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This paper is produced by Tim van Zwanenberg and Graham English as a collaborative think-piece. It is intended to spark debate and promote wider and deeper thinking about one of the most pernicious issues in the modern NHS:

Our Crisis of Medical Leadership

Tim van Zwanenberg[1] writes:

A year into his role David Nicholson, Chief Executive of the NHS in England has decided to re-create the post of Medical Director for the NHS. The appointee, Sir Bruce Keogh, is also a Deputy Chief Medical Officer. The former NHS Executive included the position of Medical Director, but present circumstances are different in two important respects:

Firstly, the preferred new appointee has been drawn from the ranks of secondary care clinicians, rather than public health. Secondly, the world has moved on, and the medical profession, after a decade of turbulence and retreat, appears to be in complete turmoil.

Junior doctors have been marching the streets in protest at the new recruitment arrangements for training posts. The health correspondent of The Times, writing in the British Medical Journal, accused the medical royal colleges of being spineless. The chairman of the British Medical Association resigned. The chairman of the BMA Consultants' Committee has spoken of the profession losing faith in the government's running of the health service – the same government that has overseen such a massive increase in NHS funding since its election ten years ago. What then should a new NHS Medical Director do to establish leadership of the profession and by the profession?

History may show that the first decade of this labour government coincided with a watershed the profession. A sense of uncertainty and loss of confidence, has arisen. The series of well-publicised cases of medical malpractice culminating in the conviction of the serial killer Shipman undoubtedly contributed. Both the Chief Medical Officer and the General Medical Council have been prompted to respond by instituting stronger controls in the contractual and professional regulation of doctors. And there has been progressive change in the way doctors work, and the way they are seen in the workplace and in society more widely.

Edwards et al argue the "compact" between the profession, employers, patients and society is changing, and this is contributing to a worldwide phenomenon of "unhappy doctors". The old compact meant doctors sacrificed early earnings and studied hard; saw patients; and provided "good" care as defined by the doctor. In

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return they received reasonable remuneration; reasonable work/life balance later; autonomy; job security; deference and respect. Edwards contends, these sit uneasily alongside the new imperatives – greater accountability; patient centred care; being more available to patients and providing a personalised service; working collectively with other doctors and staff to improve quality; being evaluated against non-technical criteria and patients' perceptions; and a growing blame culture.

Degeling describes how calls to modernise require health professionals to accept that all clinical decisions have resource implications, to recognise the need to balance clinical autonomy with transparent accountability, to support the systemisation of clinical work, and to subscribe to the power sharing implications of team based approaches to clinical work. Degeling's studies have shown consistent and marked differences in how medical, nursing and managerial staff evaluate and respond to service reform. This contributes to a continuing "danse macabre" between medicine, management and modernisation.[ref] Others have called for constructive dialogue to replace the mutual suspicion between doctors and managers.

The issue is recognised. Endlessly managers are exhorted to secure "clinical engagement", in much the same way as they are expected to achieve public participation. National clinical czars have been appointed to provide leadership in specific clinical areas. Yet we would argue, on the basis of our experience[i] working with challenged NHS trusts, that medical leadership (not engagement whatever that means) is critical to the success of NHS organisations, and that its development is not being taken seriously enough.

This phenomena is not solely seen on the England. Elsewhere in the developed world the development of medical leaders is being explored and addressed explicitly. In Australia, for example, Dowton's review concludes that, despite leadership roles being critical, we persist with outmoded models of organisations and pay inadequate attention to developing individual leaders and new models of leadership within the medical profession. He maintains that new forms of leadership are required. Such leaders need to enhance the identity of the profession; to create effective links with other healthcare professionals and stakeholders, including managers; to interpret complexity so their institutions and followers can operate successfully in uncertain times; and, to model consistently ethical behaviour.

In 2005 Professor John Horvath, Australia's Chief Medical Officer, stated clearly that doctors would need to change their traditional approaches and broaden their skills.[ref]. - that doctors *should* be leading. Both the Chief Medical Officer in England and the NHS Chief Executive are reported as saying they would like to see more doctors as chief executives of NHS trusts, as in North America where the model works well. With the right training and development, a medically qualified manager could be very credible. But what is being done to bring this about?

The NHS Institute, on behalf of a broadly based stakeholder group including the General Medical Council and Postgraduate Medical Education and Training Board are compiling a curriculum to support leadership and management development as a

generic skill for all medical students and doctors in training up to five years post certification as a specialist or general practitioner.[ref] Various bodies have put on leadership development programmes for doctors, though in our experience doctors bring a level of naivety to these courses unseen in other health professional groups.

In any case this is all push, and where is the pull?

A recent survey of global companies by the Hay Group, focused on what successful organisations do to produce talented leaders for the future, suggests six steps:

1. make leadership development a priority
2. invest early in leadership development programmes
3. create leadership experiences
4. spot future stars early and support their progress
5. train the team (to follow leaders), and
6. make current leaders accountable for creating future leaders.

And others in the healthcare particularly in North America have identified the need to identify and activate champions in a systematic way.

The contrast in respect of medical leadership in the NHS could hardly be starker. There are few incentives or assistance to encourage doctors to move from simply being leaders within a clinical field who identify purely with their professional group to being leaders of services or more complex health organisations. Medical and clinical directors are not rewarded for the work through the Clinical Excellence Award system nor through any comparable scheme of remuneration and professional recognition. There are very few examples of doctors who successfully lead NHS organisations. There is no serious educational support to develop doctors as leaders and managers, such as access to an internationally recognised postgraduate qualification for medical and clinical directors. In primary care the very existence of medical directors is wholly ignored in the latest Department of Health guidance, (on the role of 'Professional Executive Committees) even though many primary care organisations are appointing them.

As a result we have repeatedly found medical leaders who are elected not selected. Many are unprepared and untrained, and simply unable to be part of an effective senior management team. Almost without exception none see medical management as a career, and almost universally undertake the roles part-time so that they can maintain their clinical skills for "the day job", where they see their eventual escape. Perhaps still worse is the still existent phenomena of medical management or leadership, as the last role before retirement ('There's no way back'). In one of our client trusts there was only one candidate for the post of medical director from a consultant population of over 600, and this is a common experience.

We suggest that the development of medical leadership needs to be taken seriously instead of being allowed to drift, or at best happen haphazardly. The professional and financial reward system needs to change so that the best doctors are encouraged to pursue a career in medical management. There needs to be proper

educational support, perhaps through the creation of a faculty or even royal college, with the development of appropriate postgraduate training and qualifications.

We believe that issues such as patient safety and medical performance, so dear to the heart of the Chief Medical Officer, are best tackled by excellent medical leadership at the level of healthcare organisations – where the care is provided – rather than by the establishment of national agencies, which in the case of the National Patient Safety Agency has been such a disappointment in reducing medical error.

Graham English[2] responds

And so what are the strategies that might successfully be deployed to address the central conundrum - that medical leadership is needed and sometimes wanted by the medical profession but it is seemingly impossible to find a cohort of clinicians who have the skills, or more importantly, the inclination, to take up senior medical leadership positions and even Chief Executive posts?

We know from our own work and contacts within the service and from reading the media, that David Nicholson and the new Management Team see this to be important. The elevation of Lord Darzi and his Government appointment also send clear signals of interest in such development, even before the agenda is pronounced. We also know that the NHS Institute, Royal Colleges, BAMM and others are seeking to instigate long-term solutions. These are far from irrelevant but solutions founded in addressing skills-sets during training and career advancement are essentially looking at the far horizon. This is worthy and valuable but necessarily fails to address the more immediate problem - how to get good medical leadership without waiting half a career (and many lifetimes) for it? And how can we know that doing so will actually generate better management and leadership – how can we know that such leadership delivers overall benefits to the patient and improved health? (In this respect we would question whether the goal should be medical leaders as Chief Executives, when what we see is a service crying out for good medical leadership of the medical profession per se and of the medical functions of the service itself).

Other approaches we are aware of include attempts to quantify 'medical engagement' in service-providing organisations as a means to identify the approaches and interventions that might have benefit. By all means have a number – we know that good data is at the core of good management. Yet the danger is we get to find out the thickness and shell-density of the egg without finding anything that helps us crack it open!

[2] Graham has been an Associate and Account Director with NHS Performance Support Team, and was a PCT Chief Executive for many years.

If the issues are here and now what are the actions that could make a difference here and now? What should be on the new Medical Director's task list at the start of their new role?

We suggest the new MD must address both the push and ***especially*** the pull right from the outset and that the new post represents a significant opportunity to shift both the culture of the profession and the environment in which medical leaders operate.

This task list could cover a range from the radical to the mundane:

Potential incentives include financial rewards for progression into medical leadership roles at each career level AND a requirement to have generated practical solutions to issues on the joint clinical:managerial agenda at each career level. So, junior doctors would be expected to have made service change happen at say ward level, as a necessary part of their training and career progression. Our concern is to ensure the contributions are required owned and developed in conjunction with local management requirements and have a direct and exponentially impactful effect locally, quickly.

Making secondments into leadership roles at each level could be a requirement for career progression too. And this could be tied to clear outcomes for such secondments, defined between participant, organisation and a local 'agent' for the new MD.

But for this to work will require a change in culture too. This would require modelling of alternative behaviours (a cohort of clinicians prepared to show leadership by moving to 'the dark side', and a cohort of managerial leaders prepared to take a form of organisational risk which few currently contemplate). Lord Darzi's listening process and review could have a role to play here – has it already fallen into the trap of generating burdensome additional business meetings often held away from site and on timescales that fail to allow the very best and most committed to participate actively, or has it mistaken exhortations to generate participation as generatative of 'engagement', assuming this will deliver 'leadership'?

And how about addressing the clinicians' relationship to the source of both their income and of their troubles – fundamentally changing their relationship to the 'organisation', in part by changing the form of that organisation to one in which clinicians have a financial stake in all forms of success – moving from a desire for 'metaphorical ownership' to real ownership – ownership of equity in an organisation. Alignment of objectives and incentives is seen as a mojor component of effective system reform in such influential approaches as that of Julian Le Grand[ii] *So, should we return to a debate about 'chambers' of consultants contracted to an FT or similar organisation, with a different incentive to engage with making the system work to patient and medics' advantage? Or clinicians holding share-capital in their Trust via a vehicle similar to the Partnership model common in other areas of the legal, accountancy and consultancy sectors each which see similarly intelligent and motivated professionals operating in large groups to mutual and client advantage?*

These are models already evident in the Primary Care sector. And they might sit interestingly alongside extended concepts of membership of FTs (or even PCTs), generating an equivalent relationship to the co-operative ownershop models (John Lewis Partneship springs to mind) with forms of socially controlled equity holding a majority interest and the potential for clear rules about sale and ownership of such equity to prevent this being a route to privatisation.

A few experiments in progressive FTs would readily demonstrate the capacity of such models to generate both fast-moving and evolutionary change, without requiring yet more centrally-imposed structural change.

We have a crisis. Is anyone ready to get serious in addressing it?

Tim van Zwanenberg and Graham English

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[i] Both authors have worked extensively with the NHS Performance Support Team, which has supported the most severely challenged NHS Trusts and PCTs.

[ii] Of Knights and Knaves, Pawns and Queens – Motivation, Agency and Public Policy OUP 2003

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