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In the medical profession, our colleagues are among the most academically able of any professional group. It is therefore surprising, and an area of some concern, that many doctors feel unable to influence the wider healthcare agenda. There are many related factors: we spend much of our professional lives focusing on patient care rather than developing strategic management skills; our national voice is split among a range of organisations; and with females now forming 60% of the medical school intake, there is the question of whether women are less likely to take on leadership roles over and above their main career. The health service is currently undergoing radical change, and it is essential that health professionals preserve the capacity to influence, and to be involved in the development of supporting policy to ensure that the profession delivers the best possible patient care, whatever the structure or demography. How can we as a profession increase the influence exerted on decision making about health-related issues? This article will explore areas where we could work to strengthen our role by broadening medical education, enhancing leadership and management, and developing strategies for the changing demography.

Medical education

The training of medical students and young doctors is evolving, with medical school curricula expanding the education provided to include a series of skills essential for success in the profession. This has included changing the areas traditionally learnt in medical school to include aspects of professionalism. The General Medical Council (GMC) encourages the development of these areas, and audits progress in quality assurance visits to medical schools.¹ Recommendations, and examples of good practice, can be seen on the GMC's website.²

There is currently so much to include in the training of a doctor that fitting new areas into the curriculum is difficult. This is made more problematic by the challenges that exist in the assessment of the 'softer' skills that are an essential component of professionalism, like communication and teamwork. As assessment drives student learning, lack of a clear and comprehensive assessment strategy for professional skills reduces the incentive.

To maintain our authority as a profession, it is

crucial that medical undergraduates are selected for their potential influencing, management and leadership skills, as well as the scientific ability demonstrated in their examination results. These professional skills are then developed and enhanced in the new curricula.

The publication of a Royal College of Physicians (RCP) working party report defined medical professionalism and illustrated some innovative ways in which it can be encouraged.³ A series of professionalism roadshows held throughout 2006 and 2007 also disseminated the messages. The key definition in the report was that, 'Medical professionalism signifies a set of values, behaviours and relationships that underpins the trust the public has in doctors'. The recommendations include clear advice for the profession on the need:

- to develop strong leadership and managerial skills in doctors
- to strengthen our ability to work successfully in teams
- to select individuals into the profession with the potential qualities of medical professionalism, and to develop these skills in the undergraduate course
- to review the professional content of appraisal, incorporating professional values as key components
- to improve the management of medical careers
- to develop research expertise in the area of medical professionalism.

Progress is being made, but often against criticism from 'traditionalists' about the dangers of reducing the high standards of academic attainment in science deemed necessary for a practising doctor.

Of course, there needs to be a comprehensive and strong scientific basis to medical education but this needs to be balanced with equally strong professional, management and leadership skills training.

Leadership and management

Although doctors are influential in clinical practice, and consultants are often put into team leader roles on their individual clinical firms, only a smaller proportion of doctors are actively involved in strategic medical management and leadership.

As a profession, we are trained to specialise in

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Clin Med
2008;8:13–15

individual patient care, and too few expand this role. Clearly, it is essential to prioritise each patient that we see in clinical practice, but we need to recognise that as managers and as leaders we can influence the lives of a large number of patients for the better, by improving the decision-making processes of trusts, other healthcare organisations, and the government.

As an individual physician, for example, encouraging a patient to give up smoking and seeing that they achieve it feels good and is important, but it is less helpful to the patient population as a whole than the ban on smoking in public places, introduced in summer 2007 and campaigned for by this College. The Department of Health encouraged 'clinical engagement' in the decision-making process, and the NHS Institute for Innovation and Improvement explored how leadership is currently being taught to doctors, and will make some recommendations.

This is all in the right direction: with encouragement and training, physicians can actually become excellent strategic managers. Management theories stipulate that effective leaders accept responsibility, listen and communicate well, and work through teams. Is this not exactly what physicians already do in their daily lives?

In terms of national leadership, the NHS is a large and complex organisation, with healthcare overall even bigger. It is hardly surprising that this is a difficult environment in which to lead or influence. The large number of different medical professional bodies, each with different agendas, means that it is easy to point to differences, rather than to emphasise similarities.

It also means that the profession rarely speaks with one voice. Some may argue that this plurality is a good thing. But in an era of highly centralised government and policy making, it has led to a dilution of our ability to influence.

One single voice for the profession may be too difficult, or even undesirable, but to sing in harmony would be a good start. The increasing importance of the Academy of Medical Royal Colleges (AoMRC) under the chairmanship of Dame Carol Black should help in this process. The Academy will be coordinating the Colleges' work on recertification following the publication of *Trust, assurance and safety: the regulation of health professionals*.⁴ This is an excellent opportunity to strengthen the relationships between each royal college and to work on a large and collaborative project with the GMC. The improved working relationship between the royal colleges will be a lasting legacy of Modernising Medical Careers (MMC) and of the Medical Training Application Service debacle.

Developing a strategy for the changing demography of the profession

I would now like to consider the complex and at times controversial issues around women in the profession in relation to its leadership. A council member of another royal college mentioned that he could not think of a single woman with children who had been on his college council. In some of the other colleges, the president is elected from council members only. This means the chance of electing a female president is small. With the increasing number of women entering the medical profes-

sion overall, this issue needs to be addressed and we should work harder at ensuring that women with children are able to get through to the top of the profession.

Why is this important? Firstly, we need to be seen to be a fair and non-discriminatory profession; secondly, we need to make sure that our leaders are truly representative of the people who work in the profession; and thirdly, we need to recognise that many women actually adapt well to the demands of a senior management role.

Three women have held the position of vice president of the RCP and all have children. We like to think of ourselves as representative of the profession of physicians. Our voice is heard, we do not feel discriminated against, and we have not been marginalised. We have been able to influence.

The senior women in the college have all brought a similar approach to their roles. We tend to be collaborative, and although each of us is assertive, we are rarely confrontational. This style seems to help during difficult negotiations, and allows us to be transparent and equitable when chairing sessions.

Women with families have also learnt about ruthless time management and prioritising by having to juggle work and home lives. Any business trips abroad require careful planning, as everything needs to be covered at home (like the school run) before we can go. If it is not possible to attend a meeting or stay for the duration due to family reasons, we try to be assertive enough to say so. Having a supportive partner and a cohort of people to call on for practical support is crucial. As a full-time working woman, with a full-time salary, investment in good quality child care is also essential.

Although these juggling skills are not in the written curriculum of our medical schools, in MMC, or are assessed they are invaluable. Flexible working arrangements are also important. Although it is still difficult, there are many women entering training who will be able to 'have it all', because they already have the skills, and just need to be encouraged and supported. We need to ensure that the emerging structure of training programmes will facilitate this, rather than create artificial barriers.

In conjunction with the Medical Schools Council, AoMRC set up a working group to explore the issues facing women in academic medicine. There is a problem with recruitment of women into this area. The rise in women entering medical schools has not been matched by women entering academic medicine, or reaching senior positions.⁵ In America, the profession is more aware of this potential problem and has audited the number of women being admitted.⁶ Specific interventions have been established to increase the number of women in senior academic positions although, so far, with disappointing results.

The RCP has also commissioned a piece of research to gather data on the latest demographics of women in the non-academic clinical medical workforce, and to answer the question, 'What is the likely impact on medicine, traditionally male-dominated, of an increasing proportion of women entering the profession?'. The aim of the research is to assess the impact of this change, and to identify and define any need for a national policy review.

Working at the RCP is a good introduction to the necessary influencing skills needed to succeed in the medical world. It is a

good environment to work with colleagues from other backgrounds and other institutions towards a common goal. It feels good to have influenced something for the better, and is worth doing.

The profession is changing at a rapid pace. The physicians involved have a duty to maintain their commitment to patient care. The development of a strong voice, individually and as a group, is an essential part of addressing this challenge. This is a complex task, which is supported by physicians maintaining and enhancing their roles in medical education, taking management and leadership seriously, and paying attention to the changing demography of the profession.

References

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