



# Medical leadership: why it's important, what is required, and how we develop it

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## ABSTRACT

Good medical leadership is vital in delivering high-quality healthcare, and yet medical career progression has traditionally seen leadership lack credence in comparison with technical and academic ability. Individual standards have varied, leading to variations in the quality of medical leadership between different organisations and, on occasions, catastrophic lapses in the standard of care provided to patients. These high-profile events, plus increasing evidence linking clinical leadership to performance of units, has led recently to more focus on leadership development for all doctors, starting earlier and continuing throughout their careers. There is also an increased drive to see doctors take on more significant leadership roles throughout the healthcare system. The achievement of these aims will require doctors to develop strong personal and professional values, a range of non-technical skills that allow them to lead across professional boundaries, and an understanding of the increasingly complex environment in which 21st century healthcare is delivered. Developing these attributes will require dedicated resources and the sophisticated application of a variety of different learning methodologies such as mentoring, coaching, action learning and networking.

## MEDICAL LEADERSHIP IN THE NHS

It is indisputable that to deliver high-quality care consistently to patients requires, among many other factors, good medical leadership. However, within the UK, leadership skills have traditionally not been prominent in either the curricula or the appraisal and assessment systems of medical students and doctors. When present, leadership as a subject has often been expressed within other areas, such as 'professionalism' or 'communication skills', and attempts to develop and assess leadership have been inconsistent and without a framework.<sup>1</sup> Furthermore, medical career progression has traditionally been based on technical and academic ability at the expense of the so-called 'softer' attributes that contribute to good leadership, such as strong emotional intelligence. This lack of focus and emphasis has led to significant variation in the standards of medical leadership at the top of, throughout and between different NHS organisations and has impacted on the standard of care provided to patients; the enquiries and resulting reports into clinical negligence at Bristol, Alder Hey and Maidstone and Tunbridge Wells Trusts all highlighted organisational deficiencies in medical leadership.<sup>2-4</sup>

Attempts to improve this situation by increasing medical engagement and leadership are sadly not

new; the Griffiths report in 1983 sought for doctors to play a significant role in general management, particularly at unit level (leading in many places to the creation of Clinical Directorates),<sup>5</sup> and the 1986 NHS Management Board's 'Resource Management Initiative' was predicated on the full involvement of doctors to improve patient care through better utilisation of hospital resources.<sup>6</sup> In the 1990s, different authors argued for improved doctor leadership and increased medical involvement in the delivery of healthcare,<sup>7-10</sup> and, in 2005, the Royal College of Physicians report 'Doctors in Society' stated that 'the complementary skills of leadership and 'followership' need to be incorporated into doctors' training to support professionalism'.<sup>11</sup> In the last 3 years, Lord Darzi's reviews on the future of healthcare within London<sup>12</sup> and subsequently throughout England<sup>13</sup> highlighted clinical leadership as an essential component of quality care and emphasised this by creating an NHS National Leadership Council to oversee leadership and its development throughout the system.

Encouragingly, despite this significant journey, it would appear that the current focus and set of initiatives on medical leadership and engagement are achieving more impact and at more levels than earlier attempts. One possible reason for this is the Medical Leadership Competency Framework (MLCF), jointly developed by The Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement.<sup>14</sup> The MLCF describes the leadership competencies *all* doctors need to develop and is being incorporated into undergraduate and postgraduate curricula and assessment processes, something not previously attempted. It seeks to ensure that all doctors throughout their careers attain an agreed set of leadership competencies that are essential to being a good doctor; it is predicated on the belief that all medical practitioners should be leading to improve the quality of the service within their speciality, practice or unit. Another possible reason for the increase in the profile of medical leadership lies not in the need for system-wide leadership but in an increasing desire within the system for doctors to aspire to significant positional leadership roles, particularly that of chief executive. A recent report showed that the NHS still lags behind many other developed healthcare systems in this regard, with just 5% of the total chief executive community currently being doctors,<sup>15</sup> compared with around 30% in the USA. Developing a cohort of future medical leaders to accede to these roles requires a different developmental strategy to improving the leadership competencies of all physicians system-wide (and this is discussed in more detail below),

but is, we would suggest, equally important and more likely to occur if there is earlier awareness and education about leadership in medical curricula as driven by the MLCF. A third reason appears to be demand; junior doctors are becoming increasingly interested in developing these skills for themselves, attracted by the opportunity to affect the environment in which they work and lead improvements in patient care. This rise in interest has driven the emergence of fellowships, courses, schemes and member organisations designed to provide increasing opportunities for medical leadership development.

### WHAT LEADERSHIP ATTRIBUTES ARE REQUIRED FROM DOCTORS?

If we are to achieve a position where medical leadership is of a consistently high standard and is embedded throughout the NHS, we need all doctors to be able to take a macroscopic view on healthcare provision and resource allocation and to understand the political, economic, social and technological drivers for change that will influence this view throughout their careers. Doctors, who until now have been taught little of the NHS, will need to learn about the funding, organisation, governance and management that are integral to its workings. They need to be supported by well-developed systems, clear lines of reporting and responsibility, and an organisational culture that provides good information and encourages its use as a vehicle for performance improvement. Finally, all doctors, whether they remain predominantly as medical practitioners, move to lead organisations or take on more strategic roles, need to learn more about 'followership', an increasingly discussed concept that recognises the importance of participation and allowing others to lead. Without doing these things, doctors will remain significantly disadvantaged, unable to participate in discussions regarding service delivery, unable to navigate and lead others through the organisation and system in which they work and on occasions perceived, sometimes rightly, to be barriers to change or toxic influences within their organisations.

For those doctors who aspire to perform more significant positional leadership roles, simply having the knowledge, skills and information described above will not be enough. Future medical leaders will require, and will need to utilise, a broader range of non-technical skills to allow them to lead others, not just within medicine but across all professional boundaries. These skills include creating and communication their vision, setting clear direction, service redesign and healthcare improvement, effective negotiation, awareness of both self and others, working collaboratively and networking. They will need to be able to balance many different competing interests and priorities and manage themselves effectively; to enhance peer credibility, many will seek to continue to deliver high-quality clinical care alongside these prominent leadership positions. They must hold, voice and enact strong personal values and beliefs that impact positively on those around them and place the patient at the centre of decision-making, not the priorities of the provider.

### WHAT METHODS ARE AVAILABLE TO DEVELOP MEDICAL LEADERSHIP?

There is considerable debate about whether leaders are born or whether they can be made. While Kotter<sup>16</sup> argues that leadership consists of a series of definable skills that can and should be taught, others have suggested that there must be a prerequisite level of innate natural leadership ability. Regardless of this debate, there is little contention that, while certain individuals and personality types appear to take to leadership roles more

readily, all professionals can develop their ability to lead others and can learn some of the techniques and behaviours that are essential for effective leadership at whatever level they work.

The methodologies available and practised for leadership development are vast, ranging from self-directed learning using books and audio recordings, to one-to-one coaching, mentoring, action learning and seminars. In some instances, learning occurs alone and is entirely self-directed, and in others it occurs in teams, or as part of a cohort participating in schemes, fellowships or undertaking formal qualifications.

### Schemes and courses

Many doctors at some point in their careers will participate in a medical management and leadership course, typically of a few days duration. Significantly fewer will join a programme, scheme or fellowship to develop their leadership capabilities. Regardless of the exact mechanism of provision, before any individual junior doctor or associated organisation commissions a package of leadership development, they must have clarity on what it is they are seeking to achieve.

For an organisation, it is essential to clarify what the specific aims of any programme or scheme are. Is it to increase the standards of leadership on a system or organisation level, by developing a large cohort of junior doctors through a broad inclusive programme—for example, a scheme for all general practice trainees in a region? Or is it to develop a cohort of high-potential future medical leaders through a more targeted approach involving assessment of potential and competitive recruitment? Proponents of both approaches exist, but in our opinion, neither is 'wrong or right'; they simply address the different strategic challenges of improving the quality of medical leadership throughout the system as opposed to talent spotting and developing high-potential future system-level leaders. However, it is key to making a decision in the knowledge that the choice made will affect the methods that are possible and appropriate for leadership development to occur. For an individual junior doctor, issues of cost, time commitment and provider reputation are important, as are the true learning opportunities and sustainability of any development.

Once participants on any given programme, scheme or course have been confirmed, regardless of selection method, we advocate that each individual's learning needs is assessed. This allows those providing leadership development to tailor their approach, enhances the self-awareness of the participant, and can allow individuals to monitor their own progress. A range of diagnostic tools are available to help individuals to self-assess their leadership skills, and superiors, colleagues and reports can also be involved in any assessment by utilising a 360° appraisal mechanism. Individual participants can be encouraged to express their own personal aims and expectations and these can then be aligned alongside the sponsor organisation's strategy, culture and human resources management.<sup>17</sup>

Leadership schemes and courses definitely have a part to play in developing leadership skills in junior doctors. We believe them to be especially beneficial if the participating individual or team uses 'real-time' challenges facing them and/or their organisation as case study material to be explored within some of the sessions. Further gain is made when programmes are relatively lengthy in duration, allowing learning to be interspersed with periods of reflection, work experience, career progression and further challenges. However, this tends to increase the cost. Purchasing on an individual basis one of the plethora of two or three day courses available in the marketplace can be interesting and beneficial and can significantly improve the knowledge base

of participants with regard to healthcare systems, processes, structures and governance. However, this 'piecemeal' approach is likely to have a limited effect on leadership behaviour—particularly once back in the organisation—and minimal impact on large-scale service improvement.

The leadership-development methodologies listed below, while only a sample, are the most frequently used within leadership programmes.

### Mentoring

Mentoring has been defined as 'off-line help by one person to another in making significant transitions in knowledge, work and thinking'<sup>18</sup> and elsewhere as 'a form of human development where one person invests time, energy and personal know-how in helping another person grow and improve to become the best that he/she can become'.<sup>19</sup>

Mentoring can bring significant benefits to the mentee, the mentor and the organisations they work for, and these benefits have been reported for several decades in the management and business press.<sup>20–22</sup> Mentoring has been used in both private and, more recently, public sectors to support the development of people throughout their careers and ensure that organisations are developing future leaders. Most of the research into mentor–mentee relationships has examined the benefits of mentoring to the mentee, finding that mentoring is related to important career outcomes, such as job satisfaction,<sup>23 24</sup> and thus many corporate organisations have encouraged mentoring relationships between organisational members.<sup>25</sup> Less work has been done evaluating the beneficial effects for the mentor, and for the organisations supporting these relationships probably due in part to the complexity of assessing and defining both what is or is not a mentoring relationship and what may be appropriate outcomes.

The medical literature on mentoring remains relatively sparse, but anecdotally, mentoring within medicine has traditionally been an informal process, occurring spontaneously between junior doctors and their seniors. These uni-professional arrangements tend to be associated with a high level of satisfaction, as they are often based on mutual respect and admiration. However, increased clinical, research and administrative demands and the modernisation of medical career pathways have eroded somewhat the opportunities for these traditional mentoring–mentee relationships to be established,<sup>26</sup> and where they are, they are not without disadvantage; mentors are often inextricably linked to the appraisal, assessment and future prospects of the mentee, may have competing interests and agendas, and potentially impose their viewpoints on workplace issues and culture. Furthermore, traditional medical mentoring has tended to centre on clinical skill development—only a portion of the abilities desirable in a senior doctor—and has on occasions been inaccessible to minority groups, such as women or black and minority ethnic trainees. These factors mean that, if mentoring is to be used as a leadership developmental tool for doctors, we must be aware of its potential limitations and consider undertaking a more formalised process to establish mentor–mentee pairings.<sup>27</sup>

We have been in a mentee–mentor relationship for 2 years now, and have found it mutually beneficial, stimulating and rewarding. Subjects that we have frequently discussed in mentoring sessions are detailed in box 1. We strongly advocate that any aspiring medical leader should seek to establish a mentoring relationship to help personal and professional development. What form this might take and with whom is very much down to the individual concerned. One might opt to identify potential mentors through senior colleagues, formal

### Box 1 Potential topics for discussion between mentors and mentees

- ▶ Career aspirations and career planning over the short, medium and long term
- ▶ Management of difficulties within professional and personal relationships
- ▶ Delivery of previously agreed goals
- ▶ Project management and leadership challenges currently facing the mentee
- ▶ The impact and management of political factors in delivering healthcare
- ▶ Personal life issues and events

schemes or by approaching senior leaders in the organisations in which one works. The mentor may be of the same professional background or from a different one, but should have some experience in developing others and be truly interested in investing the time and energy required to mentor someone. Individuals attempting to create new mentoring relationships should not be disheartened if initial attempts do not meet with immediate success; establishing productive mentoring relationships is not easy and even schemes utilising formalised matching of mentors and mentees meet with variable success.<sup>28</sup>

In our experience, we have witnessed clear benefits in the mentoring of junior doctors by senior non-medical leaders (or where medical, now occupying a predominantly managerial role). It can be enlightening for both participants, providing a view into each other's world and bringing a very different perspective to issues. Furthermore, it allows truly 'off-line' support and advice; mentees are able to discuss fears, doubts or concerns regarding their career paths without fear of appearing uncommitted to their current route, something many participants have made clear cannot happen with supervising consultants or GP partners.<sup>29</sup> Finally, opportunities may be provided that otherwise would not be open to someone working at a more junior level, including attendance at meetings, advisory roles, invitations to address key audiences, and opportunities to influence the decision-making process.

Once a mentoring relationship is established, it is important to regularly consider the ongoing benefits of continuing to meet, the stage at which the relationship is at, and whether it remains useful for both involved. A 'no-fault' divorce clause set up at the start of any relationship is commendable as it facilitates a trouble free exit from the relationship at any point at which either party no longer feels willing or able to participate.

### Coaching

Coaching, especially for senior leaders, has been expanding over the last few years. Coaching is aimed at performance enhancement in a specific area—that is, it is goal orientated and thus tends to be a relatively short-term process. The goals are usually set in conjunction with the coach, and the coach has predominant ownership of the process. There is still insufficient research looking at what happens in the coaching process that can support leadership development, when it is successful, why it is successful in some settings, and what sort of leaders benefit most from coaching. Both of us have received coaching, and found it useful, although benefits vary according to professional circumstance and the relationship formed with the coach in question. Junior doctors have little opportunity to access this



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leadership development resource (which may in part be due to the significant cost per person involved), although more organisations are offering coaching for more senior doctors when appointed to new leadership roles, such as clinical or medical director. Coaching is also incorporated into certain UK schemes for junior doctors, such as NHS London's Darzi fellowships.<sup>30</sup>

### Action learning

Action learning is based on the notion that leadership knowledge, skills and attitudes can be developed through the joint problem solving of issues that arise in the work place, during real life projects, and by observing and working with others. Not only can learning occur, but the individual whose issues are being focused on can, by working through them in a safe, supportive and facilitated environment, gain valuable insight and reassurance and formulate plans to take the issues forward. Typically, an action learning 'set' consists of six to eight individuals with a common purpose or interest—be that their workplace, sponsor organisation or beliefs—accompanied by an experienced facilitator. Participants will request time slots to air the issue they feel they wish to work through and address, and then, through any mixture of open questions, appreciative enquiry, role play and alternative perspectives, seek to address it. The aim is not to give advice, as tempting as this can be at times, but to help and empower the individual in question to reach their own conclusions. Reflection by all involved can often help members of the group learn from others' problems and challenges, particularly where individuals are working on similar improvement or change projects within similar environments.

### Networking

Networking can play an important part in leadership development, and, when successful, networks may be sustained over a longer period than coaching or even mentoring. Networking is difficult to define but tends to involve the creation of interdependent, often mutually beneficial, relationships. It can occur formally—for example, by participating in national groups or being an active member of a society—or informally, by getting to know, interact with and then work with others who share a common purpose or interest in similar issues.

The impact of networking can be very powerful, but the creation of networks requires not only a significant conscious effort by the individual, but support and help from the organisation or group with whom they work. We have witnessed networking occurring in two distinct ways within the leadership-development schemes in which we have delivered or participated.

### Peer networking

Expressing an interest in leadership positions and developing one's leadership abilities can bring with it some risk. Nowhere has this been more true than in medical leadership, where claims of 'going over to the dark side', although diminishing, are still familiar refrains. This can lead to a sense of isolation. Establishing a network of like-minded individuals, who can support, encourage and provide opportunities for each other not only to learn and develop but also to take on new roles or leadership positions, can have pronounced effects, diminishing the sense of isolation and making individuals feel like they are part of a team or movement. Combining people's expertise and energy can result in achieving projects that would have previously felt unattainable to individual participants.

### Networking with senior leaders

Networking with senior leaders can provide opportunities to experience and witness interactions and events to which individuals

## Key learning points

- ▶ Medical leadership is vitally important to delivering high-quality care to patients.
- ▶ Medical leadership skills have traditionally been given less credence than technical or academic ability, though there are signs that this is changing.
- ▶ Doctors must develop a wide range of leadership knowledge, skills and behaviours during their training if they are to be effective practitioners and leaders within their organisations. Vitally this includes 'followership'.
- ▶ Courses, programmes and schemes can use a variety of methods to develop medical leaders, including mentoring, coaching, networking and action learning.
- ▶ Leadership training is most beneficial to individual and organisation if this development occurs alongside 'real-time' experiential learning, where trainees can experience the challenge of leading projects not intricately linked to their day-to-day clinical work.

## Key references

- ▶ The NHS National Leadership Council (<http://www.nhsleadership.org.uk/>), where you can access links to opportunities in different regions, the first annual report of the NLC, and more information on Clinical Leadership Fellowships.
- ▶ The NHS Institute for Innovation and Improvement (<http://www.institute.nhs.uk/>) and The Academy of Medical Royal Colleges (<http://www.aomrc.org.uk/>), where you can access the Enhancing Engagement in Medical Leadership project, Medical Leadership Competency Framework and the Medical Chief Executives in the NHS study.
- ▶ The Department of Health (<http://www.dh.gov.uk>) to access publications such as 'High Quality Care for All', the report of the Next Stage Review.
- ▶ **Clutterbuck D.** *Everyone Needs a Mentor—Fostering Talent in your Organisation*. Fourth edition. London: CIPD, 2004. An excellent text exploring the importance and types of mentoring used to develop people.
- ▶ **Sambunjak D, Straus SE, Marusic A.** Mentoring in academic medicine: a systematic review. *JAMA* 2006;**296**:1103–15. A thorough recording and evaluation of the available literature evaluating the impact of mentoring in academic medicine, from three authors who have published widely on the topic.

may not normally be privy. Senior leaders often provide a wide range of contacts, and thus further networks, and offer a more diverse range of perspectives, views and information. Networking and learning with them allows individuals to increase their own profile, that of their organisation and of their staff and colleagues. This may bring further opportunities to contribute and be involved in key decision-making. Furthermore, it is prudent for any future medical leader to establish a network of supporters and senior leaders around them, rather than rely on the patronage of a single mentor or senior sponsor for two reasons: firstly, relationships change, and over-reliance on any single individual can create dependency and subservience; secondly, for those who aspire to lead in different organisations and regions and at

different levels of healthcare (local, regional, national and international), it is unlikely that any single individual can provide the opportunities and experiences required to progress.

### Experiential learning

If real learning about leadership and the management of others is to occur, at least some of it should be experiential. Real challenge in the form of 'stretch assignments' can offer important developmental opportunities, requiring the individual to work outside their comfort zone and learn new skills to achieve the desired results. Experiential learning can take many forms, including entirely new jobs, secondments to other organisations, or part-time roles alongside ongoing clinical work. In the case of junior doctors, the newly formed Medical Leadership Fellowships, funded centrally but delivered by the Strategic Health Authorities, typically last 1 year and require participants to take an 'Out of Programme Experience' to work within trusts on quality improvement projects and service redesign. The Chief Medical Officer's Clinical Advisor Scheme, run from the Department of Health but involving other partner organisations including the WHO, BUPA and the National Patient Safety Agency, provide another opportunity for junior doctors to take time away from clinical work and experience some public health, medical management and patient safety challenges. However, not all stretch assignments require stepping out of clinical work; much can be learnt by balancing clinical work alongside contributing to other projects or working part time in another capacity.

### SUMMARY

Good medical leadership is becoming increasingly vital to the provision of high-quality healthcare. Leadership development should be an essential component of the education of all medical staff. Doctors must not only be strong academically and clinically but must begin early in their careers to develop a set of knowledge, skills and behaviours that will enable them to engage and lead in highly complex, rapidly changing environments. This will not occur by accident, but must be the responsibility of every individual doctor, the organisation they work in, and the system as a whole. Different leadership methodologies are available to do this, and each individual will find some more pertinent to them than others, but mentoring relationships, strong professional networks and experiential learning are all excellent ways for future medical leaders to start developing the requisite skills and experience.

### MULTIPLE-CHOICE QUESTIONS (TRUE (T)/FALSE (F); ANSWERS AFTER THE REFERENCES)

#### 1. The following organisations were responsible for the development of the Medical Leadership Competency Framework:

- British Medical Association
- British Association of Medical Managers
- The Academy of Medical Royal Colleges
- The National Association of Primary Care
- The NHS Institute for Innovation and Improvement

#### 2. The Medical Leadership Competency Framework:

- Describes a range of leadership competencies integral to medical practice
- Is predicated on the belief that all medical practitioners should be leading to improve the quality of healthcare
- Is now fully embedded in all postgraduate curricula
- Pertains only to the assessment and appraisal of junior doctors

- Contains five domains, all of which contain four further elements

#### 3. Mentoring:

- Is only really beneficial for the mentee
- In medicine is traditionally an informal process occurring between doctors in similar specialities
- When not formalised may be difficult for women and black and minority ethnic groups to access
- Is most effective when the mentor is directly responsible for the assessment, appraisal and career progression of the mentee
- Is thought to have little or no influence on career outcomes and job satisfaction in areas outside of medicine

#### 4. When developing leadership and management skills in doctors:

- Short courses away from the workplace may improve knowledge base but often do not allow enough time for reflection, work-based development and significant improvements in leadership skills
- Coaching is a relatively inexpensive option
- It is best that learning and development occur in isolation from other members of the healthcare team
- Action learning sets require experienced and sophisticated facilitation
- The individual or organisation commissioning a development package must be clear exactly what they are seeking to achieve in doing so

#### 5. Doctors interested in leadership and management:

- Should consider networking as a powerful way to access opportunities and to gain influence
- Need not network with senior colleagues if they have one significant sponsor or mentor
- May find peer-to-peer networking a valuable source of support and reassurance if lacking within their normal peer group or organisation
- Can acquire important skills by undertaking 'stretch assignments', fellowships and new role
- Can raise their profile by being embedded in both formal and informal networks

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## ANSWERS

1. A (F); B (F); C (T); D (F); E (T)
2. A (T); B (T); C (F); D (F); E (T)
3. A (F); B (T); C (T); D (F); E (F)
4. A (T); B (F); C (F); D (T); E (T)
5. A (T); B (F); C (T); D (T); E (T)



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