Doctors’ perspectives on clinical leadership

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Executive summary

Within the health and political environments there is considerable debate about the type of leadership required for a modern NHS. The BMA has frequently called for doctors to be more involved in the big decisions that affect patients. Such calls long pre-date the focus upon the role of doctors in clinical commissioning in the Health and Social Care Act 2012 which concluded its 15-month passage through Parliament in March this year. However, only in relatively recent years have concerted efforts been made to define and communicate a concept of leadership for the profession.

Although some doctors aspire to hold designated clinical leadership roles it is probably true that a majority of doctors do not. The ability of health policy makers and the medical profession to convince the broadest audience of the value of individual contributions to leadership will ultimately decide the success or otherwise of concepts which actively promote ‘shared leadership’ such as the Medical Leadership Competency Framework (MCLF).

In the course of our discussions with doctors there were some apparent contradictions in the views expressed. Although the vast majority were of the view that individuals can demonstrate leadership through leading by example there remained a tendency to perceive opportunities for leadership as limited by extrinsic factors, for example the availability of designated leadership roles. Some designated leadership roles are likely to have greatly reduced or little patient contact and our discussions identified the importance of ‘clinical credibility’ for leaders by remaining clinically active. Together, these findings raise implications for the current level of visibility, perceived relevance and attractiveness of leadership within the profession.

Clinical leadership is a readily used term to describe doctors as leaders within the health service but has thus far been less well defined. Our discussions showed that doctors aspire to give expert leadership to the health service, driven by their clinical skills, deep knowledge and advocacy of patient interests. The perception of leadership being dislocated from everyday medical practice suggests that more must be done to explain the relevance of leadership to all doctors from a variety of backgrounds in order to provide the type of expert leadership they espouse.

There were subtle differences in the leadership challenges faced by secondary care doctors and GPs, mostly related to their clinical setting. In common to both groups, time, resources and the status and relative autonomy of medical professionals were consistently identified as challenges for clinical leadership. Encouragingly, both groups considered their peers to be the strongest enabler of leadership opportunities.

That so many doctors felt time poor and under pressure to meet existing clinical commitments is a concern. The NHS is entering one of the most turbulent periods in its history, required to make significant cost efficiencies and implement a complex series of reforms. Such competing pressures could constrain doctors’ ability to provide the leadership the NHS will need in the coming years.

In fitting with similar discussions in this area, there was little evidence from doctors of the presence or relevance of leadership in their early medical training. For the future, the inclusion of leadership in pre-registration medical training must be carefully applied and based around doctors’, skills, values and interests in becoming expert leaders.

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The debate concerning the need for greater clinical engagement within the NHS is well rehearsed. Better engagement between health service leaders, managers and doctors should achieve a more coherent and long term vision of health service provision. The received wisdom also dictates that such engagement will empower doctors and unlock their potential as leaders within the health service, be they in secondary or primary care. The BMA itself has long called for doctors to have a greater decision making role in the delivery of healthcare services.

Other stakeholders have undertaken work to connect the aspirations of the medical profession with working in a modern NHS. Anecdotally it is widely acknowledged that clinicians often become frustrated in their efforts to deliver high quality care for patients whilst contending with a drive to implement what are often perceived as an overabundance of new and untested reforms.

In recent years there has been increasing recognition for the role that clinicians can provide in meeting the demands for a future NHS. For the NHS to respond effectively to demographic and population health stressors within a finite health budget clinicians must not merely be at the forefront of treatment but also integrated into NHS decision making.

Lord Darzi’s NHS Next Stage Review developed further upon a model of clinician engagement, empowerment and clinical leadership for the NHS. By advocating a more local approach to the delivery of healthcare where greater responsibility for the quality of patient care rested with clinicians, the Review aspired to provide frontline staff with greater freedom. The Review used the World Class Commissioning programme to emphasise the importance of clinician informed decision making.

The trend to place clinicians into more integral decision making roles within the NHS appeared to strengthen further with the release of the Coalition Government’s Health White Paper for England in July 2010. The White Paper initially proposed a system of GP-led commissioning groups to assume responsibility for the majority of NHS commissioning by replacing Primary Care Trusts (PCTs). By making clinicians responsible for commissioning and announcing a closer alignment of the NHS with a reconfigured system for public health the proposals sought to ensure the health needs of populations could be better met by their local NHS.

The proposals changed throughout 2011. Among the changes, the involvement of clinicians in commissioning was widened to include hospital consultants, public health representatives and other health professionals. The proposals were clearly significant for clinical leadership and their potential importance may not be limited to England in the long term. The impact of formally allocating responsibility to clinicians for some of the most fundamental health decisions is likely to be closely observed by policy makers throughout the whole of the UK.

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2 Joint Medical Consultative Council (JMCC) and the NHS Confederation. A clinical vision of a reformed NHS. 2007.
The formation of the National Leadership Council (NLC)\textsuperscript{6} in 2009 (since subsumed by the NHS Leadership Academy) and its programme of clinical leadership fellowships\textsuperscript{7} were visible examples to all in the health service of the increasing relevance of clinical leadership to a future NHS. The NLC also translated the Medical Leadership Competency Framework (MLCF) into a Clinical Leadership Competency Framework (CLCF)\textsuperscript{8} for all health professions. Intended to align with the work of professional and educational bodies, the CLCF placed an unprecedented emphasis on prospective leadership for the NHS.

Recognising the year to be one of considerable change for the NHS with renewed focus upon doctors as leaders, we thought it was an important opportunity to reengage with a sample of our members and gauge their concepts of and attitudes to leadership. Our discussions were broad ranging but included:

\begin{itemize}
\item participants’ definitions of clinical leadership;
\item the skills they considered most valuable to clinical leaders;
\item the barriers and enablers of clinical leadership within primary and secondary care and;
\item the role that education and training could or should provide to leadership.
\end{itemize}


\textsuperscript{7} National Leadership Council (NLC) Clinical leadership Fellowships. \url{http://www.nhsleadership.org/workstreams-clinical-fellowshipprogramme.asp}. (accessed December 2011).

Design of the study

Focus groups took place with BMA members between June and October 2011 with consultants, GPs, staff grade, specialty doctors and associate specialists in four UK locations; London, Leeds, Edinburgh and Cardiff. At each location groups with GPs and secondary care doctors were held separately to ensure that discussions were as relevant as possible to the widest range of participants in their field of medicine.

For the focus groups in England, members of the BMA’s Intouch Research Panel were invited to take part in the events. Panel members were invited according to their geographical region. To ensure a sufficient number of participants for focus groups in Scotland and Wales, a sample of consultants and GPs was obtained from the BMA’s membership database together with details for all staff grade, specialty doctors and associate specialists in each country. All invited members were asked to complete a brief online screening questionnaire describing any relevant interests or experience in leadership.

In the event that attendance at focus groups was oversubscribed, participants were assigned to groups according to sex, age and any experience of clinical leadership or medical management to ensure varied group demography. Overall, 70 doctors took part in our leadership discussions across the four UK locations.

Group discussions lasted approximately two hours and were conducted by one or two facilitators using a semi-structured script. In addition to note keeping, an audio recording of the session was made for later transcription.

The BMA Intouch Research Panel is a panel of approximately 8,000 BMA members from across medical specialties and BMA branch of practice.
What does clinical leadership mean to doctors?

“What leadership comes with vision. If you want to bring change in the best interest of your patients and doctors, that is what we do, our thinking process starts with patients. When it comes to the systems, making sure systems work in a set fashion is management.”

(Consultant, Leeds)

Overview

While the terms ‘clinical leadership’ or ‘clinical leader’ were considered by a small proportion of doctors as modern parlance or a reincarnation of ‘medical management’, most doctors identified a strong distinction between leadership and management.

Most participants believed that leadership can be shown by all doctors, particularly through leading by example. However, many doctors identified leadership as more readily associated with seniority and could be perceived as a criterion that precluded less senior doctors from satisfying leadership potential.

This may also reflect a perceived lack of leadership opportunities at the top of the medical profession or that such roles are relatively unattractive. Existing literature suggests there is little incentive for junior doctors to aspire to roles such as that of the medical director, given the significant increase in responsibility for relatively little reward, and perhaps more importantly there is no clear career path into and beyond such roles. A lack of clarity about leadership roles and lack of definition of clinical leadership has been described as contributing to keen individuals feeling the system is against them.

Worryingly, a King’s Fund survey of clinical directors found that many feel cut off from decision-making and planning processes, suggesting that the separation of clinicians and management may be present at all levels. However, in the same survey clinical and medical directors described confidence in their influencing, negotiation and communication leadership skills.

From among all of the focus groups there was a strong sense that for doctors to connect with clinical leadership then such leadership must retain a clear advocacy of patient interest. Expressed differently, the demands of clinical leadership or specific leadership roles should not divert doctors from their position as a patients’ advocate which is of vital importance to their role as a doctor and professional satisfaction.

10 NHS Confederation Reforming leadership development…again.

11 NHS Confederation Developing NHS leadership: the role of the trust medical director.

12 National Association of Primary Care Developing Clinical Leadership.

The importance of vision to clinical leadership was also a common theme. The ability to offer a vision to the widest audience within the health service including doctors, health professionals and non-medical managers was considered a quality that sets clinical leadership apart from management. Although visionaries may not exclusively be senior doctors, it was generally felt that to effect change and influence others, those in existing leadership roles or other senior positions are more likely to be successful among their peers. Recognised leadership roles were more likely to gain the authority of other senior professionals.

**Perspectives from doctors**

Inevitably in such a small sample of the workforce there was variation across all doctors in their definition of clinical leadership. For many doctors, initial views of clinical leadership were defined by their individual experience as doctors and any awareness of formal leadership roles within the health service.

Group participants did identify some clear differences between clinical leadership and management responsibility. Leadership was thought of as ‘doing’ and showing the way by helping to shape and manage clinical services for the better of patients and staff. Whereas a manager might be expected to regularly deal with relatively routine tasks, a clinical leader would also use their expertise and evidence to provide solutions to clinical problems. This view is also reflected in the wider management literature, and similar views described in literature looking at nursing leadership compared with management.

Within general practice, GPs identified their colleagues as clinical leaders if they were responsible for the design of clinical services, commissioning local services or clinical leads with responsibility for specific disease areas.

It was generally considered that leading by example should be encouraged at any level including ‘grass roots’ and should not be regarded as exclusive to the most senior hospital doctors, GPs or designated leaders.

“At three o’clock in the morning the FY1 is the clinical leader and they are on the ward, they are in charge of that patient’s care. Yes, they will ring me several times in the night to discuss it, but they are the leader. My registrar that is looking after 20 beds in the intensive care unit, he is the clinical leader for that intensive care unit. He has to manage the difficult nurses that say, ‘Oh no, you can’t have another bed’. He has had even less training in it than I have had.”

(Consultant, London)

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Similarly GPs commented that opportunities for leadership can arise through the delegation of responsibilities between GPs and clinical leaders should not solely be defined by their partnership status or otherwise.

“It was the young guy who was new into practice that was driving this forward and was taking the lead on this, and the experienced folks that were following him, bringing a little bit of wisdom and experience along with them granted, but you do not have to be the oldest guy in the practice to be the clinical leader.”

(GP, Scotland)

The ability to provide innovative solutions and fresh ideas, such as in service design, was acknowledged as a key difference from management responsibility. Innovation can transcend the hierarchical relationships which exist in hospital medicine and general practice and most doctors recognised this as important.

“I see my Medical Director’s role not as a medical leader as such, but as a manager and the clinical leadership comes from much further down – it comes from my level and it is about innovation and about developing services and keeping the current services running to the best effect.”

(Consultant, Leeds)

Whilst management and leadership were considered as different there was a general perception that management responsibility and seniority in its own right could be helpful to effecting change within the health service. Conversely, some participants, particularly hospital doctors, were of the view that while they were able to recognise leadership traits in many of their fellow colleagues they were concerned at a perceived lack of clinical leaders in responsible positions within their hospital or Trust.

“You know, a hospital ideally should have clinical leadership but in fact it has political leadership or financial leadership. The whole concept of what you do in the health service or in health care is driven by the clinicians rather than by anybody else. To me it is clinical leadership and I think there are very few examples of that.”

(Consultant, Cardiff)

Many focus group participants felt that most doctors possess a very high degree of innate professionalism and many of the skills that are helpful for clinical leadership. However, it was generally felt that such inherent skills were not enough to characterise clinical leadership. Clinical leaders were perceived as doctors who had the vision to see improvements to services or who were able to address limitations within the health system and share their vision with their fellow doctors. Longer term, doctors who were able to use influencing or change management skills were considered most likely to be successful in turning a vision into reality.

GPs were strikingly clear in their view that to be defined as a clinical leader it was most important that extensive clinical experience is maintained. Clinical leaders who remained “in practice” were perceived as more credible among their peers than those who were not. Whilst general practice is an
environment rich in varied expertise such as educational or medico-political leaders, most GPs were of the view that unless an individual remained in clinical practice they were unlikely to be considered a clinical leader.

It was felt that staying in touch with clinical issues through direct experience was crucial to ensure those in responsible positions understood the most important problems in health and remained focussed on the interest of patients and better able to represent doctors.

“I think it is important that you are in clinical contact with patients, otherwise you become disenfranchised from the people you are supposed to be representing – the practising doctors.”

(GP, London)

Most doctors commented on a degree of mistrust if the progression of colleagues into leadership posts was not perceived as transparent. It was a general view among participants that if doctors were to provide more clinical leadership to the highest echelons of the health service it was equally important that such opportunities are communicated and recruited transparently. Leaders perceived as being ‘hand picked’ led to feelings of alienation among their peers and a poor regard for their clinical leadership.

“We can’t really see them as a leader of us because we are not engaged in the selection process.”

(Consultant, Leeds)

In addition to transparency, GPs also placed considerable emphasis on the importance of clinical leaders being perceived as representative. GPs that were perceived as self-appointed or appointed without transparency were sometimes referred to as self-promoting or not the most appropriately qualified GP for the role.

GPs tended to be of the view that clinical leadership roles in general practice could be used much more effectively as channels to communicate the collective views of GPs on issues affecting clinical practice to other primary or secondary care organisations and those in health service management. There was a feeling that although general practice has a system of elected medico-political representatives, many GPs would value there being more delegates within general practice who are responsible for passing on a collective view to other groups. Some participants felt there should be more ‘servant leaders’ within general practice.

Generally, group members were able to recognise designated leadership roles elsewhere within the health service but perhaps unsurprisingly were generally less able to conceive of their own positions as exemplifying leadership. Even where individuals recognised their potential leadership qualities they were more likely to envisage encountering obstacles. From these early discussions, it was evident that many doctors require greater empowerment and confidence that clinical leadership has a real opportunity to influence the health service.
Summary

The meaning of clinical leadership to doctors

- Secondary care doctors and GPs identified a distinction between clinical leadership and medical management.

- Group discussions among secondary care doctors and GPs defined clinical leadership as skill-based, leading by example, innovative, clinically engaged, demonstrating expertise and providing vision to colleagues.

- Clinical leaders were considered able to gain the support and influence of colleagues and push forward ideas. For GPs in particular, remaining active in clinical practice was important to be defined as a clinical leader.

- All doctors described having a high regard for clinical leaders appointed in a transparent process. GPs particularly stressed a regard and desire for clinical leaders who were perceived as representative of general practice and the views of ordinary GPs.
What skills and attributes do doctors think are important for clinical leadership?

"I definitely think you need to remain credible, and that means my retaining at least some clinical work, because I do not want to be classed as going over to the 'Dark Side'.“

(Consultant, Edinburgh)

Overview
We asked doctors to describe to us the attributes and skills they believed were important for clinical leaders. We received a wide range of responses ranging from commonly acknowledged leadership and communication skills to attributes that were more specific to a clinical or medical setting.

Much of the content of our discussions with doctors was in broad agreement with the existing Medical Leadership Competency Framework (MLCF) particularly those paradigms focussed on ‘Demonstrating Personal Qualities’ and ‘Working with Others’. This was perhaps unsurprising as participants in our discussions were drawn to the personalities of clinical leaders and the way they should interact with peers. Such emphasis on the personal is probably not surprising for others reasons too. Our discussions touched upon some of the deeply held core values among doctors such as integrity and respect for others. Further, whilst it would be too simplistic to suggest that doctors viewed the discussions as a ‘wish list’ for an ideal leader, it was evident that negative perceptions of medical and non-medical managers were an important influence in shaping the views of participants and the attributes they sought most in clinical leaders. Nevertheless, doctors were generally positive about their potential contribution to leadership of the health service using attributes they associated with medicine and other health professions such as their ability to identify problems and explain the rationale for their decisions.

There were few differences in the attributes, skills and values considered desirable in clinical leaders between primary and secondary care doctors which was both a slight surprise and encouraging. The prominence of clinical leadership in NHS reforms in England led to considerable debate about the diversity of the clinical leadership required to support new structures, such as commissioning. Understanding that doctors across primary and secondary care expect similar leadership attributes could be an important step in focussing the profession.

Where some doctors were strongest in their view concerned the ‘clinical credibility’ of leaders. The importance of maintaining credibility among their peers has also been identified previously by some Medical Directors. By contrast other Medical Directors believe that clinical responsibilities can make the already high demands of their role excessive and are not necessary to demonstrate credible performance in the post. Nevertheless, maintaining clinical practice might be a practical advantage for those doctors who believe their credibility is threatened by pursuing such roles and would also keep open the prospect of a return to frontline care in future.

Differences between primary and secondary care doctors were subtle and related mostly to their clinical setting. GPs were likely to advocate that clinical leaders should provide a representative function for practices and GPs. Hospital doctors as a relatively diverse group of different specialties were more likely to want a clinical leader to support and defend their particular service, specialty or hospital trust.

**Communication skills**

It was most notable from our discussions with doctors across primary and secondary care that the communication skill almost exclusively mentioned was the ability of a leader to listen. The discussions relayed great frustration that doctors did not feel that they as individuals, or as a professional group, are listened to. Almost all doctors believed an important attribute of clinical leadership to be listening to the views and informed judgement of peers.

“Good leadership, whether it be clinical or non-clinical, is that horrible word – consulting with people and bringing them along with you. Above all it is not talking, it is listening. That is what good clinical managerial issues are about.”

(SAS doctor, Leeds)

Reflecting upon advice and occasional criticism was considered important in clinical leaders as a means of demonstrating they are prepared to engage with their fellow colleagues. Many doctors attached great value to the ability of leaders to admit to mistakes or failing ideas and change tack.

“You see people ‘doing humility’ and this is different from somebody being able to take a piece of criticism, reflect, and then act on it.”

(Consultant, Scotland)

**Political skills**

Some of the political skills most frequently mentioned as important in clinical leaders were the ability to build consensus among medical colleagues, negotiating and influencing skills.

These findings were significant for what they reveal about doctors themselves. Many doctors recognised that building consensus and consulting the views of the medical profession is often challenging even for colleagues with a medical background. Many doctors identified that negotiation, persuading and influencing skills were not integral to the role of every doctor and that it was unrealistic to expect all doctors to be proficient at them.

Most doctors valued an open and consultative approach to leadership although it was acknowledged that trying to reconcile a largely autonomous professional group with wide ranging interests was difficult, perhaps especially across the specialties within hospital medicine.

“It’s managing the diversity, because in a sense the diversity is our strength… if that diversity can be brought together it multiplies and has a good effect but if it is not then it can be a real drain.”

(Consultant, London)
The ability to reach concise and comprehensible decisions which can be explained among peers in a rational way was identified as an important attribute in itself but was also valuable to leaders in building their credibility and seeking to bolster support among colleagues.

There was also a fairly clear view among doctors that it was important that clinical leaders must be able to perform within a team rather than be insulated from one and delegate as appropriate. They should also be capable of taking personal responsibility for the decisions they make and be accountable for their outcomes.

**Clinical credibility**

Some of the attributes that doctors mentioned as paramount in good clinical leaders were quite specific to health and the medical profession.

One of the clearest priorities among doctors was that clinical leaders should possess ‘clinical credibility’ among their colleagues. This criterion was considered relevant to any doctor who wished to display leadership skills in their role but also applied particularly to doctors working in designated leadership positions. For doctors who had accrued extensive knowledge, experience and strong clinical skills upon appointment to such roles, it was considered equally important that they continued to maintain a clinical role and a demonstrable commitment to patients for as long as they occupy their position.

Throughout our discussions it became increasingly clear that ‘clinical credibility’ was crucial for doctors who seek leadership opportunities to achieve respect and authority among their peers. This was true of primary and secondary care doctors.

“I don’t think anybody can be a good leader if they do not have clinical credibility. You have to start off by at least being up with your peers, and that involves not overstepping the mark, and admitting that you do not know the answer.”

(Consultant and Medical Director, Edinburgh)

The majority of doctors believed that a commitment to being an advocate of patient interest should be at the heart of a clinical leader’s role in whichever field of medicine they worked. As a parallel to clinical credibility, maintaining patient contact and a substantial clinical responsibility was deemed ideal to enable doctors to understand the interests and concerns of patients. This in turn was also likely to enhance a leader’s reputation among peers.

“…you have to be the patient’s advocate and that is part of the role as a doctor, let alone a clinical leader…”

(Consultant, Leeds)
Personality, behaviours and moral values

Many of the attributes in clinical leaders that doctors were most quick to voice during our discussions were drawn from their positive experiences of working and training with colleagues who had impressed with their leadership skills. The discussions also gave strong indications of some of the core values held by many doctors.

Many doctors referred to the way in which good clinical leaders made them feel about both their attitude to their work and towards fellow professionals. Many doctors mentioned that good clinical leaders made them feel inspired by conveying passion or exuding a charisma. Superficially, many of these qualities are hard to define and translate into discrete skills. However, if we consider many of these experiences to reflect positive interactions with clinical leaders, then it is possible to identify many of the attributes and behaviours in leadership which are most valued by doctors.

Doctors recognised the need for clinical leaders to be resilient, determined and to retain a strong mental and emotional resolve when under pressure particularly as it is often fellow colleagues who can present the biggest challenge.

“(You need)...Very, very broad shoulders. You get it from both sides. There are my colleagues shouting at me, ‘Why can’t we have our clinical fellow?’, and the chief executive and colleagues shouting at me saying, ‘You should understand the corporate picture better. What are you doing arguing with me? You know I have got no money’.” (Consultant, London)

Doctors believed that clinical leaders should demonstrate enthusiasm and passion for their role and their wider profession as well as a cheerful disposition to see them through difficult times.

“That enthusiasm for what you do is important in being a good leader because you have to believe in what you are doing, to want to do it, and to do it well. I would therefore say that one of the attributes is staying power and sticking at the job, and also enjoying it and seeing a future for it. There needs to be a purpose for which you lead people.” (GP, London)

Many doctors told us that they believed to be an effective clinical leader you had to be able to help your colleagues to feel empowered in their own roles. Empathy was identified as an important means of learning more about colleagues, motivating them and getting the most out of the people around you but could be difficult to teach or learn.

It was abundantly clear during our discussions with doctors that there were several very strong values described as absolute pre-requisites for clinical leadership. Doctors expect integrity, honesty, and accountability for decisions made by clinical leaders. These were conveyed as ‘non-negotiable’ assets to providing good care to patients and positive leadership to doctors. These core values were clearly deeply held by all who spoke about them and reveal much about the factors that guide and motivate doctors in their daily work.
Summary

Attributes and skills for clinical leadership

• Communication skills – doctors valued clinical leaders who were able to listen and act upon the informed judgement of others.

• Political skills – Doctors acknowledged that they can be a challenging professional group with which other professionals must work and consult opinions from so it is vital that clinical leaders should be able to convey clearly reasoned and rational arguments.

• ‘Clinical credibility’ was considered essential for clinical leaders to achieve the respect of their peers and to continue to support the best interests of patients.
What are the barriers and enablers of clinical leadership?

Overview
Opinions on what were barriers and enablers of clinical leadership varied slightly with seniority and experience and between primary and secondary care.

Differences between doctors in primary and secondary care tended to reflect the distinction in their status that of independent contractor versus employed doctor, as well as the clinical setting. A lack of time was identified by all doctors but was most frequently cited by GPs where it was also associated with practice funding limitations and allocation of clinical responsibilities. Secondary care doctors were most likely to recognise the disparate nature of hospital medicine, the pressures of service delivery and relationships with NHS managers. A view of relatively poor access to leadership opportunities tended to be associated with differences in grade and among SAS doctors and sessional GPs in particular.

It was not unexpected that we received far more opinions on the barriers rather than enablers of leadership. This in part may reflect a feeling of lack of empowerment among doctors in addition to deeply embedded views on the factors they perceive limit their professional influence. Nevertheless, what was significant was that doctors both in primary and secondary care identified their fellow colleagues as being capable of acting as both barriers and enablers of clinical leadership depending on the circumstances. The example of colleagues highlights that in many cases barriers and enablers of clinical leadership are ‘two sides of the same coin’.

By hosting events in England, Scotland and Wales we were able to collect opinions from a wide range of GPs. Proposed NHS reforms for clinical commissioning in England did appear to have crystallised some views of clinical leadership among GPs in England particularly. These groups tended to identify perceived differences in opportunities for clinical leadership depending upon their involvement or non-involvement in early stage clinical commissioning and issues around the suitability of individuals already involved.
Barriers to clinical leadership

"I think the most important and challenging (barrier)...is the time management. It is one of the biggest problems we face being a clinician."

(Consultant, Cardiff)

Time, clinical pressures and resource allocation
Unsurprisingly many doctors spoke about the constant pressure to meet their basic clinical commitments and contribute to service delivery. Many doctors felt this prevented them from taking up new opportunities to become more involved in leadership or to reflect upon their clinical activity and provide new ideas. Whilst within hospital medicine it was generally recognised that leadership and management responsibility are not explicitly linked it was felt that those doctors with a medical management responsibility could find it at least as difficult as others to set aside time for innovation.

For most GPs regularly based within the same practice, this lack of time was most commonly a consequence of individual GP and practice workload and a need to negotiate time away from clinical commitments with their practice colleagues. For many GPs, they said they had experienced difficulty in justifying non-patient facing activity because of the workload consequences for their practice colleagues and/or the impact on practice finances.

"Partnership structure and willingness of the partnership to let somebody take on the leadership role outside the practice is a big issue..."

(GP, Edinburgh)

Negotiations with colleagues over the allocation of time for consultations with patients were often described as uncomfortable and unhelpful to the long term stability of practice relations. It was also important to note that not every GP would wish to reduce the time they spend in consultation with patients as they see that as absolutely paramount to their role as a doctor.

However I chose to do medicine for the patient contact, and that is the biggest barrier for me to doing any kind of management or leadership role within medicine

(GP, Edinburgh)

Autonomy, independence and diversity
Many doctors referred to the diversity of their profession and their autonomy as presenting a challenge for clinical leadership. Within hospital medicine a high level of professional autonomy combined with a relative lack of hierarchy was identified as a particular barrier. Whilst it was generally felt that highly skilled and responsible professionals are enormously valuable to their specialty there was recognition among hospital doctors that their status can be a deterrent to their peers providing leadership.
“There are inherent conflicts within the nature of the profession itself. We are trained to develop to be autonomists and yet the reality is we work in a system. There is conflict around autonomy and fellowship I think and I don’t think the medical profession has quite come to terms with that yet.”  

(Consultant, Cardiff)

Harnessing the diverse range of skills and knowledge which exist across secondary care was identified as a potential benefit of clinical leadership provided hospital specialists can develop a vision which is inclusive of other specialties.

“I would suggest that doctors are perhaps self-interested and I don’t mean just on their own, but maybe their own group of patients and you have to look beyond that.”  

(Consultant, Cardiff)

Many doctors outside of general practice might be tempted to think that the relative autonomy that GPs and practices have as independent contractors is overwhelmingly an enabler of clinical leadership. The responses from many GPs in our discussions suggested a more temperate attitude to autonomy. Many GPs cited a lack of coherence that can exist between GP partners and practices, thereby making effective leadership across the profession seem less achievable.

“…how can we be expected to drive the change because we have not defined in our minds exactly what change it is. All we know is that people are imposing change from outside and we are not really happy with that but we are not cohesive enough to define a change that we want to bring about.’ This is because of the traditional way that general practice works.”  

(GP, London)

**Availability of leadership opportunities**

Some partners and sessional GPs described their frustration that access to leadership opportunities was relatively limited due to the presence of existing post-holders or practice and area leads. Specifically, many commented that those in existing leadership positions may not be the best qualified, may not always have taken up such posts for the ‘right’ reasons and had in some cases acquired such opportunities by virtue of seniority or being in the later stages of their career.

“In my practice those people have already been involved for so long that there is no way that I could do it, because they have been doing it for so long – you don’t even ask! There is no opportunity because somebody has to see patients at the end of the day. It is the same old faces and they have done the same – they have been working for the PCT – it is just we need some fresh blood.”  

(GP, Leeds)
The absence thus far of a well defined career structure for GPs seeking opportunities in leadership was seen as a further limitation as many leadership roles were perceived as less visible than they could be. However, such a career structure within general practice was not realistic to all GPs who perceived that secondary care might be better placed to implement a more structured system of access to leadership posts.

“What you are saying is you need to have a leadership cadre within general practice and that is potentially possible within hospital practice because it is stable and you know how many consultants you have and what the structure is, but you can’t impose that on general practice.”

(GP, Leeds)

It was sometimes considered to be relatively more difficult for non-partner GPs to access opportunities or demonstrate leadership. Although some GPs recognised that not all sessionals wish to further their career in leadership positions, there was some concern that sessional GPs risked becoming an untapped resource. The development of clinical commissioning groups in England was cited as a particular example where sessinal GPs might not have access to leadership opportunities.

Non partner GPs were also more likely to describe difficulties in justifying time aside from patient consultations, not least because many practice-employed and freelance GPs will be contracted on a relative strict basis of a number of sessions per week principally for patient consultations.

Some SAS doctors described experiencing similar barriers to opportunities in secondary care. Negative assumptions about their interest in or suitability for clinical leadership was mentioned as counterproductive to an ethos of ‘shared leadership’.

“Our own perceptions within our own grade and other people’s too of what we are and what our abilities are can be real barriers.”

(SAS doctor, London)
Health service management

From our discussions with secondary care doctors it was very evident that some were highly critical of NHS managers, particularly those from non-clinical backgrounds. There were many individual examples of poor managerial relations and even notable hostility towards managers which other doctors were concerned could be deterrent to doctors putting themselves forward for leadership.

“Some of the language around here is quite pejorative about managers and pejorative about doctors who take part in management; that they lose sight of their clinical role; that they lose their integrity somehow, and whilst we think that, it is difficult to encourage the really bright influential, good people to engage fully in medical management.” (Consultant, Cardiff)

Many hospital doctors perceived short-termism in health service policies as the biggest cause of consternation rather than philosophical indifference to managers per se. A lack of consultation or rational explanation for policies and frequent change of priorities within secondary care was a major source of frustration and often led to disempowerment and a reduced appetite for clinical leadership.

“I don’t know whether in 10 years’ time that trust will still exist. Clearly I wouldn’t do the same kind of job exactly then as I would do now, or even know whether it will be in that hospital. That kind of professional uncertainty leads to a level of discontent generally.” (Consultant, Leeds)
Enablers of clinical leadership

“You need to have colleagues that value what you do, and perhaps value the fact that you have different strengths than they do, and that you should play to your strengths.”

(SAS doctor, Edinburgh)

Colleagues
Despite already having been identified as a potential barrier to leadership through their independence and autonomy, many doctors commented on the importance of the support of their colleagues. Most believed that their peers could make a big difference to the confidence of fellow doctors, boosting esteem and creating empowerment. Learning how to establish networks among colleagues could be a means of achieving this.

Among secondary care doctors it was felt that the support and leadership of peers in senior positions was a potential facilitator of clinical leadership. The nurturing influence of senior doctors such as existing Medical or Clinical Directors could set an example and reassure their peers about the value of their ideas to secondary care. Pejorative associations with NHS managers were a further incentive for strengthening peer support to potential secondary care clinical leaders.

“You need respect from the others within your organisation in order to enable you to do the best job you can – so you need respect from your Medical Director, for example, and encouragement.”

(SAS doctor, Edinburgh)

Many GPs identified their colleagues, particularly within their practice, as potential enablers of clinical leadership. Just as being unable to agree time for activities outside patient consultations could be a barrier, having the support of colleagues who are persuaded of the value of a broader range of interests both for the individual and the practice was a strong enabler.

“One of the practice GPs became a very respected GP trainer, and another became very involved in medical politics and so on, and this was actively encouraged because the senior partner felt that it was good for the practice to have an influence in what was going on…”

(GP, Edinburgh)

There was a noticeable difference in confidence and empowerment among GPs who felt they had the support of their practice colleagues. GPs that did not receive such support were less likely to be aware of or seek out new opportunities.
Experience

Experience and age were perceived by many GPs as important factors in the awareness of and access to leadership opportunities, particularly through increasing knowledge of primary care and the interactions outside the practice with other professionals. Whilst it was not always explicitly the case, being a GP partner was often referred to as at least as important as experience and age when it came to opportunities. It was commented that GP partners can enable opportunity for themselves and for others including sessional GPs. The role GP partners can play was particularly important in negotiating protected time for activity outside of patient consultations.

“It is something about mentorship; I got involved quite early because my trainer encouraged me to get involved, which is something you don’t see very often – encouragement by experienced individuals recommending young doctors to get involved or have some sort of shadowing.”

(GP, Leeds)

Hospital doctors with experience of a range of specialties in training and as a qualified doctor could find their broad knowledge of secondary care helpful in identifying opportunities for clinical leadership. Although such ‘portfolio’ careers might be more relevant to doctors below consultant grade, understanding the role of others and how to achieve influence across secondary care was identified as valuable by a wide range of participants in our discussions.

“I feel I have got a much wider general experience than many people who are growing up now; they specialise early, they do all the right things and they go along very successfully up a narrow path, whereas if you are somebody who has done a hotchpotch of different things and worked in different trusts, you have a greater experience in terms of how other people work together.”

(SAS doctor, London)

Being a generalist

GPs considered being a generalist to be more of an enabler than a barrier to clinical leadership. The experience that GPs accrued during their training, including familiarising with the secondary care system, was identified as an advantage. Similarly, there was a view among a significant number of participants that, as frequent decision makers, GPs were primed for clinical leadership.

“(you are working with four people in a profession as a general practice who have to make decisions every ten minutes. We get trained to make decisions.”

(GP, Edinburgh)

While many GPs tended to look to the experience of their colleagues within their practice for advice on professional issues; the overwhelming majority also remained firmly guided by the interests of their patients. The regular contact that GPs have with patients from across their local population was considered an important strength for GPs’ clinical leadership skills ensuring that GPs are able to offer informed judgement about the impact of a wide range of health policy and patient concerns.

“(we have feedback every day from what the patients say”.

(GP, Edinburgh)
The current economic climate and the NHS

Although some doctors in our discussions held the view that the financial constraints within which the NHS must operate for the foreseeable future could stifle clinical leadership there were others who perceived the present time as an opportunity. This view, although not held by all doctors, might appear to contradict our earlier discussions which elicited considerable dissatisfaction at instability among NHS management and policy. Nevertheless some doctors in secondary care perceived a need for greater clinical input in implementing reforms and efficiencies which in turn could enable doctors to innovate and drive changes within hospital services.

“Current existing systems not performing well can be a catalyst for someone to take a leadership role.”  
(Consultant, Leeds)

Summary

Barriers and enablers of clinical leadership for doctors

• A consistent barrier to clinical leadership mentioned by all doctors was a lack of time and resources with which to meet existing clinical pressures. These competing pressures may manifest differently for GPs who must negotiate protected time with practice colleagues and hospital doctors whose contract of employment will limit their non-clinical activity.

• Competing interests within an independent and autonomous professional group can create a challenging environment for leadership. The diversity of hospital medicine, the status of specialists and challenges in achieving consensus among GPs was deterrent to clinical leadership.

• Perceived poor access to leadership opportunities may alienate some doctors and for GPs could be compounded by a poorly defined career structure for clinical leadership within general practice.

• Achieving the support of peers was considered most likely to empower doctors for clinical leadership. Designated clinical leaders in secondary care and senior GPs within practices have a role to play in encouraging their colleagues and promoting clinical leadership.
The role of medical education and training in clinical leadership

“We... most of us probably can remember someone about whom we thought ‘I want to be a doctor like that person’.”

(Consultant & Medical Director, Edinburgh)

We asked GPs and secondary care doctors about their recollections of their undergraduate medical training and any relevance they felt it had to clinical leadership in a modern health service. Additionally, doctors were asked to consider the usefulness of their postgraduate and professional training as a preparation for leadership.

Undergraduate medical training

GPs and secondary care doctors were generally unable to recall discrete taught skills they considered particularly relevant to leadership within their pre-clinical medical undergraduate curricula. There were references to some of the skills and attributes previously identified as valuable to clinical leaders and these tended to be centred on clinical or diagnostic skills and problem solving. Although the medical school environment performs a vital role in building upon some of the core values and behaviours which are central to being a doctor it was slightly surprising that relatively few participants recalled their relevance to leadership. This may in part reflect the elapse of time as most participants in our discussions graduated in medicine ten or more years ago. It may also indicate deep rooted concepts of leadership whereby even after considerable prior discussion participants remained more likely to conceive of the relevance of leadership specific training rather than some of the inherent skills they had begun to learn in medicine.

Some participants remarked that medical school was a good place to begin to learn about the importance of collaborative team working but only with fellow medical students. Most doctors were of the view that it was only possible to learn to work closely with other health professionals by gaining the direct experience of doing so after entering initial hospital training.

Many of the doctors in our discussions also felt that medical school may not be the best place to begin to introduce formal or taught leadership skills as there was a belief that traditional methods of medical undergraduate training remained most important. Some doctors were also of the view that if undergraduate training were to incorporate taught elements of leadership it could stifle individual development or become merely an aspect of training that individuals were obliged to partake in but without appearing to grasp its relevance.

“(We)...are involved in foundation training and one of the real challenges when you teach some of these generic skills, they don’t understand and it seems irrelevant to them. They want to learn about chest pain, because that is what is relevant to them day to day. So although we can see the relevance now, it is with the value of hindsight so in order to integrate it, it has got to be seen to be relevant so there need to be tangible examples of how they use that and how it is meaningful. That is more difficult.”

(Consultant, Cardiff)
In slight contrast to specific skills or curricula, doctors were more able to refer to the leadership qualities of inspirational tutors and colleagues in their time at medical school. In this respect it was felt that individuals possess an ability to demonstrate the value of leadership to others in a way that a curriculum rarely can.

**Postgraduate medical training**

The leadership skills and training that doctors identified having experience of after qualification were sporadic at best and was generally dependent upon the ability of the individual to seek out new opportunities for themselves. Relatively few if any participants in our discussions described being offered training by colleagues or employers on what they regarded as leadership specific courses. The exceptions tended to be doctors in existing leadership orientated roles within their Trust or primary care organisation.

Some secondary care doctors identified the potential benefits of other forms of professional training such as networking and influencing skills in order to be able to increase their influence among NHS managers.

> “As a leader you are expected to articulate things on behalf of your clinical group in foreign places, like finance meetings and strategic planning, so you need to understand their language.”
> 
> (Consultant and Medical Director, Edinburgh)

Some GPs commented that professional and leadership development could depend heavily upon the start an individual makes to their career in general practice. If a GP is supported by their practice colleagues in seeking to broaden their experience then their opportunity for development could be greatly enhanced. Similarly, much could depend upon the practice in which a GP undertook their training. An influential trainer and a supportive practice environment could do much to promote the development of leadership potential for GPs by demonstrating the value of leadership and providing relevant experience.

> Speaking from my own experience it is taking opportunities when they come to get out of the practice and do different things. That is what I have found to be beneficial. If you stay just looking inwards, then you never learn to do anything bigger.
> 
> (Sessional GP, Leeds)
Summary

Medical training and leadership

- Most doctors had difficulty in recalling elements of their pre-clinical medical training and any relevance to leadership development but were more able to identify the leadership qualities of inspiring individuals.

- Doctors believed that attempts to include leadership concepts in modern pre-clinical training should be properly described and relevant to applied medical training.

- Relatively few doctors had experience of leadership specific training post-qualification. Some secondary care doctors expressed interest in developing their networking and influencing skills.

- For GPs, leadership and professional development depended on whether their practice environment was supportive and the ability of the individual to proactively seek out opportunities.
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