Leadership and decision making: a skill for all?

Leadership: a process of social influence in which a person can enlist the aid and support of others in the accomplishment of a common task – Martin Chemers[1]

Make a decision. Make a DECISION. Make ANY decision. Make it NOW! – staff sergeant to officer cadet, Royal Military Academy Sandhurst (2012).

The above definition and quotation respectively provide your editor with food for thought concerning the concept of leadership, which is the special focus of this issue of *Future Hospital Journal*. On the one hand this appears to be a collaborative and persuasive skill exercised in measured and controlled circumstances; while on the other it involves taking immediate responsibility for executing a task with potentially profound consequences for all involved, and moreover doing so when tired, hungry and challenged by imperfect knowledge and understanding of the situation in which the leader finds themselves. Parallels between this military approach, in which the challenge of leading more experienced operatives through complex manoeuvres is imposed on the successful trainee immediately after qualification, with that applied to pre-registration house officers in 1979 (the year of your editor's graduation) seem superficially to be numerous, excepting the element of physical danger. Thus, a one-in-two rota leading to progressive exhaustion, insertion into the 'frontline' with minimal experience immediately post medical school, and the need to convey authority to nursing and allied health professionals with immensely more experience and ability than oneself when fearful of the consequences of 'getting it wrong' are strangely familiar concepts.

So if this is how leadership is exerted, how can we know if we are ever going to be up to the task? Maybe the armed forces again show the way. The systems employed by Admiralty Interview or Army Officer Selection Boards have been developed over decades and are designed to evaluate the potential for displaying 'effective intelligence', communication skills, values and motivation. By contrast, while the GMC publication *Leadership and management for all doctors*[2] sets out the wider management and leadership responsibilities of the workplace, including those relating to employment issues, teaching and training, planning, using and managing resources, raising and acting on concerns and helping to develop and improve services; I am unaware that the potential to exercise such skills effectively is assessed at medical school entry.

Historically, the relevant competencies were only indirectly evaluated in our trainees, at least in their most junior years post qualification. Furthermore, there may be an argument for saying that the 'stripping out' of real responsibility at an early stage of the medical career which has occurred progressively and appropriately in recent decades, while being good for patients, no longer necessarily engenders the sense of confidence and achievement attributable to spending the first few years of a professional life totally immersed in clinical practice. Indeed, the potentially adverse impact on the practical experience of surgical trainees following the reduction of their training hours in accordance with the application of the European Working Time Directive and New Deal has been commented on in many forums. Newly qualified subalterns, by comparison, continue to be required to exercise their leadership skills very soon if not immediately after leaving Sandhurst, often in extremely demanding and unfamiliar environments.

So where is leadership training being gained by junior doctors in the modern NHS, except by diffusion from more senior colleagues? Not all is doom and gloom. With the support of the Academy of Medical Royal Colleges, the NHS leadership framework now requires all doctors to develop leadership skills, and a growing number of deaneries and trusts integrate leadership and service improvement into training for junior doctors. The so-called Darzi Fellowships, established within the NHS in London to this end, involve some of the brightest trainees from all specialties in out of program experience to undertake specific pieces of work with direct relevance to service change, and represent invaluable experience for subsequent leadership roles.

The National Clinical Fellowship scheme, in which some 30 junior doctors are attached to the 'medical establishment', ranging from Royal Colleges (including our own, where we are now welcoming our seventh year of trainees) through the Department of Health to the British Medical Journal and General Medical Council, has similarly been greatly appreciated by those whom it has touched. These initiatives mean that doctors are exposed to the possibilities of leadership and management early in their careers, and are thereby less likely to

perceive a sharp divide between management and clinical staff. The creation of the British Association of Medical Management by Jenny Simpson was an early and invaluable attempt to formalise training and professional standards for those from a clinical background who wanted to undertake leadership roles. The Faculty of Medical Leadership and Management under its very able CEO and medical director Peter Lees, co-editing the special focus part of this edition of the Journal, represents a logical and very welcome development in this field and is already establishing itself as an invaluable resource.

If we are able to select potential leaders effectively, and can increasingly provide access to the relevant and effective training opportunities, what appointments are available for the graduates of such programs to fill? One could argue that, based on the definition of leadership provided above, the skill set acquired is likely to be broadly applicable in any environment. That being said, even five years ago less than 6% of NHS managers possessed any sort of clinical degree compared to 64% in France, 71% in Germany, 74% in the US and 93% in Sweden. This is despite evidence that clinically qualified managers improve performance through a better understanding of the processes of care delivery. This should make it easier for them to communicate with staff delivering frontline care, and to give them greater credibility in the NHS environment, where authority without power is the norm. By contrast, the job of NHS trust chief executive seems to be designed to dissuade doctors from applying.[3] Mark Newbold, former CEO of the Heart of England NHS Foundation Trust, wrote recently of his frustrations and the difficulties he encountered during his decade in charge.[3]

The harsh and allegedly bullying performance culture encountered by senior management is often foreign to doctors: their knowledge of scientific method and evidence-based practice may mean that attempting to adhere to unrealistic timetables and simplistic measures of success are particularly frustrating. Even those who have undertaken more junior leadership positions will have become aware of this culture in which difficult situations can become exasperated through the inappropriate use of grievance procedures, and the inability to manage resources effectively can be masked under the guise of whistleblowing. Embarking on a path that seems calculated to end in tears, and which is often characterised by professional ruin and public humiliation is not likely to encourage others. Paradoxically, it can even encourage successful chief executives to adopt a protective and inward looking culture; a tendency that may have been exaggerated by the advent of foundation trusts. Whether devolution to regionally-based healthcare systems with integrated primary and secondary services, social and mental health, as advocated by the Future Hospital Commission (and about to become reality in Manchester), can avoid these pitfalls remains to be seen.

So where does this direct us? One option is that we leave management to professional managers. However, if clinical qualification among leaders truly does result in improved outcomes this will be a destructive approach to advocate. Nevertheless, the focus of medical training for many is towards attaining specific competencies and thereby moving through a series of graded evaluations towards a consultant appointment, in which the rewards are significant for specific focus and achievement. This will arguably mitigate against the assumption of responsibility and a willingness to lead and implement change. Second, an awareness of generational differences in the approach to work and employment values, which your editor is probably displaying to perfection in this piece, is of paramount importance in selecting leaders and exerting leadership. Workplace consultants suggest baby boomers (born 1946–1964) can be generalised as being competitive and think workers should pay their dues. Those of Generation X, born between 1965 and 1977, are characterised as more likely to be skeptical and independent minded, whereas Generation Y, born in 1978 or later appear to appreciate teamwork, feedback and technology. In the context of this editorial, the generational gap is possibly best characterised by the older generation of doctors regarding management as 'the dark side'. Medical trainees, particularly over the past five years, seem focused more encouragingly on the leadership and teamwork aspects of their career. Finally, we should be aware of the influence of the 'flat' clinical career structure, although this is probably not immediately apparent to those training within it. Specifically, once a consultant position is achieved, not only is there a tendency to sit within it – as evidenced by little mobility among the consultant body – but also a tendency to build an empire and protect it from outside interference at all costs. A career structure for clinicians involving leadership of the medical service through the chief resident or chief of medicine appointments advocated by the report of the Future Hospital Commission might just be the way forward.

Make a decision…Make it NOW! ■

Timothy W Evans

References

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3 Vize R. Why would a consultant think of going into management? *BMJ* 2015;350:h922.