Medical leadership – in the scrum or shouting from the sidelines?

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ABSTRACT

As has often been the case in its nearly 70-year history, the NHS finds itself in difficult times with very real clinical and financial sustainability challenges and a need to transform itself. The vision has been laid out in the *Five Year Forward View*, but if there was a 'how-to' manual for delivery it could be argued that it isn't always completely clear and some chapters are incomplete. In the context of change in the modern NHS, medical leadership is often spoken about as being key and yet what this means varies between different people and at different times and on a whole spectrum of scale, from small projects to whole health-economy redesign. This article consists of some personal reflections on what it feels like to be in the midst of both.

KEYWORDS: Medical leadership, training

I was always rubbish at team sports at school. Indeed, come to think of it, I was pretty bad at sport full stop. Neither do I consider myself an avid sports fan, even as a spectator, but I understand why others are and am content with leaving it at that. However, I often think in pictures and draw parallels between the day job and everyday life outside of work. Picture this: a cold, wet Saturday afternoon on any rugby pitch up and down the country. The players are doing what they do in pursuit of winning, giving up their time (probably voluntarily) because they like what they do, having possibly been told at some stage that they have some skill and want to do their best for the team. Undoubtedly they could be doing other things, but it's their choice. Similarly, the spectators, not necessarily having been forced to be there, are shouting 'advice' – constructive or otherwise. Some of the language may be a little 'colourful'. They have things in common but there is a fundamental contrast between player and spectator.

I've been in a fair few situations with clinicians that have not felt terribly dissimilar.

We find ourselves at a crucial point in the history of the NHS, although I do wonder if it has been ever thus and how many times that kind of phrase has been used over the decades. The financial gap is massive – so easy to get the decimal point wrong – with patient and regulatory expectations ever higher in the context of real recruitment problems, which make delivery of our current clinical model of care more and more challenging. So much so that even our terminology is changing. I am pretty sure that, at the time of writing, this time last year we weren't talking about STPs (Sustainability and Transformation Plans) and LDSs (local delivery systems) – as part of the response to the *Five Year Forward View* and in everyday parlance as we are now. Or if we were, I must have missed it. Essentially, it boils down to one simple message: we cannot carry on doing all the things we do now in exactly the same way that we have always done them.

As part of the delivery of our current clinical model, clearly doctors can play a big part in perpetuating the *status quo* but they also have a crucial role in working out the solutions to our current problems through to large scale implementation. If I were to get the 'management manual' out for a moment, it would say something about it being 'transformation into a clinically and financially sustainable NHS' without radical changes to our constitution or 'offer' free at the point of care (in the context of much wider public sector austerity). I couldn't put it better myself. It's hard to argue against getting the very best value for public money possible that plays to a serious pursuit of best-in-class clinical effectiveness. Reducing variation and improving the quality of care for our patients through harmonisation, if not standardisation, is not really an attack on professionalism when you overlay the added value of clinical judgement we have spent our careers refining. That is very powerful.

It has been suggested that if doctors fail to be central in any transformations to healthcare delivery such changes are 'doomed to failure'.[1] It is recognised that medical engagement needs to be part of a wider organisational approach and is frequently a 'journey that requires doctors to be motivated and to assume greater engagement with, and responsibility for, improving the quality of patient care in partnership with clinical and non-clinical colleagues' (alongside a view from patients of course).[2] Moreover, genuine adaptive leadership, rather than technical leadership – that is, providing purely technical solutions to technical problems – is the practice of mobilising people in a way that they can tackle tough challenges and thrive.[3]

Most of us have been on the receiving end of healthcare either as a patient of one form or another, or as a parent, other relative or friend. We talk about patient pathways *de rigueur*, but I wonder if patients actually feel as if they are on a pathway, or is it just convenient for us to assume they are? Clearly, doctors

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also know what we need to do our jobs and have a fair idea of 'what good looks like' for themselves and their patients. We can set ourselves aspirational or stretch targets than can push standards ever higher, even though the reality can be more frustrating – how does the long-known-about gap in the rota, missing drug chart and clunky IT make *you* feel? On a bad day I might just blame HR, pharmacy and IT. Or indeed finance. It's generally easier to make it somebody else's fault.

I guess there are two possible approaches to dealing with this kind of environment, beset with the daily frustrations – a) keep your head down and just wait for it to be done to you with all the uncertainty and scary inevitability that comes with it or b) get involved in making improvements, big or small, using all the skills in your own toolkit. I suppose there is a third way – have a good old moan and criticise somebody else's efforts. Let's face it, there is plenty to be done either as a leader or as a team member supporting the leader. The great thing about medicine is the wonderful diversity of careers it enables – a truly international qualification that allows you to travel nationally and internationally, have a portfolio of things you like doing and diversify as often as circumstances allow. I would also suggest that it's a great team 'game'. We work with superb colleagues, way beyond nursing and the allied health professionals to those who enable it all to happen. Back to HR, IT and finance again. Operational managers are much maligned, but they often have the 'know how' to make things happen and are there to pick up the pieces when things don't quite go to plan. Great managers are worth their weight in gold. None of the above can be done on our own.

It can often be assumed that doing all of the above requires some form of special role – a job with 'director' in the title or some other form of formal authority. This really isn't the case. Time is clearly an important factor – I have been through enough consultant job planning rounds to know that. Nor is this automatically the preserve of the senior doctors – plenty of trainees can get involved; they have some fantastic ideas and often bring recent good practice from elsewhere in their rotation. If that is not innovation, I don't know what is. How good are we at sharing best practice? Even relatively small service improvements can improve quality of care or the working lives of our staff, and if you do it right it can bring along cost improvement as well. It's clearly not always the case but do it at scale across large numbers of encounters and you start to chip away at the deficit. Yet, if I labelled it as part of a cost improvement programme (CIP) it might be regarded as cost-cutting and that sounds so much more negative doesn't it?

All of this is expressed eloquently by Theodore Roosevelt as part of a 1910 speech:

> *It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better. The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; 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, so that his place shall never be with those cold and timid souls who neither know victory nor defeat.*[4]

Back to that rugby pitch. Would you rather be a commentator, 'critiquing' from the side-lines, or the one that plays their part in taking the ball over the line? Even more satisfying if no one thought you could. ■

Conflicts of interest

The author has no conflicts of interest to declare.

Note

Simon Constable trained as a clinical pharmacologist and is a consultant physician. Having worked for a period of time outside the NHS doing early-phase clinical trials on behalf of the international pharmaceutical and biotechnology industries, he has done a number of leadership roles within the acute NHS provider sector. He is medical director and deputy chief executive of Warrington and Halton Hospitals NHS Foundation Trust and a visiting professor at the University of Chester.

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