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A medical director's perspective on healthcare leadership

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ABSTRACT

Healthcare leadership needs doctors in particular to step forward, despite the pressures, lack of recognition and challenges to bring their talents to aid improvement for patients and staff. There is clear evidence worldwide of the power of clinical, particularly medical leadership and its benefits are currently underutilised in the UK; now is the opportunity for major change. Focusing on the patient first ('what matters to you?') will be a necessary change. Healthcare leadership needs to understand and drive 'value' despite the challenges. Taking the healthcare management and leadership path should be properly recognised as a strong career choice for doctors, not a move away from patient care. Healthcare leadership of the future needs to understand what motivates people, the important 'triumvirate' of medical managerial and nursing/allied health professional leadership, and how taking a quality improvement approach will give more sustainable patient-centred results.

KEYWORDS: Leadership, motivation, healthcare, value, change

> *It is not the critic who counts…The credit belongs to the man who is actually in the arena…who strives valiantly; who errs, who comes short again and again…but who does actually strive to do the deeds…who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly*[1]

This quote from Theodore Roosevelt perhaps sums up for many in healthcare leadership how it feels to undertake a task that is often unrecognised and frequently attracts criticism, but which is crucial to the successful delivery of high-quality patient-focused care. Indeed, the ability not just to 'do things right (management), but to do the right things (leadership)' as Peter Druker says, summarises the importance of leadership in healthcare and will be critical in the coming months and years.

There is currently a significant gap in many aspects of high-quality leadership in healthcare, which will be filled by others should clinicians not step forward to do so. The challenges facing the service are immense, with rising patient demand both for improved quality and experience, increasingly complex medical technology enhancing 'what is possible', and pressures from age, comorbidities and lack of personal 'ownership' of health by citizens. Placing these demands alongside the financial limitations of the current era has driven many to articulate that the NHS is in crisis; a Google search for which reference records 21.3 million results. At such times it is vital for both patients and staff that there is coherent leadership.

The history of involving doctors in NHS leadership is less than illustrious. It could be argued that we currently face another 'Griffiths Moment' to come forward and be counted similar to that faced by the profession in 1983–5. At that time, following years of stretched resources, challenging clinical outcomes and recurrent 'crises' the then secretary of state for social services (equivalent to secretary of state for health now), Norman Fowler, called upon Sir Roy Griffiths (director and deputy chairman of the food retailer J Sainsbury's) to 'give advice on the effective use and management of manpower and related resources in the NHS'. The Griffiths report – actually a letter[2] – had two key recommendations: enhancement of general management training and greater involvement of clinicians who it was felt 'must participate fully in decisions about priorities in the use of resources'.

In the years that followed there was a significant advance in 'general management'. The nursing profession, rightly incensed by the apparent demotion of nursing leadership in the report[3] fought and gained significant positions in the general management structure and their own standing in healthcare leadership. Doctors, initially, stood back. Despite several examples across the world of the power of effective medical leadership, such as at the Mayo Clinic,[4] there were few examples in the UK, excepting possibly Guy's Hospital in London which adopted the system of clinical directorates used at Johns Hopkins.[5] For most others, the challenge of stepping into management and leadership positions and assuming budgetary responsibility for the services they oversaw was 'dodged' in the name of maintaining clinical independence.[6] This vacuum was filled by general managers, often with a nursing background. While later changes brought clinical directorates to most hospitals, these roles are often not valued or supported.

We currently stand at a similar point, where clinicians need to step forward to lead in UK healthcare. Current challenges require a greater input from clinical leaders, particularly doctors. The need to focus on and listen to the patient, client or 'customer' is accepted, but lapses in patient safety, organisational failures such as those highlighted in the Francis Inquiry or the need for successful organisational changes to follow clinical strategy suggest these principles are ignored,

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Table 1. The author's career track in medical leadership.

Date	Within hospital	Regional or national
Bristol Medical School 1982–8		> BMA Associate Members Group
Junior doctor years	> Doctors' mess and rota organiser	> BMA Junior Doctors Committee: involved in new deal and Calman discussions and implementation
1994–5	> Working in Sydney, Australia	
1997–2001		> Royal College of Anaesthetists: council member
1998	> Royal Berkshire Hospital: appointed consultant in anaesthesia and intensive care medicine	> BMA Consultants Committee (1999–present) > BMA: council member (various years to 2009)
1998–04	> Royal Berkshire Hospital: ICU audit and governance lead	
2000–3	> Royal Berkshire Hospital: emergency services clinical director	
2001–4	> Royal Berkshire Hospital: emergency care lead	
2001–3		> BMA Consultants Negotiating Committee (consultant contract): member
2004	> Royal Berkshire Hospital: medical director; Upton Nervet train disaster, major incident response	> BMA Consultants Committee: deputy chairman (negotiations) > Implementation of consultants' contract
2004–6		> Led negotiation and agreement of maintaining higher professional standards
2005–6		> Review of CEA scheme
2006–9		> BMA Consultants Committee: chairman
2005–9 (various dates)		> PbR External Advisory Board: member > Next steps Review workforce planning > Lord Darzi sounding board > Secretary of state health summits and sounding board > Revalidation program board > Joint Consultative Committee: member
2007		> Douglas Review group MMC/MTAS 2007: member
2008	> Royal Berkshire NHS Foundation Trust: director of medical education and development – lead hospital at night and EWTD implementation	
2008–12		> National ACCEA: professional member
2009		> National Leadership Council > Medical Education England (now HEE)
2009–12	> Royal Berkshire NHS Foundation Trust: chief medical officer, then medical director > Maintain intensive care clinical role > 2010 CHKS hospital of the year > *HSJ* safety award 2010 > CQC registration 2010 > Care of the Future review of Berkshire and Buckinghamshire: clinical lead > 2011 runner up CHKS hospital of the year > *HSJ/Nursing Times* patient safety award	> NHS Top Leaders first cohort > Future Forum (phase 2): member

(*Continued*)

Table 1. The author's career track in medical leadership (*Continued*).

Date	Within hospital	Regional or national
2012	> Royal Berkshire NHS Foundation Trust: hospital reorganisation to clinical leadership model: clinical lead > Royal Berkshire NHS Foundation Trust: acting chief executive (two months)	> Thames Valley HIEC: board member > Patient Safety Federation: executive member > Aylesbury Vale Clinical Commissioning Group Governing body: member (2012–present) > ACCEA: employer member (2012–present)
2012–present	> UCLH: medical director (medicine)	> National Stakeholder group > RCP Future Hospitals project > RCP care advisory board > Mentor HealthBox Europe > The Learning Clinic: advisory board member (2012–14) > The Nuffield Trust: board trustee > *HSJ* awards: judge and panellist > Health Services Laboratories (pathology joint venture): board member > Advisory meetings with Rose review, Dalton Review, prime minister special policy advisors and the King's Fund

ACCEA = Advisory Committee on Clinical Excellence Awards; CQC = Care Quality Commission; EWTD = European Working Time Directive; HEE = Health Education England; HIEC = Health Innovation and Education Cluster; HSJ = Health Service Journal; PbR = payment by results; RCP = Royal College of Physicians.

despite the fact they are core to the General Medical Council's concept of what constitutes 'good medical practice'.

Those who are medically qualified can bring both professional knowledge and ability combined with a strong ethical background to leadership, thereby aiding better patient-focused decision making. The benefits of this approach are evidenced by the number of highly successful healthcare organisations who have ensured strong medical leadership is incorporated into their structures and ethos.

However, this focus on the 'patient first' requires significant change for (some) doctors; specifically working 'with' patients, discarding the professional hierarchy and paternalism that has been a strong part of our history, and truly sharing decisions with patients. Really finding out 'what matters to you' as a patient, rather than the traditional 'what is the matter with you' enquiry, and walking, talking and promoting this change is a key challenge to today's healthcare leaders to best navigate the turbulent times ahead. The path towards such appointments is currently varied (an example is shown in Table 1).

Healthcare leaders also need to focus on value, perhaps best defined by Porter[7] as the outcomes (both clinical and experience) gained by a patient or system, for the cost of achieving those outcomes. We must look to ensure that all our efforts are focused on improving value in each decision and act. To do so needs a deep understanding of the cost of actions and omissions. In Porter's view, moving up the 'tiers' of outcome towards prevention and sustainability of health, rather than fixing our efforts on delivering the costly acute care that consumes so much of our current resources, represents the real challenge. To meet this, with clear direction from the *Five year forward view*,[8] requires strong input and guidance from clinical and particularly medical leaders, even at the potential risk to the traditional ways of working in individual organisations, particularly hospitals, which we lead.

Currently medical leadership perhaps faces its biggest challenge in gaining acceptance, recognition and reward. There are clear managerial and nursing pathways leading through the departmental, executive and board leadership roles which are broadly accepted as valued career advancements. In medicine still, in many hospitals and practices in the UK and elsewhere, the move into leadership, executive or commissioning roles or board level is seen as a move away from patient care; indeed, away from being a 'proper doctor' rather than representing *bona fide* career paths, which are as crucial to the improvement of patient care and meeting our challenges as are 'traditional' research and educationally orientated careers. An NHS Trust medical director and many clinical directors arguably hold responsibility for the improvement of care for significantly more patients and resources than most professorial colleagues are entrusted with. Some of these operational and board level roles in larger trusts would rank in the 'real world' as equivalent to running major organisations listed on the stock exchange. Moreover, the complex adaptive nature of healthcare makes leadership in this arena particularly problematic. The successful captaincy that healthcare and medical leaders bring is thus vital.

Looking to the future, what key attributes are needed? First and foremost is a clear understanding of what motivates people.[9] The evidence, both inside and outside the healthcare environment, points to three factors. First, a common purpose is required. Improving the quality of care, treatment and experience provided for patients (and staff) should be the driving force and unifying centre. Without this, change

or progress is not possible. To underplay this, often in the mistaken belief that money is the sole motivator, is frequently a reason for lack of progress or perverse outcomes. Providing a burning ambition for progress is a key area where effective leadership can contribute. Burning ambition truly motivates; burning platforms do not.[10] Second, each of us is driven to master a skill or set of skills. The recognition of this need and associated benefit, allowing more freedom to the frontline or sensitivity to operations and deference to expertise, allows progress and higher reliability. However, this must be done in the organisational context to ensure safety and team alignment. A key failing of our past and current training regimens for doctors is the continued promotion of the 'artisan craftsman': the apprentice approach to training aims at individual excellence and loyalty to 'craft' rather than organisation. While this promotes individual brilliance, the risk of failing to develop a common purpose or bringing together of teams across professions and specialties often increases the risk of poorer safety outcomes.[11] A change to training, focusing on team development with mastery by the individual is key. Finally, allowing individuals and teams to 'earn' autonomy and flourish promotes better outcomes and is a strong motivator. Clearly, this needs to be encompassed within the same common purpose and aligned for both safety and coherent organisational and patient benefit.

The second key area is ensuring the 'triumvirate of leadership' is present in each healthcare organisation. The case for medical leadership is strong, but so often this is not properly supported and balanced by partnership with managerial colleagues. Griffiths saw this in the 1983 report.[2] The third leg of this optimum leadership stool is that of nursing (and allied health professional) leadership. The complimentary skills of nursing, healthcare management and medical leadership bring out the best for patients and organisations as a whole.

A final imperative is taking a quality improvement approach to advancing care and treatment outcomes. The English NHS, and its counterparts elsewhere in the UK, have taken a bureaucratic 'performance management' approach to improvement for far too long. While this may work where technocratic or command and control leadership is needed, it fails, as has been seen so clearly in 2014–15, to improve where our complex system requires more adaptive leadership styles. Setting out a clear plan with stated aim, implementing, studying the effects and acting on this to effect further change towards a common purpose brings longer term sustainable performance, but also a more motivated, patient-centred workforce.

There is a central critical role for medical leadership in the NHS now and in coming years. To ensure the service is world class we must focus on clinical quality, safety and outcomes, to enhance productivity and lean operational performance, and engage our patients and staff to these common ends. Physicians have a key role in delivering this agenda both within organisations and across the healthcare system; leading by example in their own organisation, linking to others and integrating care through networks for patients. At this critical time healthcare needs leadership and doctors must heed this call for a better healthcare future for our staff, and importantly our patients and the public. ■

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