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Medical leadership and management: An international revolution

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ABSTRACT

Medical leadership and management are increasingly receiving widespread attention internationally. Significant focus has been paid as to the style of leadership within healthcare and how to develop both leadership and management skills and competencies (the two are inseparable yet distinct) throughout the careers of all healthcare professionals. This article discusses how leadership and management development is being considered internationally, both at an organisational and personal level, helpful models and frameworks and challenges and opportunities.

Keywords: Development, international, medical leadership and management, trainees, training

INTRODUCTION

Global attention is currently focussed on harnessing the clinical knowledge and expertise of doctors in leadership and management roles. This shift is happening with an almost palpable sense of revolution as to its importance within healthcare organisations. Effective leadership and management activities underpin every aspect of service delivery helping to ensure clinical care is safe, of high quality and informing the allocation of (often scarce) resources efficiently, ethically and effectively.

Increasingly recognised and valued as the leadership style to achieve high quality healthcare are the concepts of shared, distributed, collaborative or collective leadership.^[1,2] In these approaches, all healthcare professionals shoulder responsibility, no matter how large or small, direct or indirect their role is to the patient or healthcare organisation. Integral to the

success of collective leadership are strong, shared professional values and a culture which enables these values to flourish, driving the provision of the highest standard of care. To support doctors in developing these attributes and skills, numerous competency frameworks and standards have been drawn up over the last decade. Most influential, the NHS Leadership Academy and King's Fund in the UK, the US Institute for Healthcare Improvement (IHI) and the Royal College of Physicians and Surgeons of Canada have led the way. While their positions differ slightly, fundamental common principles can be identified and adapted to meet the needs of different organisations, professions or clinical specialities.

In this article, we discuss the leadership versus management debate, how the concept of medical leadership has developed and why its formal recognition in the training of doctors is essential for the future of health services around the world.

LEADERSHIP AND MANAGEMENT

In the clinical setting, the terms 'leadership' and 'management' are often used interchangeably but in the management literature thousands of definitions and many theories have been produced to explain the differences between the two. For example, Kotter (a 'management guru') considers leadership as the ability to cope with change and management the ability to cope with complexity.^[3] We might also explain the difference in that leadership provides vision, direction and energy to sustain a change, whereas management ensures the organisation remains viable and stable in

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order to cope with that change. In terms of job roles or positions, attempts to distinguish between and separate leadership and managerial roles are often made, but it is more helpful to view leadership and management as comprising different (but inextricably linked) activities undertaken by individuals depending on circumstances. Although they require different skill sets, all doctors should be able to utilise both confidently, freely and interchangeably on a daily basis, for example when providing leadership for a team that is managing a quality improvement project.

Historically however, leadership (and leaders) and management (and managers) have been seen as separate activities and people, with leadership often seen as superior to management and thus the latter becomes undesirable. This is highly divisive and can be dangerous. Doctors who move to the 'dark side' into management positions,^[4] particularly when stopping clinical work may feel their careers have ended, and might be ostracised by clinical colleagues. Managers from non-clinical backgrounds are often criticised by clinical staff for focussing simply on finances and targets and being perceived as lacking in understanding of what matters most, high quality patient care.^[5] However, there is increasing recognition (although often as a result of tragic failures) that should the divide between management and leadership continue, the ability to care for patients and deliver high quality care will be compromised. Furthermore, evidence from the United States demonstrates a strong association between chief executive officers of healthcare organisations holding medical backgrounds and their organisation's success.^[6]

In order to develop these skills in doctors working on the 'front line', incorporation of leadership and management competencies within, education and training programmes are now high on many political, educational and organisational agendas. For example in the UK, the General Medical Council took a firm stance in issuing guidance about the leadership and management expectations that all doctors 'should' or 'must' adhere to.^[7] This guidance from the professions' regulator clearly articulated that it is not just doctors with formal leadership and management positions who are expected to demonstrate leadership and management activities and behaviours, but rather every doctor working in the UK, whatever their stage of training or career.

LEADERSHIP DEVELOPMENT IN PRACTICE

We next can consider some international examples of how the leadership and management capabilities of doctors are being developed and supported,

in healthcare organisations, through competency frameworks and professional standards and through training schemes for individuals. As noted earlier, some common themes, attributes and behaviours run throughout these initiatives which provide us with a template for developing and assessing medical leadership internationally.

The organisation

It is at organisational level that the real impact of leadership development and doctors' engagement in leadership and management can be felt. However, this is very difficult to measure as many of the changes relate to culture shifts, occurring over the long-term and resulting from many internal and external factors. However, some examples of their impact are emerging around the world such as in Kaiser Permanente. Often cited for delivering high-quality, integrated and cost-effective care, Kaiser Permanente is one of the largest not-for-profit healthcare organisations in the US. It is widely considered an exemplar of effective medical leadership and management.^[8]

Through a systemic focus on 'joint leadership', 'alignment' and 'management training for physicians' Kaiser Permanente has established sustainable success and crucially has embedded quality improvement as the bedrock for this.^[9] Recommended as fundamental qualities for healthcare organisations are three key criteria:

- Joint Leadership – Comparably described elsewhere as 'shared leadership,' partnership working is modelled 'from board to ward' throughout the organisation
- Alignment – Mission, vision and values are echoed throughout and through determination to remove barriers between clinicians and administrators; a collective approach has brought alignment of competing priorities together to hold the patient at the centre of care
- Management Training – Parity of clinical and management skills is held paramount with in-house development programmes providing the critical skills of collaboration and cooperation, negotiation and persuasion as well as delegation and teamwork.^[10]

Competencies and standards

As noted above, many countries now incorporate leadership and management competencies and outcomes in their professional standards, both at the undergraduate level and for practising licenced doctors. Here, we consider four examples of generic standards and those specific to medical leadership and management.

CanMEDS – Established by The Royal College of Physicians and Surgeons of Canada in 2005, the CanMEDS ‘daisy’ framework has been adapted over time and is now adopted throughout all speciality education programmes in Canada to provide guidance on the role of every doctor within modern healthcare. It is also used widely internationally by other regulatory bodies. The framework has recently been revised to include specifically the ‘leader’ role, echoing the rhetoric of shared and collaborative leadership as has been seen in other parts of the world. The remaining roles include: Medical expert (the central role in the model), communicator, collaborator, leader, health advocate, scholar and professional.^[11]

NHS Healthcare Leadership Model – This Model has evolved from the first formal recognition of defined leadership and managerial competencies in the Medical Leadership Competency Framework in 2010 (see www.leadershipacademy.nhs.uk for both models). The Healthcare Leadership Model is underpinned by the collective leadership approach and presumes that all individuals working in healthcare organisations have the potential to develop as exemplary leaders. Nine dimensions are outlined: Inspiring shared a purpose, leading with care, evaluating information, connecting our service, sharing the vision, engaging the team, holding to account, developing capability and influencing for results. In a shift away from competencies, this model describes the leadership behaviours, which are to be developed and assessed.^[12]

US IHI: High-impact leadership – The institute has developed an approach to leadership which includes particular mental models, behaviours and domains that leadership efforts should be targeted through in an accompanying framework. This is highly regarded in the US^[13] and considered vital to achieving what the IHI consider the ‘Triple Aim’: Improving patient experience of care; improving the health of populations and reducing the cost of care.

The UK Faculty of Medical Leadership and Management (FMLM) – The emergence and increasing influence of the FMLM demonstrates the commitment and passion of doctors towards the importance of clinicians remaining at the forefront of healthcare provision and design. Recently, publishing what it considers to be ‘gold standard’ leadership and management standards, the FMLM urges that these skills be recognised and developed within a professional role within its own right.^[14] The standards should be applied to all doctors working in the UK at all levels of the organisation. They include the following core values and behaviours: Self-awareness and self-development, personal resilience, drive and energy; effective teamwork and cross-team

collaboration; corporate team player, culture and innovation.

Developing the individual

A vast number of training and development schemes, programmes and courses exist to support doctors who want to ‘learn leadership’ ranging from one-day workshops to masters’ programmes. Here, we give examples of two schemes aimed at building capacity.

The Royal Australian College of Medical Administrators (RACMA) Fellowship Training Programme – Operating across both Australia and New Zealand, RACMA provide opportunities for registered doctors to undergo and gain vocational registration in medical administration. This recognises leadership and managerial skills as a ‘speciality’ in its own right by supporting doctors to undergo at least 3 years of experience/time to complete an approved masters’ degree in this field. In conjunction with their curriculum framework, which mirrors that of CanMEDS, their strong ethos of distributed leadership encourages clinical leaders to excel at both governmental and local board level.^[15]

NHS England and FMLM National Medical Director’s Clinical Fellow Scheme – Having gained growing interest within the UK over recent years, this fellowship programme follows an apprenticeship model whereby doctors in training come out of formal training for a year and are attached to senior people in national organisations, both NHS and non-NHS, before returning to their clinical training. Such schemes are echoed across the UK at the regional level.

CHALLENGES AND OPPORTUNITIES

While there is a need to provide development and support for existing leaders, much attention is also being paid to developing future leaders, ‘talent management’ and succession planning. Increasingly, doctors in training are recognised as powerful agents for change and an extraordinary leadership resource.^[16] However, it is not always easy to be a little ‘I’ leader,^[17] doctors in training need support and encouragement to maintain their enthusiasm to develop and utilise these skills. Without appropriate support and encouragement, there is a risk that these future leaders (considered in the traditional sense) will become disheartened, disillusioned and ultimately, dangerously disengaged.^[18]

In order for this culture shift to happen, there needs to be a revisiting of dominant leadership styles and approaches. Within social and cultural norms and values, we must critically examine the impact of the hierarchical nature and traditional autocratic leadership

style so frequently embedded within medicine. This style can potentially stifle development and innovation (particularly of more junior or less powerful staff) and possibly create a pathological culture which directly conflicts with a systems approach to patient safety. If individuals feel they cannot speak out or suggest a change, they are highly unlikely to wish to engage in leading quality improvement projects for fear of ridicule or lack of support. Individuals (and organisations) need to be made aware of the damage that autocratic leadership ('do as I say') can cause with its association with a culture of fear, demoralisation, underperformance, unsafe practice and poor quality care.^[19,20] Rather than being ignored and pacified, (as often these styles are embodied by elder, highly respected clinicians), unhelpful autocratic leadership must be actively challenged with a view to moving towards a more value-led and collective leadership approach.^[2]

Progressing beyond simply delivering the service is vital for the modern trainee, healthcare organisations, patients, families and communities. And while many doctors in training and medical students are now engaging in clinical audit, this is only one skill to learn. Audit has brought an increased awareness of evidence-based practice and its relationship to providing high-quality care but it is not the only intervention to change clinical practice. In actuality, the majority of audits achieve improvements that are only of 'small to moderate' effect.^[21] Furthermore, this process is typically driven from the top down and so doctors in training gain very little insight into the importance of the subject of the audit area to the wider system or more importantly, do not gain experience in leading the resulting change. Far too often a trainee's involvement is typically limited to data collection and report writing on behalf of someone else.^[22] If audit is the only option for doctors in training to gain 'leadership and management experience', then the majority will become disinterested and unmotivated, with engagement in audit becoming a 'tick box' exercise for training progression.^[23]

To stop the potential stifling of innovation and talent amongst these future leaders a cultural shift must occur which enables and fosters a questioning of assumptions and promotes change by putting patient safety and health improvement at the heart of all patient-centred care.^[24] Integral to this ideological shift is quality improvement,^[25] that is: 'Achieving better patient experience and outcomes through changing provider behaviour and organisation through systematic change methods and strategies'.^[26]

This approach will facilitate the utilisation and engagement of a large but undervalued part of the

medical workforce-our doctors in training.^[27] It should also enable individuals to see themselves as leaders, not because they are personally exceptional, senior or inspirational to others, but by seeing where improvements are needed and working with their teams to achieve them.^[28] However, it needs to be implemented in the right way through dedicated mandatory training in quality improvement science and time away from service provision in early postgraduate education. Through a co-ordinated approach around improving the culture and systems, patient safety will be seen as everyone's business and healthcare organisations will move away from the 'blame culture' that identifies individuals as the cause of system failures.^[29]

CONCLUSION

In many countries, leadership and management skills are becoming increasingly more highly regarded and sought after throughout the hierarchy of medical practice, 'from the ward to the board'. The drive to further develop and support doctors currently in leadership positions and provide training for aspiring leaders is becoming embedded routinely throughout healthcare organisations. To enable this to succeed, the development of leadership and management skills for doctors in training must be seen, not as a diversion from patient care or a compromise to a clinicians' commitment to put the patient first,^[30] but just as important as teaching and academic research. Leadership development is beginning to be provided as a longitudinal key component of training which, rather than occurring in isolation, is being integrated routinely within all speciality curricula in the form of quality improvement initiatives.^[31] Ultimately, through doctors at all levels becoming actively engaged in leadership and management activities, healthcare organisations will be better supported to survive, thrive and deliver the safe and compassionate care that patients deserve.

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