

Medical leadership in perioperative practice: I

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Key points

- Developing clinical leadership is increasingly important as management structures change to encourage greater clinical participation.
- There are many different models to describe leadership, used interchangeably to explain the skills required from a leader and the team.
- Modern leadership theories concentrate on team-working and communication rather than the character traits of those in charge.
- Teams work together to achieve shared objectives. Members have different roles and skills; their interaction determines the success of the team.
- There are many resources in the NHS for leadership development, many of which are free and easily accessible.

In the last 10 yr of UK healthcare planning, there has been a growing body of policy, strategy, and guidance that have raised the profile of clinical leadership. Alongside this progressive integration of clinicians into leadership and management structures, there are many new formal education programmes such as the NHS Leadership Academy programmes and associations

dedicated to developing this area of interest, such as the Faculty of Medical Leadership and Management.

The consultation paper 'High Quality Care for All', commissioned by the Prime Minister and written by Lord Darzi in 2003, drew a line under the 'managers as leaders' mindset that has directed NHS management structures since the Griffiths Report introduced the general manager role in 1983. The case presented for clinical leadership of healthcare services was compelling: stronger focus on quality care, ability to partner with patients and other professionals at the point of care, and the use of existing clinical team leadership skills within a management role.

In subsequent years, the Francis report, Berwick report, and other key publications have highlighted the need for strong clinical leadership in ensuring that future care is of an appropriately high level of quality and safety. The Health and Social Care Act, introduced by Andrew Lansley in 2012, laid the ground-works for the large structural changes that we have seen in UK healthcare over the last 18 months. One of its principal aims was a move towards clinically led commissioning, putting clinicians 'in charge of shaping services, enabling NHS funding to be spent more effectively'. This vision of involving clinical leaders in planning healthcare models and pathways to improve efficiency and clinical effectiveness has been echoed in subsequent key reports, most recently by the current Chief Executive of NHS England in his 'Five year forward view'.

This article will explore the principals and models behind clinical leadership, critically analyse whether medical leadership improves healthcare delivery, and evaluate the educational and support resources available.

Leadership vs management

Both leadership and management are needed to administer and develop health services. Leadership roles that have a significant administrative burden can distract from important leadership functions and make leadership roles unappealing. The terms are often used interchangeably, but require different skills and focus as seen in Table 1.

Models and theories behind clinical leadership

The term leadership has proved difficult to define, with a myriad of definitions and theories being born over the last six decades. A useful definition by Stodgill in the 1950s states that ‘leadership may be considered as the process of influencing the activities of an organized group in its efforts towards goal setting and goal achievement’. This describes the process between a leader, and those being influenced, it does not, however, describe the individual behind the leadership. Peter Drucker, who researched and published widely on the subject of leadership for more than 50 yr, describes it more succinctly as ‘the only definition of a leader is someone who has followers’.

In 2010, Hartley and Benington¹ described three perspectives on leadership. Each perspective placing an emphasis upon a different leadership variable:

- (i) the personal qualities of the leader,
- (ii) the leadership position in the organization,
- (iii) the social processes of leadership.

Personal qualities

There has been much written regarding the personal characteristics of those who lead. The Great Man theory as populated by Thomas Carlyle in the 1940s was based upon the assessment of military men, and it assumed that great leaders are born, and not made. The following two decades expanded on this theory by attempting to describe the attributes and behaviours that led a person to successful leadership; namely exhibiting qualities such as self-confidence, self-awareness, and resilience.² This model is

conceptually easy, and has been studied for the longest time of any leadership model. However, despite many attempts, it has not been possible to isolate a defined list of leadership traits related to outcomes. A fixed set of traits does not take into account different requirements depending on the situation, and furthermore is incorrect in the implication that leadership training will be of no benefit.

Research by the consulting firm Hay, sampling 3871 executives worldwide, found that leaders can exhibit up to six distinct leadership styles, seen in Table 2. Goleman³ describes these styles in more detail and explains that although each leader will have their own innate style, in order to be effective, one must also be flexible in using their less dominant styles.

The skills involved in leading a team may exhibit ‘role diversity’ depending on whether the leader is ‘near’ or ‘far’ from the team (Fig. 1). For example, a clinical director may need to be approachable, show empathy, and engage with teams, while a CEO of a large organization needs to be charismatic and visionary. This has implications for an individual’s progression, where a skillset may flourish in one role but be inadequate for higher roles.

Leadership position

Leadership can be described as having a position or role that commands authority. For example, a clinical consultant or chief executive has formal authority and therefore the legitimacy to lead others. However, exerting authority is not the same as leadership. There are many examples of ineffective leadership by those in authority, just as there are many examples of leadership that take place outside of formal roles.

Authors have described the differences in leadership between those with and without authority. Mountford and Webb⁴ argue that although the most obvious leaders within an organization may be those that hold formal positions of authority, those without formal authority are just as able to take ownership of a problem and drive through change.

In the NHS, clinical staff are in a unique position to take on an informal leadership role as their close proximity to patients

Table 1 Summary of differences between management and leadership

Management	Leadership
Managing processes or stable tasks, e.g. writing the rota	Managing people through changes, e.g. providing a safe service with reduced resources and increased demand
Short-term focus	Long-term focus
Target setting	Vision setting
‘Tame’ problems (problems with solutions readily apparent)	‘Wicked’ problems (problems that have complex solutions or perhaps no solution at all)
Doing things right	Doing the right thing

Table 2 Summary of key characteristics of different leadership styles. Adapted from Goleman³

Leadership style	Ambition	Example phrase
Directive	Immediate compliance	‘Do it the way I tell you’
Pacesetter	Accomplishing tasks to high standards	‘This is the way to do it’
Visionary	Providing direction and vision	‘This is where we are going, and why’
Coaching	Professional development of employees	‘Here is an opportunity to practice’
Participative	Building commitment and generating new ideas	‘What do you think’
Affiliative	Creating harmony	‘It’s important we all get on’

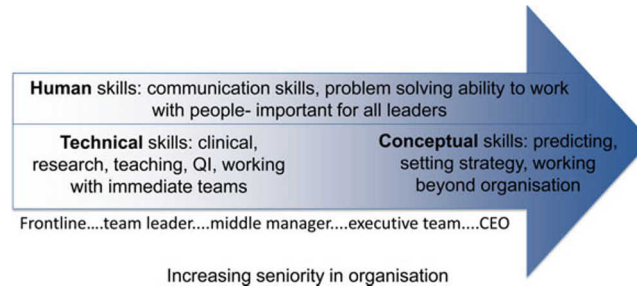


Fig 1 Importance of skill diversity in leadership roles depending on position. Adapted from Mumford (2000).

allows them to understand frontline realities and opportunities for improvement. However, their lack of formal role can often prevent them from being able to tackle the problems they face. Those without authority can exert leadership, but they need to tackle issues through influencing others, rather than direct control.

Leadership as a social process

A popular perspective of leadership in healthcare is as a complex and adaptable relationship between people in a group, where leadership by one person is not permanently possessed and where there is the potential for a shift of leadership, governed by both formal and informal influences. This view considers the relationship between ‘leaders’ and ‘followers’ and highlights how ‘followers’ may shape the kind of approaches that leaders use.

Viewing leadership as a ‘social process’ allows a better understanding of the importance of democratic or distributed leadership in healthcare. ‘Distributed leadership’ is described by Grint,⁵ as being the collective responsibility of lots of individuals, each with their own unique skills. For distributed leadership to work, there is also a requirement for ‘collective flexibility’ where individuals undertake leadership, but only as, and when, necessary, that is, they must know when to lead, and when to follow. This description is familiar to all working in theatre, trauma, or resuscitation teams, where leadership of the group may change hands depending on the skills available and the evolving situation.

Organizations that develop collective leadership and capability are more successful than those who focus on developing individual capability. This includes evidence of better financial outcomes in commercial organizations, and clinical and financial outcomes in healthcare for organizations that utilize distributed leadership models. Leadership should be distributed to ‘wherever expertise, capability and motivation sit within an organisation and that all staff must take responsibility for striving for excellence in providing safe, compassionate care’.⁶

Leadership as a social process in the NHS

The national improvement body ‘NHS Improving Quality’ has built on ‘social movement’ theory, in improvement projects like NHS Change Day (<http://www.changeday.nhs.uk>) and Sign up to Safety (<http://www.england.nhs.uk/signuptosafety>). Social movement theories developed from the observations of large-scale changes seen in mass action like the American civil rights movement. These involve

collective action by individuals, in groups that may have shifting and ill-defined leadership, but result in sustained change on a scale that is difficult to achieve with traditional ‘top down’ change projects. The leadership required to direct such a movement is distributed among the group, and is a ‘shared social process’. Leaders must be connected to many people, able to communicate well across traditional boundaries, and be able to take information and share it with many.⁷ In the case of NHS Change Day, social media communication encouraged more than 280 000 pledges of improvement actions.

The evidence for clinical leadership

As the UK healthcare model becomes more complex, good patient outcomes are no longer just dependent upon excellent clinical management at the individual clinician–patient level. There are now tiers of supporting processes, microsystems, and organizations that can determine the provision of good quality care, and clinicians can provide leadership throughout these tiers.

Permeating these different levels affords clinicians multiple benefits. At the strategic level, they can keep the focus on funding and delivering strategies that are responsive to the patients’ needs. At the service level, clinicians can influence and design processes to provide better organizational performance. Where clinicians and patients interact, clinical leaders play a role as role models in providing good quality care.

There are ample case studies of successful organizations using strong clinical leadership to improve the quality of care. Kaiser Permanente, Virginia Mason, and Intermountain Healthcare in the USA, Jönköping County in Sweden, Canterbury District in New Zealand, and Salford Royal Hospital in the UK have all instigated clinical leadership and improvement training, and clinically lead management and leadership infrastructures to successfully improve care, often on a large scale and with impressive and sustained results.⁸

In a McKinsey consulting survey of 1200 hospitals in 2011, those with a higher proportion of clinically trained managers had better management practices, and these better practices correlated to a number of clinical outcomes, including mortality, re-admission, and infection rates. In 2011, a cross-sectional study in America showed a positive association between having a medically trained chief executive and top ranking quality scores in a number of specialities. This association was replicated in the UK, where a study in 2012 examined hospital performance data and showed that higher clinical representation on the hospital board correlated with better performance, patient satisfaction, and mortality.

The motivation of clinical leaders

Max Weber described four main ‘motivations’ that drive social change; a recent health-worker-oriented adaptation of these original motivations⁹ describes the motivation of medical leaders.

- (i) ‘Shared purpose’: This may act as an extrinsic motivator, inspiring clinicians to take up leadership roles to help further an aim they strongly believe in.
- (ii) ‘Self-interest’: Career progression and job security may act as both intrinsic and extrinsic motivators to encourage clinicians to assume leadership roles.
- (iii) ‘Respect’: The desire to seek professional credibility or personal approval may act as an intrinsic motivator, encouraging clinicians to pursue leadership positions.
- (iv) ‘Tradition’: Pressures to uphold appropriately professional practice (e.g. membership of professional bodies) may be a powerful extrinsic and intrinsic motivator for clinicians to take leadership roles to ensure appropriate standards are being met.

Barriers to clinical leadership

Despite the wealth of evidence suggesting that clinical leadership is important for the provision of safe, clinically effective care, many clinicians are ambivalent about taking on a formal leadership role.

These barriers are particularly important when considering the failing or struggling organization, where the inverse leadership law dictates that those organizations in most need, will find it even harder to recruit attractive candidates (Table 3).

The importance of teamwork

Leadership can only exist in combination with followership, and so it is important to outline some of the theories behind what constitutes a successful team.

Table 3 Barriers to leadership. Adapted from leadership vacancies in the NHS (The Kings Fund)¹⁰

Barrier	Explanation
Professional risk	Clinical leaders can feel more exposed as they hold clinical accountabilities, e.g. Caldicott Guardian and responsibility for care provided by the whole clinical workforce. Clinical leaders can lose their clinical registration if serious failings occur and the job security of leadership roles is significantly less than clinical roles—the average trust CEO tenure is 700 days
Lack of training	The lack of formal training in unfamiliar subjects such as finance, lack of mentorship, and talent management stops talented leaders from applying for senior clinical positions
Clinical conflict	Clinical leaders face dilemmas regarding committing themselves to more non-clinical work, deskilling, and ‘losing face’ among their clinical counterparts
Personal and financial disincentives	Clinical leaders can find themselves juggling both clinical and non-clinical duties with worsening work-life balance and less financial incentives compared with their clinical colleagues

Effective teams are generally made up of groups of individuals with differing skills that come together for a period of time to work towards a common goal or goals. Within the team, individuals will have defined roles and will share accountability for the collective work of the team and its respective outcomes.

This is an idealized model, and does not represent many of the teams seen in clinical practice. It is commonly understood that most teams will not work effectively from the start and that they need to grow, evolve, and learn together. The move from a working group to a real team¹¹ constitutes evolving from a state in which decisions are made solely by the team leader without discussion, to a more democratic position whereby the leader guides discussion and the team feel empowered and consequently able to accept accountability for outcomes.

Roles within teams

Belbin¹² characterizes nine roles that individuals within teams can play (Table 4). These roles are linked to ‘individuals behavioural strengths and weaknesses in the workplace’ (www.belbin.com). Determining what role you would innately tend towards can be useful in understanding how you may behave within

Table 4 Summary of Belbin team roles. Adapted from the Belbin website, www.belbin.com

Role	Description of role
Shaper	<i>Pushes the team to focus and improve</i>
Implementer	<i>Plans practical, workable strategies to achieve goals</i>
Completer finisher	<i>Finishes, scrutinizes, and quality controls team’s work</i>
Co-ordinator	<i>Focuses the team’s work around their objectives</i>
Team worker	<i>Helps the team to get together</i>
Resource investigator	<i>Considers external application of team’s ideas and work</i>
Plant	<i>The creative problem solver in the team</i>
Monitor-evaluator	<i>Helps weigh up team’s options</i>
Specialist	<i>Team’s specialized knowledge input</i>

Table 5 The five dysfunctions of a team. Adapted from Lencioni (2003)

Dysfunction	Leaders role in diminishing the dysfunction
1. Absence of trust	Building an environment that does not punish vulnerability while also demonstrating their own vulnerability to promote trust
2. Fear of conflict	Recognizing conflict can be productive and exercising restraint in monitoring conflict, ultimately allowing it to resolve naturally
3. Lack of commitment	Pushing the team for closure and adherence to schedules but also displaying confidence in making decisions that may ultimately be wrong
4. Avoidance of accountability	Creating a culture of accountability but being willing to enforce discipline if necessary
5. Inattention to results	Demonstrating and maintaining a commitment to results

teams. In particular, Belbin highlights the importance of a balance or spread of roles within teams.

Dysfunctional teams

In ‘The trouble with Teamwork’,¹³ Lencioni explores some of the common problems encountered by teams. He focuses on what he sees as the five dysfunctions of teams and what the role of the leader should be in helping to diminish these dysfunctions (Table 5).

Developing clinical leadership

A variety of leadership frameworks exist to support leadership development in the NHS. In 2008, the NHS Institute of Innovation and the Academy of Medical Royal Colleges produced the Medical Leadership Competency Framework, intended to define which aspects of leadership should be covered in medical learning and curricula. It describes competencies that can be achieved in undergraduate and postgraduate training, and during continuing practice, focusing on ‘delivering the service’ as the key goal of medical leadership (Fig. 2).

The NHS Leadership Academy has updated this work with their Healthcare Leadership Model published in 2013 (Fig. 3). Rather than competencies, this focuses on leadership behaviours and their impact on others, and so more accurately reflects current thinking about leadership focusing on interpersonal skills. It is aimed at all healthcare workers and for those in any position, not only formal leadership roles.

Both the framework and model were based on a review of existing healthcare leadership research, consultations with key organizations, and focus groups and structured interviews within the NHS.

There is a range of resources available from newly formed and existing bodies to those who wish to learn more about leadership in theoretical and practical roles (Table 6).



Fig 2 The Medical Leadership Competency Framework—©NHS Leadership Academy and Academy of Medical Royal Colleges, 2010. All rights reserved.

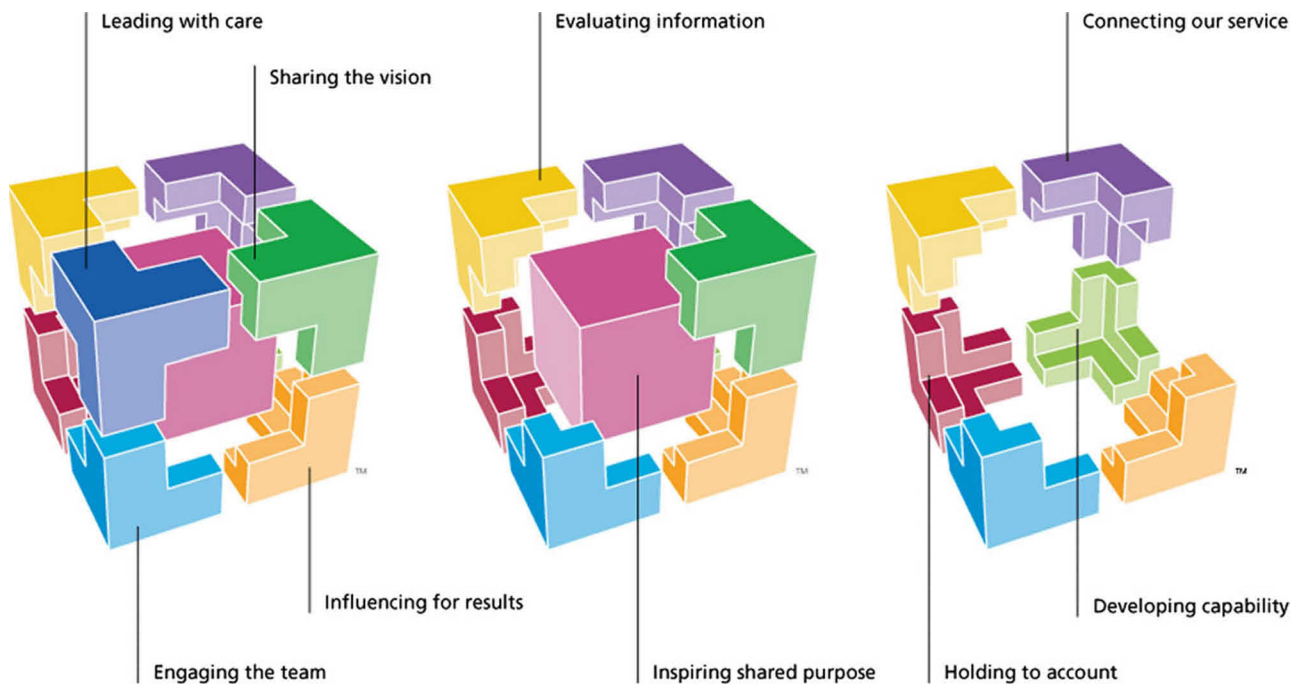


Fig 3 The NHS Leadership Academy Healthcare leadership model. ©NHS Leadership Academy, 2014. All rights reserved.

Table 6 Sources of information or training on medical leadership

The Institute for Healthcare Improvement: www.ihl.org	An independent not-for-profit organization in the US that works to improve quality care for patients using a variety of improvement tools. The IHI Open School has open access, free improvement, and leadership online teaching courses
NHS Leadership Academy: www.leadershipacademy.nhs.uk	Hosted by NHS England, NHS LA runs tiered leadership training and online resources that are free to NHS staff, alongside local delivery partners that promote leadership training in regions
NHS Improving Quality: www.nhsiq.nhs.uk	NHS England's national improvement body created from the NHS Institute of Innovation. Their remit is to provide improvement and change expertise
Academi Wales: http://www.academiwales.org.uk	All public sector leadership and resources in Wales are held under the umbrella of Academi Wales, run by the Welsh Government. They provide online and face-to-face courses and learning resources
NHS Scotland National Leadership Unit: http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/leadership-and-management	Leadership resources for clinicians and managers in Scotland. Running development programmes, encouraging network formation and cross-sector working
The Health Foundation: www.health.org.uk	An independent charity promoting safety and quality improvement work. It runs several fellowship schemes and provides funding for safety research and improvement projects
The Kings Fund: www.kingsfund.org.uk	An independent charity and think tank which runs leadership development courses and producing commentaries and policy guidance based on healthcare research
The Faculty of Medical Leadership and Management (FMLM): www.fmlm.ac.uk	Constituted by the AoMRC, this is a membership organization requiring a subscription that allows access to conferences, coaching, and networking. Membership spans a diverse cohort, from medical students to chief executives of hospital trusts. It also administers the national clinical advisors scheme for trainee doctors

opportunities in local and national programmes to develop these skills, and there is ample evidence for an improved quality of care in organizations which encourage training and development of clinical leaders.

Declaration of interest

None declared.

MCQs

The associated MCQs (to support CME/CPD activity) can be accessed at <https://access.oxfordjournals.org> by subscribers to *BJA Education*.

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