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Setting the scene

Author: Neil Douglas[A]

ABSTRACT

Doctors have a critical role in ensuring good teamworking which improves patient outcomes. UK hospitals with more doctors in their boards have lower morbidity and better patient satisfaction. In the USA, hospitals with doctors as the CEO have better performance, but in the UK less than 5% of hospitals have doctors as the CEO. There is an urgent need to improve training in medical leadership among UK doctors and to make careers in medical management more attractive to high fliers. The Faculty of Medical Leadership and Management has launched standards of medical leadership and management which will give credibility to this field and ensure that highly qualified candidates are appointed to all levels of management posts within the NHS.

KEYWORDS: Leadership, management, doctors, training

Introduction

The last century has seen dramatic improvements in UK healthcare. These have been accompanied by less obvious but equally radical changes in healthcare management from a paternalistic regime dominated by doctors to a more proactive multi-professional approach. There is no doubt the former approach had to go, but some flaws of the current system are only too evident.

Running healthcare in a managed and politicised system like the NHS is always going to be challenging. Politicians deal in short-termism seeking solutions before the next election, often setting well meaning targets which have unforeseen deleterious consequences for other aspects of care. The almost infinite potential for growth in health spending continually needs to be reined in to match the limited or non-existent real increases in funding. A key factor in many of the recent problems in the NHS has been managers feeling an overriding pressure to balance the books.[1]

Junior managers and clinicians have too often been victims of a 'command and control' style of management which can verge on bullying, and may be facilitated by political imperative and financial pressures. In these situations some clinicians have, for whatever reason, lost sight of their prime focus of delivering kind and compassionate care and failed to take the appropriate action when faced with clearly unacceptable patient care.

Author: [A]chairman, Faculty of Medical Leadership and Management, London, UK

Clinical teams

In reality, all doctors are leaders, but doctors often do not lead well. There are robust data indicating that good teamworking helps staff morale and critically is associated with improved clinical outcomes and lower patient mortality.[2–4] However, too often clinical teams are dysfunctional with individual approaches to patient care and friction between the senior doctors. In addition, doctors too frequently tolerate clearly inappropriate behaviour from fellow clinicians. Permitting such behaviour destroys teams, harms the mutual support networks among staff and ultimately damages patient care. Stress among NHS employees is extremely high.[5] All clinicians should be doing everything they can to improve cohesive teamworking and support for their colleagues from all professions and all stages of their careers. Good relationships outside the immediate team are also important. Relationships between interacting clinical teams are too often poor, with disparaging comments being passed when mutually trying to advance collaboration to improve patient care should be the goal. Appropriate action following intelligently targeted and mandatory multi-source feedback could be used to greatly improve teamworking and inter-team relations, and thus patient outcomes.

Senior doctors face challenges in providing nurturing leadership to doctors in their teams who are in the early stages of training, and especially in mitigating the unintended consequences of recent changes in work patterns. Junior doctors change jobs rapidly and frequently, particularly in the early years of training, and do not feel part of a team. They rotate around posts before they get a chance to build a support network or identify long-term mentors who see their role as developing the trainee's career. Doctors in training are further dehumanised by having little or no say in their on-call rotas or holiday dates, with rotas often not published more than a few weeks in advance. This is unacceptable and the more senior doctors should not be turning a blind eye; local leadership should be shown by ensuring these rotas are as humane as possible and published at least six months in advance at all times. Consultants should also change their team's work practices so that doctors work in more consistent teams where the individuals know and support each other. This failure to feel a valued and supported part of a cohesive team is a real factor in young UK medical graduates feeling stressed and for many choosing to leave UK medicine. As good teamworking correlates with good clinical outcomes it

is important that all focus on developing harmonious and self-supporting teams encompassing all grades of staff to the benefit of patients – and staff.

Senior management

At a more strategic level, the best senior managers of any business have a thorough understanding of the processes in their industry. They also surround themselves with high-quality information sources from all levels of the business so they know rapidly when something is going wrong in any aspect from finance to customer satisfaction. The same is true in healthcare, but in many institutions senior managers remain remarkably unrecognisable to even senior clinical staff. This is a problem but the solution requires input from both sides, with some clinicians needing to be more welcoming of managers of all levels into their services. Good NHS managers – and good board members – should have regular contact with all the major services and their patients to help them make appropriate decisions. Managerial rounds and patient safety walkabouts[6] have been helpful in many hospitals but are still far from universal.

One of the remarkable disparities between the healthcare management in the UK compared with other countries is the dearth of doctors in senior management positions. A survey by the UK Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement[7] found that only 5% of NHS chief executives were doctors and the numbers have probably decreased in the years since this was conducted. This contrasts with leading managed healthcare systems in the USA where the majority of CEOs are doctors. Further, in the USA there is a strong relationship between medical CEOs and hospital performance rankings.[8] The presence of a doctor as CEO as opposed to having a professional manager as CEO was shown to be strongly associated ($p<0.001$) with better hospital performance, with doctor-led hospitals having significantly higher quality scores. An associated problem is that there are fewer doctors on the boards of UK hospitals than in other countries. The data suggest this may be an important issue, as UK hospitals whose boards had better doctor representation had better patient satisfaction and lower morbidity rates.[9] A study in the UK found that both the best managed hospitals and the best performing hospitals were those with a high proportion of managers with clinical degrees.[10] All these studies suggest that high-level involvement of doctors in hospital management is associated with improved hospital performance and better patient outcomes, and that doctors could and should be more involved in hospital management in the UK.

An equally important problem in the UK is that medical management roles are not much sought after. They are often filled with little or no competition and, particularly at clinical director level, by candidates with little leadership experience or proven track record of delivery in management. We are failing to identify and nurture potential leaders early in their career and this is harming future patient care. Our best medical graduates tend to target roles as stellar academics, leading clinicians or private practitioners rather than seeing their future in improving the broader delivery of healthcare by focusing on medical management.

Making careers in medical management more attractive needs action in many areas at all stages of the medic's career. Few medical students interact with medical directors or trust CEOs whereas all will see professors, consultants and general practitioners, so it is not surprising to which role models they aspire. Leadership is mentioned in all specialty curricula but the delivery of leadership training is variable. Of equal importance, the assessment of leadership is difficult and is rudimentary in current college processes, a major problem as there is no doubt that assessment drives trainees' learning. There is a clear need for standards of medical leadership and management to be applied, to which doctors can aspire and against which applicants for management posts can be judged. The Faculty of Medical Leadership and Management (FMLM) is finalising such standards which will hopefully drive up the levels of training, demonstrable achievements and leadership skills which such applicants must show.

While there is a clear career structure in clinical or academic medicine there is not in medical management. Too often clinical director roles are filled even in major hospitals by internal appointment and often 'buggins' turn'. These are more important roles for the future of the hospital and service than the appointment of a consultant or senior academic, and like these roles, applications for clinical director should require open advertisement and genuine open competition. A doctor who has proved to be good in a clinical director role in another hospital should get an opportunity to widen their skills and experience while benefiting another institution. Clinical directors must be given the appropriate sessional time and administrative support to perform the role properly and not be expected to add this role to a full clinical contract. Good clinical directors can then go on to apply in open competition for medical directorships in any hospital and, at this level, open competition has become more the norm in recent years. Medical directors must also be given the appropriate resources to allow them to fulfil their roles to the best of their ability. This means realistic time to perform their role and adequate administrative and other staff support. Too often these important roles have been part time and with only part-time personal-assistant support.

Senior clinicians, usually medical directors, who wish to become trust or hospital chief executives, face a major contractual quandary. At present they have to decide whether to leave a firm contract as a consultant with long-term employment rights and pension arrangements to move to a post which may be better paid but with much less certain tenure. The average chief executive remains in post for around 2–3 years before all too often being removed from office and having to look for another job. Such uncertainty is undoubtedly a major factor in deterring doctors from applying for chief executive roles. There is an urgent need to examine how this almost 'Catch 22' situation can be resolved. Doctors who lead medical schools do not have the same deterrents to take on these equally important roles.

Primary care

The vast majority of patient interactions with healthcare workers in the UK occur in primary care where doctors have, to a large extent, remained in charge. Most practices have coped well with the complex funding changes, increasing patient need and very significant increase in work, with hospitals off-loading

significant amounts of both routine and complex outpatient activity to general practice, and have shown significant flexibility in doing so. The general practitioners (GPs) who run the practices often have little training in management before assuming these roles. While some degree of learning on the job is unavoidable, more needs to be done to ensure greater understanding of how to lead before one assumes such roles.

Even more importantly, GPs in England now control around 80% of the health budget, some £80 billion, in clinical commissioning groups (CCGs). These are major management roles requiring considerable expertise in management, leadership and finance, yet many on these groups have had little or no training to help them 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 that all CCG members have the training and development that allows them to develop these skills.

Conclusion

At present, doctors do not fulfil their potential as contributors to NHS management. There is an urgent need to improve leadership across the profession and all doctors at all stages should work closely with non-medical managers to produce engaged clinical teams to the benefit of patients and staff. Standards produced by the FMLM will professionalise medical management by establishing the levels of skills, experience and achievements required by those seeking roles as medical managers. A genuine career pathway promoting those who perform well is needed for those pursuing a career in medical management. ■

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Address for correspondence: Prof Sir N Douglas, Faculty of Medical Leadership and Management, 6 St Andrews Place, London NW1 4LB, UK.
Email: n.j.douglas@ed.ac.uk