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An introduction to medical leadership and engagement: A perspective on this text

1.1 INTRODUCTION

The importance of medical leadership and engagement has become ever more evident and critical since the first edition of this book was published in 2011. This has been confirmed not only by various political and organisational initiatives but also by the increasing research and papers on the topic. There are now significantly greater national and international literature and a plethora of papers outlining different initiatives and perspectives. This has largely happened as part of a wider (and perhaps belated) recognition that health systems faced with increasing public scrutiny through a very strict regulatory approach and fiscal constraint needed to move from a heroic leadership approach based around performance targets to one where leaders are responsible for creating cultures that encourage a stronger collaborative or collective approach where all staff, but particularly doctors, act as if shareholders in the system and organisation.

As Dickinson et al. (2015) comment, 'medical engagement is a topic that has started to receive significant international attention over the last twenty years and is thought to be a helpful mechanism through which health systems can drive the efficiency of health organisations, patient experience and clinical outcomes'.

We should stress at the outset that this is a book about medical leadership and engagement. Too often, commentators use the term 'clinical leadership' when clearly meaning 'medical leadership'. We make no apology for focusing on doctors; other texts usefully cover the wider range of roles that clinical professionals play in health systems. Much of the content of policy directions and statements prefer to use the term 'clinical leadership' when all subsequent text is focused on doctors. They are, de facto, the major decision-makers regarding the use of resources. This is not to detract from the key role other clinical professionals and non-clinical managers and leaders play. Another facet of this uni-professional

approach is that there has traditionally been much greater difficulty getting doctors interested in management and leadership roles. They have many other alternatives—research and education, college roles, not to mention private practice. Often, a drop in salary is involved in undertaking leadership roles. These issues do not apply to other clinical groups, where there is generally a financial incentive to undertake leadership roles and many, particularly from nursing backgrounds, readily move into these other roles. Delivery of healthcare is a team activity, with all members having a major contribution to make to improve health and the way in which services are delivered. Much of what we have to say about doctors being more involved in management, leadership and transformation can be applied to other clinical professions, but this is not the remit of this particular book. Medical leadership is a particular focus within the National Health Service (NHS) currently and indeed many other countries and, we anticipate, for the foreseeable future.

The last five years has also seen growing evidence both within the NHS and internationally that organisations with high levels of what might loosely be termed 'human resource features', for example, team working, staff (and particularly medical) engagement, clinical leadership, values-based approaches to recruitment, induction, appraisal, revalidation and training and development, coupled with a strong focus on quality improvement, delivering better clinical outcomes, higher quality of care and financial performance. Much of this evidence has been around for many years. The public exposure of many hospitals and general practices delivering poor care has served to bring politicians and policy-makers to recognise that leaders need to focus on culture as the means to achieve improvement.

There is widespread international advocacy of increasing the involvement and participation of doctors in the leadership of healthcare organisations (Darzi, 2008, in the United Kingdom; Falcone and Satiani, 2008, in the United States; and Dwyer, 2010a, 2010b; Health Workforce Australia, 2011, in Australia; Lega and Sartirana, 2015, in Italy). These are specific examples, but the viewpoint is quite widespread, and many other references will be offered throughout the book.

In the United Kingdom, most hospital chief executives are non-physicians, whilst in the United States, out of 6500 hospitals, only 235 are led by physicians (Gundesman and Kanter, 2009). Goodall (2011) reported on a study in the United States that there was a strong positive association between ranked quality of a hospital and whether the chief executive officer (CEO) is a physician. One UK newspaper even provided a headline stating that 'Doctors are the best hospital managers, study reveals'. This study is probably the first analysis of its kind, and further studies need to be undertaken to ascertain whether this association attains in the NHS. It is our contention that this is unlikely given the very small number of medically qualified chief executives, the constant churn in these roles and the greater political involvement in the way organisations in healthcare can operate. More importantly, other studies, including those by Spurgeon, support the growing view that there is also a strong association between the extent of medical engagement and clinical and organisational performance in the NHS,

and this is also being seen in Australian hospitals, that is, that securing the sustained engagement of a large number of doctors is critical to high performance, irrespective of the professional background of the CEO. Veronsi et al. (2013) also found that UK trusts with a higher proportion of doctors on the board performed better.

Whilst our original motivation for the book was partly inspired by Lord Darzi's review of the health system culminating in the publication of *High Quality for All* in 2008, our enthusiasm to revise the first edition has been triggered by the increased energy for the medical leadership and engagement movement over the past five years. Policy analysts in the future may well see his strong messages about the importance of getting clinicians, and particularly doctors, more engaged in leading service improvement as a defining moment in the way in which health services are organised and led. However, in many ways, the impetus given only served to reinforce a movement that had started some 20 or more years earlier. Doctors have been involved in the running of health services, locally, nationally and internationally, since the pioneers who initiated and organised health services many centuries ago. What is new is the emerging evidence of the relationship between the extent to which doctors are engaged in the planning, prioritization and shaping of services and the wider performance of the organisation. Engagement is more than doing what the organisation wants doctors to do; it is doctors taking a leadership role in the doing.

Whilst initially increasing medical leadership and engagement made sense and was the subject of a number of past reports and initiatives, the evidence of its value is now being realised through different studies that we explore in this revised edition. It is also evident that poor clinical outcomes, patient experiences and quality of care are very much the result of poor cultures with a lack of effective engagement by clinicians in decision making and improvement.

The *Francis Report into the Mid Staffordshire Hospitals* (2013) and others related to disturbing clinical performance over the past few years have all highlighted the consequences of organisations with cultures that fail to focus on genuinely patient-orientated care. Leadership style is inevitably context based and the movement towards greater medical leadership and engagement is partly a construct of health policymakers recognising that whilst relevant performance targets have a place, they cannot be achieved and sustained without greater local ownership by clinical professionals.

The role of general practitioners (GPs) as local leaders in prioritising and commissioning services has also gained considerable momentum since the first edition. As the first edition was being published, the coalition government was establishing Clinical Commissioning Groups (CCGs) in England as part of the Health and Social Care Act 2012. Whilst GPs have had increasing influence across local health systems since the establishment of GP Fundholding in the 1990s and subsequently through Primary Care Groups and Trusts, the last few years have seen this accelerated through CCGs and emerging General Practice Federations and similar bodies.

GPs now control around 80% of health expenditure through the CCGs in England. As Douglas (2015) contends, 'these are major management roles requiring considerable expertise in management, leadership and finance, yet many of these groups have had little or no training with these vital tasks. They bring intelligence, clinical nous and goodwill to CCGs, but managing huge and limited budgets effectively needs special skills and ways need to be found to ensure all CCG members have the training and development that allows them to develop these skills'.

This edition, therefore includes a new chapter on primary care leadership, but throughout the book, we stress the need for system-wide clinical leadership and engagement. We highlight how high-performing health organisations are typified by not only high levels of internal medical engagement but also by taking a more integrated and system-wide approach based on what is best for their communities and patients and not what might be best from any individual part of the system. It is perhaps interesting to note that plans for any reconfiguration of acute hospital services 20 or more years ago might have had a token GP amongst a large number of hospital specialists on any review group. Now, GPs are very much at the helm of such reviews, seeking to secure more cost-effective and safer networks of acute services across a population.

The recognition of the growing pressure of those with chronic conditions only serves to reinforce the urgency for a stronger focus on system leadership with clinicians driving new pathways and approaches to care. We will explore this in more detail as the desire for greater medical leadership and engagement is not an isolated strategy but part of a new leadership and cultural approach that enables sustained improvements to be made to the delivery of care.

1.2 STRUCTURE OF THIS REVISED EDITION

In this revised edition, we have reduced the historical coverage of health reforms. This is not to say it is unimportant, but more of a reflection that the past five years have created a new policy context and organisational landscape for the NHS. Many of the policy initiatives are complex and interactive. They require detailed analysis, often being adopted or modified according to changing governmental priorities. This is not a text based upon policy analysis. Rather our contention is that almost any policy may founder if there is a failure to engage and obtain the support and commitment of the medical profession—a key and fundamental component of the delivery system. Understanding the current challenges requires some appreciation of past managerial, organisational and professional contexts, but the present paradigm of commissioning, targets, inspection, individual and organisational regulation, accountability and mixed economy within a harsh fiscal environment has particularly highlighted the importance of collective leadership and medical engagement. The NHS is not alone in having to face ever-increasing demands from an ageing population and higher expectations fuelled by the almost daily availability of new technologies. Most developed countries face similar challenges to the United Kingdom and all are seeking

new ways of engaging doctors as one means of ensuring value. Lee and Cosgrove (2014, p. 105), writing from a mainly American perspective, sum this up well in stating that 'despite wondrous advances in medicine and technology, health care regularly fails at the fundamental job of any business: to reliably deliver what its customers need. In the face of ever-increasing complexity, the hard work and best intentions of individual physicians can no longer guarantee efficient, high quality care. Fixing health care will require a radical transformation, moving from a system organised around individual physicians to a team-based approach based on patients. Doctors, of course, must be central players in the transformation. Any ambitious strategy that they do not embrace is doomed'. The authors share this view and see some exciting organisational and system transformations both in the United Kingdom and internationally, where this philosophy has led to high performance. Alas, despite the strong evidence, too many health organisations and systems are still failing to recognise the importance of medical leadership and engagement, and poor patient care and fiscal performance are the consequences. Effective medical leadership and engagement can no longer be an optional extra but are fundamental elements of every health body and system. It is hoped that this book will contribute to the movement of medical leadership and engagement and will help policymakers, practitioners and consumers do more to make it an integral and sustained part of every health body and not just the exemplars.

We have combined the previous chapters on health system reform and a historical perspective on medical leadership into one as the medical leadership and engagement movement over the past 60 years is so entwined with successive health reforms. So, in Chapter 2, we explore the historical journey of medical leadership as responses to different reform initiatives. However, we have significantly reduced the coverage from the early decades of the NHS as the last five years have seen more significant changes and initiatives around the role of the doctor both from policy-makers and the medical profession. In the authors' leadership development activities with doctors, it is evident that many do not appreciate the extent to which the past split between general management control with a few doctors in 'leadership' roles to represent their colleagues' impacts on the current arrangements. Today's arrangements are the next stage in a journey that started from a major domination by the medical profession preceding the setting up of the NHS in 1948 through a period of disenfranchisement thereafter until perhaps the first main reorganisation of the NHS in 1974. We contend that by this time, some doctors, generally reluctantly, accepted representative roles. The Cogwheel Reports between 1967 and 1974 have had a significant impact on the way in which hospital services have been organised, that is, around specialties ever since. The Reports also started the process whereby doctors initially took on representative roles for their specialty Cogwheel Division and then assumed executive responsibility for their specialty business unit and the concept of Service Line Management increasingly being introduced into hospital Trusts in England. This historical context is important and has shaped attitudes and perspectives. However, we believe the movement towards medical leadership has

reached a stage of maturity and acceptance that suggests more is to be learned (and gained) from focusing on current challenges.

This shift from representation to accountability was reinforced by the Griffiths Report published in 1983 and further endorsed by the DHSS Resource Management Initiative in 1986 and the establishment of Clinical Directorates. The Griffiths view back in the early 1980s has continued to be stressed since then, and although new models and structures have been developed, the fundamental principle of encouraging some doctors to take on positional medical leadership positions and being accountable for clinical and business activity has been accentuated only over the past two decades. Put simply, Griffiths and later commentators could not see how a service, department or organisation could be managed effectively unless it was managed by those who commit resources.

In Chapter 3, we draw on more recent research on the historical perceived gap, or sometimes chasm, as evidenced by Mid Staffordshire Hospitals between clinicians and managers. We explore some of the factors that potentially exaggerate "the divide" but also highlight some of the ways in which high-performing health organisations nationally and internationally value the contribution of both and create leadership and management approaches and structures that are based on partnerships of mutual respect.

We also explore how the medical profession itself has changed over the same period as policy and organisational arrangements have altered. Whereas management and leadership were frequently dismissed by doctors in derogatory terms in previous eras, the medical profession is now very positively espousing the importance of doctors assuming leadership roles at all levels of training and careers and stressing their importance as being part of being a good doctor. This view is endorsed by Bohmer (2012), who argues that while individual doctor excellence is necessary, it is no longer sufficient to generate good patient outcomes. He highlights the way in which processes and micro-systems are largely controlled by practising physicians and hence the importance of their leadership skills and behaviours being exerted to improve overall health system performance.

We explore in more detail why many of the initiatives introduced over the past 65 years or so have perhaps only been partially successful. We suggest that both managers and doctors represent two very powerful groups. Unlike many other countries, the United Kingdom has experienced a very strong managerialist culture, particularly over the past 30 years, which has often led to conflict between clinicians and managers.

Trying to achieve some congruence between the individualistic nature of clinical practice and professionalism and the managers' broader population and organisational perspective is an inevitable area of potential conflict and tension. The exercise of clinical autonomy is a crucial part of the application of knowledge acquired by doctors through their medical training. As Oni (1995) suggests, at worst, some doctors will view managers as 'agents of government to control the expert power of the professional'.

In this chapter, we explore the perspective offered by organisational theorists such as Henry Mintzberg who characterise healthcare organisations as

professional rather than machine (for example, government agencies) bureaucracies (Mintzberg, 1979). One of the characteristics of professional bureaucracies is that front-line staff have a large measure of control over the content of work by virtue of their training and specialist knowledge. Consequentially, hierarchical directives issued by those nominally in control have limited impact and indeed may be resisted by front-line staff. Leaders of health organisations who do not recognise and respect this perspective are unlikely to create organisations where doctors would want to be more engaged. As Ham (2012), writing in the *British Medical Journal*, summarises, 'my view…is that any leader…of any professional bureaucracy…can only succeed if they have a really strong diagnosis of how these organisations tick, where does the power and influence lie to do good or to do ill, and how do you harness that power in pursuit of the corporate good'.

The doctor–manager conflict is perhaps a stereotyped portrayal often reinforced by media coverage, including television dramas that delight in exaggerating the gap between the clinicians' desire to provide the highest quality and quantity of care unfettered by resource constraints against the managers' need to control expenditure within allocated budgets and other constraints. The demands have been accentuated in recent years by the increased pressure on managers to meet government and regulatory bodies' performance targets. It is perhaps this 'battle-zone' of the performance management philosophy inherent in the concept of managerialism that creates the real challenge for health leaders. Seeking to get some shared and balanced understandings between the individual doctor's desire to deliver high-quality care to every patient and the managers' need to deliver political and organisational imperatives has been a long-standing challenge. As we explore in later chapters, the more this potential chasm can be minimised, the more likely local communities will benefit from high-quality and efficient services. It is not an impossible dream, but understanding the different motivations and perspectives is perhaps the critical issue. Various reports where this chasm has led to disastrous consequences for patients have consistently confirmed this dysfunctionality. There can be no greater incentive or argument for seeking to reduce the divide and, as we will highlight, where there is shared respect and partnership working patients, communities, staff and the taxpayer all benefitting.

It is, as Barnett et al. (2004) contend, a need for a 'convergence of cultures' and not a contest between any perceived or real emphasised differences. Finding common ground is the challenge. Who could deny that this is around service improvement and patient safety? Throughout this book, we shall keep coming back to this need for alignment of values and aspirations.

In Chapter 4, we provide a brief chronology of different roles and models of leadership but particularly offer contemporary thinking and research into the importance of collective and system-wide leadership. We highlight how the best-performing health organisations are typified by collective leadership. We also appreciate the size of the challenge to those organisations that are still typified by heroic leadership and lack of medical and indeed staff engagement often not helped by a regulatory process that often appears to be short-term target-focused

rather than supporting long-term sustained cultural change that motivates doctors and indeed all staff to be more involved.

The authors have spent over two decades being involved with the leadership development of doctors and associated research. However, much of the thinking behind this book emanates from leading a joint project between the Academy of Medical Royal Colleges and the now demised NHS Institute for Innovation and Improvement entitled 'Enhancing Engagement in Medical Leadership'. This project ran from 2006 to 2011. One key output was the development of a Medical Leadership Competency Framework (MLCF), which was first published in 2008 and has subsequently been refined and also adopted by all other clinical professional bodies as a Clinical Leadership Competency Framework (CLCF). It describes 'the leadership competences doctors need to become more actively involved in the planning, delivery and transformation of health services as a normal part of their role as doctors' (NHS Institute for Innovation and Improvement, Academy of Medical Royal Colleges, 2010, p. 6). The MLCF and CLCF subsequently formed the basis of an NHS Leadership Framework. Whilst the NHS Leadership Academy (2013) developed a Healthcare Leadership Model aimed at all those who work in health and care to become better leaders, the medical profession continues to generally adopt the MLCF as the basis for undergraduate and postgraduate medical education curricula and standards. The Faculty of Medical Leadership and Management (FMLM), which was conceived from the Enhancing Engagement in Medical Leadership Project in 2011, published a set of leadership and management standards for medical professionals in 2015 (Faculty of Medical Leadership and Management, 2015). The standards are linked to appraisal and revalidation of medical leaders. This important area of appraisal and revalidation is explored further in Chapter 8. In this regard, medicine has become the only profession to have addressed the recommendation in the Francis Report (2013) that healthcare leadership should become a profession. In Chapter 5, we explore this new framework and also review some other international models as well as provide a more detailed review of the MLCF.

In Chapter 6, we explore some of the best practice around medical leadership and engagement. An increasing number of reviews and empirical studies are underpinning the vital importance of medical engagement to organisational performance.

It is perhaps a reflection of how much more effective medical leadership and engagement has become in the NHS that in the first edition, we focused on some of the exemplars in the United States. There is no doubt that these have positively influenced many NHS organisations, but there are now many great examples in the United Kingdom and indeed other countries. There is still much to be learnt from other international examples, but now other countries are also looking at some of the best models in the NHS as well as some of the other initiatives implemented, for example, MLCF, that apply to all medical students and doctors at all levels and the growing research evidence of the strong association between medical engagement and clinical outcomes, quality and organisational performance.

We devote a new chapter to primary care medical leadership and engagement in this edition. This should be no surprise given the changing architecture of the NHS and the importance of strong leadership and engagement by primary care physicians. Chapter 7 describes the dramatic changes in the power and influence of GPs over the past 25 years. Prior to the introduction of GP Fundholding around 1990, any reviews on the provision of acute hospitals across part of a region would have had a token GP around a table of hospital executives. How this has changed with GPs through initially Primary Care Groups and Trusts and more recently CCGs having major roles in commissioning services and leading changes in the way in which health and social care is organised and delivered.

In Chapter 8, we explore the background of revalidation and how it has given a much stronger focus on the value of appraisal. It is not surprising that those hospitals or services that have high levels of medical engagement also see genuine appraisal as a key activity. Doctors are being more heavily scrutinised than perhaps any other profession. Following the Kennedy Inquiry into children's cardiac surgery at Bristol in the late 1990s and the failure of health bodies to identify the high number of deaths under Dr Shipman's (GP) care, the medical profession has been subjected to much stricter regulation, perhaps more so than in any other country. This has led to a much more systematic approach to the appraisal and revalidation of doctors to practice. We explore the drivers for this and how this is contributing to doctors in positional leadership roles accepting greater executive responsibility and accountability and more medically engaged cultures. The role of doctors reviewing other doctors' variations in practice is a crucial component of the changing landscape of the NHS and is of increasing interest internationally.

In Chapter 9, we explore some of the practical initiatives being taken in the NHS and internationally to operationalise the MLCF or similar competency frameworks and the promotion of greater medical engagement. The most exciting initiatives involve junior doctors and there appears to be a growing interest from medical students and postgraduate trainee doctors to acquire leadership skills and knowledge, particularly around service improvement. A number of Medical Royal Colleges and NHS Trusts are positively encouraging trainees to undertake a service improvement project instead of a clinical audit. We provide details of some of these initiatives, but the movement towards more effective medical engagement and leadership needs to start in medical schools. It needs to be an integral part of a doctor's education, training and development throughout his or her career, not a remedial development activity once a doctor has moved into a positional leadership role, as has been the case in the past and sadly still is in many organisations.

Ibrahim et al. (2013) suggest that it is becoming more apparent to health services internationally that junior medical staff have immense potential as contributors and drivers of service reform. Historically, they have often been ignored in any discussions around clinical reform, with their superiors stressing the need for them to totally concentrate on getting experience in their chosen specialty. Given that junior doctors are at the centre of the admission and discharge processes and diagnostic requests and in the hospital across 24-hour periods, they are in

ideal positions to identify where there are inefficiencies and potential improvement processes. Furthermore, as Micallef and Straw (2014) rightly identify, their mobility across many hospitals during their rotations provides them with great opportunities to compare different practices. This has always been the case, but perhaps the difference now is that enlightened managers and leaders are recognising the value of seeking the views of junior doctors and encouraging their participation in improving services. They are, of course, tomorrow's senior doctors, and such involvement at this early stage in their careers should reap rewards for the health system at a later time.

Jorm and Parker (2015), writing from an Australian perspective, suggest that the return on investment from healthcare leadership development programmes remains largely unmeasured worldwide. There are many examples of well-designed clinical leadership development programmes, but many of these are delivered at state, regional and national levels. This has led Fulop and Day (2010) to be critical of what they term the 'sheep dipping trade', where intermittent training is divorced from daily work and is therefore more individually centred. West et al. (2015) confirm this view, suggesting that the approach to leadership development has been distorted by a preoccupation with individual leadership often provided by external providers in remote locations.

The authors agree with these views and argue for a more locally and system-based approach to leadership development. High-performing health organisations put leadership development at the very centre of their culture and ensure that all those with management and leadership responsibilities are provided with the skills and knowledge to be effective within the culture of their organisation. These are generally multi-disciplinary and based around teams tackling real improvement issues.

Finally, in Chapter 10, we explore the future and suggest that in whatever way the health system evolves over the next decade, medical leadership and engagement will be critical. We are not advocating for all senior health leaders to be doctors. Apart from the limited study by Goodall (2011), there is no evidence that doctors as CEOs are the panacea. The evidence is certainly there that those organisations who value doctors' engagement and create distributed cultures where doctors wish to contribute to decision making, priorities and improvement deliver the best outcomes for patients and the taxpayer. We hope that this book will contribute to the realisation of this philosophy.

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