271. <https://doi.org/10.1108/02610150610706249>

KEY POINTS

- Developing leadership capacity is a priority for the NHS in a drive to improve health care.
- Collective and collaborative leadership are seen as the most relevant approaches to engage health workers at all levels in improving services and patient care.
- Studies reveal discrepancies in the way that medical and nursing students and qualified doctors and nurses perceive leadership and leadership development.
- This has implications for teamworking, working practices and leadership development programmes.
- Changing the culture, mind-set and approach to leadership development should help encourage more health professionals at any stage to see the relevance of leadership development and become engaged.

- Hyrkas K, Appelqvist-Schmidlechner K, Kivimaki K (2005) First-line managers' views of the long-term effects of clinical supervision: how does clinical supervision support and develop leadership in health care? *J Nurs Manag* **13**: 209–220. <https://doi.org/10.1111/j.1365-2834.2004.00522.x>
- Kippist L, Fitzgerald A (2009) Organisational professional conflict and hybrid clinician managers: the effects of dual roles in Australian health care organisations. *J Health Org Mgt* **23**: 642–655. <https://doi.org/10.1108/14777260911001653>
- Leeson D, Millar M (2013) Using the 7 habits programme to develop effective leadership. *Nurs Manag* **20**: 31–37. <https://doi.org/10.7748/nm2013.10.20.6.31.e1123>
- Mahmoud A, Nkanga D, Onakoya A (2010) Views of West African surgeons on how well their educational and professional backgrounds may have prepared them for health leadership roles. *N Am J Med Sci* **2**(12): 580–585. <https://doi.org/10.4297/najms.2010.2580>
- Martin JS, McCormack B, Fitzsimons D, Spirig R (2012) Evaluation of a clinical leadership programme for nurse leaders. *J Nurs Manag* **20**: 72–80. <https://doi.org/10.1111/j.1365-2834.2011.01271.x>
- McKay KA, Narasimhan S (2012) Bridging the gap between doctors and nurses. *J Nurs Educ Pract* **2**(4): 52–55. <https://doi.org/10.5430/jnep.v2n4p52>
- McKenna M, Gartland M, Pugno P (2004) Development of physician leadership competencies: perceptions of physician leaders, physician educators and medical students. *J Health Adm Educ* **21**(3): 342–354.
- NHS East Midlands (2010) NHS East Midlands Visible Leaders Support Network. www.leadersipeastmidlands.nhs.uk/networks/visible-leaders-network (accessed 11 July 2017)
- Nicol ED, Mohanna K, Cowpe J (2014) Perspectives on clinical leadership: a qualitative study exploring the views of senior healthcare leaders in the UK. *J R Soc Med* **107**(7): 277–286. <https://doi.org/10.1177/0141076814527274>
- Ozturk H, Kahrman I (2013) The opinions of nurse students regarding leadership in nursing. *Procedia Soc Behav Sci* **93**: 111–115. <https://doi.org/10.1016/j.sbspro.2013.09.161>
- Pereira LA, Primo LS, Tomaschewisk-Barlem JG, Barlem ELD, Ramos AM, Hirsch CD (2015) Nursing and leadership: perceptions of nurse managers from a hospital in southern Brazil. *J Res Fundam Care Online* **7**(1): 1875–1882. <https://doi.org/10.9789/2175-5361.2015.v7i1.1875-1882>
- Power A, Allbutt H, Gillies J et al (2017) An evaluation of experiences and views of Scottish leadership training opportunities amongst primary care professionals. *Educ Prim Care* **28**(3): 159–164. <https://doi.org/10.1080/14739879.2016.1266239>
- Quince T, Abbas M, Murugesu S et al (2014) Leadership and management in the undergraduate medical curriculum: a qualitative study of students' attitudes and opinions at one UK medical school. *BMJ Open* **4**: e005353. <https://doi.org/10.1136/bmjopen-2014-005353>
- Read C (2014) The Future of NHS Leadership: unpicking Griffiths' complex legacy. <https://www.hsj.co.uk/5072855.article> (accessed 6 June 2017)
- Royal College of Nursing (2016) Frontline nurse leadership: an international perspective. RCN Policy and International Department. Policy Briefing 02/16. www.rcn.org.uk/-/media/royal-college-of-nursing/documents/policies-and-briefings/consultation-responses/2016/february/lr-0216.pdf (accessed 28 July 2017)
- Spehar I, Sjovik H, Frich J et al (2017) General practitioners' views on leadership roles and challenges in primary health care: a qualitative study. *Scandinavian J Prim Health Care* **35**(1): 105–110. <https://doi.org/10.1080/02813432.2017.1288819>
- Spurgeon P, Clark J, Ham C (2011) *Medical Leadership: From the Dark Side to Centre Stage*. Radcliffe Publishing, London
- Stoddart K, Bugge C, Shepherd A, Farquharson B (2014) The new clinical leadership role of senior charge nurses: a mixed methods study of their views and experience. *J Nurs Manag* **22**: 49–59. <https://doi.org/10.1111/jonm.12008>
- Swanwick T (2017) Leadership theories and concepts. In: Swanwick T, McKimm J, eds. *ABC of Clinical Leadership*. Wiley Blackwell, Chichester
- The King's Fund (2012) *Leadership and engagement for improvement in the NHS: Together we can*. The King's Fund, London
- Varkey P, Peloquin J, Reed D, Lindor K, Harris I (2009) Leadership curriculum in undergraduate medical education: A study of student and faculty perspectives. *Med Teach* **31**(3): 244–250. <https://doi.org/10.1080/01421590802144278>
- West M, Eckert R, Steward K, Pasmore B (2014) *Developing collective leadership for health care*. The King's Fund: London

Clinical Leadership made easy: Integrating theory and practice

Foreword by Peter Lees

Edited by Judy McKimm and Helen O'Sullivan

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